The 'Best Interest of the Child': Exploring the International Human Rights Norm as an Applied Standard in Residential Care Centers in New Delhi, India

By

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Thesis submitted in partial fulfillment of
the requirements for the degree of Master of Science in the Duke Global Health Institute in the Graduate School of Duke University

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ABSTRACT

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Abstract

Background: Although used previously as a function of the judiciary primarily in custody battles, the best interest of the child became an international human rights standard with the 1989 adoption of the United Nations Convention on the Rights of the Child (UNCRC) by the UN General Assembly. The 'best interest' standard has consequently been adopted and used in many State-level child protection polices, particularly in reference to orphans and separated children (OSC), in low and middle-income countries (LMICs), including India. However, little attention has been paid to how State-level actors, including policy stakeholders as well as direct caregivers of OSC, interpret and implement this standard in their local contexts.

Objective: This study's objective was to explore how the best interest of the child as a norm of international human rights is interpreted and applied to the care and protection of OSC in residential care policy in New Delhi, India.

Methods: We conducted semi-structured in-depth interviews and focus group discussions with two distinct groups: 1) Child Protection Policy Stakeholders and 2) Direct caregivers of OSC working in a multi-site residential care center (RCC). Policy group participants completed in-depth interviews about current child protection policies in India and their interpretation of the best interest of the child. Direct caregivers of OSC completed in-depth interviews and, for certain caregiver sub-categories, focus group discussions on their daily lived experience working with, and sometimes living with, OSC in residential care settings.

Results: Thirty-eight direct caregivers of OSC from one particular RCC in New Delhi took part in the study. Eighteen policy stakeholders, including government bureaucrats, policy researchers, child rights advocates, and directors of RCCs also took part. Interview results were grouped into 'key area domains', with three domains emerging per group. Ultimately, three

domains emerged for both groups: Resources, Accountability, and Approaches to Care. Distinct differences and similarities between the two participant groups were noted. All domains related to the attempt to construct the best interest of the child in RCCs in India.

Conclusion: Although a de jure standard, both internationally and nationally, the best interest of the child seems to be a de facto reality in India, especially as defined by direct caregivers of OSC. In this setting, the best interest emerged not as a standard that individuals and organizations held themselves to, but as a construct that was created and re-created based on, in particular, availability of resources, accountability mechanisms, and the way in which individuals approached caring for children.

Dedication

This research project is dedicated to the millions of children in India who experience the direct and structural violence of being orphaned or separated children. It is my hope that this project can add to a growing respect and use of empirical evidence in the protection and cultivation of the rights of these children.

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1. Introduction

This study explores the international human rights norm the 'best interest of the child' in the context of residential care centers (RCCs) in New Delhi, India. In the following section, we outline the emergence of this norm as an international de jure standard and then examine how it has been applied to children in need of alternative care in general and, finally, describe specific policies for this population in India.

1.1 Background

Establishing Global Standards: Best Interest of the Child in the Context of International Human Rights Law

The United Nations Convention on the Rights of the Child (UNCRC) occupies a unique place in the treaty history of the UN. The treaty received near-universal ratification (with the exception of the United States) and was enforced within months of adoption by the UN General Assembly, a procedural anomaly (Kaime 2011, Chiu and Charnley 2019). The Convention itself applies to "every human being below the age of 18 years" and includes 54 articles total, encompassing (1) civil and political as well as (2) economic, social, and cultural rights; two distinct bodies of human rights according to the UN (UN 1989). While the UNCRC is meant to define international norms concerning child rights, the treaty has been criticized for being heavily influenced by Western rights ideology and reaffirming international human rights norms, particularly children's rights norms, that may be at odds with traditional values and concepts of rights by non-Western nations (Kaime 2011, Chiu and Charnley 2019).

Although the best interest of the child is itself an independent article (Article 3) in the UNCRC, the language of the best interest of the child appears in six separate articles of the treaty

(UNICEF 2007). The best interest (hereby referred to as Article 3) has three sub-paragraphs of equal importance. The first, 3(1), states that:

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (UN 1989).

The use of "a" rather than "the primary consideration" or "the paramount consideration" as well as the inclusion of "in all actions concerning children" were much debated in the Working Group drafting the Convention (UNICEF 2007). Ultimately the above language was adopted to include actions or circumstances in which various parties may have "equal claims to have their interests considered" (UNICEF 2007). This differentiation is far from a mere lexical choice. In comparison to other uses of the "best interests" throughout the Convention, this wording does not refer to deciding appropriate action for children on an individual or case-by-case basis. Instead article 3(1) uses broader language to encompass situations where the interest of the child her or himself may not in fact be paramount when deciding what the best interest actually is. The only thing article 3(1) actually guarantees is that children's interests have been "explored and taken into account as a primary consideration" (UNICEF 2007). This effectively establishes a precedent in which the applied primary considerations, or deciding factors, taken into account when establishing best interests of the child may not actually be that of the child at all. For example, the availability (or lack thereof) of residential care may be the primary consideration when choosing to remove a child from one's home, rather than the actual physical or emotional safety of the child in question.

Article 3(2) then establishes obligation, particularly of States, to protect and care for children as well as to take into account "rights and duties" of parents and legal guardians when considering the best interest of the child (UN 1989).

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures (UN 1989).

Notably, article 3(2) specifically references "legislative and administrative measures" in reference to the State's undertaking the protection and care of the child (UN 1989). The Implementation Handbook for the Convention on the Rights of the Child recognizes that there are certain elements of "care and protection" which parents or legal guardians may be unable to provide for children and, in these situations, the State should serve as a "safety net" of sorts (UNICEF 2007). Critical readings of article 3(2) have also noted that the terms "care and protection" should be read "expansively" since there is no specific reference to protecting the child from negative experiences (i.e. harm) but is instead focused on the child's overall well-being (Alston 1991). Article 3(2) thus simultaneously affirms the State's obligation to provide care and protection for children, especially children without legal guardians, while not specifically deeming what this care and protection should look like.

Finally, article 3(3) states:

3. State Parties shall ensure that the institutions, services, and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision (UN 1989).

In the Implementation Handbook for the Convention on the Rights of the Child it is stated that implementation of article 3(3) would require "a comprehensive review of the legislative framework applying to all such institutions and services" and that "In institutions, widespread violence against children, both physical and sexual, has been uncovered in recent

years in many States, emphasizing the lack of appropriate safeguards, including independent inspection and effective complaints procedures" (UNICEF 2007). This assumes that an implementation of article 3(3) by a State would require not only major legislative restructuring, particularly if the State government does not currently have childcare and protection policies in place, but also sizeable monitoring and evaluation mechanisms, particularly in the case of institutions.

This brief analysis of article 3 brings up three major considerations that are relevant to this study:

1. The best interest of the child is not empirically defined but is referenced in other articles of the UNCRC.
2. It is up to States to determine the application of best interest when legal guardianship of children is unavailable or impossible due to resource constraints and it is strongly suggested they do this by legislative means.
3. The types of legislative reform that implementation of article 3 would require necessitate significant infrastructure both in terms of legal systems and enforcement and accountability.

In reference to the scope of this study, it is worth noting that while India became a party to the UNCRC in 1992, it did so with a reservation particular to article 32 regarding child labor, specifically paragraph 2(a) of the article regarding minimum ages for child employment (UN Treaty Portal: 2019). This reservation stated that the Government of India would undertake measures to "progressively implement" the provisions of article 32, rather than immediately implement them, due to the fact that "it is not practical immediately to prescribe minimum ages for admission to each and every area of employment in India" (United Nations Treaty Collections 1992). This is most likely due to the fact that, according to the most recent Indian census data,

there are 10.1 million children between the ages of 5-14 working in India (International Labor Organization 2017). This brings into question the applicability of certain articles of the UNCRC to India, whether because of cultural relevance or, in this case, awareness of economic realities.

In the context of institutionalization of OSC, we must consider Newton's (2017) point that we cannot assume a child is better off not in an institution in "care settings where poverty and violence are endemic". If the government of India itself recognizes ,as a party to the UNCRC, that the economic conditions of its country are such that a minimum working age for children may hinder economic stability for both families and/or individual children, then we must be forced to ask fundamental questions about the child's best interest in such a setting. Most relevantly, we must ask if there is a fundamental mismatch between the 'theoretical' best interest outlined in these high-level human rights instruments and the 'practical' best interest of children, particularly OSC in India. While a set of standards such as the UNCRC is an obvious prerequisite for any functional level of jurisprudence regarding best interest, there must be a recognition that said standards can only work effectively based on the factual reality of live in a given country; particularly the economic reality of said locale.

The International Best Interest Standard Applied to Orphaned and Separated Children: the Guidelines for the Alternative Care of Children

The UN General Assembly adopted the Guidelines for the Alternative Care of Children in 2010 to establish a framework for the provision of care for children who "are deprived of parental care or are at risk of being so" (UN 2010). The phrase "best interest" in reference to the wellbeing of a child occurs 57 times in the 23-page document. The Guidelines definitively reaffirm both the Universal Declaration of Human Rights as well as the Convention on the Rights of the Child (UN 2010). Several aspects of the Guidelines are pertinent to this study in reference to the case of OSC in institutional care in India as well as the UNCRC.

First, the Guidelines reaffirm the responsibility of the State to provide care and protection to the child in the event that legal guardians of the child are unable to provide adequate care or abandon and/or relinquish the child (UN 2010). Secondly, the Guidelines state that "All decisions, initiatives and approaches falling within the scope of the present Guidelines should be made on a case-by-case basis, with a view, notably, to ensuring the child's safety and security" (UN 2010). This could be read as being in conflict with article 3(1) of the UNCRC and its intentional definition of best interest as explicitly not a construct to be applied on a case-by-case basis. Thirdly, and perhaps most importantly, in article 2(3) the Guidelines posit that the "family is the fundamental group of society and the natural environment for the growth, well-being, and protection of children" (UN 2010). The Guidelines then go on to state that alternative care should effectively be a last resort of care for OSC and that "enabling the child to remain or return to the care of his/her parents, or when appropriate, other close family members" should be the focus of States (UN 2010). Finally, the Guidelines reaffirm article 3(2) of the UNCRC, stating that "States should take all the necessary measures to ensure that the legislative, policy, and financial conditions exist" for the provision of alternative care options for OSC if family or community-based options are not viable (UN 2010).

The Best Interest and OSC in India: Key Policies

Three pieces of legislation constitute the framework of child protection policy in India:

1. Juvenile Justice (Care and Protection of Children) Model Rules (Latest Revision: 2016)
2. The Juvenile Justice Act [Latest Revision: 2015]
3. The Integrated Child Protection Scheme [Latest Revision: 2014]

While the Juvenile Justice (Care and Protection of Children) Model Rules and the Integrated Child Protection Scheme outline the details of governance, administration, and, to

some extent, accountability of child protection mechanisms in India, for the purposes of this study, we will mainly discuss the Juvenile Justice Act.

The current Juvenile Justice Act (2015) is the cornerstone of Indian legislation surrounding the care and protection of children. It is preceded most relevantly by a version from 2000. The Juvenile Justice Act states its purpose as "catering to the basic needs" of two distinct groups of children: children in conflict with law and children in need of care and protection (CNCP) (Ministry of Law and Justice 2015). For the purposes of this study we will focus on procedures related to CNCP because it is this group, rather than children in conflict with law, who are eligible to live in the type of RCCs of interest to this study. The definition of CNCP includes 12 distinct categories including children who are found to be "in contravention of labor laws", children who are abandoned or separated from their legal guardians, and children who are "mentally ill", among others (Ministry of Law and Justice 2015). In practice, the main function of the Act is to define the key terms of child protection policy in India and to establish basic frameworks by which care and protection will be provided for both categories of children.

In reference to the best interest of the child, the most informative passage from the 2015 Act is in the opening, stating that the Act will cater to the basic needs of children in conflict with law and CNCP primarily:

> "…through proper care, protection, development, treatment, social re-integration, by adopting a child-friendly approach in the adjudication and disposal of matters of the best interest of children and their rehabilitation…" (Ministry of Law and Justice 2015).

