DISSERTATION | DOCTORAL THESIS

Titel | Title

An Interdisciplinary Study on the Implementation of the Right to Family Life for Children with Disabilities in Austria, Serbia and South Africa
Children with Disabilities between the UN CRC and the UN CRPD

verfasst von | submitted by
Lazar Stefanović EMA

angestrebter akademischer Grad | in partial fulfilment of the requirements for the degree of
Doctor of Philosophy (PhD)

Wien | Vienna, 2024

Studienkennzahl lt. Studienblatt | Degree programme code as it appears on the student record sheet:	UA 794 242 101
Dissertationsgebiet lt. Studienblatt | Field of study as it appears on the student record sheet:	Interdisciplinary Legal Studies Rechtswissenschaften
Betreut von | Supervisor:	Univ.-Prof. Mag. Dr. Ursula Kriebaum

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Acronyms

ACERWC - African Charter on the Rights and Welfare of the Child
ACHPR - African Charter on Human and Peoples' Rights
CAT - Convention Against Torture
CBS - Community-Based Services
CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women
CILT - Conditional International Law Theory
CRC - Convention on the Rights of the Child
CRPD - Convention on the Rights of Persons with Disabilities
CSO - Civil Society Organisation
CWD - Children with disabilities
DI - Deinstitutionalisation
DPO - Disabled Persons Organisation
ECHR - European Convention on Human Rights
ECtHR - European Court of Human Rights
ESC - European Social Charter
ESCR - Economic, Social and Cultural Rights
EU - European Union
GC - General Comment
HRC - Human Rights Council
ICCPR - International Covenant on Civil and Political Rights
ICESCR - International Covenant on Economic, Social and Cultural Rights
ICJ - International Court of Justice
IGO - Inter-governmental organisation
IHRL - International Human Rights Law
ILC - International Law Commission
NGO - Non-Governmental Organisation
NHRI - National Human Rights Institution
NIT - New Institutional Theory
OPCRPD - Optional Protocol to the Convention on the Rights of Persons with Disabilities
RESC - Revised European Social Charter
SGHs - Small Group Homes
TLP - Transnational Legal Process School
UN - United Nations
UNGA - United Nations General Assembly
UNICEF - United Nations International Children's Emergency Fund
UNIEF ESARO - UNICEF Eastern and Southern Africa Office
UPR - Universal Periodic Review
VCLT - Vienna Convention on the Law of Treaties

Austria

ABGB - Federal Civil Code
ACDP - Advisory Council for Persons with Disabilities
AOB - Austrian Ombudsman Board
B-KJHG - Federal Child and Youth Welfare Law
B-RK - Federal Constitutional Act on the Rights of Children
B-VG - Federal Constitutional Law
BBG - Federal Disability Act
BBGStG - Federal Equality of Persons with Disabilities Act
BPGG - Federal Care Allowance Act

CFREU - Charter of Fundamental Rights of the European Union
ESI Funds - European Union Structural and Investment Funds
FLAG - Family Burdens Equalisation Act
HeimAufG - Federal Residential Care Act
ILA - Independent Living Austria
IMC - Independent Monitoring Committee
KIJA - Office of the Ombudsman for Children and Youth
LTC - Long-Term Care
NAPD - National Action Plan on Disability
OeB - Disability Ombudsman
OGH - Supreme Court
VfGH - Constitutional Court
VwGH - Supreme Administrative Court
WPPG - Vienna Provincial Law on Residential and Nursing Care

Serbia

ACDP - Advisory Council for Persons with Disabilities
APC23 - Action Plan for Chapter 23
CSW - Centres for Social Work
CYD - Facilities for children and youth with disabilities
CYWPC - Facilities for children and youth without parental care and children and youth with disabilities
DIS - Deinstitutionalisation Strategy
LSG - Local Self-government
LSP - Law on Social Protection
MODS - Network of Organisations for Children of Serbia
NAPD - National Action Plan on Disability
RISP - Republic Institute for Social Protection
SNS - Serbian Progressive Party
UCY - facilities for the upbringing of children and youth

South Africa

ANC - African National Congress
CC - Constitutional Court
CCL - Centre for Child Law University of Pretoria
CDG - Care Dependency Grant
CSG - Child Support Grant
CYCC - Child and Youth Care Centre
DBE - Department of Basic Education
DSD - Department of Social Development
DWYPD - Department of Women Youth and Persons with Disabilities
FCG - Foster Child Grant
GDH - Gauteng Department of Health
GEAR - Growth Employment and Redistribution (Macroeconomic Strategy)
HHC - Hope and Homes for Children
MEC - Member of the Executive Council
NDRM - National Disability Rights Machinery
NMHPF - National Mental Health Policy Framework
OHO - Office of the Health Ombud
ORC - National Office on the Rights of the Child Rights

SADA - South African Disability Alliance
SAHRC - South African Human Rights Commission
SALRC - South African Law Reform Commission
SASSA - South African Social Security Agency
SCA - Supreme Court of Appeal
WCFID - Western Cape Forum for Intellectual Disability
WPF - White Paper on Families
WPRPD - White Paper on the Rights of Persons with Disabilities

Acknowledgments

Starting this PhD in the year the COVID-19 pandemic began presented unique and unprecedented challenges. Navigating these obstacles would not have been possible without the unwavering support of my family. I am profoundly grateful to them for believing in me and celebrating each milestone of this journey with boundless enthusiasm. To my late grandparents, whose pride in me never wavered, even when there was little to boast of, and whose unconditional love and wisdom have indelibly shaped who I am, I owe a debt of gratitude that words cannot fully capture.

I would like to express my deepest gratitude to Professor Manfred Nowak, whose guidance and unwavering support made this PhD dissertation possible. His profound insights and encouragement have been invaluable throughout this journey. Additionally, I am deeply grateful to my supervisor, Professor Ursula Kriebaum, for her invaluable guidance and insightful contributions. My heartfelt thanks go to Dr. Ursula Naue for her steadfast support and incredibly selfless dedication, which have been a constant source of inspiration. Dr. Naue shaped my PhD journey through her academic and moral support. Without her insights, this study would be far less methodologically sound and would not achieve the quality it possesses. Moreover, Dr. Naue's expertise in the rights and the position of persons with disabilities in Austria helped me greatly to produce a quality country study and navigate Austria's complex social protection system of today and of the past. Therefore, Dr. Naue factually acted as a co-supervisor to this dissertation, which would have not been what it is today without her engagement.

To my friends, who provided indispensable respite from the rigours of academia, I extend my deepest appreciation. I am equally thankful to my colleagues and friends, who offered moral support, insightful feedback, and shared PhD-related memes that brought much-needed levity to my days. Special thanks to Georg Bauer, Richard Raber, Radoš Keravica, Holly Wescott, and Teodora Miljojković for their unwavering support.

The Centre for Child Law at the University of Pretoria in South Africa welcomed me with open arms from the very first day. I am forever indebted to the fantastic individuals there, especially Liesl Muller, Karabo Ozah, Stanley Malematja, and Pontso Phahlane, whose warmth and

support made my time there truly enriching. I also sincerely thank the people from the Centre for Human Rights at the University of Pretoria, especially Frans Viljoen, Dianah Msipa, Elvis Fokala, Faith Njahira Wangari, Mai Aman, Janet Gbam, and others.

I also owe a great debt of gratitude to the eminent academics and practitioners who generously shared their time and expertise during the initial stages of my research: Anna Lawson, Petra Flieger, Ann Skelton, Delia Ferri, Ana Laura Aiello, Ketevan Khomeriki, Gabor Petri, Marboe Irmgard and Priscila Rodriguez. Their guidance was instrumental in shaping the direction and depth of my work. Special gratitude goes to the supervisor of my master's thesis at the Eötvös Loránd University in Budapest Prof. Katalin Tausz, as well as Dragana Ćirić Milovanović and Snežana Lazarević, who greatly shaped my professional approach in advocating for the rights of persons with disabilities. I am grateful to my designer Mladjan Petrović for the technical editing of my thesis, which has significantly enhanced the presentation of my work.

My sincere thanks go to the Global Campus of Human Rights and the Right Livelihood Foundation for their financial support with living expenses, tuition fees, and travel grants for most of my PhD journey. Their recognition of the value of my research provided the crucial resources needed to bring this project to fruition. Additionally, I am profoundly grateful to the University of Vienna for their funding, which enabled me to conduct an essential field visit in South Africa. This experience enriched my research by providing invaluable insights and first-hand experiences that significantly enhanced the depth and breadth of my work.

Lastly, I extend my sincere thanks to all the key informants who participated in my research and provided invaluable insights. Without their contributions, this research would not have reached its current depth and nuance.

Introductory chapter

1. Introduction

Beneath the shadow of global aspirations for human rights, the issue of institutionalisation of children with disabilities (CWD) lays bare a profound disconnect. This dissertation embarks on an intricate exploration of the nuances and complexities surrounding the realisation of the right to family life for CWD across three diverse legal jurisdictions: Austria, Serbia, and South Africa. By dissecting the legal frameworks, analysing policy implementations, and exploring the works of major stakeholders, the study aims to highlight the factors that drive and impede the realisation of the right to family life for CWD. Herein lies an academic endeavour that seeks to bridge the gap between theoretical human rights commitments and their practical realisation.

The institutionalisation of children remains a pressing global issue, prevalent in the majority of countries worldwide. Studies have roughly assessed the number of institutionalized children at approximately 5.5 million; however, due to a lack of data, different quantitative analysis methods have yielded varied estimates.[1] UNICEF estimates that the number of CWD worldwide is around 240 million, although significant gaps in data availability are present.[2] Of particular concern is the disproportionate representation of CWD within the institutionalized population, accounting for one in three children.[3] Disability emerges as the most significant predictor of institutionalisation, with disabled children being 17 times more likely to end up in institutional care than their counterparts.[4] Most institutionalized CWD have living parents, and the lack of disability-inclusive programs, support, and services significantly contributes to their overrepresentation in institutional care.[5] The mortality rate of CWD in institutional care is 100 times higher than that of other children.[6] According to Desmond *et al.* institutional care is more likely to occur in high-income countries, than in low-income ones.[7] While some countries are

[1] Chris Desmond, et al., *Prevalence and number of children living in institutional care: global, regional, and country estimates*, 4 THE LANCET CHILD & ADOLESCENT HEALTH (2020); Nicole Petrowski, et al., *Estimating the number of children in formal alternative care: Challenges and results*, 70 CHILD ABUSE & NEGLECT (2017).
[2] Seen, Counted, Included. Using data to shed light on the well-being of children with disabilities (UNICEF 2021).
[3] MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 189.
[4] Children with disabilities, UNICEF ECARO accessed: 3rd March, 2023, available at https://www.unicef.org/eca/children-disabilities.
[5] Fact Sheet: Children with Disabilities (UNICEF 2022), p. 48.
[6] Status of the Convention on the Rights of the Child. Repot of the Secretary-General A/74/231, (United Nations General Assembly), 2019, para. 54.
[7] Desmond, et al., THE LANCET CHILD & ADOLESCENT HEALTH, (2020).

actively working to reduce the number of CWD in institutions, in others, the situation is worsening, leading to an increasing number of children being placed in institutional care.

While there is no universally agreed-upon definition of institutional settings, the European Commission *Ad Hoc* Expert Group offers a particularly useful one, stating: 'residents are isolated from the broader community and/or compelled to live together; residents do not have sufficient control over their lives and over decisions which affect them; and the requirements of the organisation itself tend to take precedence over the residents' individualized needs'.[8] This description is similar to the Gofman's definition of a 'total institution' from 1961: '(..) a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life'.[9] On the other hand, the Committee on the Rights of Persons with Disabilities (CRPD Committee) has asserted that for disabled children, any living setting that is not a family should be considered an institutional setting, recognising the particular vulnerability of these children, as well as the importance of the family environment for the development of the child.[10]

Sociological and philosophical critiques of the inadequacy of institutional care and other forms of care and treatment for persons with disabilities commenced more than half a century ago with the emergence of the so-called 'social model of disability'[11]. Pioneering works of Erving Goffman and Michel Foucault contributed significantly.[12] The social model recognized that disability is shaped through the interaction of a person who has an impairment (physical, sensory, mental etc.) with his / her surroundings, asserting that any form of segregation, including institutional care, constitutes a manifestation of societal oppression. Ground-breaking at its inception, the social model laid the groundwork for the development and

[8] Report of the Ad Hoc Expert Group on the Transition from Institutional to Family-based Care, (2009), European Commission.
[9] ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (AldineTransaction. 1968), p. xiii
[10] General comment no. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, Committee on the Rights of Persons with Disabilities, 2017. Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022.
[11] Tom Shakespeare & Nicholas Watson, *The social model of disability: an outdated ideology?, in* EXPLORING THEORIES AND EXPANDING METHODOLOGIES: WHERE WE ARE AND WHERE WE NEED TO GO (2001); Mike Oliver, *The social model of disability: thirty years on*, 28 DISABILITY & SOCIETY (2013); Anna Lawson & Angharad E Beckett, *The social and human rights models of disability: towards a complementarity thesis*, 25 THE INTERNATIONAL JOURNAL OF HUMAN RIGHTS (2021).
[12] MICHEL FOUCAULT, MADNESS AND CIVILIZATION (Routledge. 2003); MICHEL FOUCAULT, THE BIRTH OF THE CLINIC (Routledge. 2012).

codification of the 'human rights model of disability' during the drafting and adoption of the Convention on the Rights of Persons with Disabilities (CRPD).[13]

This study aims to investigate the factors that hinder and support the realisation of the right to live in a family environment for CWD in Austria, Serbia, and South Africa. In addressing the question, which fundamentally concerns state compliance with international human rights law, this study predominantly adopts the Transnational Legal Process School (TLP).[14]

Part I of the study concentrates on the initial two phases of norm implementation (internalisation) according to the TLP - interactions and interpretation (of international human rights norms). Parts II, III and IV delve into domestic factors that impact implementation in three states parties. Parts II, III and IV are core parts which directly contribute to addressing the central question, with the findings from Part I forming the basis for the country analysis. A research framework, including analytical framework and methods are further expounded upon in the subsequent subchapters.

The transition from institutional to family-based care, often referred to as deinstitutionalisation (DI), is intricately linked to International Human Rights Law (IHRL) and presents an operationalisation of IHRL within states parties. In the course of these DI processes, states modify laws, policies, and practices of state and private subjects, and influence citizens' attitudes to ensure the rights of CWD and fulfil IHRL obligations. Consequently, examining the implementation of norms related to family life, alternative care, and residential care (institutional care)[15] for CWD under the Convention on the Rights of the Child (CRC) and the CRPD can be also framed as an exploration of DI processes in states parties.

The CRPD Committee aligns with this perspective, emphasizing that '(…) deinstitutionalisation should be directed towards protection of the right to family life (for children)'.[16] Therefore, the terms DI and the transition to family-based care will be frequently

[13] Theresia Degener, *Disability in a Human Rights Context*, 5 LAWS (2016); Lawson & Beckett, THE INTERNATIONAL JOURNAL OF HUMAN RIGHTS, (2021).
[14] Harold Hongju Koh, *The 1998 Frankel lecture: Bringing international law home*, 35 HOUS. L. REV. (1998).
[15] 'The terms 'residential care' and 'institutional care' are used interchangeably in this dissertation. Both denote day-and-night care for children in facilities. When the size of a facility is relevant, it will be emphasised in the text (e.g., small-scale residential care). Additionally, when the length of the stay in a facility is short-term (e.g., respite care), this will be expressly stated; otherwise, it is assumed to be care for a longer term. Moreover, if care in a facility is provided for several hours during the day, this form of care is not classified as institutional/residential care, but by another name (e.g., day centre).
[16] Draft guidelines on DI, CRPD Committee para. 42

employed in this thesis. One of the focal points of inquiry in the country studies will be each country's approach to DI, assessing its strengths and weaknesses, as well as identifying drivers and blockages.

The principal international human rights instruments pertinent to this context, namely the CRC and the CRPD, are the most extensively ratified human rights treaties, with 196 and 186 ratifications respectively.[17] Critical provisions that regulate issues closely related to the family life of CWD and institutional care as a form of alternative care are encapsulated in Article 20 and Article 23 CRC, as well as Article 19 and Article 23 CRPD.

The respective treaty bodies, namely the Committee on the Rights of the Child (CRC Committee) and the CRPD Committee, have been proactive advocates for the elaboration and advancement of the rights of CWD within the scope of their mandates. Similarly, the United Nations General Assembly (UNGA) has adopted over a dozen resolutions since the inception of the CRPD, pertinent to the standards of alternative care for all children, encompassing CWD. This body of resolutions adds significant secondary law to complement the existing treaties.

Arguably, there is an established consensus among states parties, the treaty bodies, academic and professional community that institutional care in large institutions is inconsistent with the IHRL and the care for children, whether with or without disabilities, in such settings should be eliminated. This consensus is evidenced in the general comments (GCs) of the treaty bodies, their jurisprudence and UNGA resolutions, as well as practices of numerous countries that are, to varying degrees of success, abandoning large institutional care. Notwithstanding, the question of institutional care in facilities smaller than the traditional, large institutions, is highly contested and seemingly creates a discord between the two treaty bodies and the understanding of 'interpretive communities'[18] regarding whether such a form of care aligns with the IHRL.

While each treaty is interpreted by a specific committee, it should be acknowledged that differences surrounding a particular issue can contribute to the fragmentation of the international human rights regime, resulting in divergences. This fragmentation has the potential to impede the implementation of norms from both treaties into state parties. Such concerns are reasonable, particularly in hypothetical situations where a state party to both

[17] *Status of Ratification Interactive Dashboard*, UN Office of the High Commissioner, (2023), accessed: 20th February, 2023, *available at* https://indicators.ohchr.org/.
[18] Koh, HOUS. L. REV., (1998).

treaties receives conflicting recommendations from the committees on the same issue. This could potentially undermine the authority of both committees before states parties. For scholars following the TLP scholarship, the interaction of different transnational actors, including human rights bodies, and their interpretations of norms is considered one of the essential elements of norm implementation.[19]

This analysis increases the understanding of the primary law contents – what is prescribed in the CRC and the CRPD concerning institutions and institutional care on one hand, and family-based care on the other. It takes into account an evolutive approach to treaty interpretation adopted by the Committees and secondary law-making bodies, while also recognizing the significant role of other 'transnational norm entrepreneurs'.[20]

Beyond serving as a foundation for the analysis of treaty implementation in three countries, understanding the contents of the treaties and the process of dynamic interpretations by the committees will facilitate the identification of potential directions for interpretation and development. This insight can bring together interpretive communities in their efforts to advance and harmonize standards, addressing divergences and enhancing the efficient implementation of these norms. Therefore, the dual objectives of the first section analysis are to facilitate the analysis of norm implementation in domestic jurisdictions by revealing the development of relevant norms and their current meaning, and to explore potential solutions for divergences in interpretations among interpretive communities. This harmonisation is considered a prerequisite for a unified human rights regime and successful enforcement.

The process of implementation of relevant norms is examined through the cases of Austria, Serbia, and South Africa. All three countries are parties to the CRC and the CRPD, receiving recommendations from both treaty bodies regarding disabled children, and varying in the extent to which they implement these conventions. The analysis places particular emphasis on legal and political forms of implementation and the actors participating in these processes, along with considerations of social internalisation. By scrutinizing these processes and involved actors, the study seeks to answer questions about the factors contributing to and impeding the implementation of these norms, to what extent and how each state has internalized relevant

[19] Id. at.
[20] Id. at; Harold Hongju Koh, *The 1994 Roscoe Pound Lecture: Transnational Legal Process*, 75 NEBRASKA LAW REVIEW (1996); Koh, HOUS. L. REV., (1998); Harold Hongju Koh, *How is international human rights law enforced?*, 74 INDIANA LAW JOURNAL 1937(1999).

norms. The methodology employed is designed to facilitate the replication of the study and the application of lessons learned to other cases and countries.

2. Reasons for the transition from institutional care to life in a family environment

The transition of reliance from institutional to care and living in a family is driven by two principal factors: firstly, scientific evidence highlighting the profound detriment of institutional environments to a child's development and well-being; and secondly, the recognition that institutional care contravenes the fundamental principles of human rights, primarily the non-discrimination, and that violations of various IHRL norms being more widespread than in family care. This dissertation addresses the latter, whilst summarising research pertaining to the development, health, and well-being of children in institutional care here.

A multitude of studies corroborate that institutional care can detrimentally affect the well-being, social, emotional, cognitive, and physical development of children.[21] Furthermore, transitioning from institutional to foster care is linked with improved psychological and other outcomes, suggesting that the adverse effects of institutional placements can be completely or partially reversed if a child is moved to foster care sufficiently early.[22] The duration of institutionalisation correlates with the severity of its harmful effects.[23] Moreover, the less child-friendly and more depersonalising the approach in institutional care - that is, the more socially

[21] E.g. Mary Dozier, et al., *Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association*, 84 AM J ORTHOPSYCHIATRY (2014); M. H. van IJzendoorn, et al., *Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on development*, 7 LANCET PSYCHIATRY (2020); F. Tibu, et al., *Disruptions of working memory and inhibition mediate the association between exposure to institutionalization and symptoms of attention deficit hyperactivity disorder*, 46 PSYCHOLOGICAL MEDICINE (2016); B Heidi Ellis, et al., *Predictors of disruptive behavior, developmental delays, anxiety, and affective symptomatology among institutionally reared Romanian children*, 43 JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY (2004); Anna T. Smyke, et al., *A Randomized Controlled Trial Comparing Foster Care and Institutional Care for Children With Signs of Reactive Attachment Disorder*, 169 AM J PSYCHIATRY (2012).

[22] Mark Wade, et al., *Effect of Foster Care Intervention on Trajectories of General and Specific Psychopathology Among Children With Histories of Institutional Rearing: A Randomized Clinical Trial*, 75 JAMA PSYCHIATRY (2018); Anna T Smyke, et al., *Placement in foster care enhances quality of attachment among young institutionalized children*, 81 CHILD DEVELOPMENT (2010).

[23] Ellis, et al., JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY, (2004), p. 1284.

depriving the environment - the more detrimental it is to children's attachment development.[24] Similarly, larger institutional settings are associated with greater harm to children, including increased exposure to violence and abuse.

From the perspective of attachment disturbances, Smyke *et al.* found that children cared for in small group homes (SGHs) of 10 to 12 children, showed less attachment disturbance than children in large groups, but still more than children in family homes.[25] However, the authors cautioned about limitations due to potential bias from reporting caregivers in SGHs, as these were operating as special pilot units at the time of the study. The observed benefits in attachment disturbance from care in SGHs, as opposed to larger facilities, were attributed to the improved child-to-caregiver ratio and reduced caregiver turnover, rather than to the facility's size per se. A lower staff turnover enables children to form more stable relationships with caregivers. Smyke *et al.* noted that a critical factor in the low turnover of caregivers was high unemployment in Romania, where the study took place, implying that the quality of such care will depend also on external factors. An independent monitoring report of Bulgarian SGHs from 2019, titled 'A Dead End for Children', identified nearly identical issues in this form of care as in large facilities.[26] Thus, smaller facilities, including those with up to 10 – 12 residents, do not guarantee better outcomes for children. Furthermore, as suggested by the title of the monitoring report, CWD who are placed in institutions early in life are often institutionalised for life. [27] This pattern is not exclusive to Bulgaria but is also typical in other countries, including Serbia.[28]

Based on the understanding of the harms that any form of institutional care can inflict on a child, in 2014 a group of psychiatrists issued an impactful statement, arguing that: 'Every child has a basic right and need to grow up in a safe home with a stable continuous relationship with at least one adult who is a trusted, committed parent figure.' The group also emphasised that 'group care is not an appropriate living arrangement, and it can never substitute for a home environment'. The psychiatrists sent a strong and science-based message that systems of child -welfare should not rely on institutional care as a living place for children. They also made a distinction between an institution as a place of living, and short and temporary, so-called respite

[24] Anna T Smyke, et al., *Attachment disturbances in young children. I: The continuum of caretaking casualty*, 41 see id. at (2002).
[25] Id. at.
[26] A Dead End for Children: Bulgaria's Group Homes, (2019).
[27] Id. at, p. vi, xii.
[28] Part III, Serbia, Chapter Institutional (residential) care.

care placements.[29] Additionally, in their opinion, only when there is no less restrictive option, should a child be only temporarily placed in such a care for the purpose of receiving a mental health treatment.[30] Finally, the experts stressed that group care should never be used for young children due to the profound developmental harm it can cause, and that placement in families is an urgent intervention in such cases.[31]

On the other hand, an international, comparative, longitudinal study examining the outcomes of institutional care for orphans in Cambodia, Ethiopia, Kenya, and Tanzania found that children in institutional care exhibited better physical health outcomes than their counterparts in families, with no statistically significant differences observed in other measures.[32] This study stands as an outlier, underscoring the necessity to consider the specific contexts of the countries in question and their local communities for a complete understanding of the findings. The authors emphasised that the study presents an argument for the improvement of support and services for families in the given countries, and that when children are doing 'relatively well' in an institutional setting it could be worse for them to move to a more deprived setting.[33]

The term 'protective institutional care' used in the Global Study refers to certain facilities that, unlike some local communities, can provide basic shelter and nutrition to children, thereby contributing to better health outcomes in some instances.[34] However, it is crucial to note that, despite showing better outcomes for children in a Cambodian institution in a specific study, Cambodian orphanages have faced significant criticism for engaging in 'orphanage tourism' to financially benefit from tourist visits and donations, a practice also linked with various forms of child abuse, much like in Kenya as highlighted by UNICEF Eastern and Southern Africa Office (ESARO).[35] Therefore, while the comparative study suggests that institutional care can sometimes offer benefits to children, these advantages are not universal but rather highly

[29] Dozier, et al., AM J ORTHOPSYCHIATRY, (2014), p. 221.
[30] Id. at, p. 219.
[31] Id. at, p. 223.
[32] Kathryn Whetten, et al., *Three-year change in the wellbeing of orphaned and separated children in institutional and family-based care settings in five low-and middle-income countries*, 9 PLOS ONE (2014).
[33] Id. at.
[34] NOWAK. 2019, p. 156.
[35] Tess Guiney & Mary Mostafanezhad, *The political economy of orphanage tourism in Cambodia*, 15 TOURIST STUDIES (2015); Kathie Carpenter, *Childhood studies and orphanage tourism in Cambodia*, 55 ANNALS OF TOURISM RESEARCH (2015); Tess Guiney, *Orphanage Tourism: The Need for Protection and Policy*, *in* RISK, PROTECTION, PROVISION AND POLICY (Claire Freeman, et al. eds., 2017); Caring Systems: Maximising synergies between care reform and child protection system strengthening in Easterrn and Southern Africa, (2021), UNICEF ESARO, p. 14.

context-dependent and specific to each institution. The Global Study offers a comprehensive review of multitude of studies on the impact of institutional care on children worldwide.[36]

The scientific findings continuously inform the development of international human rights law, including the standards of care for CWD. This is evidenced through the examination of two conventions, alongside the practices of treaty bodies and resolutions passed by the UNGA, highlighting their significant influence. This section provides background information, explaining why institutional care is generally approached with caution and is almost universally recognised as the least adequate form of care, though the dissertation does not delve into psychological and medical sciences specifics. In the case of CWD, institutionalisation at a young age almost inevitably leads to lifelong institutionalisation and social exclusion, resulting in the deprivation of basic rights that are universally taken for granted by persons without disabilities. This, indeed, was the main reason for the creation of a disability-specific international human rights treaty. This very concern was a primary catalyst for the creation of a disability-specific international human rights treaty. Despite the universal inclusion of anti-discrimination and equality principles in all human rights treaties, their implementation revealed that most states regarded disability as a legitimate basis for depriving children and adults with disabilities of certain rights, including the right to live in a family environment.

