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Deinstitutionalization of children in residential care facilities: Experiences and perceptions of professionals in Ghana

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Abstract

According to the literature, the success of deinstitutionalization (DI) practices in low- and middle-income countries (LMICs) is dependent on key factors including, a well-functioning family-based alternative care and social protection system, adequate funding and resources, and professional and other stakeholders' engagement and support. Following a practice research qualitative method, the study explored practitioner's experiences and perceptions on the status of Ghana's ongoing DI efforts and their recommendations for improving implementation. The study's main themes were establishing the need for residential homes for children (RHCs), RHCs not being an ideal family environment and RHCs as respite. Family marital problems, poor financial situation, stigma attached to some children in care, abusive parents and a lack of suitable alternatives when families have a crisis were identified as key factors that impede DI implementation in Ghana. The findings suggest the need for a progressive approach towards DI implementation in LMICs, with the first step being the re-positioning of RHCs as respite care centres while progressively developing other alternative family-based care options (such as kinship care) for children.

KEYWORDS
alternative care, deinstitutionalization, family-based care, Ghana, residential homes

1 | INTRODUCTION

Globally, millions of orphaned and vulnerable children (OVCs) are without parental care or in need of care because of poverty, social deprivation, parental death, child illness and disability, child maltreatment, harmful cultural practices, and disasters (Martin & Zulaika, 2016; Yousafzai, 2020). For example, caregiver deaths due to the recent COVID-19 pandemic resulted in an estimated 10.5 million children becoming orphans (Hillis et al., 2021). Many of these OVCs live in low- and middle-income countries (LMICs) in South and East Asia, Eastern Europe and Sub-Saharan Africa where the majority are housed in institutions, also called orphanages or children's homes. Most of these institutions are funded and run by religious and private organizations and are not registered with the appropriate licensing agencies (Ainsworth & Thoburn, 2014; Martin & Zulaika, 2016).

Based on the United Nations Guidelines on Alternative Care (UNGAC, 2010), alternative care should be provided through family- and community-based care options, such as foster care and adoption, rather than large-scale institutions, particularly for children under 3 years old (Davidson et al., 2016). Quality residential care, provided in small family-like settings, could serve as a measure of last resort for specific groups of children. UNGAC's recommendations are based on a large body of research evidence showing the negative effects of institutionalization on children's general well-being, health and developmental outcomes (van IJzendoorn et al., 2020).

Over the last two decades, Ghana, along with a number of LMICs, has redesigned its childcare system with a focus on deinstitutionalization, which has become a global norm in alternative care for children (Frimpong-Manso, 2014; McTavish et al., 2022). Deinstitutionalization (DI) refers to the policy of dismantling or reforming large institutions

in favour of family-based and family-like care for children in the community (Goldman et al., 2020; Terziev & Arabska, 2016). Despite some achievements, DI implementation in Ghana has been slow, with the number of residential homes for children (RHCs) reducing from 148 in 2006 to 139 in 2019 (Ghana DSW & UNICEF, 2021). Ghana's challenges in meeting DI-related objectives have received scant attention in research, particularly from its practitioners. This study explores practitioners' experiences and perceptions of the status of Ghana's ongoing DI efforts, and their recommendations for improving DI policy implementation. The study was guided by the following question: what are practitioners' experiences and views on Ghana's DI implementation process? As key frontline stakeholders in DI implementation, their experiences, feedback and views are vital to developing effective and sustainable on-ground actions and strategies to achieve DI goals in Ghana as well as providing key lessons for other practitioners and policy-makers other LMICs.