The Act's "child-friendly approach" is a placeholder for the "competent authorities" in article 3(3) of the UNCRC, which are supposed to be the body which establishes standards of care for children (Ministry of Law and Justice 2015, UN 1989). The Act, however, finds itself in a definitional feedback loop, later defining a "child-friendly approach" as:

"Any behavior, conduct, practice, process, attitude, environment, or treatment that is humane, considerate, and in the best interest of the child" (Ministry of Law and Justice 2015).

The standards which article 3(3) of the Convention asks States to determine are defined only by the terminology of best interest without ever concretely stating what the best interest is. Essentially, in Indian policy anything that is in the best interest of the child is 'child-friendly', and anything that is 'child-friendly' is in the best interest of the child; but if the two terms are essentially equivalent, than neither can be actually substantively defined.

In accordance with the Guidelines to Alternative Care, however, the Juvenile Justice Act does state that institutionalization of a child is a measure of last resort, implying the primacy of biological family (Ministry of Law and Justice 2015). This further suggests that family settings are both child-friendly and in the best interest of the child, since we previously established these terms to be synonymous in this piece of legislation, and that institutions are the least child friendly and have the least best interest of the child in mind.

Interestingly, in a national study completed by a partnership of civil service organizations (CSOs) in 2019, entitled 'Child Rights in India: An Unfinished Agenda', the study authors found that, "Due to the large number of children requiring [alternative] care visa-à-vis the services available for them, institutionalization is still one of the main forms of substitute care" (Joining Forces for India 2019). This statement again puts the situation of OSC in institutional care in India in direct contrast with both national policies and the Guidelines to Alternative Care, which focus on the primacy of the biological family unit and institutional living as a last resort.

In the current study, our research aims were as follows:

1. Describe the child protection policy environment of New Delhi, India
2. Explore how care providers of OSC in New Delhi navigate the child protection policy environment as both informal policy interpreters and implementers

3. Describe how interpretations and conceptions of the best interest of the child in New Delhi vary between high-level policy stakeholders and low-level caregivers of OSC
4. Explore how these variations, both inter- and intra-group, may or may not affect ideas about child protection policy creation and implementation

While research has been done in India, particularly in Hyderabad and Nagaland and specifically about physical and mental health outcomes for OSC in institutional and family-based settings, there is a dearth of evidence concerning the way in which conceptions of child rights may affect both policy creation and implementation (Huynh et al. 2019, Gray et al. 2017, Escueta et al. 2014). There is substantive evidence showing that it is the quality of care for the unique, and often traumatic, experiences of OSC that relates to positive child outcomes than the care setting being institutional or family-based (Huynh et al. 2019, Gray et al. 2017). In addition, substantive research has been done to illustrate that there are neither inherent socio-emotional nor biological effects of institutional care on OSC (Wright et al. 2019, Slopen et al. 2019, Debnath et al. 2018). Thus, there is a need to shift the discussion from where children receive better care to how mechanisms of care (including care provision and accountability) are constituted and implemented.

Further, national policies and international treaties are important and helpful, but ultimately they are enacted at the local level. For this reason, it is essential to understand the local interpretation and implementation of such policies. Rather than comparing care settings or Indian policy against the ‘gold standard’ of the UNCRC, as has been done before (Neagu 2015, Panter-Brick 2002) in this study we sought to examine perspectives and implementation of child protection policy in New Delhi, India.

This study's focus is motivated by the previously discussed factors of the UNCRC and the Guidelines to the Alternative Care of Children that may be inherently problematic to the Indian context, as was acknowledged by the Indian government in their reservation to article 32 of the UNCRC. Through this study, we sought to explore the ways in which best interest and child rights are actually conceptualized and implemented both by policy makers and by caregivers of OSC. To our knowledge, a study focused on the perspective of both higher level policy stakeholders and direct caregivers of OSC in the context of the best interest of the child in institutional care for OSC in India has not been conducted and reported before. This study's approach to child protection policy via local and contextualized understandings of global standards of care established in international human rights mechanisms is unique. While monitoring efforts of childcare institutions by the Indian government are fairly robust, these reports only illustrate the empirical state of CCIs and the children within them. While extremely useful, such empirical data does not describe the child protection policy environment of India. National research has shown that in India, efforts towards deinstitutionalization (meaning the mass closure of CCIs and/or removal of OSC from institutional settings) have only "just begun" (Joining Forces for Children in India 2019). This effort, influenced by both the UNCRC as well as the Guidelines for the Alternative Care of Children, should be informed not only by international human rights norms but also by the context in which they are applied. A study illustrating this context, both at the policy formulation and implementation levels, has not been completed before in India.

2. Methods

Data were collected for this study in the New Delhi National Capital Region (NCR) of India between May 2019-August 2019. In this qualitative study, semi-structured in-depth interviews and focus group discussions were conducted with two kinds of key informant groups. Purposive sampling, described in more detail below, was used to recruit participants for two participant groups: 1) Child protection policy stakeholders and 2) Direct 'carers' of OSC. Due to the fact that the title 'caregiver' is a specific type of care provider within the staff structure of the residential care network of focus for this study, we will use the term 'carers' of OSC rather than the usual 'caregiver' of OSC that is the norm in the literature. In the context of this study, 'carer' will include all categories of staff that provide care for children within this residential care NGO.

2.1 Policy Stakeholder Group

Recruitment

The policy stakeholder group was targeted to obtain the most holistic understanding of the child protection policy environment of New Delhi and, more largely, India as a whole. Inclusion criteria for this group were: working in child protection for at least five years, working for a civil society organization or a government body directly related to child protection, and being in an upper-management or leadership position at said organization or government body.

In total, 33 potential policy stakeholder participants were invited at the outset of the study. Invitations for participation were based on inclusion criteria insofar as the research team was aware. Thirteen potential participants did not respond to multiple inquiries or refused involvement. Twenty participants responded and were consented. Two participants who consented did not meet inclusion criteria and were excluded from the study. In total, eighteen

participants were included and consented for this participant group sample of the study. Figure 1 outlines the recruitment process.

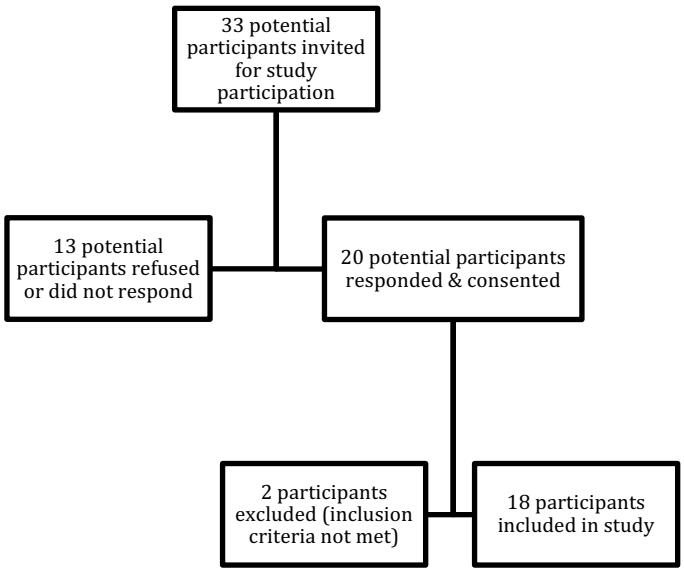

Figure 1: Recruitment procedure for policy stakeholder group

Sample Description

The makeup of the 'Policy Stakeholder Group' was intentionally diverse. Participants were chosen using purposive sampling, a "non-random" sampling technique used to obtain the perspective of a specific category or sub-type of participant (Robinson 2014), to obtain the most well-rounded sample possible. This included RCC directors and administrators, policy experts, government officials, policy researchers, and child rights advocates, all within the child protection sphere of New Delhi. Many of the members of this sub-sample, and by relation their organizations, have nationally recognized statuses and influence as well. Participants were not

included or excluded from the study on the basis of race, age, gender, caste or socio-economic status.

2.2 Direct Carer Group

Recruitment

All direct carers of OSC were recruited from one particular multi-site residential care center (RCC). This particular RCC was chosen for multiple reasons. Firstly, the RCC has 15 homes in the Delhi-National Capital Region (NCR). Each home has an intentionally small number of children, ranging typically from 10-15 children, of mixed ages. Each home is separated by gender. This was of particular interest to the study due to potential variance across so many homes, and therefore staff, under the same organizational umbrella. As well, the organization claims to employ a unique model of service delivery to OSC, based primarily on its staffing structure and family-like care. These aspects made the organization particularly well-suited to the study, to explore the best interest of the child in a residential care setting that is aligned, at least in its model, with certain tenants of the UNCRC and the Guidelines to Alternative Care, particularly the primacy of the family unit.

The direct carer group participants were chosen to represent a subset of the whole group of carers who provide care for children at the multiple residential care centers. The specific sub-categories of carers included: caregivers, mentor parents, supervisors, social workers, and mental health counselors. The differences in these sub-categories will be explained in more detail below.

The recruitment process for these different members of the care staff varied due to how they are managed and employed (either as volunteers, full time employees, or contract-based). Caregivers, supervisors, and social workers are all full-time employees of the RCC who either live at or work at an individual home on a daily basis. Mentor parents occupy a volunteer status

and have high variability in terms of time commitment with each home. Finally, mental health counselors were contracted through a Delhi-based mental health care company. Each of these varying levels of employment/volunteering incurs different types of interaction with the RCC network of homes, and thus recruitment varied by employment type. With each varying level of staff and/or volunteer, the research team had to use different recruitment tactics.

Mentor parents (volunteer-based carers) and mental health counselors (contract-based carers) were recruited exclusively through convenience sampling via an invitation for participation. This was distributed to the entire team of mental health counselors as well as to the entire team of mentor parents.

The recruitment for social workers, caregivers, and supervisors (i.e. all full-time employees of the organization) was comparatively more complex. Social workers were chosen purposively to represent every home the RCC has in the Delhi-NCR region. Social workers, who serve as the primary liaison between each home and the head office of the organization, were then asked to nominate at least one other staff member from their home who could speak at length about their daily responsibilities and the organization. Diagram 2 outlines this process in more detail.

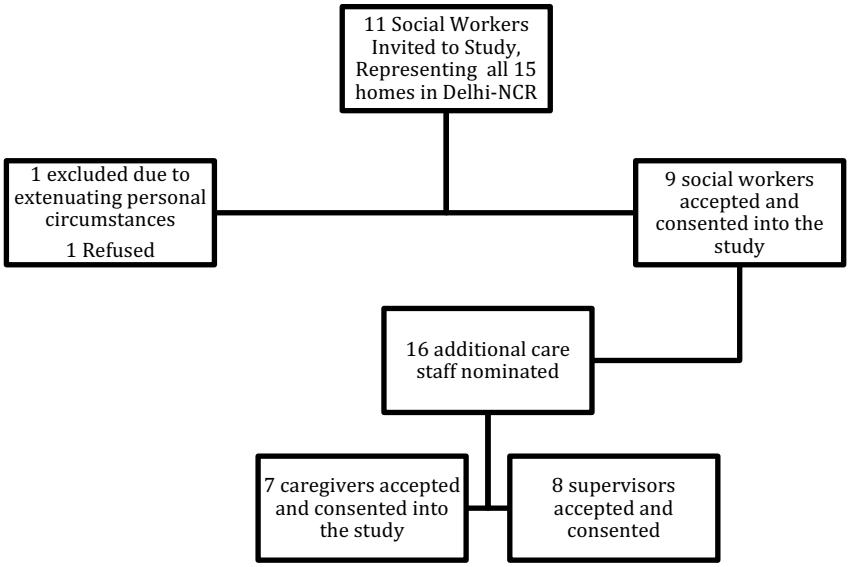

Figure 2: Recruitment process for full-time carer employees (social workers, caregivers, and supervisors only)

Meanwhile, Table 1 outlines the specific inclusion criteria for the distinct categories of care staff for this particular residential care NGO.

