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

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

History

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

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

Children

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

No other country’s metropolitan social services handled the volume of abandoned children that Russia’s did. At the height of its operations in the second half of the 19th century, the central children’s home in Moscow received 17,000 children a year—most of whom were sent to wet nurses and foster
families in the countryside. Infant mortality in homes for illegitimate children and foundlings was frightening—three times higher than in the general population. In 1912 only 11 provincial regions maintained orphanages; in other regions children were sent to almshouses, private orphanages, or foster homes where infant mortality was about 80 percent (Madison 1968, ch. 1; Ransel 1988).

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

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

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

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

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

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

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

**THE KHURSHCHEV YEARS AND BEYOND.** During the early years of Nikita Khrushchev’s administration (1953–64) the number of orphans declined as the population stabilized. The number of children in
children’s homes was reduced by nearly half, from 635,900 in 1950 to 375,000 in 1958, then decreased at a slower rate into the 1960s (Harwin 1996, p. 30). With the population growing, the emphasis on pronatalist policy was reduced and the prohibition on abortion was lifted.

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

Several factors worked against the successful implementation of this policy. Parents strongly opposed this approach, so educating children in boarding schools was made optional. Boarding schools were also very expensive—about four times the cost of regular schools (Harwin 1996, p. 29). In addition, in the early 1960s Soviet researchers and newspapers reported on the harmful effects of residential care and the importance of family upbringing (Harwin 1996, p. 67). Soon thereafter boarding schools were no longer considered a solution for educating and raising most children and were used primarily to care for children from underprivileged families (Madison 1968, p. 74). In 1963 about 1.8 percent of the 82 million children in the Soviet Union lived in residential institutions (table 1.1).

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

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

<table>
<thead>
<tr>
<th>Table 1.1</th>
<th>Estimated Number of Children 0–18 in Residential Institutions in the Former Soviet Union, 1963 and 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of institution</td>
<td>1963</td>
</tr>
<tr>
<td></td>
<td>Number of children</td>
</tr>
<tr>
<td>Boarding schools for normal children</td>
<td>1,047,900</td>
</tr>
<tr>
<td>Social orphans</td>
<td>94,000</td>
</tr>
<tr>
<td>Nonsocial orphans</td>
<td>246,000</td>
</tr>
<tr>
<td>Children's homes for normal children</td>
<td>84,000</td>
</tr>
<tr>
<td>Infants</td>
<td>—</td>
</tr>
<tr>
<td>Children</td>
<td>—</td>
</tr>
<tr>
<td>Schools (primarily boarding) for children with intellectual and physical defects</td>
<td>217,000</td>
</tr>
<tr>
<td>Institutions for severely retarded and grossly handicapped children</td>
<td>3,500</td>
</tr>
<tr>
<td>Residential treatment centers for “nervous” children</td>
<td>1,250</td>
</tr>
<tr>
<td>Total children in institutions</td>
<td>1,515,650</td>
</tr>
<tr>
<td>Total children in the Soviet Union</td>
<td>82,000,000</td>
</tr>
<tr>
<td>Children in institutions (percent)</td>
<td>1.8</td>
</tr>
</tbody>
</table>

— Not available.

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

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

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

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

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

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

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

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

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

People with disabilities

Under socialism, the approach toward people with disabilities was defined by the Soviet science of “defectology.” Developed in the Soviet Union in the 1920s, defectology is both the theory and treat-
ment of disability with its own methods and techniques (UNICEF 1998a, p. 50). Defectology has a strong medical orientation that defines disability as a diseased state (invalid, defective, abnormal children with mental or physical disease) or a problem of the “abnormal” individual. The role of the environment in supporting the individual is ignored; treatment consists of a diagnosis, segregation of the “normal” and “abnormal” individuals, and correction of the defect (Jonsson 1998).

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

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

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

The philosophy and science of defectology and the care provided to people with disabilities remained fundamentally unchanged through the end of the socialist period and continue to dominate the treatment of them today.

**The elderly**

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

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

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

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

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

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

In Poland about 1.5 percent of the elderly lived in social care homes in 1989 (Velkoff and Kinsella 1993). In Hungary about 2.6 percent of individuals over 60 lived in social care homes in the mid-1980s (Szeman 1997, p. 28). In the republics of the former Soviet Union 364,500 people lived in institutions for the elderly and people with disabilities in 1990. The range was from 0.2 percent of the population in Azerbaijan and 0.3 percent in Georgia, to 1.8 percent in Belarus and Russia (see table 1.2).