2 | LITERATURE REVIEW

Several LMICs and Eastern European countries have embarked on the journey of DI to varying degrees, with countries like Rwanda and Georgia making significant strides at improving children's access to family-based alternative care through reductions in the number of RCIs (Kanyamanza & Nsabimana, 2023; Greenberg & Partskhaladze, 2014; Ulybina, 2020). Though variations exist in different contexts, the countries that have achieved success have done so through strong political will, a well-functioning family-based alternative care and social protection system, and adequate funding and resources. However, DI has been proven to be a complex and challenging policy area to effectively programme and implement in many other LMICS (e.g., An & Kulmala, 2020; Bindman et al., 2019; Forber-Pratt et al., 2020; Rogers & Karunan, 2020). Even though many of the LMICs are not prepared or ready for DI, there is pressure from parties (e.g., the European Union) to show their compliance with international child laws (Fronek et al., 2019; Petersen, 2018). As a result, some LMICs manipulate their statistics to suggest a reduction in residential care for children while they still remain the dominant form of alternative care (Babington, 2015; Bogdanova, 2017; Lizarazu, 2018; Nordin, 2015).

In some instances, DI also results in children being pushed out of residential institutions and into family-based settings without enough social worker monitoring and supervision (Petersen, 2018). The areas to which children return frequently lack adequate protection and support services. This circumstance may have unintended repercussions and negatively impact deinstitutionalized children. Many of them face an increased risk of mistreatment and disruptions to their educational and social networks, raising concerns about the quality of care provided to children in family-based care and increasing the risk of re-institutionalization (Lizarazu, 2018; Nordin, 2015).

Most LMICs lack foster carers or adoptive parents due to cultural prohibitions against caring for unrelated children, lack of education on alternative care options and resistance from those with vested interests in maintaining the status quo (Frimpong-Manso, 2014; Nayar-Akhtar, 2018). Researchers (Harlow, 2021; Hoffman, 2021; Islam & Fulcher, 2021) also note that the difficulties associated with developing foster care and adoption in LMICs is because the theories that inform DI processes, for example attachment theory, promote nuclear families' individualistic values (Harlow, 2021). These concepts or theories, critics argue, are often incompatible with collectivist ideas prevalent in LMICs, where child circulation and fosterage in the extended family, involving multiple attachments with different adults, are common. This results in limited ownership of DI interventions among the populace in many LMICs.

A lack of investment in alternative care, as well as infrastructure to support and oversee these placements, frequently contributes to these difficulties (Petrowski et al., 2022). Examples from some post-Soviet LMICs have, however, demonstrated that funding availability can be a significant enabler of DI efforts (Greenberg & Partskhaladze, 2014). DI implementation, especially during the transition phase, requires substantial resources (Hunsley et al., 2021; Wilke & Howard, 2022). However, most LMICs lack access to such funding, which is sometimes double the regular budget (Nordin, 2015). It is expected that the closing of residential care facilities would free up cash for family support and foster care. However, in the LMICS, this is unlikely to occur because residential care is funded by benefactors who may stop donating when the care model shifts to family-based options, affecting DI efforts' long-term sustainability (Frimpong-Manso, 2021b; Islam & Fulcher, 2021; Wilke & Howard, 2022).

Although many LMICs have made some commitment to DI, implementation of DI is influenced by stakeholders' perspectives. These stakeholders, such as practitioners, nongovernmental organizations (NGOs) and policymakers, frequently hold opposing views or interpretations of what DI should be, including framing DI from a human rights and cost efficiency perspective (Ulybina, 2023). Some stakeholders advocate for the urgent abolishment of all residential facilities (Abdel Aziz, 2021; Miseki, 2018) whereas others favour the gradual abolition or marginalization of residential care (Goldman et al., 2020), with some favouring the strengthening of small family-like facilities as the solution to DI (Islam & Fulcher, 2021; Murthi & Jayasooriya, 2020). Conflicting views may prevent stakeholders from building a comprehensive DI implementation plan, including defining the most critical activities to undertake.

Addressing these issues requires a collaborative effort from policymakers, civil society organizations (CSOs), and the broader community. This may entail investing in training social workers and foster parents, raising awareness and education campaigns about the negative effects of institutional care, developing legal frameworks that prioritize family-based care and promoting DI through collaboration among government, CSOs and communities (Goldman et al., 2020; Raneesh & Mohan, 2020; Vadlamudi, 2018).