3. Research Framework

3.1. Research Objectives and Research Questions

This dissertation critically examines the realisation of the right to live in a family environment for CWD in Austria, Serbia, and South Africa. It does so by probing into the complex fabric of IHRL concerning children's rights and the rights of persons with disabilities, examining the interactions between the conventions and between corresponding interpretive communities (Part I). The study centres around this interplay, aiming to unravel the intricate process of implementation of the human rights law pertaining to CWD, within varied legal contexts and socio-political contexts. At its core, the dissertation seeks to identify the barriers and enablers affecting the realisation of the right to live in a family environment for CWD, against the

[36] NOWAK. 2019.p. 152 – 165.

backdrop of states' obligations under IHRL (Parts II, III and IV). To achieve the objective, the study posits the following central research question:

How do various factors facilitate and impede the implementation of the right to live in a family environment for children with disabilities in Austria, Serbia, and South Africa?

The secondary objective of this dissertation is to unravel the delicate relationship of the CRC and the CRPD regarding the rights of CWD, specifically the right to live in a family environment, to detect possible divergences and propose resolutions. To achieve this objective the study asks:

What are the international legal standards on the right to live in a family environment for CWD, and are there divergences between the CRC and the CRPD in that regard?

Considering the complexity of the central research question, and based on the theoretical framework of primarily the Conditional International Law Theory (CILT) and the Transnational Legal Process (TLP) scholarship, as elaborated in the following section, the study asks several subsidiary questions:

- *How have statutory laws incorporated the relevant CRC and CRPD norms?*
- *Have the judiciary contributed to the implementation of the CRC and the CRPD norms?*
- *How have policymakers addressed the right to live in a family environment for CWD in strategic public policy documents?*
- *How have national human rights institutions and state structures that facilitate the implementation of the CRC and the CRPD addressed the right to live in a family environment for CWD?*
- *How has civil society, primarily disabled people's organisations and human rights NGO addressed the right to live in a family environment for CWD?*
- *What other significant factors have impacted the implementation of the right to live in a family environment for CWD?*

Analytical Framework

The present study does not inquire whether international (human rights) law matters, but instead focuses on how specific norms of IHRL are implemented in domestic contexts. It aims to uncover the factors that facilitate and hinder the implementation of selected norms, as outlined in the research questions. This approach aligns with the post-ontological period of IL scholarship, characterized by a shift towards examining enforceability and effectiveness of IL, empiricism, as opposed to questions about the nature of IL.[37] The study is empirical and positioned within the CILT, which, in the words of Ginsburg and Shaffer '(…) focuses on midrange theorizing concerning the conditions under which international law is formed and those under which it has effects in different contexts, aiming to explain variation.'[38]

The CILT requires empirical enquiry, quantitative and/or qualitative.[39] Ginsburg and Shaffer highlight that CILT acknowledges the importance of qualitative data in assessing the conditions under which IL operates effectively in practice.[40] Consequently, examinations grounded in the CILT are context-specific and thus not appropriate for the development of grand theories, but rather mid-range ones.[41] Similarly, this study aims to elucidate the conditions influencing the implementation of selected IHRL norms in three countries, demonstrating the high degree of context specificity involved. Conversely, the further progress in implementation will depend on the changes in those country-specific conditions.

The incorporation of both qualitative and quantitative data is crucial for the CILT studies, and this dissertation employs both types. Secondary quantitative data, chiefly sourced from governmental publications, serves as a metric for assessing the implementation of the right to live in a family environment for CWD, and to monitor progress over time where feasible. However, the study reveals substantial limitations in using quantitative data as the sole indicator of successful IHRL implementation, recommending triangulation with additional data sources, as detailed in the concluding chapter of this thesis. Qualitative methods, predominantly interviews with key informants, aim to explore the vast array of factors, mostly extra-legal, that affect the implementation of selected norms. The CILT, however, does not propose a

[37] Regina Jefferies, *Transnational Legal Process: An Evolving Theory and Methodology*, 46 BROOK. J. INT'L L. (2020), p. 321.
[38] Tom Ginsburg & Gregory Shaffer, *The Empirical Turn in International Legal Scholarship*, 106 AMERICAN JOURNAL OF INTERNATIONAL LAW (2012), p. 1.
[39] Id. at, p. 3-5.
[40] Id. at.
[41] Id. at, p. 1.

framework that should be followed in the examination of conditions under which IL works in practice.

The parallels between older empirical legal theories and the CILT are evident, making the latter a successor of the former. CILT integrates elements from other schools, including the TLP and New Institutional Theory (NIT), both of which scrutinise state compliance with international human rights law.[42] Both TLP and NIT are situated within the realm of international legal compliance theories, focusing on the process and reasons for states' compliance with international law.[43] They address questions such as 'why and how do nations obey IL?', 'how law influences the obedience?', 'how is international human rights law enforced?'. These questions closely align with the objective of this study, which is to uncover barriers and facilitators to the implementation of the right to live in a family environment for CWD in Austria, Serbia, and South Africa.

The TLP fosters both a normative and interdisciplinary approach to IL, often drawing on the disciplines of international relations and political science.[44] According to Koh, TLP is described as non-traditional, non-statist, dynamic and normative, which underpins the methodology within this scholarship.[45] The TLP is arguably more methodologically elaborate than other comparable theories, and as such is valuable to inform the framework of this research. The primary focus of TLP lies in the process of 'internalisation' of IL, primarily addressing the question of states' compliance with IL norms.[46]

Koh explained that internalisation is acceptance of a norm as a part of individuals' internal value system, and individuals are obedient only when they have internalized the norm as part of their value system.[47] According to him, the internalisation can be social, political and legal.[48] Social internalisation occurs where there is a broad public recognition for the norm and adherence to it, which can exist independently of prior legal and political internalisation.[49]

[42] Koh, NEBRASKA LAW REVIEW, (1996); Harold Hongju Koh, *Is There a New New Haven School of International Law*, 32 THE YALE JOURNAL OF INTERNATIONAL LAW (2007). Andrea Bianchi, *The New Haven School*, *in* INTERNATIONAL LAW THEORIES: AN INQUIRY INTO DIFFERENT WAYS OF THINKING (2016).
[43] Koh, NEBRASKA LAW REVIEW, (1996), p. 183; Jefferies, BROOK. J. INT'L L., (2020), p. 312.
[44] Koh, NEBRASKA LAW REVIEW, (1996); Bianchi. 2016, p. 94.
[45] Koh, NEBRASKA LAW REVIEW, (1996), p. 184.
[46] Harold Hongju Koh, *Why do nations obey international law*, 106 YALE LAW JOURNAL (1996); Koh, NEBRASKA LAW REVIEW, (1996); Koh, THE YALE JOURNAL OF INTERNATIONAL LAW, (2007).
[47] Koh, INDIANA LAW JOURNAL (1999), p. 1400.
[48] Koh, HOUS. L. REV., (1998).
[49] Id. at, p. 643.

Political internalisation exists where political elites advocate for the domestic adoption of an international norm.[50] Legal internalisation can be done through legislative, executive and judicial branches.[51]

The term 'internalisation' is not typically used to denote the adherence of states parties to their international human rights law obligations. Koh advocated for the use of the term 'internalisation' to emphasise the importance of deep social acceptance of a norm, which may exist even without prior legal and political efforts to implement norms of IL. In this thesis, both 'internalisation' and 'implementation' are used. The latter is preferred when referring to legal and political actions aimed at complying with IHRL norms, while the former is favoured when considering the broader, socio-cultural factors influencing adherence to IL in a state party.

The transnational aspect of IL, as reflected in the TLP scholarship, underscores the concept of permeating international and domestic legal regimes, where the boundaries between the two are not distinctly clear.[52] The process of norm internalisation is depicted as more circular than linear, a perspective that is also mirrored in the present study.[53] Koh outlines that this process typically involves four phases: interaction, interpretation, internalisation and obedience.[54] Apparently, apart from being used as a term that denotes the entire process, the 'internalisation' appears as a specific phase in that process. The TLP theory prioritizes legal and political internalisation, while social internalisation is more extensively explored by law and sociology-oriented scholars such as Goodman, Jinks, and Simmons.[55] Although Koh uses the term 'internalisation', emphasising the importance of full social compliance and acceptance of a norm, his methodology is not equipped with approaches and methods to adequately investigate reasons situated within individuals and groups of individuals for their compliance (or incompliance) with norms.

Following Koh's approach approximately, this dissertation focuses in Part I on the first two phases of norm implementation according to TLP – interactions and interpretation (of IHRL norms). Parts II, III and IV investigate the implementation of those norms in Austria, Serbia

[50] Id. at, p. 642-643.
[51] Id. at, p. 643-645.
[52] For example: Koh, THE YALE JOURNAL OF INTERNATIONAL LAW, (2007), p. 567 (Here Koh uses a convenient and simple terminology to describe a transnational characteristic of a relationship between international and domestic law).
[53] Koh, INDIANA LAW JOURNAL (1999), p. 1411.
[54] Koh, HOUS. L. REV., (1998), p. 642.
[56] Koh, NEBRASKA LAW REVIEW, (1996), p. 183-184.

and South Africa. It is important to note that all phases are interconnected and can impact one another – IL norms transition from international or regional regimes to domestic ones, where they can be further developed and refined, subsequently influencing the interpretation of IL norms in international forums. In accordance with this, seeks evidence and insights into how the three state parties interpret and comprehend different terms of the selected norms and feed their interpretation into the Part I of the study.

Koh argues that we should look into a variety of state and non-state actors' interactions and influence on creating, interpreting, enforcing and internalizing IL.[56] This perspective is particularly beneficial for developing a research framework, where actors involved include both state and non-state entities, public or private, such as governmental bodies, international organisations, international and domestic NGOs, UN agencies, UN treaty bodies, transnational and domestic enterprises, activist groups, and even individuals. In a lecture given in 1998 at Harvard University, Koh gave a closer determination of 'agents of transnational norm internalisation', by dividing them into 'transnational norm entrepreneurs', 'governmental norm sponsors', 'transnational issue networks', 'interpretive communities', 'bureaucratic compliance procedures' and 'issue linkages'.[57]

On that occasion, Koh explained that 'transnational norm entrepreneurs', i.e. international NGOs and individuals, are especially important and successful agents in the process as they can widely popularize a certain issue and gain wide support by the public and elites for certain solutions.[58] In the present study, thus, attention is also given to the role of international NGOs, that, as it will be shown, have potential to significantly impact the interpretation and further development of relevant CRC and CRPD provisions.

'Governmental norm sponsors' are described as individuals who are employed in governmental agencies and push for changes from inside.[59] They are often close to NGOs and act as an extended arm of these organisations in the government.[60] 'Transnational issue networks', elaborates Koh, is a concept borrowed from political science known as 'epistemic communities'.[61] Those networks are comprised of transnational norm entrepreneurs,

[56] Koh, NEBRASKA LAW REVIEW, (1996), p. 183-184.
[57] Koh, HOUS. L. REV., (1998).
[58] Id. at.
[59] Id. at, p. 648.
[60] Id. at.
[61] Id. at.

governmental norm sponsors, experts and others who are esteemed professionals with recognized expertise interested in the same topic, and who work on a regional or an international level, or both.[62]

Lastly, 'interpretive communities and law-declaring flora', represent actors that are interested and have competence to 'declare' legal interpretation of specific provisions of international treaties. Koh explains that these communities can be comprised of treaty regimes (e.g. UN human rights treaty bodies), courts on domestic, regional, and international levels, *ad hoc* tribunals, legislative bodies, executive bodies, NGOs, international commissions of jurists, and others. The main character of these actors, elaborates Koh, is that they are capable and competent to formally challenge certain treaty interpretations and promote specific interpretations of norms.[63]

All actors named here are intertwined, and one actor can fall into several, if not all, of the groups. Strict distinction between each group of actors is not necessary for the present study, for which the term and concept of 'interpretive communities' is, nevertheless, particularly relevant in Part I. The work of interpretive communities is important when analysing the development of IHRL that happens, *inter alia*, through the adoption of UN General Assembly resolutions on the issues of children's rights, alternative care, and rights of persons with disabilities. The sole content of those resolutions can be at times confusing, or even contradictory, as explained elsewhere in this dissertation. However, when the positions and work of interested interpretive communities are understood, even such resolutions can provide valuable information concerning the trajectory of the development of IL, which interpretations are prevailing or about the changing balance of influence of different interpretive communities.

A special type of agents of internalisation are 'bureaucratic compliance procedures'. These are procedures and internal structures of a state which are relevant for compliance with an IL norm. They are particularly important agents as they can significantly hinder prospects or facilitate compliance with IL. Sometimes, to comply with an international agreement, a state needs to establish or dismantle certain structures, mechanisms and institutes, or change institutional practice and even ideology.[64] For example, a state party to the CRPD may establish a governmental consultative and/or coordinating body that should gather and instruct different

[62] Id. at, p. 649.
[63] Id. at.
[64] Id. at, p. 651-653.

sectors of the government and assess their progress in implementing the CRPD.[65] The success in implementation may be significantly impaired or facilitated by such mechanisms. Also, an analysis of state compliance typically starts with the description of a legal system of the country at stake, as an important factor of how IL is internalized. The bureaucratic compliance procedures are given special attention when analysing each state's internalisation of relevant CRPD and CRC norms in the present study.

Lastly, in the same paper Koh gave an outline of 'issue linkages' as agents of internalisation. Koh's elaboration of this concept is not very detailed; however, he stressed the importance of issues that are intertwined and that can affect each other either by hindering or promoting the internalisation.[66] Issue linkages can be intentionally created to help internalize a norm, or they can be the reality of the interconnectedness of certain issues. For example, financial aid to a country can be approved depending on the country's fulfilment of prior human rights related requirements. *Ex-ante* conditionalities or enabling conditions for the use of European Structural and Investment Funds by EU member states is arguably an example of an attempt to create a link between the use of funds and fulfilment of criteria related, for example, to the existence of national policy frameworks for the inclusion of persons with disabilities.[67]

The TLP theory has limitations concerning the scope of agents of internalisation, which was implicitly acknowledged by Koh when commenting on the Goodman's and Jinks' work on internalisation of human rights law through socialisation.[68] In that paper, Koh recognized the importance of 'microprocesses of social influence' that those two scholars focused on in their work in the field of state compliance to international human rights law.[69] The focus on societal factors changes the symbiosis of law and political science, when examining the state compliance to IL, for a symbiosis of law and sociology.[70] In the same paper, when suggesting direction in which Goodman and Jinks should develop their theory, Koh mentions the 'moment of political transition' as another significant precursor to the internalisation of a human rights norm.[71] In the present study both South Africa and Serbia have relatively recently gone through

[65] Austria, Serbia, and South Africa each have such a body. See: Part II, Austria, Chapter 3.4.4. Federal Disability Advisory Council; Part III, Serbia, Chapter 3.3.3 Structures to facilitate the implementation of human rights treaties; Part IV, South Africa, Chapter 3.4.5 National Disability Rights Machinery.
[66] Koh, HOUS. L. REV., (1998), p. 654.
[67] See Part II, Austria, Chapter 3.5.2. ESI Funds and institutional care in Austria and the EU.
[68] Harold Hongju Koh, *Internalization through socialization*, 54 DUKE LAW JOURNAL (2005), p.
[69] Id. at, p. 977.
[70] Id. at.
[71] Id. at, p. 981.

periods of intense political transformation (as opposed to Austria) that might have impacted their readiness to internalize human rights law, and specifically the law relating to the rights of CWD, which should be taken into account in this study.

Another significant limitation of the TLP scholarship is the lack of elaboration on methodologies of treaty interpretation, and more specifically the role and use for general rules of treaty interpretation of the VCLT.[72] The general rules of treaty interpretation reflect customary law and, as such, must be observed by interpreters regardless of the status of VCLT ratification by a jurisdiction.[73] VCLT Article 31 and Article 32 do not instruct how to interpret treaties, but provide tools for their interpretation. Those tools must be kept in mind during the interpretation which should duly consider and reflect each of the interpretive elements. Depending on the relationship between those elements in the process and outcomes of interpretation, different approaches to interpretation have emerged, as further explained below. The analysis of relevant treaties in the present study, thus, duly considers general rules of treaty interpretation and the dynamism specific for human rights instruments.

This research utilises CLIT and TLP frameworks as a foundation, constructing upon them a unique framework that accounts for the specific nature of IHRL and examined norms, alongside the acknowledged limitations of those theories and constraints of an interdisciplinary legal research. The researcher thus, in comparison to the TLP, strengthens the approach to legal interpretation of the relevant IHRL norms by strictly adhering to the universally accepted methodology for IL interpretation. That is, despite acknowledging the elusive nature of some IHRL norms and the myriad of extra-legal factors influencing their development and interpretation, the researcher maintains that the principles of treaty interpretation outlined in the VCLT must be observed, and any legitimate interpretation conforming VCLT rules. Moreover, rules of international law conflict resolution are examined for their applicability in the case of potential divergences between the CRC and the CPRD, and to propose possible resolutions, and reflecting the normative essence of the research.

Secondly, the researcher designs country studies with a keen focus on major international and legal agents of IHRL implementation, juxtaposed against empirical evidence. Primarily, the research delves into the situation of the right to life within a family environment in each

[72] Vienna Convention on the Law of Treaties UNTS, 1155, p. 331., A/CONF.39/11/Add.2, 1969.
[73] Report of the International Law Commission, A/68/10 (2013), International Law Commission, United Nations, para. 39.

selected country through a situational analysis. This examination focuses on the contemporary situation, but it also aims to trace any fluctuations, especially regarding the number of CWD in institutional care and the number of CWD receiving different forms of support and services and other important aspects, over the last approximately 30 years. The span of 30 years is taken considering the years of adoption of the CRC and the CRPD. Additionally, when available, data from earlier periods, such as the mid and early 20th century concerning CWD, are also considered. The reviews and recommendations of UN treaty bodies, state reports, and reports and analyses from other stakeholders serve not only as key sources for situational analyses but also reflect these entities' engagement and their contributions towards the realisation of the right in question in each country.

Following the exploration of the situation of CWD regarding their right to live in a family environment, the research progresses to examine the legal and political agents of implementation. Initially, the focus is on dissecting the characteristics of the legal judicial systems, succeeded by an analysis of the incorporation of the relevant norms in statutory law, with historical tracing of relevant legislative amendments and their linkage to other relevant events, such as the ratification of treaties, the change of political regimes, and other relevant events. This is followed by a systematic review of judicial practice, and assessments of effects of strategic litigation on the implementation of the right in question.

Subsequently, the research assesses crucial public policy documents (e.g. strategies, action plans, government programmes), which are expected to reveal the intentions of policymakers concerning the enactment of the pertinent norms. The investigation then extends to the role and influence of national human rights institutions and other mechanisms that underpin the implementation of the CRC and the CRPD in the three countries, acknowledging them as potential key contributors. Lastly, the activities of national and international NGOs, especially DPOs, IGOs, and organisations of regional integration are examined for their effects of the realisation of the right to live in a family environment for CWD.

Similar frameworks, albeit with some differences, have been used by other human rights scholars in their examinations of domestication and implementation of the CRC and the CRPD in different states parties. The book ‘Incorporating the UN Convention on the Rights of the Child into National Law’, edited by Kilkelly, Lundy and Byrne presents 12 country studies on

the incorporation of the CRC in national legislation, written by 13 authors.[74] Ann Skelton, who authored the chapter on South Africa, started by addressing the socio-political, post-apartheid context, delved into the characteristics of the state's legal system, examined the drafting of the children's rights section of the Constitution, the South African governance, assessed the impact of the CRC on domestic legislation, and evaluated the use of the CRC in strategic litigation.[75] Other authors structured their chapter similarly, with certain additions, such as Forde's and Kilkelly's examination of non-legal measures of incorporation. Therefore, the present dissertation adopts a similar yet more comprehensive approach to he examination of the implementation of the CRC and CRPD, considering that the mentioned studies were limited to the examination of incorporation, rather than the conditions that impacted the implementation. Although, there is not a universally recognized research framework for the examination of implementation of human rights treaties' norms in states parties, the variations of the present research framework have been utilised before and could indicate the emergence of a distinctive methodology for such studies. The Concluding chapter suggests theoretical and methodological implications derived from the lessons learned during the development of this dissertation.

3.1.1. Country selection

In the phase of research proposal development, Austria, Serbia and South Africa stood out as countries whose examination will produce illuminating findings, and will make a meaningful contribution to the understanding of the problems uncovered in the UN Global Study on Children Deprived of Liberty.[76] A two-phased approach of country selection was applied,[77] namely, the collection of secondary quantitative data on countries concerning the CWD in institutions was conducted to identify those with contrasting numbers of institutionalised children and different shares of CWD among the population of all children in institutions. Secondary sources, particularly the abovementioned UN Global Study, as well as a recent study

[74] URSULA KILKELLY, et al., INCORPORATING THE UN CONVENTION ON THE RIGHTS OF THE CHILD INTO NATIONAL LAW (Intersentia. 2021).
[75] Ann Skelton, *Incorporating the CRC in South Africa*, *in* INCORPORATING THE UN CONVENTION ON THE RIGHTS OF THE CHILD INTO NATIONAL LAW (Ursula Kilkelly, et al. eds., 2021).
[76] NOWAK. 2019.
[77] ROBERT K. YIN, CASE STUDY RESEARCH AND APPLICATIONS : DESIGN AND METHODS (SAGE Sixth edition. ed. 2018). ch. Screening the Candidate Cases for your Case Study.

on the prevalence of institutionalisation of children,[78] together with a UNICEF Transmonee database,[79] were used.

In the second phase the following set of inclusion criteria was established: a) ratification of both the CRC and the CRPD; b) existence of concluding observations by the CRC and the CRPD committees on the implementation of treaties in states parties; c) existence of institutional care for children in the past and/ or present; d) each country is situated in a different world region to ensure a wider scope of the study, as a form of a follow-up on the UN Global Study on Children Deprived of Liberty.

Amongst the selected countries a high level of diversity exists concerning their social care and legal systems, historical and present political and economic systems, levels of human development and inequality, as well as different practices of institutionalisation. All three states are parties to the CRC and the CRPD and the committees to both treaties have published reports containing observations and recommendations to the states on the progress in the implementation of these treaties. The examination of these countries should contribute to the understanding of how the CRC and the CRPD norms concerning the realisation of the right to live in a family environment for CWD are implemented, and what are the main blockages and facilitators of these processes in different legal, political and social contexts.

Different paths and outcomes the implementation of critical CRC and CRPD norms in Austria's and Serbia's civil law systems, and South Africa's simple mix of civil and common law tradition, will generate a valuable interrogation of the domestication of international human rights standards. Despite significant differences, the countries have a common international human rights framework which they are obliged to implement, and the presence of a common denominator contained in the 'factual situation' that domestic legal systems are supposed to solve.[80] This factual situation is the institutionalisation of CWD, or in other words, deprivation of their right to live in a family environment.

The Global Campus of Human Rights and the Vienna Forum for Democracy and Human Rights have kindly put their financial and other resources at disposal for the implementation of this

[78] van IJzendoorn, et al., LANCET PSYCHIATRY, (2020).
[79] Transformative Monitoring for Enhanced Equity (TransMonEE), 2021, Date, 2021).
[80] Esin Örücü, *Methodological aspects of comparative law*, 8 EUR. JL REFORM (2006), p. 36.

research. This includes travel and study visits to all three countries, surmounting the issue of conducting research in geographically distant South Africa.

3.1.2. Methods

3.1.2.1. Comparative international human rights law

The first phase of the study involves a comparison of the CRC and the CRPD norms on community inclusion, alternative care and family environment for CWD. This comparison is conducted through a horizontal analysis of the CRC and the CRPD, following the normative framework of the VCLT.[81] Methods of treaty interpretation, as elaborated in the section on Human Rights Treaty Interpretation, are employed for this comparison. The primary sources for this comparison include the CRC and CRPD treaties, VCLT, Charter of the United Nations, travaux préparatoires to the CRC and the CRPD, UNGA Resolutions, CRC and CRPD Committees' Concluding Observations on state parties' reports, the Committees' General Comments, statements, Views, and Inquiry procedure reports.

Additionally, decisions and opinions from regional human rights mechanisms are systematically reviewed to identify and analyse the internalisation of relevant CRC and CRPD norms by those entities. A doctrinal analysis of decisions and opinions in which these norms are interpreted, cited, or otherwise used in any form is undertaken.

3.1.2.2. Case study approach

[81] Samantha Besson, *Comparative Law and Human Rights*, *in* THE OXFORD HANDBOOK OF COMPARATIVE LAW, 2ND ED. (2019).

The possibility of blending legal research with empirical research methods, coupled with the in-depth exploration of the interplay of the mentioned factors, the contemporary nature of the phenomenon, and the lack of researcher control over the context, make a case study the preferred research design.[82] A case study design allows for the examination of how the law functions in interaction with other determinants and is suitable for data triangulation using various sources and methods.[83] Three country studies adopt an analytic-linear strategy, as described by Robert Yin.[84] This is followed by a cross-country perspective to assess and provide explanations for existing similarities and differences in the implementation of relevant norms among the three countries.

A comparative international-domestic human rights law method is applied to answer how the relevant norms of the CRC and the CRPD are domesticated and to what extent into selected countries' domestic legislation, recognizing that international human rights treaties are specified domestically and can be found in a variety of general domestic legal acts.[85] The approach to this analysis will be descriptive and evaluative.

A systematic review of domestic court cases is undertaken with the purpose of identifying and analysing, using a traditional doctrinal approach, all cases related to disabled and non-disabled children and institutional care that could have influenced the implementation of relevant norms. The analysis primarily focuses on superior domestic courts, and in the absence of such cases, lower courts are examined.

The practice shows that public policy documents are almost a necessary part of the processes of international human rights norms implementation; thus, a policy analysis is conducted. Interactions between policymaking actors are considered in this analysis. The policy analysis helps in understanding how transnational norms are implemented, as well as the challenges in the process.