Table 1: Direct carers group breakdown by staff type (either as volunteers, full-time employees, or contract-based)

Carer Type (n = 38)	Inclusion Criteria
Social Workers, Caregivers, & Supervisors (n = 24)	• Working for the organization for at least 1 month (due to extremely high staff turnover) • Receipt of basic staff training • At least weekly interaction with the home residents
Mentor Parents (n = 9)	• No receipt of salary or compensation • Serving in a mentor capacity with the NGO for at least 5 years

	• At least weekly interaction with the home residents
Mental Health Staff (n = 5)	• Being a full-time employee of the mental health contracting company • Graduate-level training in psychology and/or counseling • Providing therapeutic services at least home per week.

Social workers, assigned to between 1-2 homes, handle legal regulations, liase with government oversight mechanisms, provide basic child care, liaise between the homes and the RCC head office, and manage all care staff. The majority of social workers do not live in the homes, although there are some exceptions. Technically speaking, their position demands a 40-hour work week. All social workers for the organization have a master's degree in social work or a related field.

Supervisors are assigned to 1-2 homes and serve a managerial role amongst the caregivers as well as assisting the social worker with her or his duties, including reporting and childcare. All supervisors live in the homes 24/7. The majority of supervisors have not received education beyond 12th standard.

Caregivers are assigned to 1-2 homes and handle basic childcare, cooking, cleaning, and emergency physical and psychological first aid. All caregivers live in the homes 24/7 full time. The majority of caregivers have not received education beyond 12th standard.

Mentor parents are generally assigned to one home and provide a wide range of services based on their experience level. Mentors are generally older women and men of retirement age with some type of relevant skill set in childcare or education; however, this is not a pre-requisite for becoming a mentor parent. Mentors interact with the homes on an exclusively volunteer basis and begin solely as part-time volunteers visiting a home once a week for a minimum of 2 years

before formally becoming mentor parents. Although their 'job description' is informal, their most important role per the organizational model is to provide a long-term parent-like presence in the children's lives.

Mental health counselors are managed through a third-party mental health provider, specializing in residential care settings for children. All counselors are managed, assigned to homes and supported by the mental health care provider management itself. All counselors have graduate-level training in psychology or a related field. Interaction with children is highly variable; some counselors provide therapeutic services for up to five homes while some provide services to only one. At minimum the mental health counselors provide five hours of therapeutic services at one home per week.

2.3 Data Collection

Policy Stakeholder Group

The data collection protocol for this sample was twofold. First, each participant participated in an in-depth interview (IDI) with the primary investigator, answering questions about child protection policy, the Juvenile Justice Act of 2015, policy reform, standards of care, and deinstitutionalization. The content of these in-depth interviews was audio recorded and written notes were taken as well. Transcription of English audio was transcribed by the interviewer and proofed by a secondary member of the research team. In addition to the primary investigator, two other members of the research team attended each interview. One research assistant was assigned to take notes on the content of the interview, while one research assistant was assigned to take more 'reflexive' notes on body language and tone of the participant. These IDIs lasted from between 40 to 70 minutes, depending on participant availability.

Secondly, a brief demographic survey was administered via Qualtrics to each participant directly after the conclusion of the IDI. This survey included six basic demographic questions. The survey had a 100% response rate. All survey responses were collected via tablet on the Qualtrics Offline App. Responses were later uploaded.

Direct Carer Group

Data collection for this group included in-depth interviews (IDIs), focus group discussions (FGDs), and administration of a basic demographic survey. The administration of specific methodologies varied by the participant sub-group.

IDIs occurred with RCC social workers, supervisors, and caregivers. The content of these in-depth interviews was audio recorded and written notes were taken as well. In addition to the primary investigator, two other members of the research team attended each interview. Some interviews took place in English (n= 7) while others occurred in Hindi (n = 17). English interview audio was transcribed directly by the interviewer and proofed by another member of the research team. Hindi interview audio was transcribed into Hindi transliterated script [meaning phoneticized Hindi using English language characters rather than traditional Devangari script characters] first by the interviewer and then translated into English by a secondary member of the research team. A third member of the research team then proofed these translations. These IDIs lasted from between 30 to 70 minutes, depending on participant availability.

Separate focus group discussions (FGDs) occurred with mentor parents and mental health counselors. This was chosen as the primary method of data collection for these particular carer sub-categories due to interest in their collective definitions and perceptions of their roles on the care staff team. Two FGDs took place with two separate groups of mentor parents and one FGD was held with mental health counselors. All FGDs were facilitated in English. Each FGD had one logistical support/reflexive note taker and one content note taker. The first author served as the

moderator for all three FGDs. Each FGD lasted approximately 60 minutes, depending on participant availability.

A brief demographic survey was also administered via Qualtrics to each IDI participant directly after the conclusion of the interview. For FGD participants, the survey was sent via email directly after the conclusion of the discussion. The survey had an 89.5% response rate. All survey responses were collected via tablet on the Qualtrics Offline App. Responses were later uploaded.

Informed Consent and Ethics Approvals

All participants in both groups completed a written informed consent process as outlined by Duke Campus IRB Protocol 2019-0415. Participants were informed that their responses would be de-identified from their name but that their organization name may be associated with quotations from their IDI. Participants in the carer group completed the informed consent process in the language of their choosing [including using a translated copy of the consent form that was translated and back translated (English-Hindi-English) by two separate translators]. Due to the fact that all policy group participants spoke English, this form was not translated into Hindi. In cases where the participant could not read, the contents of the form was explained to them. Each participant was given the option to obtain a copy of their signed written consent form. All study procedures were approved by the Duke University Arts & Sciences Institutional Review Board and the Ethics Committee of the Collaborating RCC.

2.4 Study Instruments

Policy Stakeholder Group

Question topic areas focused on childcare institution reform, restoration of orphaned and separated children to their biological families, and opinions on the efficacy, and barriers to efficacy, of pre-existing legislation. These questions were informed by Indian policies and

legislation. Questions from the Policy Stakeholder Group interview guide included items such as: "In your opinion, what does a 'gold standard' of care for orphans and separated children look like in India?" and "What do child care institutions in India need to provide to orphans and separated children in order to provide care as good as, or better, than a traditional family setting?"

Direct Carer Group

Qualitative interview questions for this group had to be created with the myriad and specific roles of stakeholders within the carer group in mind, as defined by this study. All questions took the form of qualitative question protocols, but the specific focus of each interview guide varied by carer role.

Social workers, caregivers, and supervisors were administered the same IDI guide, which was structured to understand the way in which direct carers work within the frameworks of child protection policy on a day-to-day level with children. These questions were based on analysis of Indian child protection legislation and policies as well as conversations with local experts. Questions from this IDI guide included items such as: "How does this home function like a family-like environment?" , "If children can receive better opportunities in this home versus with their biological family or kin do you think they should stay?" and "What is one thing you would change about your organization's model?" Interview guides for the direct carer group were translated and back-translated [English-Hindi-English] for local relevance and application.

Questions for the mentor parent sub-group were focused on understanding the communal definition of childcare for OSC as defined by this particular carer category. Questions from this FGD guide included items such as: "If a high government official walked into this room right now and said that you were in charge of creating child care institution reform for all of India, what would you do?" and "Can you give me an example of how your relationships with children

have changed, if at all, over time with increased government oversight around childcare institutions?"

Contracted mental health counselors were administered a separate FGD guide tailored to their specific expertise and perspective. Questions on this discussion guide were focused on understanding common mental health experiences (if any) by OSC as well as mental health clinicians' perspective of the 'best interest' of the child including items around restoration of separated children to their familes, care team efficacy, and policy reform. Topics on this discussion guide were based on conversations with local experts and stakeholders. Questions from this FGD guide included items such as: "How do you think children cope with things like lack of attachment to parental figures, instability, or backgrounds of trauma?" and "What would you say to someone who argues that child care institutions have an exclusively negative effect on child mental health?"

2.5 Analysis

The first author conducted the primary applied thematic analysis for this study. Analysis was thus a "targeted [and] goal-driven" process focused on achieved a deeper understanding of the objectives of the study (Guest, MacQueen, and Namey 2014). First draft codebooks per participant group were developed immediately after data collection concluded for each separate participant group. During this drafting process the first author created rough drafts of codebooks which were presented to the remainder of the research team in iterative feedback sessions. Codes were created inductively based off of first exposure to participant responses throughout the data collection and transcription processes as well as thorough reading of the transcripts by the three members of the research team.

After the conclusion of data collection, the first author of the study developed second and third iterations of the codebooks per participant group while coding, using the NVivo 12 software package (Jackson and Bazeley 2013). In the context of this study codes were created as "textual description[s] of the semantic boundaries" of a component of text that was especially salient within and across transcripts (Guest, MacQueen, and Namey 2014). Once all data for each participant group was coded, themes were developed inductively. Themes were developed from the topics of the interview guides as well as the concepts and ideas that arose during the analysis process. In the context of this study, themes were defined as a sentence conveying a concept or pattern of meaning that emerged from reading text grouped by code.

While codes were used primarily for organizational purposes, themes were established to draw actual meaning from the content of the transcripts. Not all codes were included in the final analysis due to their lack of infrequence across transcripts. Themes were then categorized into broader groupings which, for the purposes of this study, will be called domains. In this context, domains can be defined as broad, multi-theme categories that encompass a small number of varying ideas or concepts that are all inter-related. Domains were created for the purpose of having broad, value-laden, categories that could be compared and contrasted across participant groups. Examples of domain generation can be seen in Figure 3 and Figure 4 for the same domain, Resources, by participant group.

The backgrounds of the team members conducting this analysis is relevant as sources of potential depth of understanding or potential bias. The lead researcher is not an Indian national nor is he fluent in Hindi. However, he previously lived in India and has professional experience both with childcare and social work and education in global health. The two other research team members are Indian nationals based in Delhi, and both are fluent in Hindi and English. Each was chosen for their expertise as in psychology and in child protection policy knowledge. All of the

aforementioned demographic information about the research team certainly contributed to the approach of the team and thus any bias that may be present in the study.