3 | ALTERNATIVE CARE FOR CHILDREN IN GHANA

The Children's Act, 1998 (Act 560) of Ghana sets forth the rights of children to grow up with parents and reinforces parental duty and

responsibilities to ensure their well-being. Like many developed countries, in the event of deprivation of parental care, a child falls under the protection of the state through the Department of Social Welfare and Community Development (DSWCD). The DSWCD can place a child in an RHC upon issuance of a care order by a Family Tribunal. The Act also sets forth the procedures for the approval and regulation of RHCs, fosterage and adoption under the mandate of the Ministry for Gender, Children and Social Protection (MoGCSP).

Ghana commenced reformation of its alternative care system in 2007 through the 'Care Reform Initiative' (CRI) led by the Department of Social Welfare (DSW) under MoGCSP with the aim of strengthening families' ability to care for their children, reducing the country's over-reliance on institutional care and strengthening alternate forms of family-based care. The reform was triggered by an audit that revealed a dramatic increase in the number of RHCs from 10 in 1998 to 148 in 2006 (Frimpong-Manso, 2014). It revealed that over 90% of RHCs were operating without a valid licence and did not meet the minimum standards outlined in the Children's Act, 1998. Notably, further evidence showed that over 50% of the estimated 4000 children living in these RHCs had at least one living parent, with poverty and other socio-economic pressures contributing to parental separation in most cases (Better Care Network & UNICEF, 2015).

As part of its wide-ranging care reforms, the Government of Ghana, with support from various development partners and CSOs, strengthened its domestic legal and policy frameworks on alternative care and developed a 5-year DI roadmap for the closure of RHCs in 2017, with the goal of reducing the number of RHCs from 130 to 64 RHCs by 2021. Several standards, training programmes and regulatory frameworks, including training programme for social welfare officers and introduction of a formal foster care programme, were developed to ensure quality alternative care system and to build the capacity of Social Welfare Officers (DSWOs) to lead DI efforts on the ground.

Despite the policy commitments and practical efforts to achieve objectives of the 5-year DI roadmap; close down RHCs from 130 to 64 by 2021, evidence from a national survey published in 2021, revealed that an estimated 3530 children were living in 139 RHCs. The findings suggest less than 10% reduction in RHCs since the CRI began in 2007 (DSW & UNICEF, 2021). The results revealed a majority of the 139 RHCs are privately run and supported by local and international donations, with only 30% operating with a valid licence (DSW & UNICEF, 2021). Efforts towards DI in Ghana have been impeded by the constant opening of new RHCs. Recent evidence has noted several challenges impeding the CRI, including the risk of re-institutionalization, and a lack of programmes addressing socio-economic determinants of family separation (Frimpong-Manso, 2021b; Frimpong-Manso & Bugyei, 2019).

4 | METHODOLOGY

4.1 | Study design

To inform future practice, this study examines stakeholders' (see Note [1]) perspectives in Ghana's ongoing DI. Consequently, practice-oriented research, also known as practice research, has been adopted (Uggerhøj, 2011). Practice research is an approach to inquiry that emphasizes negotiation and collaboration between practice and research (Uggerhøj, 2014). It asserts that researchers need to collaborate with professionals in the research process to properly implement a study's findings (Gredig & Sommerfeld, 2008). In practice research, the emphasis is on collaboration and the co-development of scientific knowledge. The data collection instruments were developed in collaboration with five practicing government social workers in line with the practice research methodology requirements. The approach focused on the research process, not the outcome. Consequently, social workers were involved in refining the research questions, creating the interview guide and data analysis. Traditional research approaches (such as grounded theory) are usually not developed in collaboration with practice.