In-depth, semi-structured, individual interviews were conducted to gain insights about national processes that are otherwise hard to obtain. Representative organisations of persons with disabilities are recognised in the CRPD as subjects who need to be involved in 'the implementation of legislation and policies to implement the present Convention', monitoring,

[82] YIN. 2018, p. 43 - 45.
[83] Id. at, p. 49.
[84] Id. at, p. 244, 285.
[85] Besson. 2019, p. 1229.

and as partners to the states in the international cooperation.[86] Therefore, representatives of these organisations are assumed to be well-positioned and informed regarding the implementation of the CRPD, as well as representatives of national and international child-rights organisations. However, other well-informed disabled and non-disabled individuals are included such as disability scholars, advocates and professionals working in state institutions concerned with issues of human rights, rights of persons with disabilities, rights of children and social care.

Finally, findings from each country are put into a cross-country perspective with the intent to explore potential cross-case patterns or replications. The cross-case analysis will help assess replications and patterns in the obstacles and facilitators of DI of CWD in these countries. The analysis will treat cases as a whole, maintaining their integrity primarily within their national contexts.[87]

3.1.3. Human Rights Treaty Interpretation methods

The VCLT norms on treaty interpretation provide a framework for treaty analysis. Although, Article 31 VCLT does not offer detailed guidelines for interpretations of diverse treaties, it sets general rules that should be upheld as a minimum.[88] These rules are considered customary and prescribe several interpretive means: text, context, and object and purpose.

The wording, context and object and purpose of relevant norms are the main analytic point of the analysis of interactions and interpretations of relevant norms in the present study. The analysis is guided by an effectiveness principle, implicit in the good faith principle of Article 31 VCLT. This principle entails that each term is understood to have an effect rather than no effect and that the rights should be practical and effective, giving due regard to the overarching principle of interpretation of human rights treaties.[89]

[86] Convention on the Rights of Persons with Disabilities, UNTS, 2515, p. 3, A/RES/61/106, 2006. articles 4 (3), 33(3), 32(1).
[87] YIN. 2018, p. 245 – 246.
[88] RICHARD K. GARDINER, TREATY INTERPRETATION (Oxford University Press 2nd ed. 2017).
[89] Jean-Marc Sorel & Valérie Boré Eveno, *Article 31: Convention of 1969*, *in* THE VIENNA CONVENTION ON THE LAW OF TREATIES. A COMMENTARY (Pierre Klein Olivier Corten ed. 2011), p. 816. Başak Çalı, *Specialized Rules of Treaty Interpretation: Human Rights*, *in* THE OXFORD GUIDE TO TREATIES (Duncan B. Hollis ed. 2020), p. 538.

3.1.3.1. Dynamic interpretation and effectiveness approach

The effectiveness approach to treaty interpretation is commonly employed by UN treaty bodies and, while the European Court of Human Rights has developed the 'living instrument principle' which also falls into this category.[90] This approach considers all three interpretative elements jointly, with the end goal of yielding an interpretation that can have a real, effective, and practical impact on the lives of its beneficiaries.[91] The effectiveness approach thus might seem close to a teleological approach, but it should not neglect other interpretive elements nevertheless. Neglecting these elements could result in an interpretation that states parties view as too expansive.

Kriebaum explains that, in international treaty interpretation, appropriate time for establishing ordinary meaning of the term has not been established either in the VCLT or by the ILC.[92] According to her, there are two options – either to adopt an ordinary meaning of the term at the time of the conclusion of the treaty, or the ordinary meaning of the term at the time of interpretation.[93] The latter approach, and therefore dynamic interpretation, are indisputable in the interpretation of human rights treaties.

The basis for an effective interpretation lies in the good faith approach to treaty interpretation (Article 31 VCLT), which means that treaties should always be interpreted in a way that has an impact on the beneficiaries.[94] States parties may sometimes adopt an interpretation that completely undermines the effectiveness of a norm to avoid the costs of enforcing an effective human rights norm or for other reasons.

Çalı explains that effectiveness is also closely related to the dynamism in treaty interpretation, and the consideration of regional specificities.[95] The basic presumption is that if a treaty is not interpreted in the light of existing circumstances, which may not have existed at the time of its drafting, it might not achieve its purpose of protecting the human rights of its beneficiaries. For example, new knowledge about how children develop in institutional settings compared to family settings can justify an interpretation that further restricts the use of institutional care for

[90] Çalı. 2020, p. 538.
[91] Id. at.
[92] Ursula Kriebaum, *Interpretation of Investment Treaties over Time*, AVAILABLE AT SSRN 4442977 (2023), p. 2.
[93] Id. at.
[94] Sorel & Boré Eveno. 2011, p. 817 - 818; Çalı. 2020.
[95] Çalı. 2020, p. 538.

children.[96] In such a case, the interpretation of a norm may change over a 30-year period in light of new knowledge, by changing the interpretation of a critical, usually generic term.

In the present study, treaties are analysed with their effectiveness in mind, and the interpretations proposed by interpretive communities and states parties are assessed against the general rules of treaty interpretation to uncover the positions and intentions of the respective actors.

The following paragraphs explain each interpretive element as prescribed by the VCLT and approaches that favour each of the elements. Each of the elements must be taken into consideration, although in the reality of interpretation, one or two of the elements may dominate to produce the desired outcomes. Additionally, the concept and use of supplementary means of treaty interpretation according to Article 32 VCLT, specifically in this study, is explained.

3.1.3.2. Textual approach

The textual method (or literal method) gives priority to the text, where terms and phrases are given their 'ordinary meaning'. Sir Gerald Fitzmaurice elaborated on this, stating that words and phrases 'are to be given their normal, natural, and unstrained meaning.'[97] The ordinary meaning must be considered in light of the context, object and purpose of the treaty.[98] An important aspect of the ordinary meaning principle is its temporality; that is, words are given the meanings they had at the time of the conclusion of a treaty, reflecting the intentions of the parties. Contrary to that, in dynamic interpretation normally employed in human rights, it is the interpretation of a term, normally a generic term, that changes over time, as explained above.

This consideration is also crucial when comparing two treaties concluded at different times, such as the CRC (1989) and the CRPD (2006), and when analysing dynamic interpretations by treaty bodies. Treaty bodies can engage in evolutive interpretation simply by upholding a new

[96] See Part I, Chapter 3. 2 UNGA Guidelines for the Alternative Care of Children (2009).
[97] Comment made by Sir Gerald Fitzmaurice, International Law Commission Rapporteur on the Law of Treaties, cited by M. Fitzmaurice, 'The Practical Working of the Law of Treaties' in M. Evans (ed.) International Law (Oxford University Press, Oxford, 2nd edition, 2006), at page 198.
[98] Yearbook of the International Law Commission 1966. Documents of the second part of the seventeenth session and of the eighteenth session including the reports of the Commission to the General Assembly, A/CN.4/SER.A/1966/Add.l, United Nations, 1967. Section 3, para. 12.

definition of a crucial term, such as ‘disability’ in the case of the General Comment No. 9 of the CRC Committee. Sometimes, states will define important terms, as in the case of Article 1 CRC and Article 1 ¶2 and Article 2 CRPD. In some cases, this will completely narrow down the space for different understandings of a term (definition of a child in the CRC), but in other cases, it may aim to include critical aspects in its meaning while allowing the term itself to evolve over time (Article 1 ¶2 CRPD provides an open ended, non-exclusive definition of disability).

3.1.3.3. Contextual approach

To derive a logical and effective interpretation, the interpreter must consider the words in their context and understand them within the treaty's object and purpose.[99] The contextual method of treaty interpretation imposes an obligation on interpreters or researchers to examine both the internal and external contexts of a provision. The context of a word or phrase includes the text of the treaty, along with the Preamble and annexes (Article 31 ¶2 VCLT). Additionally, ’[A]ny agreement relating to the treaty which was made between all the parties in connexion with the conclusion of the treaty’ is regarded as part of the context for the purpose of interpretation (Article 31 ¶2 (a)).

Further, ‘[A]ny instrument which was made by one or more parties in connexion with the conclusion of the treaty and accepted by the other parties as an instrument related to the treaty’ (Article 31 ¶2 (b)) is part of the context. Optional protocols to the CRC and the CRPD can be regarded as part of the context for the purpose of the interpretation of the respective treaties.[100]

Together with the context, a researcher takes into account ‘[A]ny subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions’ (Article 31 ¶3 (a)). Also, ‘[A]ny subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation’, is to be taken into account (Article 31 ¶3 (b) VCLT). In the Kasikili/Sedudu Island case, the ICJ concluded that for conduct to be regarded as subsequent practice, parties must demonstrate that their actions reflect their position on the interpretation of the relevant treaty.

[99] Andrea Broderick, The Long and Winding Road to Equality and Inclusion for Persons with Disabilities: The United Nations Convention on the Rights of Persons with Disabilities (2015), (Doctor, Maastricht University), p. 10.
[100] Id. at, p. 9-10

Broderick argued that the committee's interpretations should be taken as 'subsidiary source of interpretation'.[101] The ILC holds that 'decisions, resolutions and other practice by international organisations can be relevant for the interpretation of treaties in their own right'.[102] Broderick further suggested that in the context of the CRPD, '(…) subsequent practice may be manifest in the decisions taken by the CRPD on individual communications, as well as in the general comments and concluding observations of the Committee (if these can be deemed to establish the agreement of the parties regarding the Convention's interpretation)'.[103] Broderick did not elaborate further how treaty bodies' documents reflect agreement of states parties regarding the interpretation of the CRPD. However, the ILC was precise on this issue:

Subsequent agreements and subsequent practice under article 31, paragraph 3 (a) and (b), being objective evidence of the understanding of the parties as to the meaning of the treaty, are authentic means of interpretation, in the application of the general rule of treaty interpretation reflected in article 31.

In its draft conclusions, the ILC held that 'recourse may be had to other subsequent practice in the application of the treaty as a supplementary means of interpretation under article 32' (of the VCLT).[104] The Commission explained that subsequent practice as a supplementary mean of interpretation consist of '(…) conduct by one or more parties in the application of the treaty, after its conclusion'.[105] The consideration of social practice as a form of subsequent practice of states is debated. The ILC holds that '(…) mere (subsequent) social practice, as such, is not sufficient to constitute relevant subsequent practice in the application of a treaty'.[106] On the other hand, the European Court of Human Rights has actually from time to time taken social practice as an element that contributes to the assessment of state practice.[107] Following that, the ILC concluded that practice of non-State actors does not constitute subsequent practice in terms of articles 31 and 32 VCLT, but can be taken into account when assessing subsequent practice of parties.[108]

[101] Id. at.
[102] Yearbook of the International Law Commission. Report of the International Law Commission on the work of its seventieth session (30 April–1 June and 2 July–10 August 2018), A/CN.4/SER.A/2018/Add.1 (Part 2), United Nations, 2022, p. 41.
[103] Broderick, (2015), p. 11.
[104] A/CN.4/SER.A/2018/Add.1 (Part 2), United Nations, 2022, p. 24.
[105] Id. at.
[106] Id. at, p. 42.
[107] Id. at.
[108] Id. at, p. 39.

Lastly, '[A]ny relevant rules of international law applicable in the relations between the parties' is taken into account alongside the context (Article 31 ¶3 (c)). The CRC and CRPD stand in a relation of relevant rules of applicable law with each other. One of the main purposes of the application of this rule is to prevent the fragmentation of international law. The three means of interpretation of the paragraph 3 Article 31 VCLT, are sometimes regarded the external context, and as such, Sorel and Boré Eveno argue they are regarded as means 'of confirmation rather than of assertion'.[109]

3.1.3.4. Teleological approach

The teleological approach to interpretation relies primarily on subjective elements, specifically the object and purpose of the treaty. It is also known as the functional or ends-focused approach, as its primary aim is to achieve the objectives and goals of a treaty.[110] It is close to the effectiveness approach as an interpretation needs to be effective in order for a treaty to realize its purpose.[111] Additionally, the teleological approach can provide a basis for dynamic interpretations of human rights treaties, taking into account evolving factual and legal contexts that may require adjustments to the treaty through interpretation to achieve its objectives. In some cases, courts may interpret treaties expansively, deviating from the literal text of the treaty, when applying the teleological approach.[112]

Human rights researchers and advocates may be tempted to subordinate other means of interpretation to a teleological interpretation as it could be conveniently used to argue expansion of states' duties to accommodate moral and political urge. This could lead to a purely purpose-driven interpretation, which is cautioned against.[113] However, according to Çalı, a holistic approach to human rights interpretation should be upheld, meaning that text, context and object and purpose need to fit together.

Çalı suggests that the most common approach to interpreting human rights treaties involves a hierarchical ordering of these elements.[114] Gardiner argues object and purpose serve to illuminate the ordinary meaning, and not to be used independently from those elements, as a

[109] Sorel & Boré Eveno. 2011, p. 825 – 826.
[110] ECtHR, Wemhoff v. Germany, application no. 2122/64 (1968) 1 EHRR 55, p. 75.
[111] GARDINER. 2017. p. 218
[112] E.g. Sorel & Boré Eveno. 2011, p. 832 – p. 835, para. 53 - 55.
[113] Çalı. 2020, p. 532.
[114] Id. at., p. 532-533.

separate approach to interpretation.[115] Therefore, even when employing a teleological approach, an interpretation should still be rooted in the ordinary meaning of the term, even if modifications are made to accommodate the treaty's objectives and goals.[116]

3.1.3.5. Supplementary means for treaty interpretation

In addition, Article 32 VCLT provides for supplementary means of treaty interpretation, namely preparatory works and circumstances of the treaty conclusion, which constitute another set of subjective interpretive tools. The supplementary means may be involved to confirm the meaning that comes from the application of Article 31 VCLT, or when a result of interpretation applying Article 31 is 'ambiguous or obscure' (Article 32 (a) VCLT) or when it is obviously 'absurd or unreasonable' (Article 32 (b) VCLT).

The International Court of Justice (ICJ) emphasised that the court should recourse to the supplementary means of interpretation only when the words of interest are ambiguous or obscure.[117] In this analysis, preparatory works of the CRC and the CRPD are primarily employed to cross-verify the meaning derived through the application of Article 31, such as in relation to the scope of states' responsibility to provide special care under Article 20(2) of the CRC. Additionally, these preparatory works are used to shed light on ambiguities, such as those related to the ordering of alternative care options under Article 20(3) of the CRC. Utilizing supplementary means can help to uncover the original intentions of the treaty parties; however, the caution is advised, considering that it can be disputed whether all parties agreed with what was discussed, including due to the absence of states from drafting processes.

The ambiguity of norms, as well as 'the polymorphous nature of interpretation',[118] necessitate the author's recognition that their interpretation may not represent an absolute truth regarding the meanings of the treaties. Different understandings could be reached by applying various approaches to interpretation. Regardless, the author's obligation is to apply the art of

[115] GARDINER. 2017, p. 211.
[116] Id. at.
[117] ICJ Reports 1991, p. 69, para. 48, in Sorel & Boré Eveno. 2011, p. 818, para. 31.
[118] Id. at, p. 807, para. 5.

interpretation in good faith and with strict observation of the rules of treaty interpretation and legal analysis to maximise the replicability of results.

4. Structure

The dissertation is divided into four pats parts. The Introductory Chapter is followed by Part I, which contains an analysis of interactions and interpretation of the CRC and CRPD norms. Parts II, III and IV include analyses of implementation of relevant norms in Austria, Serbia and South Africa. Those are followed by a Concluding Chapter, which summarizes main findings and examines cross-country patterns the implementation of relevant norms in three countries.

The structure of this thesis is designed to facilitate a comprehensive understanding of the multifaceted nature of international human rights law and its complex and sometimes elusive processes of implementation in states parties.

The introductory chapter sets the stage for this exploration by outlining the research objectives and questions that guide this study. It lays a solid foundation with a detailed section on the framework of research, which includes a theoretical framework for analysis, methods used, research limitations and gaps.

Part I provides an in-depth analysis of family-based and institutional care within the CRC and the CRPD, primarily employing the general rules of treaty interpretation and an effectiveness approach to the interpretation of human rights treaties. The thesis then progresses to an examination of the points of tension between these conventions, employing a methodological approach that combines theory and practical case studies to identify and explore conflicts, divergences, and potential resolutions. This critical analysis is crucial for understanding the interplay between different legal instruments and their impact on the rights of CWD and obligations of states parties.

In the subsequent sections, the thesis broadens its scope to include an analysis of UN resolutions and the jurisprudence and recommendations of the CRC and CRPD Committees. This includes a detailed review of General Comments, concluding observations, and other

relevant documents that shed light on the evolving understanding of the rights of persons with disabilities within the international legal framework.

The final chapters of Part I focus on the resolution of divergences and the future of the right to family life for persons with disabilities. This section proposes innovative interpretation strategies and legal approaches to address conflicts and enhance the coherence and effectiveness of international human rights law in protecting the right of CWD to life in a family environment.

Parts II, III and IV, that is Austria, Serbia and South Africa studies have an almost identical structure each. A country study commences with a contextual overview, including geographic, demographic, economic, legal and governance related information, establishing a backdrop against which the right of CWD to life in a family environment is realised. This is followed by an in-depth exploration of international and regional human rights mechanisms and their recommendations.

The subsequent segment is a situational analysis, which delves into the historical (where available) and contemporary position of CWD. Historical perspectives are valuable for understanding the current state of social protection and the rights of CWD, which is explored through a comprehensive analysis of support and services available to CWD and their families, alternative care options, institutional care, and adoption processes.

In ‘Legal and Political Implementation’, the thesis meticulously dissects the legal measures undertaken at different levels of governance to implement international commitments into domestic law. This includes an exhaustive review of constitutional amendments, federal laws, and Vienna-specific legislation aimed at advancing the rights and well-being of CWD. The analysis extends to judicial measures and public polices, illustrating the dynamic interplay between law, policy, and judicial interpretation.

An examination of national human rights institutions, monitoring bodies, and other structures reveals the mechanisms in place to facilitate the implementation of human rights treaties, assessing their effectiveness. Additionally, contribution to the realisation of the rights of CWD of other domestic and international actors, primarily DPOs, NGOs, but also organisations of regional integration, is examined and evaluated.

Each country study culminates in a critical analysis of key findings, elucidating the facilitators and impediments encountered in the process, offering hopefully insightful conclusions on the state of the right of CWD, the challenges ahead, and the potential pathways for reform.

Concluding Chapter begins by summarizing the findings of Part I and proposing a unified perspective that strategically integrates the CRC and the CRPD, addressing existing divergences while emphasising the importance of a process taken towards the resolution and reaching a 'thick stakeholder consensus'.

Following this, a cross-country analysis is presented, outlining the various factors that facilitate or hinder the effective implementation of the right to live in a family environment for CWD in Austria, Serbia and South Africa. This analysis serves to repeating patterns and major challenges, offering valuable insights into the factors impacting the application of the CRC and the CRPD.

The chapter further explores the implications of these findings on both research and theoretical frameworks. It discusses how the study contributes to the existing body of knowledge, shedding light on new areas of inquiry and suggesting avenues for future research. This discussion underscores the importance of continuous exploration and academic discourse in advancing the rights and well-being of CWD.

5. Research gaps

This thesis seeks to fill in the knowledge gap on factors that facilitate and impede the process of implementation of specific CRC and CRPD norms, from an interdisciplinary legal perspective.

It is worth noting that there is a scarcity of scholarly works on this subject for Austria, Serbia and South Africa. In Serbia, this area has been primarily addressed by NGOs. Drawing inspiration from a significant implementation gap observed in England, Anna Lawson has recently emphasized the need for disability law scholars to delve deeper into the examination of facilitators and obstacles in the process of CRPD implementation within domestic

jurisdictions.[119] Furthermore, Lawson has acknowledged the limitations of law as a discipline in comprehensively capturing all potential factors, thereby advocating for a multidisciplinary approach to this issue. While several studies have explored the impact of the CRPD on court practices, none have specifically focused on cases related to CWD and their family life.[120]

Certain research has explored the interactions between the CRC and CRPD, with Sandland's work highlighting the 'clash of conventions' concerning child participation.[121] However, it's important to note that these studies do not specifically address the topics of institutionalisation and family life.[122] Eric Rosenthal has indeed contributed to the discussion of the right to live in a family environment for both CWD and non-disabled children, along with examining interactions between the CRC and CRPD. [123] His work focuses on making a case for the 'right to family' of children and extends the applicability of CRPD norms to all children.[124] Rosenthal relied on the VCLT and a number of non-legal arguments using literature published by NGOs such as human rights monitoring reports and scientific articles on the effects of institutions on the development of children.

In comparison, this research is more comprehensive in examining the entire process of norm implementation, offering a broader scope while also providing specific and detailed insights into individual countries. It is worth noting that this study maintains a neutral standpoint in relation to interactions between the conventions and interpretive communities, which distinguishes it from Rosenthal's work aligning with specific interpretive communities.[125]

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[119] Anna Lawson, *Disability Law as an Academic Discipline: Towards Cohesion and Mainstreaming?*, 47 JOURNAL OF LAW AND SOCIETY (2020), p. 584.
[120] LISA WADDINGTON & ANNA LAWSON, THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES IN PRACTICE: A COMPARATIVE ANALYSIS OF THE ROLE OF COURTS (Anna Lawson & Lisa Waddington eds. 2018).
[121] Ralph Sandland, *A Clash of Conventions? Participation, Power and the Rights of Disabled Children*, 5 SOCIAL INCLUSION (2017).
[122] Id. at.
[123] LAURIE AHERN & ERIC ROSENTHAL, TORTURE NOT TREATMENT: ELECTRIC SHOCK AND LONG-TERM RESTRAINT IN THE UNITED STATES ON CHILDREN AND ADULTS WITH DISABILITIES AT THE JUDGE ROTENBERG CENTER (Mental Disability Rights International. 2010); Eric Rosenthal, *The right of all children to grow up with a family under international law: implications for placement in orphanages, residential care, and group homes*, 25 BUFF. HUM. RTS. L. REV. (2019); Eric Rosenthal, *Residential Care Controversy: The Promise of the UN Convention on the Rights of Persons with Disabilities to Protect All Children*, 1 THE INTERNATIONAL JOURNAL OF DISABILITY AND SOCIAL JUSTICE 95(2021).
[124] Rosenthal, BUFF. HUM. RTS. L. REV., (2019); Eric Rosenthal, Position paper: The right to live and grow up in a family for all children Revised (2019); Rosenthal, THE INTERNATIONAL JOURNAL OF DISABILITY AND SOCIAL JUSTICE, (2021).
[125] For example: Rosenthal, (2019).

Recently, the Lancet published articles on institutionalisation and DI of both disabled and non-disabled children.[126] These articles were authored by a group of individuals commissioned by the Lumos Foundation, an NGO dedicated to childcare reforms in central and eastern Europe. While these articles offered valuable insights into the global prevalence of institutionalisation and its effects on child development, they did not undertake legal analyses nor delve into the complex interactions between the CRC and the CRPD. Additionally, they did not focus on any specific country when examining the implementation of these conventions. Nevertheless, these articles have contributed to a growing body of knowledge concerning the negative impacts of institutionalisation and the benefits of family-based care for all children.

It is clear that there is a marked scarcity of legal scholarship within Austria, Serbia, and South Africa, specifically addressing the implementation of norms pertaining to the life in a family environment, community inclusion, and alternative care for CWD. While numerous academic and advocacy-oriented studies have examined various aspects of children's rights, such as education, access to justice, and child labour, a significant gap persists in legal research focusing on the rights of CWD and the challenges posed by institutionalisation.

In Austria, the interdisciplinary legal academic scene provides limited insights into the rights of CWD, family life, and alternative care options. Only a few academic papers, including a master's thesis, address this issue, making them exceptions rather than indicative of a broader trend.[127] Conversely, Austrian literature abounds with sources examining welfare systems, including long-term care, but without the focus either on CWD or IHRL.[128] The scarcity of academic research on this topic calls for more in-depth and systematic examination of the factors driving the institutionalisation of CWD in Austria. Grey literature appears to be more

[126] Desmond, et al., THE LANCET CHILD & ADOLESCENT HEALTH, (2020). van IJzendoorn, et al., LANCET PSYCHIATRY, (2020); Philip S. Goldman, et al., *Institutionalisation and deinstitutionalisation of children 2: policy and practice recommendations for global, national, and local actors*, 4 THE LANCET CHILD & ADOLESCENT HEALTH (2020).

[127] Stefan Wagner-Schuster, Pflegefamilie oder sozialpädagogische Einrichtung? Bestandsaufnahme über die Praxis der Platzierungsentscheidung in der Kinder- und Jugendhilfe (2018), (Master of Arts, Karl Franzens University Graz).

[128] E.g. August Österle, *Long-term care reform in Austria: Emergence and development of a new welfare state pillar*, *in* REFORMS IN LONG-TERM CARE POLICIES IN EUROPE: INVESTIGATING INSTITUTIONAL CHANGE AND SOCIAL IMPACTS (2012); August Österle & Karin Heitzmann, *Austrification in welfare system change? An analysis of welfare system developments in Austria between 1998 and 2018*, *in* ROUTLEDGE HANDBOOK OF EUROPEAN WELFARE SYSTEMS (Sonja Blum, et al. eds., 2020); Birgit Trukeshitz, et al., *Austria's Long-Term Care System: Challenges and Policy Responses*, JOURNAL OF LONG TERM CARE (2022).

forthcoming, with several publications by NGOs and the Austrian Ombudsman Board providing information on CWD and institutional care.

In Serbia, there is a notable presence of grey literature addressing the institutionalisation of CWD, yet this body of research is largely absent from academic discourse, save for a few exceptions. Stefanović delved into the impact of government anti-pandemic measures on CWD in institutional care,[129] while Žegarac, Grujić and other authors contributed papers on the child welfare system and foster care specifically.[130] NGO reports stand as the principal source of information and analyses concerning CWD in both family and institutional care. These organisations have been instrumental in highlighting the challenges encountered by CWD in institutional environments. However, this research has not been extensively examined and analysed from a rigorous academic standpoint, resulting in a significant void in scholarly discourse on the subject.