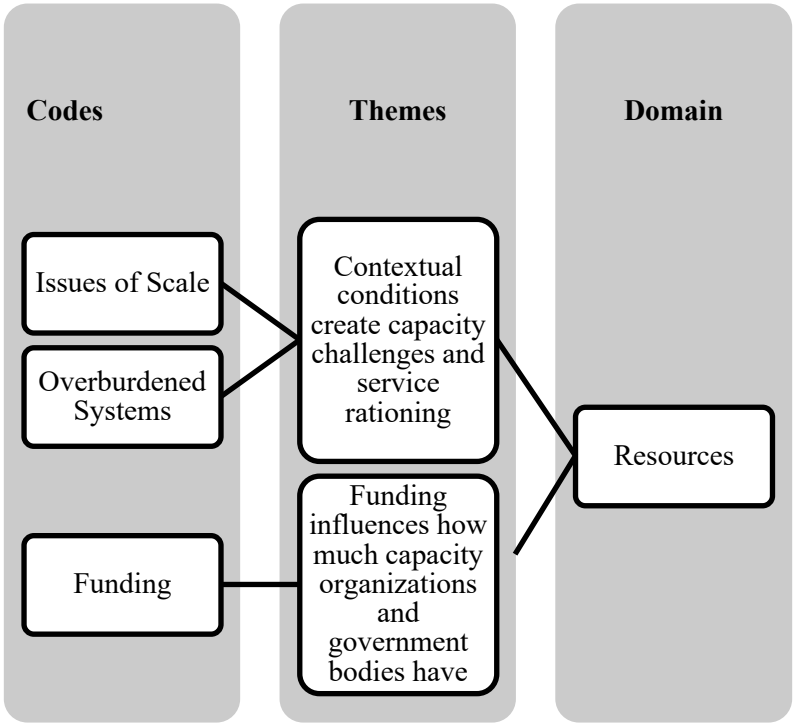

Figure 3
Example of ‘Resources’ Domain Generation: Policy Group

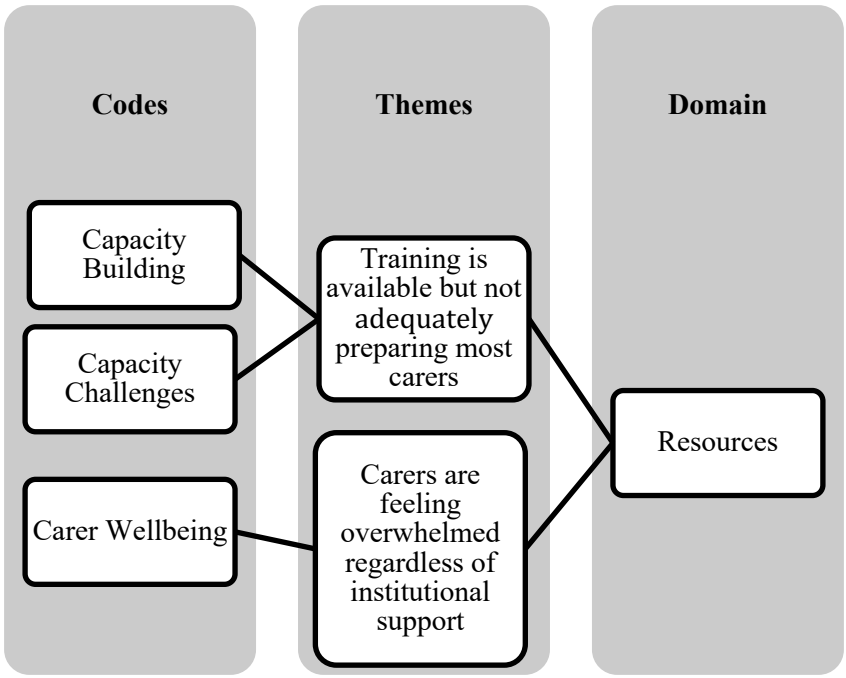

Figure 4
Example of ‘Resources’ Domain Generation: Carer Group

3. Results

A total of 18 policy stakeholders and 38 carers took part in the study. Table 2 (94% response rate) outlines basic demographic information for the policy group participants. Table 2 (89.5% response rate) includes basic demographic information for the direct carer participants.

Table 2: Descriptive Statistics: Policy Stakeholder Group (94% response rate)

Role in Child Protection	**NGO Director or Leadership Position**	**Advocate**	**Policy Maker**	**Researcher**	**Total**
n	7	4	3	3	17
Gender (%)					
Male	4 (57.14)	2 (50.0)	2 (66.67)	0 (0.0)	8
Female	3 (42.86)	2 (50.0)	1 (33.33)	3 (100.)	9
Education Level (%)					
Bachelor's or Less	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.)	1
Master's Degree	4 (57.14)	2 (50.0)	3 (100.0)	2 (66.67)	11
Ph.D.	3 (42.86)	1 (25.0)	0 (0.0)	1 (33.33)	5
First Language (%)					
Hindi	4 (57.14)	4 (100.0)	2 (66.67)	1 (33.33)	11
English	2 (28.57)	0 (0.0)	0 (0.0)	2 (66.67)	4
Other	1 (14.29)	0 (0.0)	1 (33.33)	0 (0.0)	2

Table 3: Descriptive Statistics: Direct Carer Group (Response Rate: 89.5%)

Carer Role	**Social Worker**	**Supervisor or Caregiver**	**Mentor Parent**	**Mental Health Counselor**	**Total**
N	9	15	6	4	34
Gender (%)					
Male	2 (22.2)	2 (13.3)	1 (16.7)	0 (0.0)	5
Female	7 (77.8)	13 (86.7)	5 (83.3)	4 (100.0)	29
Highest Education Level (%)					
Completed Grade 12 or below	0 (0.0)	13 (86.7)	0 (0.0)	0 (0.0)	13
Bachelor's Degree	0 (0.0)	2 (13.3)	3 (50.0)	0 (0.0)	5
Master's Degree	9 (100.0)	0 (0.0)	3 (50.0)	4 (100.0)	16
First Language (%)					
Hindi	5 (55.6)	8 (53.3)	3 (50.0)	3 (75.0)	19
English	0 (0.0)	0 (0.0)	2 (33.3)	1 (25.0)	3
Other	4 (44.4)	7 (46.7)	1 (16.7)	0 (0.0)	12
Place of Origin (%)					
Delhi	(3 (33.3)	3 (20.0)	2 (33.3)	3 (75.0)	11
Other	6 (66.7)	12 (80.0)	4 (66.7)	1 (25.0)	23
Marital Status (%)					
Never Married	7 (77.8)	3 (20.0)	0 (0.0)	4 (100.0)	14
Currently Married	1 (11.1)	7 (46.7)	4 (66.7)	0 (0.0)	12
Divorced, Widowed, Separated, or Other	1 (11.1)	5 (33.3.)	2 (33.3)	0 (0.0)	8
Length of Time in Child Care (Previous to this organization) (%)					
Never before this	5 (55.6)	11 (73.3)	5 (83.3)	2 (50.0)	23
Less than 1 year	2 (22.2)	1 (6.67)	0 (0.0)	0 (0.0)	3
1 or < 4 years (Clustered)	0 (0.0)	1 (6.67)	0 (0.0)	0 (0.0)	1
4 or < 5 years	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	1
5+ years	1 (11.1)	2 (13.3)	1 (16.7)	2 (50.0)	6
Length of Time at this Center (%)					
Less than 1 year	3 (33.3)	1 (6.67)	0 (0.0)	1 (25.0)	5
1 or < 2 years	3 (33.3)	3 (20.0)	0 (0.0)	0 (0.0)	6
2 or < 3 years	1 (11.1)	3 (20.0)	0 (0.0)	3 (75.0)	7
3 or < 4 years	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	1

4 or < 5 years	0 (0.0)	2 (13.3)	0 (0.0)	0 (0.0)	2
5+ years	1 (11.1)	6 (40.0)	6 (100.)	0 (0.0)	13
Number of Children at Center (%)					
Between 5 - 9	1 (11.1)	3 (20.0)	0 (0.0)	0 (0.0)	4
Between 10- 14	10 (55.6)	10 (66.7)	4 (66.7)	3 (75.0)	27
Between 15 -19	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0
20+	3 (33.3)	2 (13.3)	2 (13.3)	1 (25.0)	8
Responsible for Other Children (outside of professional capacity) (%)					
Yes	1 (11.1)	9 (60.0)	3 (50.0)	2 (50.0)	15
No	8 (88.9)	6 (40.0)	3 (50.0)	2 (50.0)	19

Through the iterative thematic analysis methodology, three key domain areas emerged that were overlapping between participant groups:1) Resources, 2) Approaches to Care, and 3) Accountability

Taken together, these three key domain areas for each group were taken to be what constitute and contribute to the best interest of the child, in the eyes of the participants.

Below we will discuss the three key domain areas in more detail. Each domain has several sub-themes which constituted it. These will be labeled as subheadings and are outlined in Table 3 below. At the end of each discussion of a key domain area, we will discuss the implications of the domain on the construct of the best interest of the child.

Table 4: Domains and Themes by Participant Group

Domains and Themes	Emerged in Policy Group	Emerged in Carer group
Resources		
The scale of the need is overwhelming	**X**	
Funding for OSC is insufficient and child protection policy systems are overburdened	**X**	
Training, although present, is oftentimes not sufficient for job challenges		**X**
Lack of staff is a critical problem to providing care for children		**X**
Ability of lower-level care staff is associated with their personal trauma history		**X**
Carer burnout and exhaustion is directly linked to lack of capacity		**X**
Approaches to/Styles of Care		
Approaches to care are heavily ideological	**X**	
Participants framed the 'welfare approach' in terms of responsibility of care	**X**	
Participants were confused by how to discipline children if not through corporal punishment		**X**
Emotional regulation is cited as an integral childcare skill		**X**
Carers strongly identify their individual homes as family-like settings		**X**
Distinction between family-like care and professional care varies by carer type		**X**
Child mental health challenges and trauma affect child experiences in institution and may be beyond the ability of carers		**X**
Tensions are occurring between what is developmentally, age appropriate, for children and what is allowed per law		**X**
Accountability		
Presence of governmental monitoring and evaluation is universally recognized	**X**	
Participants view quality of monitoring as reactionary	**X**	

	Current accountability mechanisms are articulated in terms of their limitations rather than successes	**X**
	Most participants describe their experience of monitoring as evoking fear	**X**

3.1. Key Area Domains

3.1.1 Domain 1: Resources

Resources: Policy Group

Theme: The scale of the need of OSC in India is overwhelming.

In reference to resources, the policy group spoke mainly about the intensity of scale for caring for OSC specifically in India, often quoting statistics such as: “It’s an admitted situation that 20 million are orphans, parentless, family-less, and they have to be kept in these homes”. It is of note that once policy group participants began quoting these types of statistics, they would often list more and more, as if this were the only way to truly illustrate the enormity of the situation to the researcher:

“So in India the situation is mammoth. Millions of children you know need alternative care support.” (P06, Residential Care Center Director)

“It’s an admitted situation that 20 million are orphans, parentless, family-less, and they have to be kept in these homes. It’s an admitted situation that 35 million children in India happen to be children in need of care and protection, under the JJ Act. So these are admitted situations. So in these admitted situations the role of voluntary organizations you can well imagine. We are a strong 3.2 million, you know that I am sure, 3.2 million voluntary organizations in India.”

(P03, Residential Care Center Director)

Theme: Funding for OSC is insufficient and child protection policy systems are overburdened.

This sense of being overwhelmed by the magnitude of the issue would often carry over into conversations of funding. Funding was most often spoken about as a deficit; there is never enough and, simultaneously, child protection is extremely expensive. However, some diverging opinions emerged between those who actually direct residential care centers for OSC and those

who do not. One director of a residential care center stated, “We’re spending 2 lakhs [roughly equivalent to $1400 USD] of rupees per child per year, there is nobody on earth who wants to fund these kids!” while another referenced the low amount allocated to child protection by the federal government itself. In direct contrast, a child rights advocate, explicitly not a director of an RCC, told us that the residential care centers and institutions in the metro areas, such as New Delhi, are “flushed with funding” (P04).

Conversations around funding inadequacies and/or inefficacies would often transition into the inefficiencies and overburdened state of child protection policy systems in general. As one child rights advocate stated:

“…child has been produced by the mother, we have conducted the proceeding, mother is poor, we direct the DCPO [District Child Protection Officer] to reimburse them rupees 1,000, right? Now this is an order in nullity because this poor DCPO cannot spend even 5 rupees without permission of the DPO [District Program Officer] who is a cadre-based employee.”

(P07, Child Rights Advocate)

In this quote in particular, the participant is discussing how the directive to reimburse a mother 1,000 INR [equivalent to approximately $14 USD] cannot be completed because of an issue with bureaucratic permission amongst the child protection governance system. These systems-based issues were also discussed in terms of the actual staffing of different kinds of alternative care. While government-run homes were consistently spoken about as being constantly “under capacity” in terms of both staffing and children, NGO-run homes were spoken of as being “overcrowded” in terms of children. As another participant, an NGO director, stated, government-run CCIs can run under-capacity because “No one asks you [about how many children you have] because you are a government-run home…government means everything is good” (P14). In other words, she is stating that government-run homes receive less oversight

because it is assumed they are doing a good job. While I will explore the relationships between resources and accountability later, the fundamental takeaway of the resource domain for the policy group was one of mismanagement of resources. The interplay between funding (whether unallocated or misallocated), inefficient administrative systems, and the massive scale of the child protection problem in India seem to produce policies that create, in the words of one participant, "a huge administrative chaos" (P17).

Resources: Carer Group

Theme: Training, although present, is oftentimes not sufficient for job challenges.