4.2 | Setting and recruitment

Greater Accra and the Eastern regions, with high and low RHC numbers as of 2020, were chosen as study settings. On the basis of DSW records, we selected the district with the most RHC closures and the district with the fewest closures. This was to explore any nuances across the two settings. However, no differences in participants' perspectives from the two settings were discovered during data analysis. All social workers of the DSWCD, NGO personnel (if any) and RHC staff (managers and social workers) who work on DI within the selected districts in the two regions were eligible to participate in the study. Purposive sampling strategy was used to recruit study participants. To be chosen, participants needed at least 2 years' working experience with the DI process and the childcare system in Ghana.

4.3 | Participants

Twenty-five participants, aged 25 to 60 years, participated in the interviews. There were more females ($n = 17$) than males ($n = 8$). The participants included social workers from DSWCD ($n = 9$), staff from NGOs ($n = 5$) and managers and/or social workers from RHCs ($n = 11$). Except for two professionals from the RHCs, all the participants had considerable experience working on reunifying children with their families (ranging from 1 to 14 years' experience). Twenty-one of the participants either had a bachelor's or master's degree with the others holding a diploma. The majority of them ($n = 19$) had degrees in the human services field. This suggests that they are knowledgeable about working with vulnerable populations. The NGOs were mostly responsible for providing support to DSWCD and RHCs working on family reunification, either with relatives or through foster care.

5 | ETHICAL CONSIDERATIONS

The research received ethical clearance from the University of Ghana before data collection. This ensured that the study was conducted

according to ethical standards. Written informed consent was sought from all participants before interviews. The consent form explained participants' rights, such as voluntary participation, the right to withdraw from the study at any time and the right to ask that their data not be included in the study. Participants' rights to ask to have their interviews removed from the study were particularly stressed. This is because it was anticipated that some participants, particularly RHC managers, might hold strong opinions about the closure of RHCs. The participants were also assured that no identifying information would be used in reporting the data.

5.1 | Data collection and interview protocol

The participants were interviewed in-depth using a semi-structured format. As part of the practice research, the interview guide was developed in collaboration with social workers. It included sections on demographic information and the DI process, including facilitators, barriers and recommendations for improvement. Examples of key questions on the interview guide included the following: (1) Can you share with me your view about the progress Ghana has made with regard to achieving the targets of DI? (2) What factors and practices have influenced Ghana's success with DI? (3) What challenges are affecting the DI process in Ghana? (4) What are the 'opportunities' for deinstitutionalization in your view? Given its exploratory nature, in-depth interviews were preferred. It allows researchers to delve deeper into participants' experiences and enrich the depth of information through techniques, such as paraphrasing, probing and the use of culturally appropriate encouragers (Silverman, 2013). In-depth interviews require interviewer's to begin with casual conversations to establish rapport and ensure participants are at ease. Two research assistants who had completed their postgraduate studies in social work were trained to conduct the semi-structured interviews. With the consent of the interviewees, all interviews were conducted in English at various locations of the interviewees' choice. Interviews lasted between 35 min and 1 h.

5.2 | Analysis plan

The research assistants transferred each completed interview to the research team for immediate vetting and comments while in the field. Braun and Clarke's (2019) reflexive thematic analysis procedures were employed to analyse the narratives from the interviews. The analysis process included familiarization, assigning preliminary codes, searching for themes and patterns, reviewing themes, defining themes and reporting findings. The thematic analysis process provided the opportunity to identify common patterns in the data and report findings shared by most participants. Three main themes were identified, which represented the overall views of the participants. The subthemes clarified the main themes.

6 | TRUSTWORTHINESS MEASURES

Using a practice research approach has an element of natural triangulation as practitioners were involved in most parts of the research process. This suggests a form of 'implicit corroboration'. Essentially, the study purpose, interview guide and key themes for reporting were agreed upon with input from practitioners. This was to further ensure that study findings are relevant to practice, contributing to practice research goals. In addition, participants were given transcripts of their interviews to corroborate and provide comments. A weekly debriefing session was conducted among the researchers to discuss the study process, transcripts and findings. An agreement was reached on the final themes after consulting with the social workers involved in refining questions for the interview guide.