Conversely, South Africa presents a unique situation where academic and grey literature on the institutionalisation of CWD is almost absent. Despite the country's rich history of academic research and strategic litigation in children's rights,[131] there is a noticeable gap in understanding the specific issues surrounding the rights of CWD with regard to life in a family and institutionalisation. Skelton, among other authors, has made significant contributions to understanding South Africa's child welfare system, encompassing aspects of foster care and material support.[132] Additionally, Stefanović and several other authors have examined DI actions undertaken in South Africa in relation to Life Esidimeni tragedy, where more than 140 persons with disabilities died.[133] This gap not only hinders the development of evidence-based

[129] Lazar Stefanović, *Implications of Anti-pandemic measures of Serbian Authorities on the Right to Life for Persons with Disabilities*, *in* YEARBOOK HUMAN RIGHTS PROTECTION: RIGHT TO LIFE (Zoran Pavlović ed. 2021).
[130] NEVENKA ŽEGARAC, U LAVIRINTU SOCIJALNE ZAŠTITE. POUKE ISTRAŽIVANJA O DECI NA PORODIČNOM I HRANITELJSKOM SMEŠTAJU (University of Belgrade, Faculty of Political Science. 2014); DOBRILA GRUJIĆ, TEORIJA I PRAKSA HRANITELJSTVA U SRBIJI (Centre for family care and adoption Belgrade. 2017); ANITA BURGUND, et al., HRANITELJSTVO I DOBROBIT ADOLESCENTA. ISTRAŽIVANJE ZA UNAPREĐENJE POLITIKA I PRAKSI (2019).
[131] E.g. Ann Skelton, *South Africa*, *in* LITIGATING THE RIGHTS OF THE CHILD. THE UN CONVENTION ON THE RIGHTS OF THE CHILD IN DOMESTIC AND INTERNATIONAL JURISPRUDENCE (Ton Liefaard & E. Japp Doek eds., 2015); AOIFE NOLAN, et al., ADVANCING CHILD RIGHTS-CONSISTENT STRATEGIC LITIGATION PRACTICE (ACRISL. 2022).
[132] E.g. Ann Skelton, *Kinship Care and Cash Grants: In Search and Sustainable Solutions for Children Living with Members of Their Extended Families in South Africa*, INT'L SURV. FAM. L. (2012); Samantha Arlene Yell, A Proposed Comprehensive Legal Solution to the Foster Care Crisis (2019), (LLM, University of Pretoria).
[133] LJ Robertson & Malegapuru W Makgoba, *Mortality analysis of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy*, 108 SOUTH AFRICAN MEDICAL JOURNAL (2018); Ebenezer Durojaye & Daphne Kabagambe Agamba, *Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa*, 20 HEALTH AND HUMAN RIGHTS JOURNAL (2018); Abigail Ornellas & Lambert K Engelbrecht, *The Life Esidimeni crisis: Why a neoliberal agenda leaves no room for the mentally*

policies and practices but also underscores the urgency of initiating comprehensive research initiatives in this area. Literature on the inclusive education of CWD is emerging.[134]

Overall, the academic research gaps in these three countries underscore the importance of this doctoral research in contributing valuable insights and addressing a critical knowledge deficit in the field of IHRL and its implementation into domestic jurisdictions.

6. Research limitations

The current study exhibits certain constraints that necessitate acknowledgement. To begin, the examination solely scrutinizes the implementation of the CRC and the CRPD within three distinct countries. Due to time and resource constraints, the inquiry is limited in scope and thus incapable of producing conclusions with broad implications and applications. Ideally, a broader range of jurisdictions ought to be incorporated, and undertaken by a group of authors, in order to achieve a wider scope and enable generalisation of findings. Moreover, in case of South Africa and Austria, the research focuses on Gauteng and Vienna, respectively. Gauteng, a major province, and Vienna, a capital and a federal state, host their respective capital cities, boast the largest populations, and serve as the seats of government branches, justifying the selection of these particular units. However, both federal legislation (in Austria's case) and state legislation (in South Africa's case), along with federal public policy documents, are meticulously considered. Judicial measures from other Austria's federal states and South Africa's provinces are also taken into account. Judicial measures from other federal states in Austria and provinces in South Africa are also taken into account. Focusing on a specific federal state and province ensures the depth of this comprehensive research. Such depth would not be feasible within a reasonable timeframe if the research were to include a detailed examination of each of South Africa's nine provinces and Austria's nine federal states.

ill, 54 SOCIAL WORK (2018); LAZAR STEFANOVIĆ, TRANS-INSTITUTIONALISATION OF DISABLED PEOPLE. A CRITICAL APPRAISAL OF SOME DEINSTITUTIONALISATION STRATEGIES IN SOUTH AFRICA AND EUROPE § 5 (Provincial Ombudsman and the Institute for Criminological and Sociological Research Belgrade. 2022).

[134] Dana Donohue & Juan Bornman, *The challenges of realising inclusive education in South Africa*, 34 SOUTH AFRICAN JOURNAL OF EDUCATION (2014); Petra Engelbrecht, *Inclusive education: Developments and challenges in South Africa*, 49 PROSPECTS (2020); Sabeeha Majid, Access to inclusive, quality basic education for children with disabilities in South Africa (2023), (LLM, Unniversity of Pretoria).

Additionally, the research addresses only several norms from two human rights conventions, although all human rights contained in these treaties and other human rights instruments are intertwined and interact in the phases of interpretation and implementation. Nonetheless, other regimes of international law might have an impact on the interpretation and implementation of human rights treaties too, as none of the regimes exist in a vacuum; however, they are not covered by this research. The provisions of treaties directly addressed in this study make up core international law provisions on the topic of this research. Additionally, the wide array of soft law instruments examined here, along with the works of the respective Committees and reginal human rights mechanisms, are all together the most relevant elements for the present analysis. All other hard and soft international law instruments would have a much less significant impact on the outcome of the present analysis. Their inclusion would not bring sufficient added value while significantly inflating the work needed.

Although this study aims to comprehensively examine the process of implementation of selected norms, from its inception to enforcement, it will not fully account for different socio-cultural factors that could potentially influence the process. These factors could include but are not limited to cultural norms related to family, child upbringing, the role of local communities and wider family in the upbringing of the child, religions impact on the care of the child, other cultural practices and beliefs.

PART I International human rights law

1. Family-based and institutional care in the treaties

This section contains an analysis of the contents of the CRC and CRPD concerning institutional care as a form of alternative care for children. The norms examined are contained in Article 20 and Article 23 of the CRC, on one hand, and, on the other, Article 19 and Article 23 of the CRPD. None of these articles contains obligations of states parties explicitly aimed at provision or eradication of such care. However, the aforementioned articles of the CRC and the CRPD contain norms on issues closely related to institutional care. These provisions include those on alternative care, special protection of CWD, independent living in the community (which, according to the CRPD Committee, entails family living for children) and provisions on the respect for home and family. Each of these provisions is important in determining the permissibility and ways of use and adequacy of institutional care for CWD from a perspective of IHRL.

1.1. The Convention on the Rights of the Child and institutional care

The Convention on the Rights of the Child was adopted in November 1989 and entered into force in September 1990. It is the most widely ratified human rights treaty with 196 parties. Two optional protocols to the CRC have been adopted, one on children in armed conflict and the other on the sale of children, child prostitution and child pornography. These protocols do not contain norms relevant for this research and will not be further considered. Critical provisions for this analysis are Article 20 on the protection of children deprived of his/her family environment and Article 23 on CWD.

1.1.1. Article 20 - Protection of children deprived of their family environment

Article 20 CRC
A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. States Parties shall in accordance with their national laws ensure alternative care for such a child. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if neccessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

The analysis of norms most relevant to the provision of institutional care to children starts with Article 20, which according to Tobin, is a 'remedial' provision.[1] In other words, this article is relevant in all cases of a child's deprivation of family environment for whatever reason, and regardless of the duration of separation.[2]

Article 20 (1) starts with the right of a child deprived of his/her family environment to a special protection and assistance provided by the state. At this point, the text of the treaty leaves no doubts with regard to the right to special protection and assistance for children who do not live in families. Cantwell and Holzscheiter argue that although the text implies a direct provision of assistance and protection by the state, the obligation implies, at a minimum, the responsibility of states to establish, regulate, make available, oversee, and control the provision of these services when they are offered by non-state actors.[3] This is particularly relevant when

[1] John Tobin, *Art. 20 Special Protection for Children Deprived of Their Family Environment*, *in* THE UN CONVENTION ON THE RIGHTS OF THE CHILD: A COMMENTARY (John Tobin ed. 2019), p. 727.
[2] Id. at, p. 729.
[3] Nigel Cantwell & Anna Holzscheiter, A Commentary on the United Nations Convention on the Rights of the Child, Article 20: Children Deprived of Their Family Environment § 20 (André Alen, et al. eds., Brill | Nijhoff 2008)., para. 115.

faith-based organisations provide institutional care for CWD, often beyond the reach of state control and oversight, potentially leading to the omission of these establishments in DI efforts.[4]

1.1.1.1. Obligation to provide and the optionality of alternative care forms

The next paragraph (Article 20 (2)) explicitly establishes the obligation of parties to 'ensure alternative care for such a child', in accordance with their laws. The phrase 'in accordance with their laws' serves two main purposes: to obligate states to regulate alternative care by law and to provide flexibility for parties to arrange this care according to their legal, political, and social contexts, making the provision of such care local-context-sensitive.[5] Building on the leeway given to states to organize alternative care in accordance with their domestic contexts, Article 20 (3) provides guidance to parties on fulfilling the obligation from Article 20 (2) and ensuring the realisation of the right to special protection and assistance for a child deprived of a family environment:

Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

The phrases 'could include' and 'inter alia' clearly indicate that none of the items on the list of alternative care options is either obligatory to exist in a country, nor is this 'Illustrative list'[6] definite. In other words, this provision is optional in a sense that a state can choose any of those alternative care types laid out, establish other types of alternative care in addition, or solely.

However, its optionality should not disregard the importance of the provision; in fact, Article 20 (3) provides guidance and explicit permission to provide (and to omit) the forms of alternative care mention there, including institutions (under certain conditions). The fact that all other (optional) forms of care listed are family-based, makes the provision of care in institutions an exception. The inclusion of different types of alternative care and the *Kafalah*,

[4] Lazar Stefanović, Toolkit on Ending Deprivation of Liberty of Children in Institutions (Global Campus of Human Rights 2022), p. 26.
[5] Cantwell & Holzscheiter. 2008, p. 50 – 51. Tobin. 2019, p. 744.
[6] Tobin. 2019, p. 747.

which was the first time that an Islamic legal concept entered a human rights treaty, is an acknowledgment of legal and cultural differences among states.[7]

The second sentence of Article 20 (3) CRC prescribes principles that must be upheld when deciding about the placement of a child in alternative care. It obligates state to pay due regard to a child's background and the need for continuity in his/her upbringing. Therefore, this paragraph contains a facultative list of alternative care options (including adoption) and an obligation to uphold certain principles regardless of the type of alternative care.

1.1.1.2. Necessity of institutions

From a legal obligation perspective, the phrase 'if necessary' restricts the use of such a form of care by implying its prohibition when it is not necessary. Considering that all other named forms of care are family-based, it can be said that the provision of alternative care in institutions is an exception. Furthermore, despite adoption not being strictly a form of alternative care, it is still placed ahead of institutions in the order of care options.

The adjective 'if necessary' in Article 20 (3) CRC, in practice, is viewed from the standpoint of social care systems, according to Cantwell and Holzscheiter, giving 'suitable institutions' the quality of an inherently undesirable solution.[8] Likewise, the authors conclude that this qualification supports DI. When viewed in practice from the angle of social care systems, it means that necessity is based on the availability of better options, the family-based options, rather than the characteristics of the child.

Tobin claims the necessity principle means that institutions can be used when they are 'suitable and appropriate to address the best interests of the child'.[9] While the best interests principle is overarching, such an interpretation might weaken the CRC's intent to relegate institutional care to the last place and give it a marginal role in alternative care when the treaty is applied in various local contexts by different actors who may misunderstand the principle and effectively disregard the approach of using institutions only when necessary. According to the CRC

[7] Cantwell & Holzscheiter. 2008. para 122.
[8] id. at, para. 136.
[9] Tobin. 2019, p. 750.

Committee, there is, indeed, a widespread lack of understanding of the best interests principle among key stakeholders.

In this regard, the text of Article 20, paragraph 3, leaves a significant amount of ambiguity and room for various practices and evolving interpretations in the future. Preparatory works do not offer much additional information. However, Venezuela proposed excluding the words 'if necessary' and changing the order of alternative care options so that the last two places would be occupied by kafala and adoption. This proposal was not adopted, indicating the strong intention of the drafters to qualify institutions as a last resort option and to prohibit their use when not necessary.

1.1.1.3. Suitability of institutions

The CRC permits placement in suitable institutions only when it is inevitable and prohibits it otherwise. This implies that placement in unsuitable institutions is never allowed, although the treaty does not further elaborate on what makes an institution suitable for the care of children. The phrase 'or if necessary, placement in suitable institutions for the care of children' could have two meanings: first, that an institution must designated for the care of children and not adults, for example, and second, that an institution for children must meet a certain standard of care to be considered suitable.

The latter meaning is much more likely, as the adjective 'suitable' is placed before the noun 'institutions.' This interpretation is corroborated by the CRC general principles, particularly in Article 3 (3), which obliges parties to ensure that all institutions, services, and facilities for the care of children conform to standards established by competent authorities. These standards pertain to various aspects, including safety, health, the number and suitability of staff, and supervision. A more detailed explanation of the suitability of alternative care in general, rather than institutions specifically, is provided by Cantwell et al., drawing from social welfare practices and the work of the CRC Committees, rather than directly from the treaty itself.[10]

[10] NIGEL CANTWELL, et al., MOVING FORWARD: IMPLEMENTING THE 'GUIDELINES FOR THE ALTERNATIVE CARE OF CHILDREN' (Centre for Excellence for Looked After Children in Scotland. 2012), p. 66 – 74.

Therefore, it is not sufficient for an institution to be designated for the care of children; it also needs to meet certain standards, although these standards are not elaborated in the text of the treaty. Given that institutions are the only non-family-based care option mentioned in this paragraph, it is likely that the drafters intended to encompass all forms of residential, out-of-family group care with the term 'institution'.[11] However, some ambiguity remains, particularly in the context of today's discussions on the suitability of institutional care in small groups with higher standards as substitutes for traditional large institutions. In light of this ambiguity, it may be justified to refer to supplementary means of interpretation, particularly the preparatory works. Namely, Australia's representative proposed the insertion of the word 'suitable,' which was accepted.[12] The reports, unfortunately, do not offer further information on this specific issue.

This provision is flexible, not only to adapt to various local contexts at the time of drafting but also to allow for the emergence of new forms of alternative care and evolving interpretations of what constitutes a suitable institution in the future. What remains inflexible is the limited role of institutional care, as indicated by the order in which alternative care options are presented and the inclusion of the phrase 'if necessary,' which underscores that institutions are an undesirable, last resort solution.

1.1.1.4. Marginal role and undesirableness of institutions

The discouragement of placements in suitable institutions is reinforced by the context of this provision, given in the other articles of the treaty and its Preamble, in accordance with Article 31 (2) VCLT. Several provisions of the CRC emphasize the protection of the family environment and the promotion of family reunification (Articles 5, 7, 8, 18 and 27 CRC). It also prohibits separation from the family against the will of the parents, except when such separation is necessary for the best interest of the child, determined in accordance with law and procedures and subject to judicial review (Article 8 CRC). States are also obligated to develop a variety of alternatives to institutional care for children who have committed offenses (Article 40 (4) CRC), and any deprivation of liberty should only be used as a measure of last resort and for the shortest possible period (Article 37 (b) CRC).

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[12] Commission on human rights report on the thirty-eighth session, E.1982/12/add. 1, p. 47, para. 55. https://digitallibrary.un.org/record/31890?ln=en

The states parties have affirmed in the CRC Preamble that the family is a fundamental unit of society and a natural environment for the growth and well-being of all children. They further stated that the family environment is indispensable for the full and harmonious development of a child. Therefore, the only interpretation compatible with this family-oriented treaty is one that reinforces the protection of family life for children. Consequently, placement in (suitable) institutions is allowed as an exception, only when necessary, while it is otherwise prohibited.

1.1.1.5. Continuity in the upbringing

The last sentence of Article 20 (3) prescribes giving due regard 'to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural, and linguistic background' when considering alternative care options. Tobin points out that the obligation of states to pay due regard to continuity and a child's background semantically refers only to the decision-making process about alternative care options,[13] when the child is already or is about to be deprived of a family environment. However, it would be correct to interpret this provision in its context, primarily in the remainder of Article 20, as well as in Articles 5, 7, 8, 9, 18, 37(b) and the Preamble. This context clearly favours care in the immediate family and then in a family environment when a child is in alternative care. Hence, the primary aim to promote reintegration with the immediate family and avoid serial displacements.[14] This continuity can be achieved through kinship care more efficiently than other forms of alternative care.[15]

Importantly, the continuity does not mean that if a child was placed in an institution from birth, he/she should remain in institutional care throughout childhood. Such an interpretation would not be in line with the context of the norm, other articles, and the Preamble of the treaty, which must be considered according to the general rules of interpretation (Article 32 (2) VCLT). The continuity in upbringing can be understood in a wider sense to encompass socio-cultural characteristics of a child's immediate surrounding.[16]

[13] Tobin. 2019, p. 752-753.
[14] Cantwell & Holzscheiter. 2008, para. 151.
[15] Id. at, para. 153.
[16] Id. at, para. 151-154.

1.1.2. Article 23 – special assistance and protection of CWD and their families

Article 23 CRC

States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 23 is specifically oriented to CWD, which was a novelty in IHRL at that time. The states parties recognised the especially challenging situation of CWD and their families worldwide by reinforcing the obligation to provide protection and assistance, free of charge whenever this is possible.

The rationale to introduce such an article stems from a similar understanding which generated the intention to have a new, specifically disability-oriented treaty - the CRPD. This understanding reflects the need to explicitly guarantee existing rights applicable to all human beings, to people with disabilities, in this case CWD, and where needed prescribe appropriate obligations to ensure enjoyment of those rights for CWD. Those obligations and ways of enforcing them might be different from states' obligations regarding the realisation of rights for the general population. For that reason, the prohibition of discrimination on the basis of disability in ensuring all the rights set out in the CRC (Article 2 (1) CRC) was not enough and the parties included a disability-specific article. Article 23 does not prescribe any particular form of care and assistance to CWD, and thus it is not subject to detailed analysis in this thesis. However, it does set general aspirations regarding the protection and care that CWD and their families are entitled to and is an important guiding principle for the rights of CWD in general.

Recognizing the overall more challenging situation of CWD, the CRC extends the protection of CWD in Article 23 by specifying the requirements that parties should ensure regarding the living conditions of CWD. This is the only CRC article which mentions that children should 'enjoy full and decent life', that their self-reliance and active participation in the community should be promoted and facilitated. It is likely that these requirements were inspired by the problems of discrimination, institutionalisation, segregation, abandonment, concealment, social exclusion, exclusion from education and consequently job market, substitute decision-making, torture and other forms of ill-treatment and other human rights violations experienced by many CWD worldwide.

Those violations served as the factual context of the adoption of Article 23. Moreover, institutional care is a context where all these violations have commonly occurred in the past and continue to do so in the present. While some states parties have initiated DI programs, CWD are sometimes left behind as states prioritize so-called 'easier cases'. This is at conflict with international standards as now generally accepted view is that CWD and other especially

vulnerable children should be prioritized in protection and assistance programs.[17] Likewise, the Sustainable Development Goals 2030 Agenda pledges 'to reach the furthest behind first'.[18]

1.1.2.1. Paragraph 1: Characteristics and purpose of the norm

The notions of a 'full and decent life' may be vague, but the conditions that promote self-reliance and facilitate active participation in the community are more specific and identifiable concepts, both in theory and practice. It is possible that one of the aims of this provision was to address the issue of widespread forms of care that clearly do not ensure such living conditions for CWD. In this regard, this provision builds perfectly on Article 20 (3) which places institutional care as not desirable and a measure of last resort, as explained above.

Although Article 23 (1) has a wider scope as it does not apply only to alternative care, the parties arguably reinforced Article 20 (3) in the context of CWD by providing more nuanced elaboration of conditions in which a child should live. This makes Article 23 (1), a comprehensive guiding principle, especially when it comes to CWD. This interpretation is further supported by the dichotomous nature of Article 23 (1), which encompasses both an element of non-interference with the enjoyment of full and decent life (e.g. by avoiding placing a child in an institution), and an element of fulfilment by providing appropriate measures to enable the enjoyment of full and decent life for a disabled child (e.g. by providing protection and assistance to CWD and their families). Following this dichotomy, states might be immediately obliged to cease interferences with the enjoyment of those rights by halting placements of CWD in forms of care that do not meet these requirements.

The first paragraph establishes an obligation of states to recognize that CWD '… should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'. According to Byrne, this phrase reflects an 'aspirational goal' and implicitly acknowledges the lack of resources on the part of many states to realise such aspirations.[19] This is a likely interpretation, as the phrase 'should' is in treaty

[17] See section *A mixed approach.*
[18] Transforming our world: the 2030 Agenda for Sustainable Development, A/RES/70/1, UN General Assembly, 2015, para. 4.
[19] Bronagh Byrne, *Article 23 of the United Nations Convention on the Rights of the Child: Children with Disabilities*, *in* A COMMENTARY ON THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (John Tobin ed. 2019), p. 861.

language less prescriptive than ‘shall’. Moreover, the wording of Article 23 (1) does not contain any specific or precise obligation for parties to implement, other than recognize a right of CWD.

However, Byrne incorrectly claims that the verb ‘should’ is used only twice in the CRC, in the fifth paragraph of the Preamble and Article 23 (1).[20] In fact, the word ‘should’ is used three times in the Preamble (preambular paragraphs 5, 6 and 7) and in three norms throughout the CRC (Article 19 (2), Article 23 (1), Article 26 (2)). The norms contained in Article 19 (2) and 26 (2) are each preceded by a minimum core obligation prescribed using the verb ‘shall’. Therefore, the use of the verb ‘should’ in both cases reflects a less prescriptive character of the norms than the ‘shall norms’. Moreover, in each of the two articles those paragraphs provide information on how to achieve the right to protect children and the right to social benefits, which considering the inherent flexibility of state parties regarding the ways of implementation of a human rights treaty, deprives these norms of a strong, legally obligating character.

In treaties ‘should’ generates legally soft norms that do not create obligations of parties to achieve a specific result but to work on their realisation as well as to guide the interpretation and development of the international child rights law.

Art 19 CRC

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

[20] Id. at.

On that note, states parties under Article 19 (1) CRC are obliged to establish legislative, administrative, social and educational measures for the protection of children from violence, abuse and forms of ill-treatment. However, the next paragraph is less prescriptive as it uses the verb 'should' to establish the parties' responsibility to develop social programmes and mechanisms for prevention, identification, reporting, referral, investigation, treatment and follow up of maltreatment as part of those measures. Likewise, Article 26 CRC prescribes the right to social security for children using the word 'shall' in the first paragraph (Article 26 (1) CRC). The second paragraph (Article 26 (2) CRC) prescribes social benefits '…where appropriate, be granted, taking into account' all relevant circumstances of the child and a person caring for him/her.

Article 26

1. States Parties **shall recognize** for every child **the right** to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.

2. The benefits **should, where appropriate**, **be granted**, **taking into account** the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

The provision of Article 26 (2) has a less prescriptive character due to the verb 'should' and the qualifier 'where appropriate', which might eventually make it hard to prove that a state party breaches such a provision. Hence, 'should', 'where appropriate' and 'take into account' are all 'softeners', which determine the character of the provision. Still, dynamic interpretations of this and other similar provisions should arguably aim at increasing their effectiveness. Similarly, the word 'should' is used in the Preamble to denote fundamental aspirations – the families *should* be afforded protection and assistance, children *should* grow up in a family environment, and they *should* be fully prepared for individual life and brought up in the spirit of the UN Charter's ideals, peace, dignity, tolerance, freedom, equality and solidarity. It should

be noted that the Preamble itself is not a legally binding part of a treaty, regardless of the wording, but it does assist in the treaty interpretation.[21]

1.1.2.2. Preparatory works and Article 23 (1) CRC

An examination of the preparatory works provides sheds light on the origin of Article 23 (1) CRC and can help further illuminate the intention of the parties. In a proposal by Canada, the contents that were ultimately adopted as Article 23(1) CRC were initially part of what is now Article 23(2) CRC. This proposal contained the phrase '… which *will ensure* him the right to enjoy a decent life …'. The Australian representative suggested isolating this 'fundamental principle' from the rest of the paragraph and positioning it as the opening paragraph of Article 23.[22] According to the OHCHR, such change was supposed to reinforce this provision as a leading principle of the article and the remainder of the CRC concerning the CWD.[23] A Polish submission on behalf of a group of states finalized the content of Article 23(1), introducing the less prescriptive verb 'should enjoy,' which marked a significant shift from the original Canadian proposal's 'will'. Arguably, such development changed the character of the abovementioned provision submitted by Canada, as the verb 'will' might be more prescriptive than 'should'.

Ultimately, the use of 'should' in Article 23(1) commits state parties to the ongoing effort to realise '… of full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'. This acknowledges that the goal will not be achieved by many states in a short period. Although this might dilute the obligation to a certain extent, the provision does guide the application of the remainder of Article 23, as well as all other norms of the CRC in the context of CWD, due to its comprehensiveness. It also sets a course for evolutive interpretations in the future that should increase the effectiveness of the provision in a given context.

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[21] Nguyen Quoc Dinh., Droit International Public as cited in: Hüseyin Pazarci, *Preamble 1969 Vienna Convention, in* THE VIENNA CONVENTION ON THE LAW OF TREATIES. A COMMENTARY (Pierre Klein Olivier Corten ed. 2011), p. 5, para. 13.

[22] Legislative History of the Convention on the Rigths of the Child, HR/PUB/07/1, Office of the High Commissioner for Human Rights, 2007, p. 568, para. 113.
[23] Ibid.