The carer group primarily conceptualized resources in terms of capacity, both in efforts to build capacity and challenges to capacity. Capacity building primarily involved training, both that which is already provided by the organization and the need for more training. Discussion of training was highly variable. In terms of consistency, some participants would describe the training that the organization provides as "constant workshops", "every month" or occurring "in a home for 3 months", while others said that there was "No preparation at all actually because you don't get to know…you don't get the feel…if you're still in it" in reference to not fully understanding the requirements of the job until she started. We found there to also be variability in discussion of capacity building by length of time at the residential care NGO; while newer care staff referenced the need for more training, care staff with more experience at this organization referenced how the quality of training used to be much more robust. In terms of specific carer type, a majority of caregivers spoke about capacity building in terms of wanting more training, whether it be in caring for specific types of children or as a refresher for past content, making statements such as, "If we get more such training, then it'll be better" and "We have still not received any training. Like handling the children who are mute or require mental health aid...".

Theme: Lack of staff is a critical problem to providing care for children.

Capacity challenges were also extremely variable, although less by carer type and more by content area. Major content areas of capacity challenges included ability of staff, lack of cohesion of staff, and actual numbers of staff. Complaints regarding the actual numbers of staff were by far the most ubiquitous. Some staff referred to a "shortage of care staff" while others stated that there "weren't enough to give that individual care". In reference again to mental health, one social worker told the researcher:

"Interviewer (I): But there is no one for counseling and all now?

Participant (P): No, not right now.

I: But do you think that the children require it?

P: Yes, they need it…there hasn't been any counseling for the past two months because the previous one left…"(C15SW, Social Worker)

Later in this same interview, the participant (who had a master's degree in social work) was asked if she could serve as a therapist for the children at her home, to which she responded:

"It's not part of my job and I cannot be good every time! And I should not be because I am not a counselor..." (C15SW, Social Worker)

Theme: Ability of lower-level care staff is associated with their trauma history.

We noticed that social workers often spoke about caregivers and supervisors in terms of their lack of ability, saying things like, "The major difference is this only, that caregiver they sometimes don't understand" or, in response to a question about whether or not caregivers receive training, "They do but then they also have traumatic backgrounds, they're not very educated, and they do not have a similar pattern of thinking that we would have." This perspective, by social workers, that caregivers seem to have different "patterns of thinking" was brought up in varying ways by different participants. Another social worker described caregivers as "a bit dependent" and needing "that kind of maturity", while one mentor stated that they function as "an employee

delivering what is required of them rather than going beyond that level and giving them motherly touch". One social worker actually described the interactions of caregivers with children as "crashes", going on to say that they "are not able to deal with" the intensity of the job at times. Later in the same interview, this social worker stated that when crises do occur with the children, particularly mental health crises, the caregivers either "pass out" or "start crying". This inability of caregivers to appropriately deal with difficult situations with children was often cited by social workers as yet another burden on them. However, social workers tended to understand why this lack of ability was present in caregivers, consistently citing their past trauma:

"Obviously...some have traumatic past with, you know, opposite sex people…they've been abused by their own fathers…we understand all those things…but giving them…the workshops…the caregivers…making them understand the trauma of children…inspection, legalities… [is important]" (C03SW, Social Worker)

This social worker identified the cause of the caregivers' lack of professional ability while also proposing the solution of more training, effectively bridging the gap between issues of capacity and capacity building.

While most care staff questioned the ability of the caregivers almost universally, a divergence emerged between 'professionalized' and 'un-professionalized' care staff emerged. For example, members of the professional mental health team noted that regardless of the amount of care and affection mentors may give the residents of their homes, there is a need to "really understand the trauma" of children and that coming from a place of affection and care is "not exactly enough for the child". Interestingly, the notice of any divergence between more 'technical' or 'clinical' skills versus 'intrinsic' parenting skills was only noted by the mental health providers.

Theme: Carer burnout and exhaustion is directly linked to lack of capacity.

This quote in particular epitomizes the connection between the lack of capacity and carer well-being, often described as a sense of burnout or exhaustion by members of the care staff. While not explicitly stated as depression or mental health challenges, members of the care staff described their mental states as "distracted" or "disturbed" as well as to illustrate burnout in other ways. One social worker described the choice to leave the residential care NGO in the following way:

"Yeah, it's been like 2 months, I've always shared this with my manager, like ma'am I am losing motivation now. And after all this happened last month…so I really thought I should do some further studies and go for some better place…there will be obviously challenges but I guess…I get this pain everyday here [participant motions to her forehead]…so I was not able to take it." (C06SW, Social Worker)

This same participant later described the experience of trying her best not to have a child restored back to her family due to medical complications, only to have the child restored to her family and die due to lack of proper medical care at home. The participant stated: "Because it's like no matter how much work you're doing for the children you're pushed up against these walls" (C06SW). These "walls" were evoked by other participants in a variety of ways, mainly in reference to finding time for themselves. One supervisor described this as "our own life is like negligent…there is no time", while another stated that "the 'me time' for your own self is a very difficult thing to find here. Even if you do, it is not peaceful".

Implications for Best Interest

In addition to their obvious differences, the Resource domain for the policy and carer groups yielded surprisingly similar themes. Policy group participants talked about capacity primarily in terms of administrative systems and funding, whereas carer group participants spoke about more individualized and organization-level challenges, such as burnout and lack of

adequate staffing. Both of these discussions, however, when taken together lead to a fairly centralized conclusion that resources, in whatever way they are conceptualized, are lacking or, at best, inefficiently allocated. While participants did not necessarily agree about whether resources were being misallocated or were completely deficient, the result was the same: a sense of residential care centers, especially NGO-based homes, being over-burdened and functioning under-capacity. We saw this on an organizational level with this particular residential care NGO care staff both in terms of their ability and actual staffing needs. On a policy level, there was a sense of the sheer magnitude of the issue of OSC in India being a nearly insurmountable problem, which therefore affected funding streams and administrative capacities. Ultimately, for both care staff and policy stakeholders, this seems to produce what one policy participant deemed a "malaise" of the broader child protection system in India: over-burdened and under-capacity.

3.1.2 Domain 2: Approaches to/Styles of Care

Approaches to/Styles of Care: Policy Group

Approaches to care, referring to the ways in which stakeholders came to conceptualize how care should be provided for OSC, is ultimately an amalgamation of organizational processes, perceptions of the child's experience, and the perspective or professional reference point of the participant.

Theme: Approaches to care are heavily ideological.

On a broad level, approaches to care for the policy group were heavily ideological in nature and residential care, which participants called "institutionalization", played a key role in these discussions. Participants were fairly avid in stating their position as, as one residential care center director stated, "a very strong institutional man" or "I am completely against them [meaning CCIs]". Approaches to care thus often became subsumed by discussions about

approaches to institutional care. The sentiment of one participant, a prominent child rights advocate in Delhi, summed up the rebuttal to the otherwise reductionist debate:

"…whether it is a privately run institution or a government-run institution…the problem is not with institution, non-institution…it's also about what are we doing to make sure that a child is safe, whether in institutional care or not in institutional care…" (P07, Child Rights Advocate)

However, even amongst such measured opinions, participants would often find themselves choosing sides in the institutional versus family-based care debate. The very same participant later stated, "I don't think we need to create more [name of residential care NGO]. But do we need to create opportunities for families to be able to look after their children better? Ideally." Conversations around approaches to care for OSC often found participants searching for answers themselves. One government bureaucrat shared that in any institutional setting, he is "expecting that the child should be given a family-like atmosphere or environment" whereas one RCC director stated that she was trying to work within an "institutional framework, [to achieve] a deinstitutionalized spirit". Nearly all policy group participants approached the conversation of care of OSC in this ideological way regardless of whether participants were pro-institution or pro-family-based care. Specific details of care for OSC were not mentioned in these conversations about institutional care. In fact, only one policy group participant used the phrase "quality of care" in reference to institutions, and this was in the context of saying that "they [institutions] should not be there for long time but it [quality of care] is required".

Theme: Participants framed the 'welfare approach' in terms of responsibility of care.

Participants also brought up a divide between what many called the "welfare approach" versus the "child rights approach". One director of an RCC discussed the internal battle within her organization surrounding this ideological divide:

"This massive battle that's happening within the organization of our historically welfare-led approach…I don't know welfare might be too strong a word but what I mean is this whole continuum of care thing to say no matter what the child needs, no matter how long the child needs it, no matter what it costs we will do it." (P13, Director of RCC)

For the welfare approach, one child rights advocate alternatively described the "welfare approach" not in terms of a carte blanche policy for children's every desire but as a minimum set of care: "rather than living on the street at least we are giving him something", which asserts a definition of welfare more as a policy of 'hand outs' to children who should be grateful they're getting anything at all. Yet another advocate framed welfare in reference to the care providers who, in the eyes of the state, can be justifiably paid less because their work is essentially "charity". These examples illustrate how variable definitions of welfare were amongst participants, yet none of them were wholly antithetical to principles of the rights of the child. Essentially all these participants discussed obligation and responsibility of care rather than actual quality of care.

This element of responsibility was often directly linked to the professional reference point that the participant identified with or as. For example, one participant drew a delineation between her identity as a citizen and her identity as a social worker, saying "As an Indian we still don't think that foster care is going to work in India. But as a social worker I know it is the requirement because for the last so many years it [foster care] has not been working (P02, Child Rights Advocate). One participant who previously worked for a large development multi-lateral organization jokingly told the research team, "I also used to define myself as children paid my salary so I don't have to be answerable to anybody else" (P05, Child Rights Advocate). This quote refers not to who literally pays the participant's salary but to whom the participant feels answerable to, or is 'really' working for. Who participants were answerable to, in terms of their

professional ethics, was an extremely important factor in how they defined the 'correct' ideological approach to care, whether it be institutional/RCC based or in family settings.

These statements, however, were often at odds with the realism of child protection policy in India. Children in CCIs are in custodial institutions and children do not actually pay anyone's salaries. Likewise, while the aforementioned participant states that India and foster care are antithetical to one another, group foster care is in the most recent iteration of the Juvenile Justice Act, as previously mentioned. There is thus a dissonance between what the policy stakeholders wish or hope would be the case for the care of OSC and what kind of care is actually being provided. In other words, institutionalized care is being provided for OSC in India regardless of how it should be provided; it is this mismatch between policy aspirations and policy realities that became clear in this analysis.

Approaches to/Styles of Care: Carer Group

While approaches to care in the policy group were highly aspirational, approaches, or more appropriately 'styles', of care amongst the carer group were predictably more based in practice. Generally, 'approaches to care' in this group actually translated to style of care provision for OSC. These styles were grouped into sub-categories including: discipline-oriented care, family-like care, individualized care, and care focused on emotional regulation. We also observed that perceptions of gender, particularly of girls and young women by their female carers, influenced styles of care provided to OSC. Finally, this domain included themes surrounding the perception of the experience of the child in their care, which we found to be highly variable and focused mainly on child trauma and mental health outcomes.

Theme: Participants were confused by how to disciple children if not through corporal punishment.

Discipline-oriented care was dominated by discussions of the frustration carers have with the inability to use corporal punishment with OSC in their care. This sentiment is perhaps best epitomized by a social worker, stating:

"You cannot punish…you cannot obviously beat them. The children you cannot beat them. Younger children I feel they should be slapped once in awhile but that is also not allowed. So, there's nothing you can do actually. We cannot do anything about this. That things should be considered." (C15SW, Social Worker)

This sentiment was often juxtaposed to the role of physical punishment of children traditionally acceptable in India, as one mentor told us:

"And Indian community…when they have grown up, the parents are just slapping and all is very very common…they beat the children…but here they know nobody touches them…" (RCC Mentor Parent)

The inability to use corporal punishment with the children in their care was connected closely with issues of respect from the children and frustration with finding a feasible alternative for discipline. The alternative that did emerge fairly frequently was approaching children with love. After stating that she cannot even speak to a child loudly for fear of reprisal, one caregiver said that, instead, children need to be spoken to "respectfully" and that "it is our job to keep this relationship with love". Another carer, a supervisor, explained that "we can't hold them, hit them…everything needs to be with love". Yet another caregiver concluded a discussion about discipline by saying that she tries to explain to the children in her care that "If I get upset with you, then the reason for that is that I love you."