7 | FINDINGS

The three main themes—RHC is not an optimal family environment, the need for RHCs and RHCs as respite—represent the views of the participants on the country's DI process. Overall, the findings suggest that whereas most of the participants agreed that RHCs may not be appropriate for children's healthy nurturing and development, several challenges resulting in demands on RHC services from the RHC system were reported on an operational level. These included the lack of suitable alternatives during a crisis, financial burdens associated with foster parenting and family reunification, poor financial situation of families, the risk of re-institutionalization, the stigma attached to children in care, limited alternative care options for children with disabilities and the sheer magnitude of children left without parental care due to socio-economic issues such as poverty, marital problems and abusive parents.

7.1 | RHC is not an optimal family environment

Almost all participants were concerned about RHCs being the ultimate alternative care intervention. According to them, facilities should be reduced, and most RHCs should be closed. This is due to several identified problems that could harm children living in these facilities. The NGO and DSWCD participants were more forthright in their remarks about RHCs' shortcomings as a childcare option. According to them, many RHCs only 'care about making money, not children's well-being'. There is a limit of 30 children per facility as per the National Standards for RHCs in Ghana (Ghana DSW and UNICEF, 2018). However, this requirement was often exceeded because facilities 'piled up' to attract donor funding. One social worker commented on the financial motive behind some RHCs:

> Almost all children have their parents alive. The real orphans are very few. So, people set up homes as

> orphanages and solicit funds to keep children. Even though there are rules and regulations, they operated anyhow.
>
> *(SW7)*

An NGO worker added that children within RHCs are often not orphans:

> Most orphanage homes and the children assigned to them are not orphans. So, they encourage the government, with UNICEF's support, to do something about the number of children in those homes.
>
> (NGO5)

It is already a challenge to meet children's individual needs in an RHC. Thus, the situation worsens when the number of children sent to the RHC is more than the existing facility can handle. In addition, private RHCs have a high percentage of children with living parents in their care. The RHC managers argued that even though each facility could accommodate 30 children, DSWCD sometimes expected them to admit children into their facility.

> Social welfare says per the standards you're supposed to have a maximum of 30 children but there are situations where the home is full, but they still give us the child, and it comes with a lot of work.
>
> (RHC4)

7.2 | Establishing the need for RHC

Majority of the participants agreed that the RHCs were needed despite the challenges and ongoing DI efforts. Their services are in demand, especially for children in vulnerable situations. According to them, in emergency circumstances (e.g., severe child abuse), DSWOs decide to resort to an RHC due to the child's urgent protection requirements and the lack of accessible family-based alternatives:

> When a child is being cared for badly by their family or even beaten, it is not safe to keep them with them. So, we [social workers] use orphanages as alternatives while talking with the family to settle the problem.
>
> (SW8)

Most districts had foster parents' shortages according to interviewees. They claimed it was difficult to place children with the current pool of foster parents because the state did not provide financial support for foster parents. Many people were hesitant to take on this role because of the financial responsibilities involved. Furthermore, many foster parents selectively chose the children they took in. Most of them were uninterested in children with disabilities or older children due to the high costs of caring for them or difficulty controlling them. According to the participants, these challenges made RHCs a suitable alternative for some children:

> Placing children with deformities is challenging. Foster parents' readiness to accept these children is another problem because they are selective. The reason is that social workers do not give foster parents resources to cater for such children. This is why they look for certain characteristics in the children they want to care for.

Several biological families refused to take their children back. Families often saw their return as a burden due to difficult financial circumstances. Mental illness, stigma, the belief that the child would be better off in residential care than at home, and marital troubles all prevented family reunification. This made the child's return home unsuitable.

> We cannot even reunite. Families are not willing to take children back because of challenges. They have problems taking care of their education and medical bills, and all that.
>
> *(NGO2)*

A social worker added that family poverty is another reason why reunification is difficult for disabled children.