The principle of progressive realisation is often favoured over immediate obligation to acknowledge that some states, constrained by limited resources, may not achieve immediate compliance. This approach serves as a 'flexibility device,' mitigating risks that stringent immediate demands could discourage treaty ratification and increase reservations.[24] Also, following the ESCR Committee's interpretation of states' obligations regarding the progressive realisation, such a goal implicitly prohibits regressions in the level of the realisation achieved by a state party, except under special circumstances.[25]

Paragraph 4 of this article, obligates parties to recognize international cooperation as an indispensable asset, adding a specific obligation on developed nations and international actors to pay particular attention to developing nations as parties that might need more assistance. It is common in the IHRL and other IL regimes, to attach an obligation or a recommendation of international cooperation and assistance to a corresponding right for whose realisation significant resources might be needed. An especially descriptive example from another IL regime is the Paris Climate Agreement Article 4 (5).[26]

1.1.2.3. Paragraph 2: Right to special care and characteristics of obligations

The next paragraph (Article 23 (2)) CRC establishes a right of CWD to 'special care' and an obligation of states to ensure and promote the extended care, subject to available resources. The obligation to ensure the special care is qualified by the availability of resources. Furthermore, the phrase 'shall encourage and ensure the extension' contains explicit obligations to fulfil and to facilitate the provision of special care by other actors. Unlike Article 20 (1) where the wording implies direct provision of alternative care by states, where an extensive interpretation is needed to include provision of such care by non-state subjects, the text of Article 23 (2) actually implies that the special care is provided also by non-state actors. This infers from the states' obligation to promote the extension, alongside an obligation to ensure the extended care. Therefore, apart from ensuring a state-run mechanism of special care to CWD, the parties have a duty to encourage other actors to do so. This should not be

[24] CESCR General Comment No. 3: The Nature of States Parties' Obligations, E/1991/23, (Social and Cultural Rights Committee on Economic), OHCHR, 1990, para. 9.
[25] Id. at.
[26] Paris Agreement to the United Nations Framework Convention on Climate Change, UNTS,vol. 3156, p.79, 2015.

understood as an obligation of states to have both state and non-state care for CWD available at the same time, but rather as an intention of drafters to accommodate different local social policies regarding childcare around the world. Some states will develop mixed - state and non-state special care mechanisms, while others will only have state-run systems of such care. Following the understanding related to Article 20 (1), when special care is provided by non-state subjects, the state still has an obligation to establish, regulate, make available, oversee and control provision of these services.[27] A look at the preparatory works confirms that the intention of drafters was to recognize that the provision of care for CWD will also come from private actors, especially in countries where only limited resources are available.[28]

The obligation to ensure and promote extended assistance to fulfil the right to special care of CWD is qualified by the availability of resources, the term 'eligible child', and the phrase 'for which application is made'. These qualifiers can be interpreted as restricting the pool of recipients for extended assistance, potentially alleviating what could otherwise be an onerous burden on state parties. According to Nolan, the availability of resources was frequently invoked by the drafters throughout the drafting process, specifically in relation to Article 4, as well as articles concerning the standard of living, health protection, education, social security, and Article 6, which addresses the right to life, survival, and development but was eventually excluded.[29] Regarding the CWD, the parties obligations are subject to availability of resources in Article 23 (2) and in Article 23 (3) using a different phrase with a similar meaning - 'whenever possible'.

The use of the qualifier 'subject to availability of resources' with an aim of easing the burden on states is confirmed by the preparatory works, where a number of representatives[30] discussed the content of Article 4 and proposed that the CRC should not weaken provisions on civil and political rights by qualifying their enjoyment with the availability of resources, as this was not the case in the ICCPR either.[31] Therefore, the drafters clearly saw the qualification as a tool to soften or weaken certain provisions. The following sentence of the workgroup's report reads

[27] Cantwell & Holzscheiter. 2008, para. 115; Byrne. 2019, p. 872.
[28] HR/PUB/07/1, Office of the High Commissioner for Human Rights, 2007, para. 59.
[29] Aoife Nolan, *Economic and Social Rights, Budgets and the Convention on the Rights of the Child*, 21 21 THE INTERNATIONAL JOURNAL OF CHILDREN'S RIGHTS (2013), p. 259.
[30] United States, Canada, Sweden, New Zealand, Argentina, Portugal, and the United Kingdom.
[31] Report of the Working Group on a Draft Convention on the Rights of the Child, (1989), Economic and Social Council, United Nations, para. 172.

that the representatives recognised that some ESC rights can be only achieved if enough resources are available.[32]

The phrase 'eligible child' does not appear in later documents in relation to Article 23 CRC, leaving room for parties to determine who qualifies as 'eligible children' to whom the obligation of ensuring special care applies among all CWD. Byrne argues that the drafters did not intend to ease the burden on states by allowing them the possibility to interpret the 'eligible children' phrase restrictively, supporting this assertion with references to the preparatory works.[33] Regardless, all interpretations of terms should be directed at realizing the aim and achieving the purpose of the treaty, whereas all restrictions should be minimal and not jeopardize the purpose of the treaty and the essence of the right.[34]

1.1.2.4. Aims of extended assistance

Article 23 (3) of the CRC reiterates the obligation of states from paragraph 2 and adds that extended assistance should be free, 'whenever possible'. The phrase 'whenever possible' serves as another softener, similar to 'subject to availability of resources'. Consequently, paragraph 3 does not establish an absolute legal obligation to provide special care to every child with a disability. Significantly for this analysis, paragraph 3 enumerates several aims of the extended assistance, specifying the aspects of life to which such assistance should contribute. In that regard, this paragraph obliges parties to provide such assistance that ensures 'effective access' to education, training, health care, rehabilitation, employment, recreation social that should promote 'the fullest possible social integration and individual development'. It imposes a strong, prescriptive obligation on parties to provide care that meets the aforementioned requirements. Crucially, special care should promote social integration and the child's development, excluding any forms of special care that do not support these objectives.

It remains unclear whether alternative care for CWD should be categorized as special care, even though foster care, residential care, and schools for CWD often include the qualifier 'special'. The provision of alternative care is described under Article 20 using the words 'special

[32] Id. at.
[33] Byrne. 2019, p. 873.
[34] Defence for Children International v. The Netherlands, The European Committee of Social Rights, No. 47/2008, para. 34–36.

care and assistance'. Regardless, from whether institutional care for CWD should be considered a form of special care or not, Article 23 CRC gives a context in the meaning of VCLT Article 31 (2) CRC. This further means that alternative care options for CWD shall be designed in such a way to ensure effective access to the abovementioned services and structures, and contribute to the 'fullest possible' social integration and personal development of CWD. Therefore, Article 23 (3) CRC should inform the interpretation of Article 20 CRC, as it outlines more detailed requirements for the design of care for CWD and the goals of such care. Regarding the abovementioned issue of absence of criteria for assessing suitability of institutions in Article 20 (3) CRC, at least some guidance is provided within Article 23 CRC, primarily in paragraph 1 and in paragraph 3.

The final paragraph of Article 23 addresses international cooperation in terms of information exchange but does not reference financial aid or other resources. Two NGOs proposed including 'international aid,' but the preparatory documents provide no details on discussions about this aid, and the proposal was not adopted. While the rest of the paragraph does not directly pertain to institutional care, it offers significant insights into the drafters' perceptions of the key issues to address transnationally for CWD. Additionally, it indicates which rights of CWD the state parties believed would be most challenging for developing countries to guarantee.

1.2. The Convention on the Rights of Persons with Disabilities and institutional care

Article 23 and Article 19 of the CRPD contain critical norms regarding the forms of care to which CWD are entitled and which parties are obligated to ensure. Those provisions should be read in conjunction with Article 5 on non-discrimination, which is a horizontal issue and a general principle of the CRPD, and human rights law in general.

Article 20 of the CRC has been discussed previously, and only a few key points will be reiterated here. First, Article 20(2) of the CRC obligates states to provide alternative care for children deprived of their family environment. Second, paragraph 3 of the same article (Article 20(3) CRC) offers guidance to help states fulfil the obligations outlined in Article 20(2) CRC. This guidance includes a non-exclusive list of alternative care options. The text of the CRC

does not obligate states to choose and develop any specific alternative care options. Among these options, the only non-family-based form of alternative care is institutional care. Given the wording of the paragraph, the text of the Convention, its Preamble, and its purpose, the conclusion is that institutions are an undesirable, last-resort option that parties can provide to children deprived of their family environment. This is further confirmed by Article 23 of the CRC, which recognizes that CWD should live in conditions that ensure dignity, promote self-reliance, and facilitate active community participation—goals that are significantly challenged in institutional care, particularly given that once institutionalised, CWD often remain in such care for life.[35]

1.2.1. Article 23 CRPD – Respect for the home and family

Article 23 CRPD

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognised;

(b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided;

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions,

[35] See Introductory chapter - 2. Reasons for the transition from institutional care to life in a family environment.

where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. States Parties shall ensure that CWD have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of CWD, States Parties shall undertake to provide early and comprehensive information, services and support to CWD and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Article 23(3) of the CRPD obligates states to prevent segregation, abandonment, concealment, and neglect of CWD to ensure the realisation of their rights concerning family life. Therefore, unlike Article 20 of the CRC, which is a remedial provision, Article 23(3) of the CRPD also aims to prevent the deprivation of a family environment and strengthen the protection of family life.[36]

The subsequent paragraph, Article 23(4) of the CRPD, comprises two sentences, the first of which is identical to the first sentence of Article 9(1) of the CRC. In the first sentence, the CRPD reiterates that when a separation is necessary for the best interests of the child it must be carried out by competent authorities and be subject to judicial review, in accordance with applicable law and procedures. However, the second sentence of the paragraph contextualizes the provision by prohibiting separation from parents based on the disability of either the child or a parent (Article 23(4) CRPD). This is another critical provision through which the CRPD

[36] Valentina Della Fina, *Article 23 Respect for Home and the Family*, *in* THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES. A COMMENTARY (Valentina Della Fina, et al. eds., 2017), p. 431.

increases the protection of family life of CWD, compared to the CRC. The second sentence read in conjunction with the first cannot be understood to allow for derogation from the prohibition to separate children on the basis of disability, as it was wrongly suggested by Della Fina.[37] This is obvious from the wording of the second sentence, which does not mean a disabled child cannot be displaced from his/her family on another basis, when it is in his/her best interest.

This provision responds to the widespread practice of removing children from their parents based on the disability of either the parent or the child, leading to a disproportionate number of CWD in institutions. Although this provision might be described as merely an anti-discrimination provision,[38] it needs to be more effective than plain non-discrimination clauses, through more far-reaching obligations to states that are found in other CRPD provisions, including Article 23 (5). Some states amended their laws before or after adopting the CRPD to abolish institutionalisation based on disability. However, due to insufficient support and services for CWD and their families, some of these states continued similar practices. Consequently, decisions were often made based on the perceived best interest of the child, resulting in their separation from families and placement in residential care effectively on the basis of disability.[39] Hence, a disabled child might not be formally removed from his/her family on the basis of disability, but on the basis of the best interests of the child, where their parents cannot care for a child appropriately, because the necessary information, services and support are not provided to the families. This can effectively result in separation of children because of their disability, regardless from legislative reforms aimed at removing disability as a basis for separation from the immediate family. A question of effectiveness should be a central one when interpreting this provision.

The effectiveness approach, based on the good faith principle (Article 31(1) VCLT), posits that a term, phrase, or provision should be interpreted in a way that enables it to have a tangible impact on rights-holders.[40] When applied to Article 23 (4) CRPD this would mean that the original intention of drafters to prohibit separation from the immediate family on the basis of

[37] Id. at, p. 436.
[38] MARIANNE SCHULZE, UNDERSTANDING THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (Handicap International 3rd ed. 2010), p. 126.
[39] E.g. on issues with the understanding of the best interests principle: Helen Stalford, *The broader relevance of features of children's rights law: the 'best interests of the child'principle*, *in* CHILDREN'S RIGHTS LAW IN THE GLOBAL HUMAN RIGHTS LANDSCAPE (Eva Brems, et al. eds., 2017).
[40] Başak Çalı, *Specialized Rules of Treaty Interpretation: Human Rights*, *in* THE OXFORD GUIDE TO TREATIES (Duncan B. Hollis ed. 2020).Cali 2012 p. 538-541.

disability should be given tools to be effective. In fact, the entire CRPD was imagined and designed as a convention that does not create new rights but makes existing ones 'accessible' to persons with disabilities.[41] In that light, this provision should be understood as not only prohibiting separation on the basis of disability directly or indirectly, but also as an implicit basis for a number of duties related to the fulfilment in order to avoid displacement directly or indirectly based on disability. The obligation to provide services and support to avoid separation are first and foremost contained in Article 19 CRPD.

A review of the Preparatory Works provides interesting insights into the negotiation of this provision's wording. The Ad Hoc Committee debated whether to retain the words 'directly or indirectly' before 'of disability', delete them, or replace them with 'solely' By deleting 'directly or indirectly', the Ad Hoc Committee opted for a slightly less stringent formulation that still implies the prohibition of discrimination based on disability, both directly and indirectly. Conversely, had 'solely' been adopted, it would imply that children could be separated from their parents based on disability in conjunction with another factor, such as inadequate care of a disabled child due to a lack of family support and services, a proposition that faced strong opposition during the negotiations.[42]

1.2.1.1. Permissible alternative care options

Article 23 (5) CRPD builds on Article 20 (2) CRC by refining and extending the duty to provide a family environment for children in alternative care. Contrary to the CRC, which lists types of alternative care, the CRPD focuses on their essential characteristic—the family environment, (as distinct from non-family-based care like residential or institutional settings). Furthermore, it obligates states to 'undertake every effort' to provide alternative care within a family environment, notably omitting any mention of non-family-based care forms. This omission likely signifies an intent to reinforce the obligation of providing care within a family environment; however, it remains unclear whether states are strictly required to ensure care only in family settings. Thus, the obligation from this provision may be interpreted as requiring

[41] Janos Fiala-Butora, *Art.23 Respect for Home and the Family*, *in* THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY (Ilias Bantekas, et al. eds., 2018), p. 639.
[42] Id. at, p. 633.

states only to make every possible effort to place a child in family care. Hence, if a state makes all possible efforts but fails to place a child in family-based care, it would not necessarily be deemed non-compliant with this norm.

Alternatively, if 'undertake every effort' applies solely to providing care within the wider family, then states would be obligated to ensure, failing that, exclusively family-based care within the community. With this approach based solely on semantics, it is challenging to determine definitively which interpretation is more appropriate. The central question concerning this norm is whether states are obligated to provide alternative care exclusively in a family setting.

Della Fina explains that the purpose of this norm is to prevent institutionalisation of children and that it actually obligates states parties to provide alternative care only in a family setting.[43] Similarly, Rosenthal asserts that this norm prohibits out-of-family placements, arguing that even if placement in family-based alternative care is not feasible, a child must still be placed within a family setting.[44] Indeed, interpreting this provision in light of the treaty's object, purpose, and context supports an obligation to provide alternative care exclusively in a family setting, with a distinct preference for care within the wider family.

The internal context of the provision (primarily Article 23 paragraphs 1,3 & 4 and Article 19 (a) CRPD) along with the CRPD's purpose, clearly indicate an obligation to provide alternative care solely within a family setting. However, when an external context of the CRPD is taken into account (in accordance with Article 31 (3) (c) VCLT), precisely Article 20 (3) CRC, one could argue that an interpretation of Article 23 (5) CRPD allowing for non-family-based care 'if necessary' may be justifiable.

Before examining the preparatory works, the phrase 'in a family setting' should be interpreted as denoting accommodation within a family. The general rules of treaty interpretation (Article 31 (1) VCLT) demand an ordinary meaning to be given to the terms, which in the present case prevents from expansive understandings that could encompass non-family-based settings which try to imitate some aspects of family care. Such an interpretation would fall short from considering the context of the term, which is obviously dedicated to the protection of family

[43] Della Fina. 2017, p. 436.
[44] Eric Rosenthal, *The right of all children to grow up with a family under international law: implications for placement in orphanages, residential care, and group homes*, 25 25 BUFF. HUM. RTS. L. REV. (2019), p. 111.

life for CWD.[45] The term 'setting' in 'in a family setting' should be interpreted to include various types of family arrangements recognised in diverse cultures and legal frameworks globally. On the opposite side, Conversely, Chilemba contends that Article 23(5) CRPD establishes a right to 'family-type care' for CWD—a term used to describe care outside of the family that replicates aspects of family living—though he does not substantiate this claim with supporting arguments.[46] The CRPD Committee was especially clear on this issue in its General Comment No. 5 and DI Guidelines.[47]

1.2.1.2. Preparatory works

The preparatory works are consulted to clarify the intentions of the parties and the meaning of this norm, in accordance with the methodology prescribed by the VCLT. The New Zealand delegation proposed the insertion of a new paragraph 3(bis) to a draft Article 23 (Article 23 (5) CRPD) which would ensure that disabled children have the opportunity to experience family life on an equal basis with others, taking into consideration the need to address rooted practices of institutionalisation, according to the Daily summary of the discussion at the seventh session.[48] New Zealand's proposal was nearly identical to that of the International Disability Caucus but included a crucial addition—the phrase 'in a family setting' was added before 'within the community'. This addition, present in the text of Article 23(5) CRPD, limits potential readings and interpretations that might suggest states could also provide non-family-based living arrangements within the community.

Canada's delegation proposed altering this provision by replacing 'provide' with 'facilitate', likely to allow non-governmental entities to provide such care while states act as facilitators.[49] The verb 'facilitate' could have also been proposed to ease an onerous burden of an obligation

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[46] Enoch M. Chilemba, *International Law on the Rights of Children with Disabilities*, *in* INTERNATIONAL HUMAN RIGHTS OF CHILDREN (Ursula Kilkelly & Ton Liefaard eds., 2019), p. 372

[47] See 'General Comment No. 5 on living independently and being included in the community (2017)' and 'Guidelines on DI, including in emergencies'.

[48] Daily summary of discussion at the seventh session, Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities.accessed 7th May 2024, available at: https://www.un.org/esa/socdev/enable/rights/ahcstata23sevscomments.htm.

[49] Id. at.

to provide. India made a similar proposal, asserting that the state should act as a facilitator rather than a provider.[50] Conversely, the EU delegation completely opposed the introduction of this provision. Although available documents do not offer further explanations, it is evident that the proposals from Canada, India, and the EU were not adopted, indicating that the drafters considered it important for states to be obligated to provide alternative care within a family setting. None of those three states (nor any other state party) have issued a reservation to Article 23 (5).

The differing submissions of the governments on the wording and the need for Article 23 (5) demonstrates the complexity of the issue of forms of alternative care that should be provided to CWD. Perhaps, the reason why agreement was eventually reached with the provision as it is, and the initially opposing states (India, Canada) and the EU have not objected, issued reservations or declarations is that the wording of the norm is ambivalent and can accommodate different interpretations.

Regardless, it is clear that the norm aims to protect family life more robustly due to widespread practices of denying a family environment to CWD by providing alternative care in non-family-based settings. Therefore, it is unsurprising that interpretations from the CRPD Committee lean towards prohibiting the provision of non-family-based care.[51]

1.2.1.3. Relationship with Article 7 (1) CRPD

Article 7 (1) CRPD reads as follows:

States Parties shall take all necessary measures to ensure the full enjoyment by CWD of all human rights and fundamental freedoms on an equal basis with other children.

The critical phrase of this norm for the purpose of the interpretation of Article 23 (5) CRPD is 'on an equal basis with other children'. One could argue that this norm prevents CRPD from

[50] Id. at.
[51] The CRPD Committee indeed interprets the norm in the way explained, as expressed in the General Comment No. 5 on Article 19, and in many concluding observations.

establishing obligations on states regarding CWD that are more far-reaching than those contained in the CRC. Such an understanding would go in the direction of discrediting and delegitimizing the purpose of the CRPD as a whole. The CRPD Preamble (paragraph y) gives an answer to the rationale behind the need to have a convention that will comprehensively address the rights of persons with disabilities, which is 'redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries…'. The wording of this paragraph implies that the CRPD is intending to address the long existing issues that previous human rights instruments did not adequately resolve. Although directly or indirectly addressing the rights of persons with disabilities too, human rights treaties before the CRPD did not provide a set of obligations that would bring the long-needed change. Hence, some obligations in the CRPD might be seen as more far-reaching because they are 'disability-sensitive'. In this context, states have recognised and created obligations to address issues such as the institutionalisation of CWD in alternative care. Consequently, the cited phrase and the norm of Article 7 (1) CRPD cannot be understood to preclude the existence of obligations that might be more far-reaching, as in the case of Article 20 (2) CRC and Article 23 (5) CRPD. Quite contrary, Article 7 (1) CRPD should be understood to support the existence of different obligations, also more demanding ones, to fulfil the purpose of ensuring the enjoyment of the rights on an equal basis with other children.

This is confirmed by preparatory works, where states and other actors firstly expressed that a specific article on CWD is needed to recognize intersectional oppression that CWD experience.[52] In the following sessions, it was stated that articles on CWD should not simply repeat the wording of the CRC, as this would not address the specific situation and issues that affect CWD in a different way than other children, thus the issue was referred to a facilitator.[53] Eventually, not only was a specific article on CWD adopted, but the rights of CWD and states' obligations directly related to CWD were also integrated into other articles too, such as Article 23 CRPD.[54]

[52] Documents of the second session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 16-27 June 2023. accessed 8th May 2024, available at: http://www.un.org/esa/socdev/enable/rights/a_ac265_2003_crp10.htm.
[53] Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its sixth session, accessed 8th May 2024, available at: https://www.un.org/esa/socdev/enable/rights/ahc6reporte.htm.
[54] Ignacio Campoy Cervera, *Legal analysis of Article 7 of the convention on the rights of persons with disabilities: children with disabilities*, THE AGE OF HUMAN RIGHTS JOURNAL (2017), p. 119-123.

1.2.1.4. A role and implications of the vagueness

To sum up, Article 23 (5) is ambiguous, possibly because it aims to end the provision of out-of-family alternative care. However, the drafters also had to acknowledge the efforts and time required for some states parties to establish and provide types of family-based alternative care to fulfil the obligation. Moreover, it was necessary to accommodate resistance from some states parties during negotiations against a norm that completely excludes the provision of out-of-family care (the case of the EU's suggestion during negotiations indicates an opposition to the total exclusion of out-of-family care, which was also detected in Portugal's submission to the Day of General Discussion 2021).[55] This omission of adjectives such as 'only', 'solely', or 'exclusively' before the phrase 'within the community in a family setting' leaves room for multiple interpretations, reflecting a compromise among the parties who were pointing in slightly different directions during the drafting process (e.g. New Zealand and the EU).

The other critical phrase, 'undertake every effort to provide', resonates as a wording commonly used to recognize limitations related to states' resources. This phrase could be understood similar with the phrase 'to the maximum of available resources' (or similar).[56] Moreover, the phrase 'to provide' indicates that this is predominantly a 'to fulfil' obligation, requiring significant resource allocation in states where many CWD reside in institutions and where other forms of family-based alternative care are underdeveloped. It is also implicitly an obligation to respect the family life of CWD by refraining from out-of-family placements.

It might be impossible to reach a definite *lex lata* meaning of Article 23 (5) regarding the permissibility to provide alternative care in non-family settings (after undertaking all efforts to provide care in some sort of a family setting) might be impossible. This is a borderline norm where definite answers should be sought *lex ferenda*, or what the law ought to be, through the interpretation that can be taken in different directions. Applying the effectiveness principle to interpret Article 23 (5) CRPD would likely result in an obligation to provide alternative care exclusively in a family setting, with a preference for alternative care in the wider family. The

[55] See 'Day of General Discussion on children's rights and alternative care (2021)'.
[56] 'Whenever possible' is the phrase used in Article 23 (3) CRC to acknowledge possible resource limitations.

norm's wording accommodates this interpretation, the purpose of the norm (to stop institutionalisation of CWD), and the internal context that clearly favours the life in a family environment (Article 23 (1)- 4, Article 19, Preamble (x)), all point in that direction. The external context that needs to be taken into account (in accordance with Article 31 (3) VCLT), primarily the CRC, also favours the family (Articles 5, 7, 8, 9, 18, 20, 37(b) CRC, and the CRC Preamble), by establishing obligations to states to provide and protect family life of children. The norm of Article 20 (3) CRC, although it names institutional care as a conditioned option, it still clearly favours placements in family settings. The existence of institutional care as an option, however, should not be neglected.

There are two arguments in favour of not considering Article 20 (3) CRC as a decisive element for the interpretation of Article 23 (5) CRPD – other applicable rules of international public law should not override text, internal context and the purpose, and secondly, Article 20 (3) provides and optional list of alternative care forms and does not create an obligation (nor a right), unlike Article 23 (5) CRPD. The external context, considering its ordering in Article 31 VCLT, according to Sorel and Bore Eveno, should primarily have a supporting rather than a crucial role in the interpretation of a treaty.[57] Due to potential divergences between Article 20 (3) CRC and Article 23 (5) CRPD, this theses includes a chapter titled 'Points of tension between the conventions'. It explores potential conflicts between the treaties, their implications, and possible resolutions.

1.2.2. Article 19 - Living independently and being included in the community

Article 19 CRPD
States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

[57] Jean-Marc Sorel & Valérie Boré Eveno, Article 31: Convention of 1969, in THE VIENNA CONVENTION ON THE LAW OF TREATIES. A COMMENTARY (Pierre Klein Olivier Corten ed. 2011), para. 42.

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

The right to independent and community living for persons with disabilities first appeared in IHRL through non-binding instruments, specifically the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities[58] and the General Comment on persons with disabilities issued by the Committee on Economic, Social, and Cultural Rights.[59] It closely relates to Article 12 of the ICCPR, Article 11 of the ICESCR, and Article 29(1) of the UDHR.[60]

The text of Article 19 does not specifically mention children; instead, it refers to 'all persons with disabilities', which naturally includes children. The text leaves some ambiguity concerning its relationship with children, particularly in how terms like 'independent living' and 'community living' apply in a child-specific context. The CRPD Committee extensively elaborates on this article in its General Comment No. 5 and stresses that '…the core of the right to live independently and be included in the community entails a right to grow up in a family'.[61] General Comment No. 5 is analysed in section 'General Comment No. 5 on living independently and being included in the community (2017)'. The focus here, however, is on interpreting Article 19 CRPD following the rules of the VCLT.

[58] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, A/RES/48/96, United Nations General Assembly, 1994.
[59] General Comment No. 5 (1994) on the rights of persons with disabilities: Committee on Economic, Social and Cultural Rights, E/1995/22, 1995.
[60] International Covenant on Civil and Political Rights, UNTS vol. 999, p. 171, 1966; International Covenant on Economic, Social and Cultural Rights, UNTS, vol. 993, p. 3, 1966; Universal Declaration of Human Rights, Resolution 217 A (III), UN General Assembly, 1948.
[61] General comment no. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, (Committee on the Rights of Persons with Disabilities), 2017, para. 37.

1.2.2.1. Chapeau: The right to live in the community

The Chapeau mandates that states must take 'effective and appropriate' measures to ensure that persons with disabilities have the right to live in the community. This includes enabling them to make choices on an equal footing with others and facilitating their full inclusion and active participation in the community. The Chapeau begins by recognizing the 'equal right' of all persons with disabilities to live in the community. The term 'equal right' explicitly signifies an anti-discrimination norm, underscoring non-differentiation based on disability, and prohibiting any exclusion from the community on the basis of disability. The choice of the phrase 'to facilitate full enjoyment' rather than 'to ensure full enjoyment' suggests a cautious approach by the parties. They likely recognize that the full realisation of this right might not solely rest with the states, or that it may not be achievable in the near future. Indeed, according to Palmisano, the EU delegation proposed this wording to align the provision with the views and capacities of states not prepared for an absolute ban on institutions.[62] However, states are obligated to ensure the implementation of measures outlined in the following three paragraphs.