Another style of care that emerged prominently among the carer group was a focus on emotional regulation of children. Carers often talked through situations where a child is expressing intense emotions and explained what they would do in these situations. This is, of

course, in lieu of clinical care by mental health professionals who are present with the children much less, as one mentor noted, “we are not the professional psychologists”. Oftentimes, carers would discuss the need to help children emotionally regulate during outbursts by describing how they themselves were emotionally regulating in that situation. One supervisor stated:

“We never try to tell a child in a demeaning manner where they have come from, or neglect them. Even when they become so hurtful towards us, but we never...sure we get angry and we say things...but we never try to hurt them by saying all this...we try to correct them and then children come back and say sorry...they will cry and will apologize as well.”

(C01S, Supervisor)

This phenomenon was present regardless of carer role. One social worker similarly expressed:

“…my strategy is always either I say it’s okay, whatever you want to say you say so that child feels a little, you know, relaxed, that yeah I have said everything…or I go away from the child so that I don’t lose my temper in front of the child and maybe talk to him or her.”

(C03SW, Social Worker)

Another social worker expressed attempting to help both the child in her care as well as her colleague, a caregiver:

“In understanding children…in understanding children’s behavior…why…like our care staff, if the child is behaving very bad, she’s yelling, she’s throwing, breaking things…caregiver will also get angry…but then we understand why she doing that…we try to find out what’s the reason behind her behavior…so this is the kind of perspective I have.” (C06SW, Social Worker)

Theme: Emotional regulation is cited as an integral childcare skill.

Emotional regulation of children was directly linked to another sub-domain of approaches/styles of care: individualized care. After discussing the need for emotional regulation

skills or describing how they helped emotionally regulate children, participants would often foray into conversation about the specific needs of specific children. Participants often made statements like “12 children come from 12 different backgrounds”, “every individual is different” and “children come from different backgrounds” before explaining further how this shapes the care they provide. One of the newest social workers summed up her approach by simply saying that, “You have to listen, you have to interact with the child to know that story” (C15SW). Similarly, one of the most senior supervisors stated, “For every child I have known their mind, body, their sadness, tension, struggles, experiences, why they are reacting in a way” (C18S). The recognition of the importance of individualized care occurred across participants regardless of length of time at the organization, likely because of the NGO’s training.

While participants discussed what providing individualized care was like, they often received the training either when they began working for the organization or as continuing education in the middle of their tenure. Participants referenced the trainings, saying they learned “to speak to children by giving them reasoning for things” and that “it was then we understood how we have to behave with them”. This also illustrates how interconnected the key domain areas are, with this linkage between approaches to care and the previous discussion of capacity building.

Theme: Carers strongly identify their individual homes as family-like settings.

The most robust theme in this category, however, was family-like care. References to family-like care were present in some capacity in every single interview and focus group discussion for the carer group. A majority of care staff referenced being called “mom”, “mummy” or didi [meaning sister in Hindi] by children and many participants described the various family roles the members of the care staff filled. However, some participants also noted how the environment of the organization actually provided more roles than a traditional family:

"So in a normal family home, we have an elder brother, elder sister, mother and father. So, the children don't not always share everything with their parents, for that they need a friend or a guardian as well. Both of them play an important role. They need someone who is a friend as well as a guardian, that role here is played by the social worker." (C05SW, Social Worker)

The role of friend appeared again in this participant group, defined as someone whom the children can "share their secrets with" which was cited as pivotal to "completing one's work". Similarly, another participant stated that, "…if you are living with a small child, till the time you are able to maintain a friendly rapport with him, he will not share the right information with you…". This idea of the "right information" and "completing one's work" highlights that carers are able to work in a family-like setting, and even identify as a family member to some degree, while still maintaining their professionalism.

Theme: Distinction between family-like care and professional care varies by carer type.

However, caregivers who work and live at their specific home 24 hours a day, made this professional distinction much less often, instead conflating the two spaces as one participant did, saying "We work here according to how it is in our homes. We don't feel like we are working somewhere else." For caregivers in particular, this lack of distinction between their 'residential care home' and their actual home related to them not wanting children to feel like "they are in an NGO". This is a prominent theme in the "Perceptions of Child Experience" domain area of the carer group that will be discussed later. Indeed, a family-like environment seemed less dependent on children identifying different caregivers with traditional parental roles and more dependent on the more realistic functioning of a family. As one mental health counselor described:

"But if we say the family's functional, I think we are missing out on something. Because a family can't be totally functional, I think something is going wrong. So, if there are problems going on, conflicts, then I think then okay they working as a family because there are different

people living…there are kids, there are adults, they have conflicts…I think if there are healthy conflicts we can say it's functional." (Mental Health Counselor)

Another example of this more 'realistic' version of family-like care emerged when a caregiver described how children were pitching in to clean the house while the caregiver was making breakfast. While these more informalized aspects of family-like care may very well be integral, they were often cited as aspects that are endangered or being made infeasible by current regulations.

In fact, instances where participants refuted the presence of a family-like environment were directly linked to the two other key domain areas, either capacity challenges:

"So they say family-like environment…it would be there if each caregiver can go to each child one to one on a daily basis, like take out sometime in evening or something…but those situations are not possible. Because there is already a lot of workload on the staff."

(C08S, Supervisor)

Or accountability:

"There is no legal tension in families. For example, if my own daughter runs away, then the police official would not put pressure on me that "why did your daughter run away". Still I take care of them like my own kids, with full responsibility…I take care of them and yet they still commit some mistake." (C12C, Caregiver)

In both of these cases, the ability of the respective homes to actually function in a family-like way is limited by, first, capacity of staff and, secondly, legal restrictions placed by the government. While the latter limitation will be discussed in more detail later, it is of note that carers do not identify explicit internal or organizational threats to providing family-like care for OSC.

Theme: Child mental health challenges and trauma affect child experiences in institutional care and may be beyond the ability of caregivers to care for.

This theme was created from due to the high prevalence of carers of all types, especially caregivers and supervisors, discussing the mental health needs of the children in their care as above and beyond what they could adequately care for. The most clinical summation of child's experiences came from out mental counselor, who responded to a question about children's behavior by offering:

"It's a manifestation of trauma so very often it looks different but ultimately the root cause is…mostly the traumatic events…different sorts of abuse, neglect, that they faced in their past and the risk factors that they have which present in different ways…" (Mental Health Counselor)

Acknowledgement of experience of significant trauma by child residents of the RCC was ubiquitous across participants, but the way in which carers were able to approach or provide crisis support differed significantly by carer group. While mental health counselors had the predictably most in-depth of both child's experiences and needs, articulation was very different, for example, for caregivers and supervisors:

"Didi [sister in Hindi] there is a girl named [names a child]…the one I mentioned is from Bihar…she always hurts herself...even we get scared for this reason…even yesterday she broke the mirror in the bathroom and then cut her hands…all of us were very scared. She needs it a lot. Either she should be restored from this place, that she should go back home anyhow." (C14S, Supervisor)

Significant mental health needs of children, especially response to suicidal ideation and attempts at self-harm, were commonly spoken about by caregivers and supervisors in the above way; as a problem that was too difficult or too overwhelming to solve. Understanding of mental health needs of children was also inconsistent, and certainly not indicative of any type of holistic mental

health training. Some carers referred to self-harm attempts of children as merely "falling sick" while others stated that they do not have "intention to kill [them]selves" but that it is just "attention seeking" behavior. Still, others would describe children's affect as "weird" or describe specific behaviors like "she would keep crying" in reference to explicit stories about child torture at the hands of a parent. Care provision in these cases was not described as clinical or with a nuanced understanding of profound child trauma but this did not seem to be a barrier for carers' (especially supervisors and caregivers) perceptions of children's mental health improving. In fact, while social workers recognized the importance of the mental health counselors, supervisors, caregivers, and even some mentors described approaching child mental health crises and trauma from an informalized version of care provision, largely based on their experience as mothers.

Theme: Tensions are occurring between what is developmentally age-appropriate for children and what is allowed by law in institutional care.

A minor theme that emerged among direct carers in response to questions about common job challenges. Carers would often immediately begin speaking about challenges, particularly in girls homes, of their children sneaking out to see young men or to go on dates. One supervisor explained:

"They [the girls at this home] used to make boyfriends…we asked them not to do that several times...the world is not a good place, people from good family backgrounds are fooled be cause of this, and with your history would just try to use you more." (C01S, Supervisor)

In addition to highlighting developmental tensions of adolescent girls' want to date but being unable this quote also highlights carer perceptions about how the children in their care will be viewed by the outside world, particularly by male suitors. While caregivers, supervisors, and mentors approached these tensions with a decidedly maternal attitude, social workers tended to discusses these issues in terms of legal compliance:

"Yeah so the kids actually have certain demands, like they want to go out alone, which is not allowed by Child Welfare Committee or is not possible…under the JJ Act, so why would I do that?" (C09SW, Social Worker)

Whether because of legal compliance or not wanting the children in their care to be taken advantage of, the reality of carers was that they could not indulge children's wants which, especially for adolescents, may have been allowed or seen as developmentally appropriate in non-residential care.

Implications for Best Interest

The way in which both participant groups conceptualized approaches to care was fairly divergent. The fact that for the policy group approaches to care was primarily an issue of ideology versus a topic of applied practice in the carer group is not surprising. However, it is interesting that two key concepts that factor into the best interest of the child according to international human rights law (as previously discussed), which are individualized case-by-case care and family-like care, were brought up only in the carer group. The 'applied' standards of care brought up by the carer group were actually more aligned with international human rights law, although not a single member of the carer group discussed the UNCRC or the Guidelines to Alternative Care. This finding was unexpected given that policy group participants might be expected to describe issues closer to actual policy and legislative standards.

The nuance of care described by the carer groups was detailed, and it should be kept in mind that the data presented here are only a representation of the larger picture that was gathered. While approaches to care were highly aspirational for policy group participants, the members of the carer group were able to articulate exactly why family-like care would be ideal if it were actually feasible based on their capacity constraints and the intensity of government regulations. Carers were also able to articulate beyond simply good and bad care, institutional or family-based

care, and instead delved into how it is actually the 'dysfunctional' elements of a family (such as arguing) that make the family-like environment realistic for children. Carers further described how a child's gender needs to be taken into consideration, with female caregivers more often describing higher 'stakes' for young girls and women in their care. This too brings a nuance to the idea of best interest for OSC in the Indian context, and further complicates the idea that restoring a child to her home is in the best interest of the child rather than of her parents or of the state.

3.1.3 Domain 3: Accountability

Accountability: Policy Group

Accountability for the policy group focused primarily on issues of monitoring and evaluation. Discussion of this topic unfolded most often in the following way: first, pre-existing accountability mechanisms were described; second, these mechanisms were criticized for either their punitive nature or insufficient rigor.

Theme: Presence of governmental monitoring and evaluation is universally recognized.

One participant outlined the current system of accountability in a way that was epitomical of the group:

"See we have mechanisms. For example here district child protection unit is working and CWC [Child Welfare Committee] is there. There we also have CWC. They are our counterparts. So if we write to them and say, "Okay we are sending these children"...the child would be produced before the CWC and he goes back to the family. The CWC and the DCPU [District Child Protection Unit] can monitor the child. The systems are already there existing. It's not that they're not there." (RCC Director, New Delhi)

The actual presence of monitoring and evaluation efforts, specifically for child care institutions, was almost universally mentioned by participants. As another participant put it:

"So monitoring is there. There is very robust monitoring. Like, for example, if there is anything which is happening in this country it is monitoring. Everybody's monitoring everybody." (P17, Child Rights Attorney, New Delhi)

Theme: Participants view quality of monitoring as reactionary.