> If the family is not financially stable, the child may go back to the streets. So the parent will say even though this is my child I don't want to take him back now because I'm not ready.
>
> (SW1)

Interviewees say 'families' were unprepared for reunification and foster care. When they encountered such reluctance from families, the 'simplest' solution was to keep the child in the RHC until alternate choices could be explored. This circumstance resulted in the inability to close several substandard or unregistered institutions:

> They [social workers] cannot find a new home for the children when you close down. Nobody is ready to take any child. If nobody is taking any children, where do you send them to, before you close the RHC?
>
> (NGO)

Participants said RHCs provided a valuable temporary space and pathway for social workers to interact with families. In addition, they provided counselling and other services for the children. Participants were, however, concerned about this. Although they subscribed to DI principles, they were forced to place children in RHCs or keep them there longer than necessary. It implied that proper processes were not followed in determining the suitability of placement for the child. It also implied that there was a lack of suitable alternatives.

> When an NGO brings you a missing child in late evening, you know it's outside office hours and things have to be done quickly. And we don't have the resources to move quickly to trace family members, so we need to find shelter for the child at that moment.
>
> (SW3)

Actions by law enforcement agencies and social welfare officers can impede RHC closure. These professionals place children in homes that are closed. One social worker shared the following:

> Even if the RHC is unlawful (i.e., ordered to be closed), the police will simply push the child there because there are no other options. The facility will remain relevant as long as DSW [CD] continues to force youngsters there.
>
> (SW4)

7.3 | RHCs as respite

In the absence of family-based alternatives, the participants opined that RHCs should be considered a place where children can take a break from 'adverse' or 'unsuitable' family situations. The plan for these RHCs is to serve as temporary shelters for children without adequate family or parental care. While children stay in the RHC, practitioners work with families or other relatives so the child can return to their community.

> We are not saying shelters are bad, but the kids shouldn't be there for a long time. They can stay for at least two months or three weeks or two weeks. They can move. The NGO [name of NGO] is now working on transitional shelter. Means you don't keep children over 3 months at that place.
>
> (NGO6)

Another RHC manager reiterated the need to restructure RHCs into respite or transitional shelters:

> We want to place the child temporarily here. I have cases like that. Since the child has been abused, we have removed them from their family environment in their best interest. And the child will be here for a while until the situation is solved and they return the child.
>
> (RHC7)

The participants understood that RHCs should not be long-term homes for children. The primary focus should be on reunifying children with families or placement in familial settings. However, some argue that there are other children for whom the RHC could be a permanent place. These were about children with severe disabilities who are abandoned by their families. For example, one participant caring for children with cerebral palsy for 3 years mentioned how they had not done reunification in years.

> The man said it was a curse to be with the mother of a child with cerebral palsy. As a result, no one wants to buy things from her when she is with the child. As a result of that pressure, she dropped the child with the father's family members. They also denied the child. So, social welfare brought the child to us.
>
> (RHC4)

A majority of the participants agreed that the DI process should be progressive in order to allow opportunities for improving the structures and related systems in the future. Apart from closing some homes, RHC managers stated that national standards must be met by those in operation to achieve minimum care quality:

> My recommendation is that deinstitutionalization is a process. It is good for the children to return to their families; the children live in smaller units, but it should be a gradual process so that we are not sending them to hell. Additionally, if the children return to their families and the same story plays out, then our country has not accomplished any work. We take it one step at a time, and we should look at our country—it is developing. We have many people in poverty.
>
> (RHC1)

8 | DISCUSSION

The current study investigated the perspectives and concerns of key professionals in Ghana's child protection system regarding the current status of the DI process. The stakeholders' responses suggested that, despite DI, there had been no drop-in residential care because it remained the most effective alternative care solution. They, however, raised concerns about the use of RHCs because, in their view, they caused harm to children because most were run for the benefit of the adults managing and supporting them rather than in the children's interests. According to research, RHCs in LMICs are a lucrative business, attracting generous funding from donors and resulting in child trafficking and abuse (Frimpong-Manso, 2021a; van Doore, 2016).