1.2.2.2. Paragraphs a, b, c

Paragraph ‘a’ of the CRPD mandates that states ensure persons with disabilities are not forced into any specific living arrangement. It guarantees their right to choose where and with whom to live, on an equal basis with others (Article 19 (a) CRPD). Apart from the explicit meaning, this provision implicitly abolishes forced institutionalisation or any other form of imposed living arrangement. The subsequent paragraph outlines a variety of support measures, including material support and counselling, and services such as personal assistance, supported living arrangements, and home help. These are designed to prevent segregation and isolation and facilitate independent living within a community. Personal assistance is specifically mentioned because it is considered crucial for supporting the independence of its users, including both

[62] Giuseppe Palmisano, *Article 19 Living independently and being included in the community*, *in* THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY (Valentina Della Fina, et al. eds., 2017), p. 358.

children and adults.[63] Furthermore, states are required to ensure that general services are accessible and meet the needs of persons with disabilities, as outlined in Article 19(c) CRPD. This clause serves as an anti-discrimination measure with explicit obligations to protect and fulfil these rights. The paragraphs 'b' and 'c' are to be realised progressively, while the obligation from the paragraph a is of an immediate nature. Importantly, the connection of paragraph 'a' with Article 10 of the ICCPR underscores its status as a civil right, whereas paragraphs 'b' and 'c' are categorized as economic and social rights.

The entire Article 19 CRPD is built around the idea to stop the practice of institutionalisation and transfer the power of decision-making regarding living in the hands of people with disabilities. The Ad hoc Committee named the essence of the article the freedom to choose where and how to live on an equal basis with others and noted that as the key aspect was seen the right to the community living.[64] Importantly, Fiala-Butora *et al.* highlight that a fundamental element of this right for persons with disabilities is the provision of 'necessary conditions to make living in a community a real choice for PWD (persons with disabilities)'. Indeed, the declaration of the right to choose would not be effective without ensuring that the people actually have a choice, which means that the living in a community is supported and provided for. Therefore, Article 19 CRPD revolves around the right to choose and the provision of conditions to live in a community.

1.2.2.3. Institutions

Although Article 19 sends a strong message against institutionalisation, it does not explicitly prohibit it.[65] The duties to provide support and services in the community (para. b), aimed at facilitating community living, along with ensuring effective access to general services accommodating persons with disabilities (para. c), are expected to eliminate the need for institutional care if implemented properly. Moreover, the duty to ensure that persons with disabilities have opportunity to choose where and with whom to live, as the rest of population,

[63] Janos Fiala-Butora, et al., *Article 19: Living Independently and Being Included in the Community in* THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY (Ilias Bantekas, et al. eds., 2018).p. 552

[64] Report on the Sixth session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ad Hoc Committee, A/60/266/, 2005, para. 11.

[65] Fiala-Butora, et al. 2018, p. 531.

and are not obliged to live in a particular arrangement (para. a), might render institutionalisation practically impossible and redundant.

Adults with disabilities are frequently placed in institutions without their informed consent, typically through the consent of a guardian or by compulsory judicial or administrative procedures. A person's legal capacity, or the right to make legally effective decisions, is crucial for avoiding institutionalisation. Therefore, Article 12 (Equal Recognition Before the Law) and Article 19 are interrelated and mutually reinforce each other. Therefore, Article 19 is written in such a way to create state duties, which if realised, make institutions redundant and the institutionalisation even impossible.

The negotiations over Article 19 reveal disputed elements and the intentions behind the final text. Perhaps, the most disputed issue was the concept of independent living, primarily due to cultural considerations and the potential for misunderstandings.[66] Apart from that, participants extensively debated the content of the paragraphs. Jordan suggested a version of para. b that would explicitly state the persons with disabilities are not obliged to live 'in an institution or in a particular living arrangement.'.[67]

The South African delegation proposed inserting the phrase 'unless there it is found appropriate', which, as it was explained, would clash with draft article 10 (Article 14 of the CRPD).[68] Nonetheless, if it had been adopted, it would contradict the purpose of this article explained in the first sentence of the previous paragraph. Indeed, the absence of certain suggestions from the final text can be as informative as the wording of the final text. Likewise, the absence of the word 'institution' is striking, especially when considering that the first draft of the Work group contained it, as quoted above. Deleting the word 'institution' does not alter the overall meaning, as the phrase 'in a particular living arrangement' is broad enough to include institutions. However, the absence of the explicit mention of 'institutions' suggests disagreement among parties, which could have dual consequences. On one hand, it might indicate a reluctance to commit to explicitly prohibiting forced institutionalisation. On the other hand, omitting a specific mention of institutions, but keeping a broader notion ('in a particular living arrangement') can provide an even broader protection of the right to choose one's own

[66] Palmisano. 2017, p. 356; Fiala-Butora, et al. 2018, p. 533-534.
[67] Report on the Third session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ad hoc Committee, UN Doc A/AC265/2004/5 (9 June 2004).
[68] A/60/266/, para. 16.

residence, as otherwise people with disabilities could be coerced to live in other forms of facilities that would not necessarily be called institutions or might not share some of the main characteristics of institutions. In that case, a specific mention of institutions alongside 'any particular living arrangement' could have been redundant or even counterproductive.

The report of the Ad hoc Committee states that some delegations opposed to have any reference to institutions, and proposed deletion of the entire subparagraph with the explanation that it is already covered by draft Article 10 (Article 14 CRPD Liberty and security of person) and subparagraph (a) of draft Article 14 (Article 19 (1) (a) CRPD).[69] In fact, institutions, as a form of residential care, are not mentioned in the CRPD text at all. The word itself was used three times but with a different meaning (articles 23 (2), 33 (2), 4 (1)(d) CRPD).

1.2.2.4. Characteristics of obligations

Arguably, a critical negotiation moment that shaped the nature of this provision is the partial acceptance of the EU's proposal, at the Sixth session of the Ad hoc Committee. The EU representative suggested softening the Chapeau's language by replacing the phrase 'States Parties to this Convention shall take effective and appropriate measures *to enable* persons with disabilities to live independently and be fully included in the community, *including by ensuring* that:',[70] with the phrase 'States Parties shall take appropriate measures *to facilitate* persons with disabilities to live independently and be fully included in the community, *including measures aimed at ensuring* that…' (emphasis added).[71][72] Although the proposal to insert the phrase 'to facilitate' was accepted, the phrase 'including measures aimed at ensuring' was not incorporated.

The wording of the Chapeau as it is, has a solid prescriptive nature, as it obligates states parties to ensure the realisation of the points expressed in paragraphs a, b and c, rather than ensure taking measures that should contribute to the realisation of the points from those paragraphs.

[69] Id. at, para. 11-22.
[70] Report of the working group to the Ad hoc Committee, A/AC.265/2004/WG.1, 2004. accessed 8th May 2024, available at: https://www.un.org/esa/socdev/enable/rights/ahc3documents.htm.
[71] Id. at, p. 33.
[72] Palmisano. 2017, p. 358.

Therefore, compared to Article 23 (3), which prescribes that 'states parties shall undertake to provide' information and assistance, and Article 23 (5), which requires state parties to 'undertake every effort…' to provide care in a family setting, Article 19 emerges as a more prescriptive norm, with a firmer obligatory character. This makes it potentially more effective in ensuring the rights of persons with disabilities.

1.2.2.5. Article 19 and children

During the negotiations of Article 19 CRPD, representatives from New Zealand, Lebanon, and several NGOs advocated for the inclusion of specific references to children and their need to live in a family environment.[73] Article 19 also pertains to children, though it should be clarified how the concepts like independent living and the freedom to choose where and with whom to live relate to children. This was elaborated by the CRPD Committee.[74] CWD are recognised as having the right to live in the community on an equal basis with others. The right to live in the community for children must be realised in the context of the above-explained Article 23, which prioritizes the protection and fulfilment of life in the family of origin, and alternatively in the community in a family setting. In that way Article 23 (5) CRPD establishes a boundary on how the community living should be realised for children by obliging states to undertake every effort to provide alternative care in the community in a family-setting. Furthermore, both Article 19 and Article 23 CRPD obligate states to provide assistance and support aimed at preventing segregation and isolation, concealment, abandonment, and neglect (Article 19 (a) and Article 23 (3) CRPD). The two articles are intertwined and mutually reinforcing, prescribing the right to live in the community and obligations of states to ensure support and services to children and their families to ensure the realisation of the right.

The concept of choosing one's own residence, particularly for very young children, should not be problematized in the same way as pertaining to adults (or even older minors). Both the CRC and the CRPD preambles recognize families as the natural environment essential for a child's growth and development.

[73] A/AC.265/2004/5 p. 33; Daily summary of discussions related to Article 15, Ad hoc Committee. accessed 8th May 2024, available at: https://www.un.org/esa/socdev/enable/rights/ahc4sumart15.htm.
[74] CRPD/C/GC/5, para. 16(c).

1.2.3. Article 5 Equality and non-discrimination and residential care

It is essential to read Articles 19 and 23 CRPD alongside Article 5, which addresses equality and non-discrimination. The equality promoted in the CRPD substantially impacts how the entire document is understood, interpreted and implemented. Article 5(2) explicitly prohibits discrimination based on disability and mandates that state parties provide 'equal and effective legal protection against discrimination on all grounds' for individuals with disabilities. Article 5(3) prescribes that state parties take '(…) all appropriate steps to ensure that reasonable accommodation is provided'. Article 5 (4) CRPD states that 'specific measures which are necessary to accelerate or achieve *de facto* equality of persons with disabilities shall not be considered discrimination (…)'.

There is a strong link between the principles of non-discrimination and de facto equality, as outlined in Article 5 CRPD, and the goals of independent living, family life, and community inclusion detailed in Articles 19 and 23 CRPD. Article 19 prescribes 'the *equal* right of all persons with disabilities to live in the community, with choices *equal* to others', the right to choose one's own residence 'on an *equal basis* with others' and general services and facilities to be available to persons with disabilities 'on an *equal* basis' (emphases added). To ensure the equality of children and adults with disabilities, states are required to fulfil obligations of Article 19. Following that, the failure of a state to fulfil the requirements from Article 19 (1)-3, which results in institutionalisation is to be considered a form of discrimination.

Consequently, the widespread institutionalisation of children with disabilities is frequently regarded as systemic discrimination based on disability. Gerard Quinn, alongside a group of academics, categorizes the placement of persons with disabilities in segregated or congregated living conditions as a 'prima facie' form of discrimination.[75] The CRPD Committee adopts the same position in its General Comment No. 6, which is explored further in the section *Other CRPD Committee general comments*.[76]

The U.S. Supreme Court decision in Olmstead v. L.C. significantly influenced the understanding of discrimination in the context of institutionalising disabled people during the

[75] Gerard Quinn, et al., Segregation and segregated facilities as a prima facie form of discrimination: the impermissibility of using the ESIF to invest monies in long term care residential institutions for persons with disabilities (2018).
[76] General comment no. 6 (2018) on equality and non-discrimination, CRPD/C/GC/6, (Committee on the Rights of Persons with Disabilities), 2018, para. 58.

late 1990s and 2000s. In Olmstead v. L.C., the Supreme Court ruled that institutionalisation constitutes discrimination under the Americans with Disabilities Act.[77] Quinn et al. argue that this decision, among other highly authoritative judicial rulings, shaped the drafting of the CRPD.[78] This serves as a prominent example of how domestic court rulings can influence the creation and evolution of transnational norms, a concept well-established in TLP scholarship.

Article 5 and the obligation to achieve *de facto* equality are immensely important and should be read in conjunction with other articles of the CRPD. This holistic approach is essential when developing laws, policies, and practices aimed at fully realising the rights of CWD.

1.3. The right to family life and the right to live (grow up) in a family environment

Neither of the two conventions explicitly mentions a 'right to family life' per se; however, this right is implied in both. The closest expression to the right to family life is found in Article 7 CRC (1) CRC, which reads as follows:

The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

A critical phrase in this norm: 'shall have (…) as far as possible, the right to know and be cared for by his or her parents', indicates that while children have the right to parental care, it is not absolute, as evidenced by the qualifier 'as far as possible'. To be precise, the norm does not recognize a right to family life but a right to be cared by one's own parents. Thus, the right to family life can be understood in various ways: as a right to live with and be cared for by one's own parents, as a right to live (or grow up) in a family environment, or as an umbrella term that encompasses a range of family-related rights, including the right to establish one's own family, for instance.

[77] Olmstead v. L.C., Supreme Court of the United States, 98-536. Fiala-Butora, et al. 2018, p. 537.
[78] Quinn, et al., (2018), p. 9-10.

The right to live in a family environment, or the right to grow up in a family, as it is sometimes called,[79] is broader than the right to be cared for by one's own parents, as it means that a child has a right to live in a family environment even when it is impossible to live with and be cared by his/her parents. In other words, a child's right to live in a family environment is ensured when the child is under the care of his immediate parent(s), adoptive family, extended family, or in foster care. Although, the limited right to be cared for by one's own parents is explicit, the right to family life could be inferred from a number of states' obligations that are aimed at the protection of the immediate family and the provision of alternative care in a family environment, as well as from the treaties' preambles. This is a similar logic as inferring obligations from existing rights. The CRC Preamble acknowledges that the family is 'the fundamental unit of the society' and that children should grow up in a family environment to ensure his/her harmonious development. The CRPD Preamble follows a similar wording emphasising the entitlement of families to protection and assistance. Obligations to respect, protect, fulfil, and promote life in a family environment are specified across nine articles of the CRC (Article 7, Article 8, Article 9, Article 10, Article 16, Article 18, Article 20, Article 21, Article 22), and three articles of the CRPD (Article 19, Article 22, Article 23 (2)-5). It is obvious that the protection of the immediate family and life in a family environment is abundant in these two conventions. Both conventions contain obligations to prevent family separation, to assist families in different ways, and in case a child cannot stay in his/her immediate family, obligations to provide alternative care primarily in a family environment in case of the CRC, and only in a family environment in case of the CRPD. Both conventions contain prohibitions to separate children from his/her family unless a competent authority deems it necessary, while the separation on the basis of a disability that of parents or a child is absolutely prohibited in the CRPD. Of the rest of the legally binding IHRL instruments, the ICCPR entitles family to the protection 'by society and the state' (Article 23 (1) ICCPR), while the ICESCR prescribes states to recognize 'the widest possible protection and assistance' should be provided to families, and especially, inter alia, for the care of a dependent child (Article 10 ICESCR). The European Court of Human Rights held that '(…) the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of 'family life' within the meaning of Article 8 of the Convention'.[80]

[79] E.g. CRPD/C/GC/5, para. 37. Rosenthal, BUFF. HUM. RTS. L. REV., (2019).
[80] M. and M. v. Croatia, European Court of Human Rights, Application no. 10161/13, para. 169.

In 2022, the CRC and CRPD Committees issued a joint statement addressing several overlapping issues from the two conventions.[81] The treaty bodies specifically addressed the 'right to family life'.[82] The Committees reiterated declarations from the preambles of the two treaties that all children should grow up in a family atmosphere of happiness, love, and understanding. They called on states to end institutionalisation on the basis of disability by implementing Article 23(5) CRPD and Article 23(1) CRC.[83] Thus, by addressing the right to family life, the two Committees specifically highlighted the need for CWD to grow up in a family setting and the obligations of state parties to provide support and services for families, including alternative family-based care where necessary.

Catalina Devandas-Aguilar, Special Rapporteur on the rights of persons with disabilities, asserted that placing CWD in residential care violates their right to home and family as stipulated in Article 23 CRPD.[84] Additionally, UNICEF has emphasized the right of CWD to 'live with their family or in family-based care in the community'.[85] Therefore, there is no clear distinction between the concepts of the right to family life and the right to live or grow up in a family (environment) for CWD yet.

The CRC text specifically used the phrase 'life in a family environment' in its Preamble, and Articles 20(1) and 22(2).[86] The CRPD used the term 'family setting' in Article 23(5). Terms 'environment' and 'setting' are both generic terms with a possibility for evolutive interpretation. It was argued above why the 'family setting' term from the CRPD should be interpreted to denote only life in a family and no other settings that were, perhaps too ambitiously and primarily by service providers called 'family-type' or 'family-like' care.[87] The two committees may have dropped the 'environment' and 'setting' due to clarity and to avoid possibilities for different understandings of their message. Given the lack of a clear distinction between the 'right to family life' and the 'right to live (or grow up) in a family environment', these terms are used interchangeably throughout this dissertation.

[81] Joint Statement of the CRC Committee and the CRPD Committee: The rights of children with disabilities, Committee on Rights of the Child & Committee on the Rights of Persons with Disabilities, 2022.
[82] Id. at, para. 10.
[83] Id. at.
[84] Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas, Rights of Persons with Disabilities A/HRC/40/54, UN Human Rights Council, 2019, para. 51.
[85] Fact Sheet: Children with Disabilities (UNICEF 2022).
[86] Convention on the Rights of the Child, UNTS 1577, p. 3, 1989. Preamble, Articles 20(1), 22(2).
[87] See 'Permissible alternative care options'.

2. Points of tension between the conventions

This chapter explores several points of tension between the CRC and the CRPD concerning the protection of family life and the permissibility of out-of-family alternative care for CWD. The primary focus is on examining the permissibility of institutions and, more broadly, any out-of-family group care environments. For this purpose, Article 20 CRC and Article 23 CPRD in conjunction with Article 19 are compared using a set of tools. An analysis of points of tension and tools to deal with them contribute to the ongoing discussion between transnational issue networks and interpretive communities involved in this issue.

2.1. Theory and methods on norm conflict

The theoretical background for exploring potential divergences between the two conventions includes scholarly writings on treaty conflicts, conflict resolutions, and practices in international law. The academic and professional works on treaty conflicts revisited for the purpose of writing this section are the report of the International Law Commission on the fragmentation of international law and subsequent agreements,[88] then works by Jenks, Vranes, Pauwelyn, Pulkowski, Koskenniemi, and others.[89]

To frame this examination, it is crucial to define the key concept of 'norm conflict'. Although Pulkowski might be right when describing definitions of the norm conflict by Jenks and the International Law Commission as too ambiguous and hard to operationalize,[90] they can still serve to provide orientation for this analysis. According to the ILC, a norm conflict occurs when 'relevant treaties seem to point in different directions in their application by a party'.[91]

[88] Fragmentation of international law: difficulties arising from the diversification and expansion of international law: report of the study group of the International Law Commission, A/CN.4/L.682, International Law Commission, 2006.
[89] C Wilfred Jenks, *The conflict of law-making treaties*, 30 30 BRIT. YB INT'L L. (1953); Eric Vranes, *The Definition of 'Norm Conflict' in International Law and Legal Theory*, 17 17 EJIL (2006); JOOST PAUWELYN, CONFLICT OF NORMS IN PUBLIC INTERNATIONAL LAW: HOW WTO LAW RELATES TO OTHER RULES OF INTERNATIONAL LAW § 29 (cambridge university press. 2003); DIRK PULKOWSKI, THE LAW AND POLITICS OF INTERNATIONAL REGIME CONFLICT (OUP Oxford. 2014); Martti Koskenniemi & Päivi Leino, *Fragmentation of international law? Postmodern anxieties*, 15 15 LEIDEN JOURNAL OF INTERNATIONAL LAW (2002).
[90] PULKOWSKI. 2014, p. 145.
[91] A/CN.4/L.682, International Law Commission, 2006. para. 23.

Jenks defines a conflict more strictly as a situation where 'a party cannot simultaneously comply with its obligations under both treaties'.[92] In the present chapter the relationship of relevant norms are assessed using different notions of norm conflict, but with a focus on a predominant understanding of norm conflict in the international law jurisprudence and scholarship, while legal theory is consulted to fill in the gaps.

Beyond Jenks' and the ILC's descriptions, Pulkowski introduces four tools to determine the existence of a norm conflict: the contradiction test, joint-compliance test, violation test, and functional test.[93] These tools provide defined steps for conducting thought experiments involving relevant treaties and hypothetical cases in order to determine whether a state party could act or not in accordance with both (or more) treaties in the same case, at the same time and under which conditions. Pulkowski also claims that in order to reach a certain level of analytic precision a distinction between the rule conflict and the goal conflict must be made, which the present analysis duly considers.[94] Rule conflict refers narrowly to direct contradictions between legal provisions, while goal conflict describes broader discrepancies in the underlying policies or visions of two treaties, arising from their distinct foundational justifications.[95] Pulkowski opposes such an expansive approach to norm conflict, but the ILC considers it legitimate,[96] and it is especially relevant for the subject of this dissertation, as shown under the section ‘Conflict of purposes’.

2.2. The nature of compared norms and overlaps

This analysis compares provisions contained in Article 20 of the CRC and Article 23 of the CRPD, in conjunction with Article 19 of the CRPD. The focus is on the obligations and permissions granted to parties to provide various forms of alternative care for CWD, either when a child cannot live with their immediate family, as stipulated by the CRPD, or when a child is deprived of a family environment, as noted in the CRC. For this analysis, the forms of alternative care are categorized into two groups: care in a family setting, such as kinship and foster care, and out-of-family group care, which includes various forms of

[92] Jenks, BRIT. YB INT'L L., (1953), p. 426.
[93] PULKOWSKI. 2014, p. 146.
[94] Id. at, p. 146
[95] A/CN.4/L.682, International Law Commission, 2006, para. 24.
[96] Id. at, para. 24 – 25.

residential/institutional care. The latter – out-of-family care are different forms of residential/institutional care. The placement of a CWD in such care deprives him/her of the life in a family environment; in other words, it results in institutionalisation. Alternative care in a family setting, such as kinship and foster care, is a way to maintain or restore the life in a family environment for a child who cannot live with his/her parents, and as such, it presents a way to the realisation of the right to live in family environment (as opposed to institutionalisation). To conduct a conflict analysis, the nature of those norms should be clarified.

Article 20(2) of the CRC mandates the provision of alternative care for any child deprived of a family environment, regardless of the reason, without detailing obligatory actions, methods, or outcomes. Article 20(3) CRC, building on Article 20(2), offers a non-exhaustive list of potential alternative care options, including adoption and kafalah—though these are not strictly alternative forms of care. This flexibility is indicated by the phrase 'could include,' as previously discussed.[97] This norm is not prescriptive, allowing state parties the discretion to provide any of the forms of alternative care listed, though they are not obligated to do so. In other words, the provision of care in any of the forms expressed is permissible, but also the omission to do that is permissible. Another important aspect of Article 20 (3) is the implied prohibition of the provision of alternative care in (suitable) institutions when it is not necessary. Also, the provision of care in suitable institutions should be understood as an exemption. This is a logical understanding coming out of the wording of the norm as explained above.[98] The second sentence of Article 20(3) of the CRC obligates parties to consider continuity in a child's upbringing when deciding on the type of alternative care for a child deprived of his/her family environment.

Nevertheless, the optionality enshrined in Article 20 (3) should not lead to its complete disregard. In fact, Article 20(3) CRC further specifies the obligation set out in Article 20(2), guiding states on implementing the treaty's provisions, particularly the mandate in Article 20(1) to provide alternative care for children deprived of a family environment. Furthermore, given the explicit mention and affirmation of certain forms of alternative care such as kinship and foster care, this norm is underpinned by a strong policy orientation. This robust public policy foundation behind a non-prescriptive norm may lead to what legal theory refers to as

[97] See 'Obligation to provide and the optionality of alternative care forms'.
[98] See 'Necessity of institutions'.

the 'hardening' of this soft norm, creating a 'hidden obligation'.[99] Well-rounded alternative care systems globally are nearly inconceivable without developed kinship and foster care services, which indicates a 'hidden obligation', that is also reflected in a number soft law instruments.[100]

The assertion of a 'hidden obligation' to provide (suitable) institutions only when necessary is ambiguous, given the prevailing trend among CRC signatories towards reducing and closing institutions for both disabled and non-disabled children - a trend also supported by soft law instruments. However, this interpretation remains plausible. It is useful to differentiate residential/institutional care into two categories: traditional or large institutions, which are widely considered inappropriate and subject to closure efforts, and SSRC, which is sometimes seen as an appropriate form of out-of-family care. The latter could be accommodated by the term 'suitable institutions for the care of children' in terms of the CRC (Article 20 (3) CRC). Although the development and provision of this form of out-of-family care could be perceived as an underlying policy, it is still restricted by Article 20 (3) CRC, meaning that alternative care in such settings cannot be provided if it is not deemed necessary. Several UNGA resolutions have explicitly or implicitly urged states to develop forms of residential care - particularly small, high-quality types - leading to both clarification and strengthening of the provisions in Article 20(3) CRC regarding this form of care.

Conversely, Article 23 (5) of the CRPD is an obligatory norm, making its disregard impermissible. It prescribes that alternative care be provided primarily within the wider family and always within a community in a family setting.[101] Effectively, though not explicitly, this excludes all forms of out-of-family care, including small residential facilities, as viable options when the immediate family is unable to care for a disabled child. Another significant aspect of this norm is its exclusive application to CWD, in contrast to CRC norms, which apply to all children.[102]

Strictly speaking, a conflict between an obligatory provision and a non-obligatory one is not feasible, as the obligatory provision would inherently prevail. However, the substantial normative influence of the non-mandatory Article 23 (3) CRC, set against the mandatory but

[99] Ewald Wiederin, *Was ist und welche Konsequenzen hat ein Normenkonflikt*, 21 21 RECHTSTHEORIE (1990). in PULKOWSKI. 2014, p. 152.
[100] See 'Conclusion on UN resolutions and alternative care for children with disabilities'.
[101] See 'Permissible alternative care options'.
[102] See 'Lex specialis'.

ambiguously phrased Article 23 (5) CRPD - prone to varied interpretations - necessitates a deeper exploration of this apparent conflict

2.3. Identifying a conflict

Preconditions for a conflict between norms include overlaps in subject matter, the persons or entities they apply to, and their temporal application (*ratione materiae, personae, temporis)*.[103] The norms under discussion belong to the same sub-system of international law, specifically the IHRL. They regulate the same subject matter - the rights of CWD, and obligations of states to provide alternative care to children who are deprived of their family environment. The CRC and its Article 20 have a broader object as they apply to all children, including those with disabilities, whereas the CRPD is specifically tailored to CWD. Both norms are applicable only when children are deprived of their family environment. Then, both conventions are almost universally ratified.[104] For those countries that have ratified only one of the two conventions a conflict cannot exist. Lastly, both conventions are applicable at the same time.[105]

In his seminal work on norm conflict, Pauwelyn argues that a conflict in case of one state stems from its relationship with another state, using an example of World Trade Organisation's rules.[106] This, however, is not entirely applicable in case of human rights treaties due to their specific nature. The international human rights regime is often said to have a constitutional, rather than a contractual character. Thus, a conflict may arise as long as a state is a party to both conventions involved. The identification or existence of a conflict also depends significantly on the definition or interpretation of 'norm conflict' used. In this context, there are interpretations that adhere to strict or technical definitions of conflict, while others adopt broader understandings. The following section assesses existence of the conflict between the relevant norms by applying a strict definition of norm conflict.

[103] PAUWELYN. 2003, p. 165.
[104] The CRC has 196 ratifications, and the CRPD 184, on 3rd April 2022.
[105] The CRC entered into force 1990, and the CRPD in 2008.
[106] PAUWELYN. 2003.