While the presence of monitoring was recognized, the systems of monitoring were often criticized as insufficient. This insufficiency was articulated as either a lack of "clarified, kind of separation of goals" for government monitors or for the need for audits of CCIs to actually be connected to "complaint and redressal mechanisms". There were multiple references to the "Bihar case" or the Muzzafarpur case", in reference to a now nationally famous independent audit of CCIs in the Indian state of Bihar conducted by the Tata Institute of Social Sciences (TISS) in 2018. The audit surfaced findings of torture-like conditions in one particular CCI in Bihar, and is one of the pivotal modern occurrences shaping the CCI policy debate in India right now, according to participants. A prominent child rights advocate in Delhi framed the issue in the following way:

"See in Bihar...children's homes one after another were in total corruption. Children were being sexually exploited, physically exploited....the only time they saw it was when a member of the TISS team went there and then this is so, otherwise it keeps up. You put children in a home, that is it. The story is over. What happens in that home, who does what to the children, nobody knows." (Child Rights Advocate, New Delhi)

The takeaway from the Muzzafarpur case for many participants was that no one would have uncovered what was happening in the CCIs in Bihar if it were not for the independent social audit that was done. As one researcher noted, "...the one [meaning the CCI] in Bihar was also monitored...it was not like no one was there". The implication for this, of course, is that the a

priori auditors/monitors, meaning the CWCs and the DCPUs in this region, were not adequately doing their jobs.

Another repercussion from the Muzzafarpur case cited by the policy group participants is the increase in punitive regulations. One RCC director said:

"And we used never keep our doors closed, like in a normal family, you don't keep on closing the door. But here, now we have to keep our doors closed, because now you know the government is so afraid... any kind of abuse can happen. So now it has become very different. Children have started feeling locked in. Children have started feeling like a prisoner." (P06, RCC Director, New Delhi)

This transferal of fear by the government onto institutions and then onto the children that institutions serve arose throughout discussions of accountability. There was not a general reluctance or disapproval of accountability mechanisms in general, as one CCI director said, "It's not like they're not needed", but it was the method in which these mechanisms were employed which was often troubling for participants. Some participants described the CWC visits to their CCIs as "raids" while others described CCIs as "vulnerable" in the face of increasing restrictions. One policy participant articulated the omnipresence of CCTV cameras (present in every CCI in India by law) as a symbol of what she called "punitive accountability".

Carer Group: Accountability

Theme: Current accountability mechanisms are articulated in terms of their limitations rather than successes.

Discussion of accountability amongst the carer group primarily focused on experiences on the 'receiving end' of government regulations. The majority of discussions around accountability in the carer group were about the limitations of current government regulations. Carers noted that CWC members and other monitoring bodies were "monitoring us on silly

things" and making criticisms on infrastructural issues such as the state of the walls in a particular home, which carers have little control over. In reference to the CWC presence in their homes, one home supervisor said, "They just try to find mistakes in any way possible". As in the policy group, carers were not criticizing that there was the presence of accountability in their homes, but rather the way in which it was being applied. The prior theme of being treated differently for being an NGO again arose:

"Yes they check the entire cupboard...and this and that...but why? Just because you can do it, so you do it. So just because anyone can come and get a warrant and start checking, you will do this. But can you do that in a normal family? Just because we are an NGO, you will do this to us. Are we that small?" (C18S, Supervisor).

In this quote the participant is again illustrating the idea that just because the CWC can check their home at any time does not mean they should. Whether or not this perception is correct, or in the 'best interest', is not as relevant as the fact that such measures are being perceived as gratuitous and ineffective.

Theme: Most participants describe their experience of monitoring as evoking fear.

These perceptions lead to the last theme regarding accountability in the carer group: fear. Fear was cited as the predominant emotion experienced by caregivers in reference to their perceptions of the government regulations imposed upon them. Explanations used phrases like "living under that fear", "a little fear inside me", and "this fear always stays", when referring to experiences with the CWC and other accountability bodies. One supervisor elaborated further, saying, "Even when I have done everything properly, I still fear them, don't know why". This quote is particularly interesting because it suggests that fear of accountability is not necessarily related to performance but rather to the monitoring body itself. This type of fear, irrespective of performance, seems to be linked to the amount of power CWCs, DCPOs, and Juvenile Justice

Board members are perceived to have. Of these monitoring bodies, one social worker explained, "But they think that they are god who has come down to the world…that kind of feeling".

Implications for Best Interest

The inter-group analysis of accountability yields questions explicitly about who is to be held accountable and for what. From the account of both groups, it would seem that the standards of care for OSC are fairly irrelevant in the realm of government accountability of CCIs. Just as policy stakeholders were forced to adapt and innovate to make more effective internal auditing mechanisms, carers were forced to cope with their fear and carry on doing their jobs. The 'who' in the above question is certainly clear: it is the carers of OSC and the directors of institutions who are being held most accountable. However, what they are being held accountable for is highly varied and, as described by those being held accountable themselves, it is not so much about quality of care as it is about infrastructural issues. One high-level government bureaucrat in the field of child protection stated the following:

"If I give example of CCI…offense has taken place, matter is reported to police station, child is apprehended, he [the child] is grilled and questioned, interrogated, humiliated, all happen…then police, if apprehended produces before, Juvenile Justice Board. So without any having that concern for the child and respect for the one who has brought the child. Because he will only go by the law and the law teaches him to be authoritarian." (P11, Child Protection Government Bureaucrat)

Of course, "concern for the child" is the crux of this statement. This participant is explaining that, in his view, those exercising the type of punitive accountability described by an earlier participant are in fact only following the law. This of course raises the question: if the law is teaching monitors to act without concern for the child [taking this wording as a surrogate of 'best interest'], is there something wrong with the law?

3.2 Stakeholder Analysis

We chose to use a stakeholder analysis as a supplementary tool to further synthesize the divergences, similarities, and, most importantly, potential effects of the various policy-level and direct-care level stakeholders we interacted with during the study. We chose to break down this analysis not only by the large participants groups that took part in the study but also the sub-groups within participant groups that are outlined in Table 2 and Table 3. Upon completion of this analysis we noticed a particular divergence along two distinct 'axes' in relationship to the actual application of the best interest of the child (See Figure 5 below).

Along one axis is "Influence on a Child's Legal Outcome", which refers to those who have the highest amount of power in terms of what a child's legal status will become, whether that is to continue as a ward of the state, to be assigned for adoption, or to be restored back to family or next of kin. Along the x axis is "Proximity to Child's Experience or Trauma" which refers to how much knowledge a stakeholder actually of the child's experience. This was accounted for in terms of actual time spent with children as well as depth of understanding and explanation of child's experiences in IDIs and FGDs. These two axes were chosen because these were the two concepts that all of our domains and themes had in common, particularly in relationship to the best interest of the child. Ultimately the best interest was spoken about either in terms of: (1) where a child would or should be placed (i.e. whether in an RCC, family setting, etc.) or (2) what the child's experience was in this setting, whether that be RCC, family/next-of-kin etc. We assigned participant sub-groups to a specific space along these two axes to determine what the relationship of stakeholders to these two key constructs were.

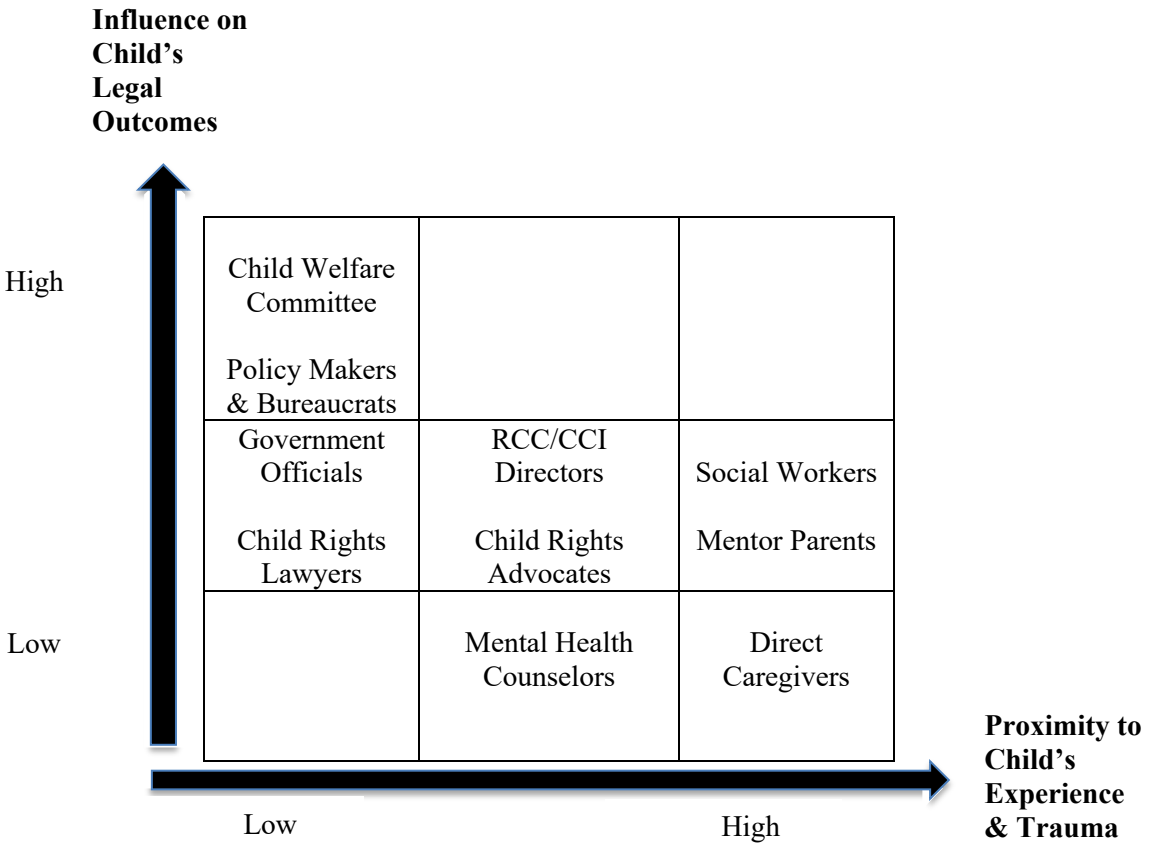

Figure 5: Stakeholder Analysis

As can we be seen above, there is an inverse relationship between the stakeholders who have the highest influence on children's legal outcomes (child welfare committee members and policy makers/bureaucrats) and those who have the highest proximity, or understanding, of a children's experience and trauma (direct caregivers). This distinct divergence is highly emblematic of the dissonance we observed between policy stakeholders and direct carers in terms of both the definition and application of best interest. Those who may have the most thorough understanding of what the child actually needs, wants, and has experienced, the amalgam of which could be argued to in fact be the best interest, are excluded from the application of the best

interest as defined by the law. This distance between knowledge of the child's experience, explicit in the construct of the best interest in both international human rights norms as well as Indian legislation, and action taken on behalf of the child for their legal outcome is certainly noteworthy when considering whether or not current child protection policies in India are working.

4. Discussion

In this study, we have presented findings from the varying conceptions and definitions of the best interest of the child as described both by high-level policy stakeholders and direct carers of OSC in New Delhi, India. We noted the emergence of three key domains across participant groups. While in no way meant to be representative of all policy stakeholders or all carers of OSC in India, these findings bring to light several points that have been previously unexplored in the literature regarding OSC in institutional care.

4.1 Direct Carers as Street Level Bureaucrats

One such aspect that deserves attention is the meaning of the role that direct carers of OSC play beyond that of just being thought of as direct care providers. Direct carers of OSC often described policies as they affected the children and their work with children, and also illustrated that there was some knowledge of national-level child protection policies. This carer perspective and data provided were consistent with the concept of the 'street level bureaucrat' as coined by public policy scholar Michael Lipsky (2010). As Lipsky defines the term, street level bureaucrats are public service-level workers who are often "low level employees" but whose collective actions "actually constitute the services 'delivered' by government" (Lipsky 2010). In this way, according to Lipsky, it is the street level bureaucrats whose decisions and actions actually make up what policy is when applied to individuals.