Despite this, participants felt that the limited availability of alternative family-based care options in the country inevitably resulted in a strong demand for RHCs at the service provision level. According to them, residential care was the most realistic and accessible option for children without parental care, especially in high-risk cases or emergencies. This narration corroborates findings in other LMICs such as Azerbaijan, Thailand and South Africa (Huseynli, 2018; Petersen, 2018; Rogers & Karunan, 2020) where residential care is identified as the most realistic and convenient option for children without parental care. Indeed, further evidence showed that, like

Ghana, these LMICs (Azerbaijan, Thailand and South Africa) are also struggling to develop quality family-based care, particularly foster care, to meet the demand for deinstitutionalized children (Huseynli, 2018; Petersen, 2018; Rogers & Karunan, 2020). These struggles are mostly attributed to cultural barriers (e.g., fear of caring for unrelated children) and limited ability to provide financial allowances to foster carers (ibid). Collectively, the findings suggest that developing quality and adequate family-based care option is a necessary condition to achieve the goals of DI.

Because of the challenges of establishing non-relative foster care in LMICs, several writers (e.g., Harlow, 2021; Islam & Fulcher, 2021) believe that these nations should place a greater emphasis on kinship care in providing family-based care for children in the alternative care system. However, the outcomes of this study show that creating familial care as a formal care alternative may be more difficult than previously thought. The study discovered that biological family members and foster carers are hesitant to take responsibility for vulnerable children in the absence of monetary assistance. This is due, in part, to the financial duties or burden of childcare, as well as the low socio-economic condition of many Ghanaian households. These findings support previous research indicating poverty is a major motivator in DI and the reunion processes involved in DI (Fernandez et al., 2019). Given that poverty is the major cause of child institutionalization in LMICs (Browne, 2017), many of the children in Ghana had living parents, according to the participants. According to the findings, social workers may not give family support services to vulnerable families, particularly children in care, in order to improve their caregiving ability. As a result, social workers must address issues such as poverty, which may prevent potential kinship and foster carers from accepting deinstitutionalized children.

The participants blamed the lack of family-based care alternatives on Ghana's inadequate and under-resourced social service staff and system. Although this finding is not entirely novel as other LMICs face similar challenges as a result of their workforce lacking the necessary skills and knowledge to support families and carry out other DI-related tasks (Horvath et al., 2019; Hunsley et al., 2021; Raneesh & Mohan, 2020), this study adds another dimension to the existing literature by identifying the issue of workforce availability. When financial, human resources (feasible social workers) and logistical constraints exist, even highly trained and skilled workers may struggle to implement DI. The lack of essential logistics such as vehicles to undertake family tracing for family reunification and sensitization of prospective foster parents may affect DI successes even if spearheaded by highly trained social workers. Essentially, the impacts of logistic and financial resources on DI processes underscore the need to look beyond DI as a separate child welfare initiative, instead address how structural factors (i.e., poverty) impact on DI and childrearing in developing countries. In Rwanda, the strategy used to resolve a similar issue relating to the workforce was to train and resource local volunteers in an evidence-based strategy to provide education and support to caregivers who reunite with children from institutional care (Hunsley et al., 2021).

Given the budget constraints under which DI is being pursued, stakeholders proposed a phased transition process. The DI process, according to them, should be progressive and paced in such a way that it balances the closure of inferior RHCs with attempts to improve family-based alternative care alternatives. Due to a lack of preparation for children and their families, a rapid reunion of children could potentially result in their re-institutionalization. As other researchers (Fronek et al., 2019; Goldman et al., 2020) have recommended, the process, timing and phasing should be set at a realistic pace and based on comprehensive assessments of children's needs and rights. As suggested by the participants, these RHCs should be utilized only as a temporary care option and a respite if no suitable family-based alternative care options are available. It has been suggested that RHCs be converted into more family-like environments in order to ensure optimal care. It has been shown that significant changes in RHCs (structures and caregiving) can improve children's social and developmental outcomes (Groark & Mccall, 2011; Julian et al., 2019). The implementation of DI should be sustainable and gradual, reducing the risks of a hasty implementation and unrealistic timelines (Fronek et al., 2019).