2.3.1. Conflict in a strict sense

As it was already said, Jenks proposed that a conflict of norms will exist only if a state party cannot comply with both norms simultaneously. This was called 'direct incompatibility' of norms and encompasses only 'mutually exclusive' obligations.[107] The ILC describes such a form of conflict as 'the basic situation of incompatibility'.[108]

The core norm of Article 20 CRC – the obligation to provide alternative care to children deprived of a family environment (Article 20 (2) CRC) is aligned with the obligation of the CRPD to provide alternative care only in a family setting. Although the CRPD obligates states to provide alternative care only in a family setting, this does not set these two obligations in conflict, because a state party can comply with both norms in a single case at the same time. In a hypothetical case, a state party to both conventions, can comply with both norms by providing alternative care for a disabled child within the community in a family setting. Therefore, a conflict between an obligation of Article 20 (2) CRC (together with Article 20 (3) CRC) and an obligation of Article 23 (5) CRPD does not exist, according to Jenks' approach, because a state party can act in accordance with both norms at the same time. The same understanding of a conflict is used when an 'impossibility-of-joint-compliance test' is applied.[109]

A crucial aspect of Jenks' theory is that a permissive norm and a prescriptive norm cannot be in conflict; the prescriptive norm always takes precedence, obliging the party to act according to its mandates. A state party in such a case will refrain from applying a norm in the form of a right or discretion and comply with the obligatory norm.[110] It is important to emphasise that the definition of conflict has an implicit conflict-resolution potential, as we saw in the example explained above. In case where an obligation of Article 23 (5) CRPD is stricter than an obligation of Article 20 (2) CRC, applying the Jenks' approach would simply lead to the resolutions by asserting the application of Article 23 (5), as in that case a party would comply with both norms.

Although the application seems convenient, such an approach neglects important realities of human rights regimes. Pauwelyn focuses his critique of Jenks' work on the impossibility to

[107] Pauwelyn notes that the strict approach to the norm conflict was also supported by Karl, Kelsen, Klein, and Wilting. in id. at, p. 167.
[108] A/CN.4/L.682, International Law Commission, 2006, para. 24.
[109] H. Hamner Hill, *A Functional Taxonomy of Normative Conflict*, 6 6 LAW AND PHILOSOPHY (1987), p. 227.
[110] Jenks, BRIT. YB INT'L L., (1953), p. 451.

differentiate between conflict identification and conflict resolution and the denial of the impossibility for a permission and an obligation to conflict.[111] Moreover, where divergence, in Jenks's terms, is found between norms, he does not offer any tools to deal with this, although he recognizes that those can generate serious issues.[112]

The subsequent subchapter explores divergences between key norms, aiming to extend beyond Jenks' approach by seeking resolutions to these divergences. Such discrepancies can pose significant challenges to the coherence of the international human rights regime and the implementation of both the CRC and the CRPD. These issues were initially outlined in the introduction and will now be addressed in greater detail, with an emphasis on identifying practical and theoretical solutions.

2.3.2. Divergence according to C. Wilfred Jenks

According to Jenks, a divergence occurs when one treaty's obligation is more far-reaching (but not contradictory) than another's, or where one treaty eliminates exceptions allowed by another treaty, provided both govern similar matters.[113]

In the present case, the obligation of Article 20 (2) CRC is broader than the obligation of Article 20 (5) CRPD. By prescribing an obligation to provide (any) form of alternative care to every child who is deprived of his/her family environment, the CRC is broader than the CRPD that prescribes the provision of alternative care for disabled children and only in a family setting (not any kind of alternative care). Article 20 (3) CRC restricts Article 20(2)'s obligation by permitting institutional care only when it is necessary. Hence, it can be said that Article 23 (5) CRPD is more far-reaching as the obligation it imposes on states is stricter and more demanding. The CRPD is also narrower regarding the beneficiary of the norm, as it is only CWD that the norm is applied to, whereas the CRC applies to all children, with and without disabilities.

While a state party can adhere to both Article 20(2,3) CRC and Article 23(5) CRPD, compliance with the former does not guarantee alignment with the latter. This incompliance

[111] PAUWELYN. 2003, p. 170-171.
[112] Jenks, BRIT. YB INT'L L., (1953), p. 427.
[113] Id. at, p. 425-427.

will happen where a state party provides an institutional form of alternative care for a disabled child. Moreover, if the permission to provide alternative care in institutions is understood as an exception to the typical provision of care in a family in accordance with the CRC, as explained above,[114] then the CRPD is effectively eliminating an exception provided by the CRC.

Therefore, in terms of norm divergence description provided by Jenks, it can be concluded with certainty that a divergence exists between the obligation of Article 20 (2) CRC and Article 23 (5) CRPD. Still the scope of the obligation of Article 20 (2) CRC together with the Article 20 (3) CRC is extremely limited beyond the obligation of Article 23 (5) CRPD.

2.3.3. Conflict in a wider sense

As previously noted, the existence of a conflict hinges on the definition of conflict applied. Consequently, how a conflict is identified influences the approach to resolving issues between two norms, determining whether conflict resolution techniques are employed or if the issue is resolved at the stage of conflict identification. The ILC adopts a wider understanding of a norm conflict 'as a situation where two rules or principles suggest different ways of dealing with a problem'.[115]

What Jenks identified as divergence, proponents of a broader conflict perspective classify as conflict. Pauwelyn, a proponent of a broader understanding of norm conflict, argues that a conflict exists when adherence to one norm could lead to a breach of another, where norms can be obligations, prohibitions, permissions or exemptions.[116] As it was explained above, an action in compliance with obligation of Article 20 (2) CRC may breach the obligation of Article 23 (5) CRPD, by providing alternative care to a disabled child out of a family setting. Pauwelyn describes a 'potential conflict' as a situation where compliance with one norm does not necessarily result in breaching another, as seen in the current case.[117] He also introduces notions of 'apparent conflicts' and 'genuine conflicts', where the former can be resolved

[114] See section 1.1.1.4.
[115] A/CN.4/L.682, International Law Commission, 2006, para. 25.
[116] PAUWELYN. 2003, p. 175-176.
[117] Id. at, p. 176.

through interpretation.[118] Vranes, almost identically to Pauwelyn, argues that a conflict exists when a state, by applying one norm, necessarily or potentially breaches another norm.[119]

Sadat-Akhavi distinguishes between 'partial conflicts' and 'total conflicts'. The former exists when two norms are 'conflicting with regard to some addressees of norms, or in some times, or in some places, or with regard to some objects, or under certain conditions'.[120] Judging by the examples provided by Sadat-Akhavi, it can be said that the present situation is closer to a 'partial conflict' as per the author's definition.

To summarise, the relationship between Article 20(2) CRC and Article 23(5) CRPD can be characterised as divergence, potential conflict, or outright conflict, according to international law and legal theory scholars whose work on norm conflict was revisited above. This conclusion stems from the minimal differences in the scope of obligations and their substantial overlap. The inconsistency arises primarily due to an exception permitted by one norm (Article 20 (2,3) CRC) but not by the other (Article 23 (5) CRPD). Given the shared broad aim of both conventions to protect family life for children deprived of a family environment, the most apt description of the relationship between these norms is divergence.

The identification of a divergence does not preclude the exploration of ways to harmonize those norms. In fact, conflict resolution methods and other harmonisation strategies will be considered and explored to achieve the most appropriate resolution for the divergence.

2.4. Conflict of purposes

To describe broader notions of conflict, the ILC explained that some situations cannot be regarded strictly as a conflict in a logical sense and named those situations 'policy conflicts'.

'Two treaties or sets of rules may possess different background justifications or emerge from different legislative policies or aim at divergent ends. The law of State immunity and the law of human rights, for example, illustrate two sets of rules that have very different objectives.

[118] Id. at, p. 178
[119] Vranes, EJIL, (2006), p. 418.
[120] ALI SADAT-AKHAVI, METHODS OF RESOLVING CONFLICTS BETWEEN TREATIES § 3 (Martinus Nijhoff Publishers. 2003), p. 11.

Trade law and environmental law, too, emerge from different types of policy and that fact may have an effect on how the relevant rules are interpreted or applied. While such 'policy-conflicts' do not lead into logical incompatibilities between obligations upon a single party, they may nevertheless also be relevant for fragmentation.'[121]

While the ILC uses examples from distinct sub-systems of international law, such as human rights and state immunity, to highlight differing underlying policies, similar differences can also occur within a single sub-system or an IL regime. In the present case, it is argued, that although the relevant norms of the CRC and the CRPD have the same broad aims, they stemmed from different background situations, with different purposes. This discrepancy heightens the potential for divergence through evolutive interpretation and underscores the need for coordinated alignment despite minor differences in the scope of obligations.

The pointing at different direction of the relevant norms becomes more prominent when considering Article 19 CRPD. Indeed, the previous conflict analysis would be incomplete if it would not consider Article 19 CRPD. An obligation from Article 19 (a) CRPD prescribes states to ensure that people with disabilities are not obliged to live 'in any particular living arrangement'. As explained above, the purpose of this norm is to practically make institutionalisation illegal, unless a person in question agrees with the placement.[122] The critical aspect of Article 19 (a) for the purpose of this chapter is that states are obligated to ensure that CWD are not obliged 'to live in any particular living arrangement'. We have demonstrated that the purpose of this provision is to end the institutionalisation of persons with disabilities, offering an interpretation rooted in the effectiveness approach that aligns with the norm's purpose, wording, and context. According to this interpretation, states are obliged to ensure that disabled children are placed solely in family settings. Consequently, the objective of Article 19, in conjunction with Article 23(5), is to halt the longstanding and widespread practice of institutionalising children with disabilities (CWD) and to reaffirm their right to live in a family environment. This is achieved by preventing separation from immediate family through amendments to laws that permit placement based on disability, by providing support and services to families, by ensuring the availability and accessibility of general services to people with disabilities, and, when a disabled child cannot remain with their family, by

[121] A/CN.4/L.682, International Law Commission, 2006, para. 24.
[122] But only after having support and services provided in home and in the community. Otherwise choosing to live in an institution due to lack of other options cannot be understood as a free choice.

arranging for family-based alternative care as stipulated in Article 23(5) CRPD and through other measures.

The TLP scholarship's idea of interactions of different transnational norm entrepreneurs, that may constitute transnational issue networks and interpretive communities is important to understand different background justifications for the relevant norms. A disability-rights community of primarily non-state actors had a significant impact in the drafting process of the CRPD. This process was the most inclusive drafting process of an international human rights treaty to that date. One of the primary concerns of this disability community was and still is the issue of institutionalisation that harms CWD around the world. This factual issue generated a motivation to prevent further institutionalisation and was embodied, *inter alia*, in Articles 19 and 23 (5) CRPD.

Conversely, the primary goal of the CRC in that sense is that children are provided alternative care, and if necessary, in institutions too. Unsurprisingly, the CRC drafters focused on establishing a global obligation for states to accommodate children deprived of their family environment. In contrast, the CRPD aimed to rectify historical injustices faced by disabled children, who were disproportionately placed in institutional care compared to their non-disabled peers.[123] Therefore, although the relevant norms are only in a slight divergence, the purposes underlying them are pointing in different (but not opposite) directions.

2.5. Why interpretations create more divergence?

Given the vagueness of terms and the possibility of accommodating different interpretations, it was likely that interpretations focusing on effectiveness would further diverge the norms of the CRC and CRPD. Specifically, it could have been anticipated that interpretations of the CRC would primarily elaborate on vague terms related to residential care, aiming to establish certain quality standards ('if necessary', 'suitable institutions') and promote the development of such care, ensuring that children deprived of their family environment always receive some form of alternative care, including residential care. In contrast, effective interpretations of the CRPD

[123] See Introductory chapter, 1. Background.

should aim to strengthen the protection of family life and move towards an explicit prohibition of institutional/residential care for disabled children.

Article 23(5) includes wording that could be interpreted to completely exclude residential care from alternative care options, while Article 19 can be interpreted as obligating states not to place disabled children in any living arrangement other than a family. Such divergence in the purposes of the two treaties' norms, along with potential further divergences through interpretation, could hinder the successful implementation of either or both conventions. This distancing through interpretation can be addressed through collaborative efforts among interpreting bodies, states, and interpretive communities.

2.6. Conclusion on the norm divergence

The relevant norms of the CRC and the CRPD exhibit a slight divergence. This divergence arises because a state party to both conventions could potentially violate Article 23(5) CRPD by complying with Article 20 CRC, specifically when providing alternative care to disabled children in (suitable) institutions. According to Article 20(3) CRC, the provision of care in institutions is conditional upon the necessity and suitability of the institution and serves as an exception to the preferred placement in family settings. The term 'divergence' is preferred over 'conflict' due to the minimal difference in the substance of the obligations and their significant overlap. The inconsistency arises solely from an exception permitted in one norm but not in the other, despite both conventions sharing the broad aim of protecting family life for children deprived of a family environment. Nevertheless, this slight divergence has the potential to lead to greater divergence due to the differing underlying purposes of these norms. Therefore, without concerted efforts to harmonize the rules and standards regarding alternative care, significant confusion and challenges in implementing the treaties are anticipated.

Considering the role of interpretive communities and states in developing and interpreting human rights treaties, the following section will analyse relevant UN resolutions, treaty bodies' general comments, concluding observations, views, inquiry reports, and other documents, including submissions from non-state actors. The chapter ends with a proposition for an appropriate resolution of the divergence through available means and avenues.

3. UN Resolutions

This section addresses several UN resolutions in chronological order. It includes all resolutions from 2005 to 2021 that address, whether implicitly or explicitly, family-based and residential care for all children, including those specifically for CWD. This timeframe is particularly relevant as the treaties in question were applicable rules of international law, allowing for an examination of potential alignments or further divergences in standards concerning non-family-based care for CWD during this period. However, the initial year is 2005 to encompass three resolutions adopted shortly before the CRPD's entry into force and in that way assess a potential impact of the CRPD. Furthermore, resolutions adopted within this timeframe are more pertinent to the current state of international law than those from the more distant past. This is due to significant advancements that are constantly made in the rights of children, rights of persons with disabilities and human rights in general, hence outdated non-binding instruments, that are succeeded by a series of other such instruments, are normally less significant for the conduct of states in the present time.

UNGA resolutions possess 'law-making potential', though their non-binding character *stricto sensu* is not questioned. An approach in this section corresponds to a moderate line of thought regarding UNGA resolutions' and soft law's normative characteristics, since it recognizes the flexibility of normativity, the importance and ability of those instruments to produce legal effects despite the formally non-binding status.[124] Boyle and Chinkin argue that these instruments can indicate existing law, contribute to the formation of *opinio juris*, affect state practices, and be regarded as part of the secondary sources of international law.[125] Their importance is especially prominent in human rights law, in which case the legality is drawn primarily from Article 55 of the UN Charter.[126] In a 1974 resolution, the UNGA stated that resolutions could be considered by the ICJ as they may reflect developments in international law.[127] The ICJ held that, although non-binding, resolutions may have some normative value,

[124] JOOST PAUWELYN, et al., INFORMAL INTERNATIONAL LAWMAKING (OUP. 2012), p. 128-129.
[125] ALAN BOYLE & CHRISTINE CHINKIN, THE MAKING OF INTERNATIONAL LAW (OUP Oxford. 2007), p. 212; C. Tomuschat, RECUEIL DES COURS - ACADÉMIE DE DROIT INTERNATIONAL (1993). In Markus Benzing, *International Organizations or Institutions, Secondary Law*, *in* MAX PLANCK ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW (Anne Peters & Rüdiger Wolfrum eds., 2007).
[126] CA Fleischhauer & B Simma, *Ch.IV The General Assembly, Functions and Powers, Article 13*, BRUNO SIMMA ET AL (2012), para. 6, p. 528
[127] Review of the role of the International Court of Justice, A/RES/3232(XXIX), (UN General Assembly), 1975. Preamble.

give evidence for the formation of a rule or a development of an *opinio juris*, which can be assessed by analysing a series of resolutions.[128] The role in the development of international law is recognised too and particularly important for this work.[129] It should also be noted that not all non-binding resolutions wield the same power and impact; some may be perceived as weaker with little to no influence on stakeholders, while others may exert significant authority and impact, depending on various factors.[130]

This analysis adopts a more flexible approach to these resolutions compared to the strict application of the VCLT rules of interpretation used for treaty provisions. This distinction is necessary because VCLT rules apply to treaties, not to secondary law. However, since these resolutions are based on treaties, particular attention is given to the context and wording of the resolutions, applying VCLT rules to an extent and by analogy. Given the TLP scholarship's focus on transnational issue networks and interpretive communities, significant attention is devoted to the drafting processes.[131] Hence, the divergent norms are also looked at through the prism of the discord between the interpretive communities, due to their impact on the interpretation of the treaties and their potential role in harmonisation and implementation. The role of NGOs is recognised as significant and in line with realities of international human right law lawmaking, which sees an increasing influence of different non-state actors and even informal procedures of lawmaking.[132] The discord among interpretive communities is crucial to this chapter, as resolving divergence may require achieving a 'thick stakeholder consensus'. Pauwelyn, Wessel, and Wouters define 'thick consensus' as the fulfilment of numerous procedural and substantive requirements in creating a non-binding instrument, despite not all states consenting, within a context influenced by a variety of non-state actors.[133] Such an instrument can have a substantial level of normativity despite its non-binding status. Although this analysis is grounded in both hard and soft law within the UN's formal framework, the concept of thick stakeholder consensus is useful for understanding discord and seeking solutions, particularly given the apparent low interest of states in this issue.

[128] Legality of Threat or the Use of Nuclear Weapon. Advisory opinion of 8 July 1996, (1996), International Court of Justice. https://www.icj-cij.org/public/files/case-related/95/095-19960708-ADV-01-00-EN.pdf para. 70.
[129] Fleischhauer & Simma, BRUNO SIMMA ET AL, (2012). Para 4.
[130] Benzing. 2007.
[131] Janet Koven Levit, *Bottom-Up International Law making: Reflections on the New Haven School of International Law*, 32 32 THE YALE JOURNAL OF INTERNATIONAL LAW (2007).
[132] PAUWELYN, et al. 2012.. Joost Pauwelyn, et al., *When structures become shackles: stagnation and dynamics in international lawmaking*, 25 25 EUROPEAN JOURNAL OF INTERNATIONAL LAW (2014).
[133] Pauwelyn, et al., EUROPEAN JOURNAL OF INTERNATIONAL LAW, (2014). 160-161.

While treaty bodies are tasked with monitoring and promoting treaty implementation, it is argued that resolutions can exert a more substantial impact on international human rights lawmaking. This primarily stems from the inclusion of a diverse array of stakeholders and state-centric adoption procedures, which confer greater legitimacy than the general comments and other outputs of these committees. Nevertheless, treaty bodies have also engaged numerous stakeholders in developing their general comments and other documents, such as the CRPD Committee's Guidelines on DI, thereby enhancing their legitimacy and authority.[134] Furthermore, the significant role of resolutions in developing international law qualifies them as a secondary source of international law with wide-ranging effects.[135] Conversely, the non-binding status of resolutions encourages states to support these instruments without much hesitation, often merely as a symbolic gesture rather than with a genuine intent to enact legal changes and implement the articulated standards. For these reasons, crucial elements of UNGA human rights resolutions should include transparency, participation, inclusiveness in drafting processes, and alignment with corresponding human rights treaties and general principles of international law. The legality, legitimacy, and importance of general comments in interpreting and developing law will be addressed below.

3.1. Selection of resolutions

This analysis revisits seventeen UNGA resolutions and one Human Rights Council (HRC) resolution, with an in-depth analysis of three UNGA resolutions and one HRC resolution. The timeframe selected for these resolutions spans from 2005 to 2023, recognizing that the impact of the CRPD would only manifest after its entry into force. However, the start year is 2005 to include three resolutions adopted shortly before the CRPD's entry into force and in that way assess potential impact of the CRPD, as explained.

Particular attention is given to the following resolutions due to their relevance for the present issues: 64/142. Guidelines for the Alternative Care of Children (adopted 2009) (GACC, UN Guidelines), 66/141. Rights of the Child (adopted 2011), 74/133. Rights of the child (adopted 2019) (Resolution on children without parental care), 40/14. Rights of the child: empowering

[134] Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, (Committee on the Rights of Persons with Disabilities), 2022.
[135] Benzing. 2007.

CWD for the enjoyment of their human rights, including through inclusive education (2019) (HRC resolution).[136]

The UNGA adopts one resolution on the rights of the child each year, following a report from the CRC Committee to the UNGA's Third Committee. The Third Committee (Social, Humanitarian and Cultural Committee) prepares a report on the rights of the child for the UNGA which is then debated if needed and voted (all resolutions revisited here are adopted without a vote).[137]

In the following paragraphs, UNGA resolutions on the rights of the child that touch upon the relevant topics are mentioned, while the abovementioned four resolutions are addressed separately. UNGA resolutions 59/261 (adopted 2005), 60/231 (adopted 2006), 61/146 (adopted 2007) called for the promotion of family-based care over institutions (para. 12(d), para. 8, para. 8 respectively).[138] UNGA Resolution 63/241 (adopted 2008) welcomed the adoption of the CRPD and 'the attention paid to children in this international instrument' (Preamble).[139] This resolution does not address alternative care in much detail apart from the statement that '…family- and community-based care should be promoted over placement in institutions…'.[140]

UNGA Resolution 64/146 (adopted 2009) does not address any of here relevant issues.[141] UNGA Resolution 65/197 (adopted 2010), recalls the CRPD in its Preamble and mentions that alternative care should be provided 'preferably in the form of family-based care', without addressing the issue further.[142] UNGA Resolution 67/152 (adopted 2012) only reiterated the previous UNGA resolution 66/141 in the part of CWD.[143] UNGA Resolution 68/147 (adopted 2013) reiterated the need to prioritize family care over placements in institutions.[144] UNGA Resolution 69/157 (adopted 2014) did not address alternative care apart from referring to the

[136] Guidelines for the Alternative Care of Children, A/RES/64/142*, 2009; 66/141. Rights of the child, A/RES/66/141, 2011; 74/133. Rights of the child, A/RES/74/133, UNGA, 2019; 40/14 Rights of the child : empowering children with disabilities for the enjoyment of their human rights, including through inclusive education, A/HRC/RES/40/14, 2019.
[137] Rules of Procedure of the General Assembly, A/520/Rev.17 UN General Assembly, 2008. Rule 65;
[138] 59/261. Rights of the child, A/RES/59/261, UNGA, 2005; 60/231. Rights of the child, A/RES/60/231, UNGA, 2006; 61/146. Rights of the child, A/RES/61/146, UNGA, 2007.
[139] 63/241. Rights of the child, A/RES/63/241, UNGA, 2008.
[140] Id. at, para. 13.
[141] 64/146. Rights of the child, A/RES/64/146, UNGA, 2009.
[142] 65/197. Rights of the child, A/RES/65/197, UNGA, 2010, para. 39.
[143] 67/152. Rights of the child, A/RES/67/152, UNGA, 2012.See UNGA Resolution on the Rights of the Child (2011).
[144] 68/147. Rights of the child, A/RES/68/147, UNGA, 2013, para. 16.

previous UNGA resolution 68/147.[145] UNGA Resolution 70/137 (adopted 2015) does not contain relevant statements apart from a general call to states to remove obstacles to education of children, including institutionalisation.[146] UNGA Resolution 71/177 (adopted 2016) did not address any of the relevant aspects for this study.[147] UNGA Resolution 72/245 (adopted 2017) reiterates that family care should be promoted over institutions, without further elaboration.[148] UNGA Resolution 73/155 (adopted 2018) only reiterates that placements in families should be prioritized over institutions.[149] Notably, in 2020, no resolution on the rights of the child was adopted. UNGA Resolution 76/147 (adopted 2021) reiterates the Resolution on the rights of children without parental care (2019) and repeats the statement that children should be provided with '…appropriate and quality alternative care, inter alia, family and community-based care.'[150] The wording of this paragraph is analysed in the subchapter UNGA Resolution on Children without Parental Care (2019).[151] Finally, UNGA Resolution 78/187, from 2023, does not address issues pertaining to the right to live in a family environment.[152]

3.2. UNGA Guidelines for the Alternative Care of Children (2009)

The GACC were adopted by the UNGA in 2009 without a vote, following a several years long drafting process. All the other UNGA resolutions examined here (except the HRC resolution) are regular, UNGA annual resolutions on the rights of the child. Unlike the annual resolutions on the rights of the child, the GACC is a standalone document, adopted in the same year as another resolution, Resolution 64/146.

The drafting process of the GACC also differs from other resolutions on the rights of the child, as annual resolutions are drafted by the Third Committee and submitted to the UNGA as a report which is then adopted. No records of the negotiation process or preparatory works for

[145] 69/157. Rights of the child, A/RES/69/157, UNGA, 2014, para. 11.
[146] 70/137. Rights of the child, A/RES/70/137, UNGA, 2015, para. 49(c).
[147] 71/177. Rights of the child, A/RES/71/177, UNGA, 2016.
[148] 72/245. Rights of the child, A/RES/72/245, UNGA, 2017, para. 4.
[149] 73/155. Rights of the child, A/RES/73/155, UNGA, 2018, para. 8.
[150] 76/147. Rights of the child, A/RES/76/147, UNGA, 2021, para. 32(d).
[151] See 'UNGA Resolution on Children without Parental Care (2019)'.
[152] 78/187. Rights of the child, A/RES/78/187, UNGA, 2023.

the GACC exist, making it impossible to analyse this document using those sources.[153] The process began with a UNICEF study on children without parental care, which highlighted the need for a document establishing standards in alternative care.[154] The CRC Committee informed the Human Rights Commission about the intention and organised a Day of General Discussion (DGD 2005 hereafter) which was dedicated to the rights of children in alternative care.[155] The central recommendation of the DGD was to advance the development and adoption of 'international standards' on alternative care.[156] In the following year, UNICEF, together with NGOs focused on children's rights, service providers, experts, and individuals with lived experience in alternative care, prepared a draft. This draft was then debated in an intergovernmental forum led by Brazil, with participation from approximately 40 states.[157] In 2006, two HRC resolutions called for advancements in the negotiations and adoption of the Guidelines, which led to intergovernmental consultations headed by Brazil on the content of the new resolution.[158] From this process emerged a 'group of friends' composed of a number of states that championed the negotiations.[159]

The GACC were finally welcomed in December 2009 to 'set out desirable orientations for policy and practice with the intention of enhancing the implementation of the Convention on the Rights of the Child and of relevant provisions of other international instruments regarding the protection and well-being of children deprived of parental care or who are at risk of being so…'. Hence, the purpose of the Guidelines was to fill-in the gap left in the CRC which does not elaborate in any detail how norms in relation to the alternative care should be implemented.