Although Lipsky's concept was originally designed and applied to public service workers in the United States, several of the key aspects of street bureaucracies were revealed during the current study's data analysis. For example, Lipsky names three key conditions of working in street level bureaucracies for workers:

1. Resources are chronically inadequate relative to the tasks workers are asked to perform

2. The demand for services tends to increase to meet the supply
3. Goal expectations for the agencies in which they work tend to be ambiguous, vague, or conflicting (Lipsky, 2010).

Point 1 was discussed in detail during the discussion of the 'Resources' domain and it was illustrated that both policy stakeholders as well as direct carers felt that resources were constantly lacking. Point 2 is an interesting one and is meant to suggest that no matter how services increase, for example the number of caregivers or RCCs for OSC, the demand will rise to meet it. This idea was unknowingly referenced by one social worker in particular who spoke about being confused between the organization's mission of small home sizes (this home had between 10-12 children) and the organization's administrative push for more capacity:

"So…[organization administrator] and the mentor mother think that it is a huge…resource and big building and it can be utilized for maybe 25 children so they are thinking to get it converted." (C09SW, Social Worker)

Finally, point 3 was also referenced by both participant groups, primarily in their discussions of approaches to care and the confusion, ideologically for the policy group and practically for the direct carers, about what care expectations are actually best for the child.

On this last point, Lipsky elaborates, saying that in street level bureaucracies workers are constantly working with job uncertainties. He gives the example of criminal recidivism, stating:

"There is no consensus on what techniques or approaches substantially reduce rates of criminal recidivism, although social workers, psychiatrists, and prison officials are supposed to be responsible for rehabilitating offenders" (Lipsky, 2010).

"Criminal recidivism" in the above quote could easily be replaced with "child separation" and "prison officials" with "directors of CCIs". "Rehabilitating offenders" could also easily be

switched for “restoring children to homes”. The resulting, interestingly applicable, sentence would be:

There is no consensus on what techniques or approaches substantially reduce rates of child separation, although social workers, psychiatrists, and directors of CCIs are supposed to be responsible for restoring children to homes.

The takeaway from Lipsky’s offering is that of a lack of consensus among which techniques work best to solve a given problem in street level bureaucracies, a theme that was ubiquitous among our participants. Legislation, such as the Juvenile Justice Act and the Integrated Child Protection Scheme, is supposed to create consensus, techniques, and approaches for street level bureaucracies to use. However, we found that it seems more common in India for direct carers of OSC to interpret and implement policies as a co-creation of their specific care team, as reported in the Approaches to Care and Resources domains for direct carers.

This is perhaps because of what Lipsky calls “the final salient condition of work” for street-level bureaucrats, which is “that the people with whom street-level bureaucrats regularly interact are not among their primary reference group to which client satisfaction has a priority” (Lipsky, 2010). In the context of carers of OSC, the final salient condition of work would mean that the “clients”, the children in their care, are not actually the group that carers are most answerable to. This circumstance became especially clear in the discussion of the Accountability domain for both direct carers and policy stakeholders, wherein participants spoke about how beholden they are to monitoring bodies which are mainly punitive and focused on infrastructural issues rather than actual child well-being. While many participants noted wishing or trying to put the child first, they are ultimately responsible to the government monitoring bodies as established in the Juvenile Justice Act.

4.2 Child Separation: Recognition of Resources

A prevailing through-line of this study was a lack of resources, capacity challenges, and the varying views on legitimate or illegitimate OSC, primarily in terms of whether or not children who are separated from their families for economic reasons should remain in institutional care.

A tension arose, particularly as described by direct carers, that separated children are experiencing in institutional care the choice between access to resources and access to their family or next-of-kin. As one caregiver stated poignantly:

"..they cannot get the happiness you get when you stay with your parents…with them even when we eat half a piece of bread we will get happiness but here a complete meal cannot compete with that." (C21C, Caregiver)

Perhaps even more impactful was the statement of one supervisor speaking to why children actually would prefecr to remain in residential care:

"If they have a family and there is only one earning member then that person cannot give anything to the children…it affects their future a lot…they come back to a similar place, right? If the child can study, can move forward in life, then why don't we…why don't we make something out of him…that child has come from that background to us. And I have also seen this - that if someone's parents are found, then the children don't want to go back…because they can see that their future is better here." (C22S, Supervisor)

The lesson, and question we must ask policy makers in India, is why a child has a better future in an institutional or residential care setting than with their parents. This is a fundamental cognitive dissonance that thousands of separated children are facing. In the language of the UNCRC, why should the right of a child to an education be at odds with their right to a family? (UN 1989). Currently, this question is being passed down to residential care centers, and oftentimes direct carer themselves, because cogent policy solutions are not in place. In effect,

many residential care centers, including the organization included in this study, end up serving as holding places for children whose families cannot adequately care for them. This is obviously an issue beyond the scope of this study, involving political, economic, and social issues, but it is important to recognize that international human rights norms are not applied in economic vacuums. It is a failure of current policy that direct carers have to be asking themselves these difficult questions in India.

4.3 Implications for Policy and Practice

Our study has elucidated the extent to which Indian child protection policy has internalized international human rights norms, including both the UN Convention on the Rights of the Child as well as the Guidelines for the Alternative Care of Children. It should be noted that, as is the case with any legal analysis, this internalization is an interpretation, and an interpretation that is particularly aligned with the norms themselves, of both the UNCRC and the Guidelines which have resulted in specific policy constructs in the Indian context. While attempting to embody international human rights norms, particularly aspirational goals, is laudatory the question remains: is such a stringent adherence to these international norms practical in addressing the daily realities of caring for OSC in institutional settings in India?

Our findings have illustrated a substantive dissonance between the views of policy stakeholders and direct carers of OSC, particularly in terms of care provision and suggested reforms. This dissonance was not related to differences in education levels or administrative power between the two groups but was directly connected to the proximity, or closeness, to children's lived experiences in the institutional care setting. As our stakeholder analysis has also shown, those with the least influence on a child's legal outcomes are actually those who have the highest 'proximity', or understanding, of the child's experience. If the goal of Indian child

protection policy is to contextualize international human rights norms through policy that is aligned with the experiences of those who have the most in-depth understanding of a child's experience than this finding may be of interest to policy makers. Large-scale integration of feedback from caregivers of OSC would certainly be a formidable task logistically and administratively from the side of government stakeholders. With this in mind, norm interpretation and policy creation must strike a balance between what is feasible and what is useful. Our findings suggest that the establishment of best practices of care for CCIs in India may be deficient without integration of caregiver feedback/perspectives which proved pivotal in understanding the daily realities of these unique care environments. We would therefore recommend that any future iterations of the Juvenile Justice Act or the Integrated Child Protection Scheme take the views of direct carers of OSC into account during the process of policy creation. Without these indispensable insights into the actual experiences of institutional care settings policy reforms may continue to address only the symptoms of this complex issue rather than its causes.

4.4 Implications for Further Research

This study raises several points about the need for further research. One general takeaway from the policy group was that there is a need for more research surrounding OSC in institutional care in India, in general. Many participants noted the lack of evidence, especially longitudinal evidence, on the subject of child well-being in institutional care settings in the country as a whole and stated that this should be brought to policy creation.

Secondly, while this study sampled primarily policy stakeholders at the mezzo level (i.e., residential care center directors and independent policy experts), further study is needed with extremely high-level child protection stakeholders, particularly government bureaucrats. In addition, this study recruited direct carers from one specific RCC (discussed more below); further

study is needed with direct caregivers in a diversity of settings and also settings outside of metropolitan areas, which are relatively resource-rich in India.

Finally, we recommend a large-scale study specifically targeted at understanding what children in RCCs in India view as in their best interest. While children were not the target group of this study, hearing from them would undoubtedly provide indispensable information as to what the actual experience of children is in terms of child protection policies. While assessing child care institutions against the articles of the UNCRC has become a go-to solution in terms of telling whether or not children's rights are protected and cultivated, the findings from this study that included caregivers suggest that research grounded in experiences of individuals who are directly affected by policy yield nuanced and useful results (Neagu 2015, Bessant 2011, Panter-Brick 2002). This method is aligned with the work of Harcourt and Hägglund (2014) who proposed a "bottom-up perspective on children's right" to understand the lived experience of rights of children in Australia, which at the time had been criticized for its lack of implementation after ratifying the UNCRC.

4.5 Study Strengths and Limitations

This study has several strengths. To our knowledge, it is the first study to directly address the question of the best interest of the child both in terms of conceptualization and implementation for OSC in residential care settings in India. This study also fills a literature gap regarding care of OSC in institutional settings, which has previously focused on child physical and mental health outcomes and their potential policy implications rather than on how policy is understood and implemented. In addition, study participants were both fairly high-level policy stakeholders and a variety of kinds of direct carers of OSC (social workers, mentor parents,

caregivers, and mental health counselors), which provided a nuanced range of data, especially given the qualitative nature of the study.

The study had several limitations as well. Perhaps the most glaring of these is the lack of incorporation of children's perspectives. While we acknowledge that this certainly would have been a worthwhile addition to the study, this was outside of the logistical constraints of our study. As well, seven out of eighteen of the policy group participants were recruited via the residential care organization that allowed us access to their direct carers. This connection could have biased these policy participants in favor of the structure and care provided by that particular residential care organization, although it is less likely that the policy participants would be biased in their nuanced conceptualizations of policy. As well, the study occurred only in New Delhi, meaning that generalizations cannot be made to the entirety of India. In addition, direct carers were sampled from only one residential care center. While this may serve as a 'portrait' of the potential prevalent issues and concepts regarding care of OSC in residential settings, it is certainly not a full picture. Finally, data analysis and interpretation requires deep cultural knowledge, especially in qualitative research. While steps to this end were taken, including hiring research team members from Delhi and having these members serve pivotal roles in initial data interpretation, even greater involvement with individuals from Delhi could have improved the study greatly.

5. Conclusion

In this study, we illustrated that the best the interest of the child is much more than a theoretical concept used in international human rights instruments. When regionally or nationally applied, especially in low and middle-income countries, the best interest of the child becomes a complex construct that, although mediated and officiated by the judiciary, is actually a combination of, often localized, factors. We sought to explore and describe how different types of stakeholders, both in the policy sphere and the direct-care environment, understand 'best interest of the child'.

It is important to note the previous evidence that outcomes for orphaned and separated children in institutional care are highly heterogeneous, and that the need for care for OSC continues, indicating that childcare institutions should not be summarily closed, especially in LMICs where the number of OSC continues to grow. While historically social and economic rights have come second to political and civil rights in the political construction of international human rights norms by the United Nations, the current study illustrates how integral these specific standards are in the case of OSC in residential care in India (Normand and Zaidi 2008).

In terms of the legal application of the best interest of the child as an international human rights norm for children, it is within the right of each State that is party to the Convention on the Rights of the Child to sovereignly both define and apply the best interest of the child. India has certainly done just this, creating a complex legislative framework including various iterations of the Juvenile Justice Act as well as the Integrated Child Protection Scheme, from which the best interest is meant to spring forth.

As this study illustrated, however, the construct of the best interest does not exist in a legislative vacuum, it must work as a functional and applied tool. The distinctly legal concept of best interest may be applied differently in different regions; it is ultimately left up to the sphere of

jurisdiction in which it is applied. In a country like India, with 29 countries and 7 Union territories, at least 5 widely practiced religions, and over 29 individual languages (not including sub-regional dialects), and, of course, over 1.3 billion people, the issue of jurisdiction and local application cannot be under-estimated.

The reality is that in each of these locales within India, a different, legitimate, version of the best interest of the child could emerge and this, in large part, is what is so powerful about the broad, undefined contours of this socio-legal construct. However, issues of resources, accountability mechanisms, and standards of childcare also need to be defined, implemented, and regulated in congruence with children's rights, and not just meeting basic needs. If this occurs, then the relative freedom of bandwidth that comes with a broad definition of child rights will be empowering for children as well as providers, rather than a loophole for abuse and violence.

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