9 | PRACTICE IMPLICATIONS

Frontline service providers, according to the study, will continue to seek RHC services until Ghana establishes a robust and efficient family-based care alternative. Under Ghana's DI principles, stakeholders must take a phased approach to defining realistic RHC closure targets. This should be done to ensure no void or gap in alternative care options. There should be more emphasis on recruiting more foster parents and strengthening child reintegration preparation and services for vulnerable families. Among these services is helping biological and alternative families accept deinstitutionalized children by removing financial barriers (poverty). A reintegration programme for children placed in foster care or returned to their families should be developed by the government. Children's and families' financial needs should be addressed by these reintegration packages, particularly food and school supplies. Furthermore, practitioners should provide families with access to current social protection programmes, such as cash transfers from the Livelihood Empowerment against Poverty. Also, as suggested by other researchers, another plausible way of addressing poverty is to provide family-centred empowerment initiatives, particularly asset-management strategies like savings, which can improve families' economic well-being and facilitate family reunification (Ismayilova et al., 2014). In this way, children's fundamental needs can be met while reducing family strain, which increases placement sustainability.

Meanwhile, DSW stakeholders at all levels must continue to monitor registered facilities' adherence to national standards and identify new or unregistered facilities. Ghana should accelerate ongoing efforts to transfer major RHCs to family-based care settings. One of the most important tactics for easing this transition will be to

gain the interest of caregivers in RHCs slated for closure by educating and licensing them as foster parents. Specialized training, particularly for caring for children with disabilities, a particularly marginalized population of children in the alternative care system, can help such caregivers. As a result of their leadership position in monitoring alternative care, the MoGCSP should generate regular and reliable insights into the development of DI. In this way, they will be able to identify enablers and barriers in the transition to family-based care and to correct course as necessary.

DI efforts are time- and resource-intensive, relying heavily on a well-trained workforce (Goldman et al., 2020). Key national stakeholders, including the Office of the Head of Local Government Services (OHLGS); Ministry of Local Government, Decentralization and Rural Development; MoGCSP; and Ministry of Finance, should integrate to improve system efficiency, effectiveness and resource allocation for the social service workforce. OHLGS should hire more qualified social welfare staff for the DSWCD to meet minimum staffing benchmarks, especially in high-demand regions and districts. This will enable DSWCD staff to better cope with high caseloads and allocate more time to quality case management, including preparation and post-reunification follow-up visits for sustainable reintegration.

10 | CONCLUSIONS

A review of Ghana's commitment to achieve the targets of DI by closing down RHCs and unify children with families revealed a contrary finding showing that instead the number of RHCs has increased. We engaged key stakeholders involved in the implementation of DI in Ghana to learn about the progress of DI in Ghana, the barriers and facilitators. Evidence obtained from the stakeholders suggests that the DI process should be gradual and there should be balanced efforts towards the closure of substandard RHCs and measures to increase family-based alternative care options. Due to the hazards of re-institutionalization, hasty reunification of children to satisfy DI targets should be avoided, and interventions to prevent initial and recurring family separation should be increased. There should also be greater urgency to reduce RHCs. Those that exist should be small and family-like in nature and used only as a last option for the provision of temporary care of children. Though the findings are limited to the views and experiences of stakeholders involved in the DI implementation in Ghana, depth of the narratives and recommendations generated provide lessons from LMICs to streamline and re-strategize their DI process.

CONFLICT OF INTEREST STATEMENT

We the authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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ENDNOTE

[1] The term 'stakeholders' refers to practitioners in residential care work, including social workers and staff. It also includes children, policy-makers and other relevant individuals. The term 'participants' refers to individuals who participated in the study.

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