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

### Legacy

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

### Thousands of large residential institutions

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

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**Table 1.2**

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

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

\(^a\) Nonweighted average.

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

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

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

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

Not all residential institutions in Central and Eastern Europe and the former Soviet Union were or are total institutions in ways defined by Goffman. Some institutions—creches or boarding schools that allow children to return home on weekends or children's homes where children live in the institution but go to a regular school—provide children with regular contact with the outside world. Still, such institutions are harmful to child development. Infant homes, residential institutions for people with disabilities, and children's homes with their own schools, however, have the characteristics of total institutions.

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

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

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

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

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

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

At the end of the socialist era and the beginning of the transition to a market economy, few if any comparative assessments were done on the impact of residential institutions on individual development. Nevertheless, many assessments and anecdotal reviews were conducted of healthy and children with disabilities living in residential institutions soon after the transition began or who were adopted from such institutions. The impression from a review of these studies and visits to nearly 100 institutions in eight countries of Central and Eastern Europe and the former Soviet Union during the early years of the transition is that many children were damaged by regimented, impersonal, institutional life and became dependent, isolated from their families and the outside world, and ill-equipped to function independently outside the institution. Vast numbers of children who have been socialized for one world are unable to fit into another.

**Barriers to change**

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

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

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

**Absence of a social welfare infrastructure.** Four barriers impede the creation of a supportive social welfare structure. The first is the lack of sufficient social services to help individuals with problems. Before the transition, policies in Central and Eastern Europe and the former Soviet Union focused on maximizing economic production. As a result the social
welfare system promoted universal employment and productive workers. This policy orientation, however, caused the absence of social work knowledge and community programs to help individuals and families when difficulties arose. Nurses and teachers, community volunteers, and individuals connected with trade unions provided minimal assistance with few resources to children, families, and the elderly (Kadushin 1980, p. 663). These individuals were largely untrained to intervene with social or personal problems and often played more of an investigative and monitoring role than a supportive social services role to resolve problems.

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

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

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

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

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

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

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

Legislative reform has occurred in several relevant areas, including social insurance (creating self-supporting systems) and social assistance (consolidating multiple cash benefits, decentralizing the provision
of cash benefits, and targeting limited financial assistance). But few countries have significantly changed laws to reduce reliance on residential institutions or to create community-based social services. Residential institutions in many countries follow laws from the Soviet era that are no longer in force but continue to guide practice. In Armenia, for example, the 1984 Soviet Law on Boarding Schools defines practice within boarding schools for vulnerable children though the law is no longer operative. The United Nations Convention on the Rights of the Child, adopted by the U.N. General Assembly in 1989, discourages the use of residential institutions for children. The convention has been ratified by all but two countries. So far, however, this convention appears to have had a limited effect on changing the conditions in or reliance on residential institutions in most countries of Central and Eastern Europe and the former Soviet Union—with some exceptions. In Romania, for example, the convention played a role in improving conditions in the worst facilities. But there has been no sustained reduction in the number of children in residential care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Centralized.** Albania—with the lowest placement rate in residential institutions of any Central and Eastern European country or former Soviet Union republic—has a centralized decisionmaking process. Any child, person with disabilities, or elderly person placed in residential care must be approved, generally in person, by the director of social care in the General Administration of Social Services in Tirana. The extremely low placement rate in Albania, conditioned by a national culture of community and family responsibility, has enabled this centralized decisionmaking process. The directors of residential institutions have relatively little influence in determining how many or which individuals enter their institutions, particularly when beds are filled to capacity.

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

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

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

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

2. Despite the recognition he received for institutional upbringing, Anton Makarenko never regarded residential upbringing as ideal for the child. In fact, his work was also the primary guide for raising children within families during the same period (Bronfenbrenner 1973, p. 41). Uri Bronfenbrenner, the child psychologist, in his introduction to Makarenko’s Book for Parents (called in English The Collective Family) wrote that “its closest counterpart in the West is Benjamin Spock’s Baby and Child Care, with the important difference that the Russian volume is concerned not with physical health but with the development of character” (Makarenko 1967, ix).

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

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

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