Although non-binding, the document is highly authoritative. Its influence is evident from frequent references in subsequent resolutions, extensive citations in both grey and scientific literature, and its integration into state policies.[160] This authoritativeness is likely a consequence of the content of the Guidelines which is characterized by a detailed elaboration of measures states may take to address the issue of alternative care that had previously lacked any such guidance, due to the large gap in the CRC in relation to the implementation of its

[153] CANTWELL, et al. 2012, p. 15
[154] Id. at.
[155] Id. at.
[156] Further analysis of the DGD 2005 report under subchapter 'Day of General Discussion 2005'; DGD 2005 report, para. 688
[157] CANTWELL, et al. 2012, p. 20.
[158] A/HRC/RES/7/29, § 20; A/HRC/RES/9/13; id. at, p. 20
[159] Id. at.
[160] See Part II, Austria, Chapters 3.1.2.2. Federal Child and Youth Welfare law B-KJHG; 3.1.3.1. Vienna Child and Youth Welfare Act; Part III, Serbia, Chapter 4.2.1 Commendable Incorporation and poor enforcement.

provisions. Secondly, the conditions surrounding the process of drafting and the adoption may have had an impact on the authoritativeness of the documents and its normative value. The process was led by states and negotiated by states, backed up by studies and backed up by a number of NGOs and UNICEF. However, the drafting process did not include disabled people's organisations, disability-rights NGOs, or a broader disability perspective, a significant oversight given the disproportionate representation of CWD in institutional care.

The GACC are closely related to Article 20 of the CRC, which addresses the right to alternative care, and are intended to facilitate the implementation of this article's broad provisions. The GACC offer recommendations on various aspects of alternative care, including forms of care, principles of suitability and necessity, decision-making processes, child protection, legal responsibility for children, quality, and oversight, as well as inspection and monitoring. In the following paragraphs, the content of this document is analysed with a focus on the position and role of residential care as a form of alternative care for children.

Given that approximately one in three children in residential care worldwide has a disability, and in some countries, they constitute the majority of children in institutions, the GACC is crucial for CWD, as well as for all other children at risk of entering or who have already entered formal alternative care. Although the GACC frequently mentions CWD throughout the document, its failure to explicitly reference the CRPD is particularly noteworthy. Arguably, the neglect of the CRPD is also reflected in the substance of the standards expressed in the GACC. The 'developing body of knowledge' in the sphere of alternative care had informed the creation of the GACC (paragraph 2), suggesting that the knowledge available in 2009 was greater than that during the adoption of the CRC and that it will continue to grow, which reflects the recognition of the importance of science and practice-based knowledge for the interpretation and the development of IHRL. Practices and policies considered optimal today may no longer be seen as such in two decades, due to advancements in science and practice. This sensitivity to factual circumstances necessitates continuous or periodic adjustments of standards, highlighting the importance of the temporal aspect in the development and dynamic interpretation of human rights treaties - a widely recognised necessity.[161] Despite the explicit

[161] E.g. CHRISTIAN DJEFFAL, STATIC AND EVOLUTIVE TREATY INTERPRETATION: A FUNCTIONAL RECONSTRUCTION (Cambridge University Press. 2016).Ch. 10; Çalı. 2020.

recognition of the importance of scientific evidence, some inconsistencies in the use of scientific knowledge in the development of standards is remarked in the following rows.

3.2.1. The position of residential care

The GACC strongly favour care in the immediate family, but focus on the provision of alternative care, primarily in families. While the document aims to standardize the provision of formal alternative care, it includes comprehensive recommendations on promoting parental care, preventing separation, and facilitating family reintegration (paras. 32-52). A substantial part of the document is dedicated specifically to residential care. A critical recommendation related to the permissibility and the use of institutional care for all children reads as follows:

'The use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests.' (para. 21)

In addition, when establishing that short term placements should be in service of the permanent placement of a child, the GACC provides that:

'Permanency for the child should be secured without undue delay through reintegration in his/her nuclear or extended family or, if this is not possible, in an alternative stable family setting or, where paragraph 21 above applies, in stable and appropriate residential care.' (para. 60)

The GACC favour permanency over frequent changes in care setting, due to harmful effects on the child's development (para. 60). Conversely, the CRPD Committee uses this argument to oppose all forms of residential care, including small group care and 'family-type' settings.[162] It is confirmed by scientific evidence that children who are cared for by professional carers working in shifts, even in small residential care, are not able to form healthy relationships which has adverse effect on their development.[163] Furthermore, the GACC stipulates that 'ongoing attachment' between a child in care and a specific caregiver should be ensured (paras.

[162] CRPD/C/GC/5, para. 16(c).
[163] Michael Rutter, *Implications of attachment theory and research for child care policies*, 2 2 HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS (2008), p. 960

87, 90), yet it fails to address the challenges of forming stable attachments in residential settings.

When compared to the understanding of Article 20 (2, 3) CRC explained above,[164] the GACC take a more constructive approach to the use of institutional care. The CRC text mentions 'suitability' as a quality of institutions that must be met (Article 20 (3) and Article 3 (3)), while the conditions in relation to making a decision are the necessity and the best interests of the child as a paramount principle related to all decisions concerning children (Article 3 (1) CRC). Thus, strictly speaking the document does not deviate much from the wording of Article 20 (3) CRC. However, the CRC text places institutional care in the last place of alternative care options, signalling the use of institutional care only as a last resort and even as an exception to a rule to place children in family-based care, when appropriately interpreted as we already explained.[165] In contrast, the GACC introduce a narrative that institutional care can be appropriate and constructive, a perspective not explicitly present in the CRC.

The constructiveness introduced by the GACC (para. 21) was a novel qualifier, which had an important differentiating quality in comparison to the CRC text. By implying that for some children residential care is beneficial to their development and wellbeing (constructive), the document deemed residential care as potentially desirable form of care. This position contrasts with findings that even small residential care settings can have detrimental effects on child development, as mentioned earlier. Such a standard could not have been developed from the CRPD either, for the reasons explained above,[166] indicating that drafters had little regard for this treaty when developing the GACC, and that they had applied scientific findings in a non-consistent manner.

This observation raises a question: by adopting a more constructive approach to residential care, did the GACC deviate from the CRC's path and dilute the undesirability of residential care in international law? If we reiterate the previously explained understanding of Article 20 (3) CRC – the text of the paragraph, remainder of the Convention and the Preamble all favour family-based care for children, and institutions, as the only form of out-of-family care, are mentioned in the last place and qualified with 'if necessary', meaning that this is not a desirable form of care and it is rather an exception to the rule of family-based care, the constructiveness

[164] See 'Marginal role and undesirableness of institutions'.
[165] See 'Obligation to provide and the optionality of alternative care'.
[166] See 'Permissible alternative care options'.

in the GACC may indeed be seen as a slight turn towards the affirmation of residential care. Commenting on Article 23 (3) CRC, Cantwell and Holzschneiter noticed that the lack of a constructive approach to institutions in the CRC text built solid justification for DI in state parties.[167] Following this slight turn from the CRC text, it could be argued that the justification for DI was weakened in the GACC, especially in relation to children for whom residential care may be seen as appropriate, which have traditionally been first and foremost CWD.

The document advises states against placing '...young children, especially those under the age of three years...' in institutional care, citing the 'predominant opinion of experts' as justification. It also proposes three possible exceptions to that limitation – to prevent separation of siblings, in case of emergency, or for a very short period where there is a reintegration plan or a plan for permanent placement (para. 22). The Guidelines fail to explain how the same type of care can be deemed harmful for certain children, warranting near prohibition, while simultaneously being considered 'constructive' and 'appropriate' for others.

Cantwell *et al.* argue that ambiguous terms of 'suitability' and 'necessity' of Article 20 (3) CRC were risen on the level of principles which are focused on ensuring that alternative care is provided only when it is absolutely necessary, while 'suitability' is supposed to ensure the provision of type of care that suits a specific child the most, and that at least minimum standards of quality of alternative care are upheld.[168] The principle of suitability, according to Cantwell *et al.*, is meaningful only where a range of alternative care options are provided,[169] which implies that if foster care is not available in a given case, the suitability is not assessed appropriately or not at all, and a child might be institutionalised as it is the only, and thus the most suitable, available form of care. Also, according to the GACC (although family-based alternative care is prioritized) residential care can be the most suitable one for a child in a specific case (para. 21).

Given that the document does not specify the circumstances under which such care would be constructive for a child, it broadly opens the door for varied state practices and interpretations. By contrast, the intention behind the CRPD was to narrow down the space for interpretations and practices that would treat residential care as a constructive or desirable form of care, due to the already mentioned historically and presently prevalent institutionalisation of CWD on

[167] Cantwell & Holzscheiter. 2008, para. 136.
[168] CANTWELL, et al. 2012.
[169] Id. at, p. 71.

the pretext of suitability of such care for their conditions. Therefore, although the GACC deviate slightly from the original CRC text by endorsing residential care as potentially desirable for some children, contrary to the CRPD, this divergence could have been anticipated due to the 'conflict of purposes' between the relevant norms, unless both treaties were considered equally.[170] The subtle departure from the original meaning of the CRC also reflects the disregard for the CRPD text adopted three years before the GACC.

3.2.2. DI in the UN Guidelines on Alternative Care for Children

The document mentions DI for the first time in para. 23, in relation to the elimination of 'large residential facilities (institutions)'. This paragraph uncovers the meaning of DI adopted by the GACC and outlines a twofold approach to residential care. The paragraph essentially divides residential care into 'large residential facilities' that should be progressively phased-out, and 'individualised and small-group care' which is also a residential form of care, i.e. provides long term accommodation in a facility, which should be developed as part of DI efforts. The latter should provide conditions 'conducive to the child's development'. Any new development of residential care should be subject to overall DI efforts, according to the GACC.

The GACC' understanding of DI encompasses not only the transition to family-based care for children but also includes a 'partial transition'. The incompleteness of the transition is reflected in the recognition and assertion of certain forms of residential care in the alternative care spectrum, which is clearly stated in the first sentence of para. 23 GACC:

'While recognizing that *residential care facilities and family-based care complement each other in meeting the needs of children*, where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall DI strategy, with precise goals and objectives, which will allow for their progressive elimination.' (emphasis added)

Therefore, the GACC uses the term 'DI' to denote the substitution of care in large residential facilities with care in a family environment and small-size residential care conducive to the

[170]See 'Conflict of purposes'.

child's development. This understanding is substantively different from the understanding of DI as a complete substitution of residential care with care in a family environment.

The two approaches to DI also reflect differing understandings of the word ‘institution’. In the 'partial transition approach,' the term 'institution' applies only to large residential facilities. In contrast, the 'complete transition approach' labels all forms of care outside a family environment, including small group residential care, as institutions. Following this, it can be said that the former takes a restrictive understanding of institutions, essentially close to the Goffman’s definition of a ‘total institution’.[171]

These two most common definitions in relation to the residential care for children (and e.g. adults with disabilities) are not the only meanings attached to the word ‘institution’. We could speak about the institution of alternative care which would also encompass family-based forms of alternative care; however, such use of this term is not common in children’s rights and disability rights scholarship and will not be used here.

In a study commissioned by the Lumos Foundation, Goldman et al. seemingly adopt a broader definition of 'institution' that includes all forms of out-of-family care. However, they explicitly exclude temporary residential care and care for children requiring 'highly specialised physical or psychiatric support,' aligning with positions previously submitted by a group of NGOs to the UNGA for drafting a new resolution.[172] A response by a group of authors associated with leading international and regional disabled people’s organisations and NGOs working for the rights of persons with disabilities refuted Goldman *et al.* article arguing that it discriminates against CWD by proposing the provision of residential care for CWD, in contrast to the findings on the harm of residential care for children and the CRPD norms.[173]

The conflicting positions of these two groups — one associated with NGOs for children's rights and the other with DPOs and NGOs for disability rights — indicate the existence of different interpretative communities and transnational issue networks. Their positions align with their respective affiliations to the children's rights and disability rights communities. This alignment mirrors the divergent interpretations of the relevant CRC and CRPD norms. These divergent

[171] See Introductory chapter, 1. Background.
[172] Philip S. Goldman, et al., *Institutionalisation and deinstitutionalisation of children 2: policy and practice recommendations for global, national, and local actors*, 4 4 THE LANCET CHILD & ADOLESCENT HEALTH (2020)., p. 608
[173] Steven Allen, et al., *Response to: Institutionalisation and deinstitutionalisation of children*, see id. at.

interpretations stem from the distinct purposes of overlapping norms in CRC Article 20 and CRPD Article 23(5), as previously explained.[174]

3.2.3. CRC Day of General Discussion 2005 and residential care

A Day of General Discussion (DGD), organized by the CRC Committee, is analysed here due to its relevance to the GACC. DGD is not a category from the CRC, but it is established by the CRC Committee in the para. 79 of its Rules of Procedure.[175] The purpose of a DGD is '…to enhance a deeper understanding of the content and implications of the Convention' about a particular article of the Convention, in a process that is transparent and open for a wide range of stakeholders. Although a DGD consultative process results merely in a report with a list of recommendations it can have a significant impact on the development of international standards, as the following paragraphs explain. Until 2022, two DGDs were dedicated specifically to children without parental care (i.e. to children in alternative care) (2005 and 2021).

The GACC were not the first documents to express a more positive outlook on residential care. A report with recommendations issued by the CRC Committee after the DGD on children without parental care (2005) addressed the issues of prevention and regulation of separation, and the challenges of 'of out-of-home care provision'.[176] According to the report, one main issue of the DGD was the 'relatively negative' image of institutions and their characterisation as a last-resort placement option, which '(…) may result in stigmatisation of children in, or about to be placed in, such institutions'. The report adds that:

'Such practice (the practice of placement in institutions as a last resort which leads to stigmatization) may harm the development of the child in need of alternative care and leave the institution in which the child is ultimately placed with an impossible mission.'[177]

[174] See 'Conflict of purposes'.
[175] Rules of Procedure, CRC/C/4/Rev.5, Committee on the Rights of the Child, 2019.
[176] Day of General Discussion: Children without Parental Care, CRC/C/153, Committee on the Rights of the Child, 2006.
[177] Id. at, para. 660.

Referencing written submissions and oral discussions during the session, the report posed the following question: 'Has the traditional institution lived out its useful life?' On that account, the CRC Committee expressed its concern with the 'ideology behind the institution model' and invited state parties '(…) to take realistic steps with a view to changing traditional institutions, for instance, by establishing smaller specialised units within the institutions, increasing the number of professionals working with and for children and providing these professionals with systematic training'.[178]

The CRC Committee expressed concern about systematic institutionalisation, emphasized the importance of family life for a child's proper development, and urged state parties to develop a range of alternative care options to consider before institutional placement.[179] The report also mentions the institutionalisation of CWD (and other especially vulnerable children) on the basis of health and social status (para. 670), calls for a more individualized approach in care determination, and the establishment of maternity centres to equip parent with information and resources to prevent institutionalisation (para. 671). That said, although the report called for the prevention of institutionalisation it did not mention DI, or the closure of institutions, but merely the transformation of traditional institutions into smaller ones.

The DGD 2005 report, a precursor to the GACC, prompted stakeholders to begin drafting a document providing detailed guidelines on children's alternative care.[180] Excerpts from the DGD 2005 report show a shift from viewing residential care as undesirable to considering it a potentially optimal solution for some children. Although the GACC did not explicitly reposition residential care as other than a last resort in 2009, they did foster a more positive narrative by focusing on smaller residential units (para. 23, 123) and improving the care/resident ratio (para. 126). Therefore, this slight but important shift in the standards can be traced back to 2005.

Over 30 children's rights NGOs and service providers participated in the DGD 2005. The CRC Committee referenced these submissions when addressing the issues surrounding residential care. Therefore, it is clear that NGOs participating in the DGD 2005 partly influenced this shift

[178] Id. at, para. 661.
[179] Id. at, para. 665.
[180] Id. at, para. 668.

during the subsequent drafting of the GACC.[181] No DPOs or disability rights NGOs submitted contributions to the DGD 2005, likely leading to underrepresentation of CWD.[182]

3.2.4. Legal interpretation and DI

It is important to notice that different approaches to DI are connected to different interpretations of the relevant IHRL norms. The 'partial transition approach' is closer to interpretations which favour the purpose embedded in Article 20 CRC, while the complete transition approach favours the purpose entrenched in Article 19 & 23 (5) CRPD. In other words, the partial transition approach cannot produce outcomes intended with the obligation to states asserted in Article 23 (5) CRPD – provision of alternative care to CWD only in a family within the community. As already explained, the purpose of Article 23 (5) CRPD is to end the rooted and widespread practice of depriving CWD of family environment through placements in residential care. Knowing this it is clear that the 'partial transition approach' to DI can hardly come as a means to fulfil this purpose of the CRPD. The two approaches to DI essentially have the same relationship as the obligations contained in Article 20 CRC and Article 23 (5) CRPD - the latter is more far reaching than the former. Understanding the relationship between the norms of the CRC and the CRPD and the difference in DI approaches, we can safely conclude that the GACC, apart from not mentioning the CRPD explicitly, also disregards the CRPD substantively.

3.2.5. Conclusion on the UN Guidelines on Alternative Care for Children

The GACC brought a subtle shift in the approach to residential care, from an undesirable option (as it reads in the CRC) to a form of care that can be conducive to the child's development and desirable in some cases. The same document also brings into play the development of smaller residential care units. The shift towards a more positive view of residential care first emerged in the DGD 2005 report, which explicitly acknowledged the need for a more affirmative approach. A body of scientific evidence on the harm of institutional care to children is referred

[181] *Documents submitted for the Day of General Discussion (16 September 2005) on "Children Without Parental Care"*, accessed: 8th March, 2023, *available at* https://archive.crin.org/en/docs/resources/treaties/crc.40/Discussion.asp.

[182] The list of stakeholders who provided oral or written submission for DGD 2005 https://archive.crin.org/en/docs/resources/treaties/crc.40/Discussion.asp

to in the Guidelines, however it seems that those were inconsistently used to inform different aspects of the document.

In 2005, the Council of Europe issued a non-binding document exclusively addressing residential care for children in Europe.[183] The Council of Ministers reiterated that '…the placement of a child (in residential care) should remain the exception and have as the primary objective the best interests of the child and his or her successful social integration or re-integration as soon as possible.'[184] The document also emphasized that residential care should take the form of a 'small family-style living unit'.[185] This document may have also influenced the GACC's affirmation of small-unit residential care. However, the insistence of the Council of Ministers on the provision of residential care only as an exception and when necessary, without a reference to the appropriateness of such care for a specific child, maintained the negative tone and as such it was not as constructive and affirmative towards residential care as the GACC. The lack of constructive approach in the CRC text towards residential care that, in the words of Cantwell and Holzschneiter,[186] had created a solid basis for DI was abandoned in the GACC. This shift could have weakened the push for DI in relation to children for CWD, for whom residential care has been traditionally seen as appropriate.

Surprisingly, the GACC largely disregarded CRPD Articles 19 and 23(5), despite their provisions overlapping and multiple references to CWD. While it is difficult to pinpoint the exact causes of this oversight, the consistent underrepresentation of DPOs and NGOs advocating for the rights of children and adults with disabilities was evident in both the DGD 2005 and the drafting of the GACC. A workgroup consisting of international NGOs and UNICEF initially drafted the document, incorporating inputs from independent experts and children. State parties later revised this initial version.[187] There is no evidence of significant participation of DPOs and NGOs for the rights of CWD in this process, neither the CRPD Committee was involved.

[183] Recommendation Rec(2005)5 of the Committee of Ministers to member states on the rights of children living in residential institutions, Rec(2005)5, (Council of Europe), 2005.
[184] Id. at. Appendix.
[185] Id. at. Appendix.
[186] See note 167.
[187] Special Series – Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children: An introductory briefing on its background, core principles and scope ISS/IRC Monthly Review N° 3/2008, (2008), ISS/IRC.

3.3. UNGA Resolution on the Rights of the Child (2011)

UNGA adopted Resolution 66/141 in 2011 without a vote.[188] The resolution specifically addresses the rights of CWD in paragraphs 31-44. This section acknowledges that 'CWD are often denied the right to a family environment and inclusion in their communities' (para. 37). Additionally, the resolution urges states to ‘consider the introduction of a commitment towards replacing institutionalisation with appropriate measures to support family and community care’ (para. 38). These paragraphs uphold CRPD provisions without simultaneously referencing the corresponding CRC provisions or relevant recommendations from the GACC. The call for the ‘replacement’ of institutional care with family care, while not mentioning the substitution of institutions with residential care in smaller groups, indicated strong conformity with the CRPD.

3.4. UNGA Resolution on Children without Parental Care (2019)

3.4.1. Drafting process and the divide

The resolution's focus on the rights of children without parental care attracted significant attention from DPOs and NGOs advocating for persons with disabilities, a contrast to their involvement in drafting the GACC. One reason these organisations may have participated less in the GACC's development is that the CRPD was adopted in December 2006 and came into force in May 2008, whereas the GACC were adopted in December 2009. Possibly, the lack of awareness of the new treaty, the meaning of its provisions, and even the number of ratifications at that time may have not sufficed to generate a number of well-organised actors that would form one or several transnational issue networks to advocate for the rights of person with disabilities. Regardless, the CRPD was an applicable rule of law at the moment of adoption of the GACC and during a part of the drafting phase, which should have been, in accordance with the VCLT, principles of treaty interpretation, incorporated in that document to a larger extent.

[188] A/RES/66/141.

The production of the Resolution on the rights of children (2019)[189] without parental care was impacted by a substantial number of NGOs, that mostly participated divided into two groups. One group was composed almost exclusively by child rights-oriented NGOs and service providers, and the other by DPOs and disability rights-oriented NGOs, including one international network for children's rights.[190] Each group submitted a joint statement supported by various organisations and networks. The differences in their submissions regarding available forms of alternative care align with those in the relevant CRC and CRPD provisions, as reflected in the Resolution's text. These groups are 'transnational issue networks', in the words of TLP scholarship, and potentially interpretive communities, if they have the possibility and competence to formally challenge or establish specific interpretations.[191]

One group, primarily focused on child rights, recommended providing '(…) quality, temporary, specialised, care in a small group setting organized around the rights and needs of the child in a setting as close as possible to a family, and for the shortest possible period of time' (para. 3(i)). Notwithstanding, the other group of organisations (primarily disability rights oriented one) argued that any placement out of a family is 'human rights violation', and stated that they '(…) broadly support the 'Key Recommendations of the Coalition on Children Without Parental Care' with the exception of any endorsement (as appears in section 3(i) of their statement) that residential care or group homes are justified or necessary'.[192] This group also recognised that children will sometimes be placed in residential care, but that this must be seen as a violation of their right to family, which must be immediately restored.[193] The child rights group on the other hand approved placement in small group care in specific cases, but also stated that its objective should be reintegration in the family or a placement in another family setting as soon as possible.[194]

Significant overlap exists between the groups, with the primary difference being one group's positive view of (small) residential care placements versus the other's view of such placements as human rights violations, though both advocate for the immediate restoration of family living.

[189] 74/133. Rights of the child, UN general Assembly, 2019.
[190] Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care (Group of organisations 2019).; UN Disability and Child Rights Groups On Behalf of Children without Parental Care: Key Recommendations (2019).
[191] See note 20.
[192] UN Disability and Child Rights Groups On Behalf of Children without Parental Care: Key Recommendations. 2019.
[193] Id. at.
[194] Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care. 2019. Para 3(i)

It should be recognised that both positions are aimed at producing a stronger protection of the right to family life than the one expressed in the GACC. The Resolution on the rights of children without parental care, however, does not incorporate any time-limitation on residential care (it does not mention it either, but implies that such care may be provided). As it was explained, the GACC do not restrict placements in a residential care to a shortest possible time, but even sees it as a permanent solution (para. 60). This omission, on the other hand, speaks to the limited final impact of both issue networks in the final text of the Resolution on Children without Parental Care (2019).

3.4.2. Outcome

Stakeholders, including child rights-oriented NGOs, service providers, DPOs, and NGOs advocating for the rights of CWD, participated in a transparent and inclusive process that led to this resolution's adoption. During its drafting, stakeholders viewed the upcoming resolution as a crucial secondary law document, offering a notable opportunity for DPOs and disability rights NGOs to better represent their perspectives compared to earlier UNGA resolutions on children's rights. The focus of the resolution on children without parental care meant that main issue – the divergence in interpretations of the CRC and the CRPD regarding the permissibility and place of residential care, could be addressed.

The Resolution references the CRPD, urging state parties to ensure CWD enjoy human rights equally, particularly highlighting the right to family life (para. 23). The right to family life, although not explicitly recognised in treaties as explained above, stems out to of the recognition of the family as the best environment for a child, and different obligation of states to prevent separation and if that is not possible, provide alternative care in a family setting (Article 23 (5) CRPD). The core of this right for a child is to live/grow up in a family environment. The right to family life embodies the objective of the CRPD on ending historical injustice of institutionalisation of CWD. The Resolution does not mention the permanency of alternative care as an objective (although it recalls the GACC as a whole) but emphasises that the separation should be temporary ‘whenever possible’ (para. 34(e)).

The Resolution echoes Article 23(3) of the CRPD by directly urging states to provide information to parents of CWD to prevent concealment, abandonment, neglect, discrimination,

and segregation, thus ensuring equal rights with respect to family life (Para. 34(h)). The states are called to provide disability-inclusive alternative care in line with the CRC and the CRPD and taking into account the GACC (para. 34 (I) & para. 35 (b)). Progressive replacement of institutionalisation with '…quality alternative care, including, inter alia, family and community-based care' is urged as well as the redirection of resources from institutional care to family and community-based services (para. 35 (g)). The meaning of 'quality alternative care' is not clarified in the resolution, however, a submission of a group of child rights organisations and service providers called for such care which includes small group homes.[195] In the following paragraph 35 (h) of the Resolution, Article 23 (5) CRPD is restated once again and states called to undertake every effort to, '…where the immediate family is unable to care for a child with disabilities, provide quality alternative care within the wider family, and, failing that, within the community in a family setting, bearing in mind the best interests of the child and taking into account the child's views and preferences'.

In the two paragraphs of the Resolution, an attempt to balance between the two approaches of interpretive communities to residential care is evident. Still, this balancing was done without an explicit mention of residential care, let alone its appropriateness, but rather with its implicit recognition. This is visible in the call for progressive elimination of institutional care and its substitution with 'quality alternative care, including, inter alia, family and community-based care' (para. 35(g)). Considering that family-based care is only one of the options, which is reflected in the use of the terms 'including' and 'inter alia', those quality alternative care forms might be some forms of SSRC, hence accommodating the GACC and the position of participating children rights-oriented NGOs. The following paragraph 35(h) paraphrases Article 23 (5) CRPD, possibly to mitigate the meaning of the previous paragraph in the eyes of the CRPD Committee and the disability rights community.

While this resolution integrates CRPD provisions more extensively than prior UNGA resolutions on children's rights, it fails to reconcile conflicting positions and interpretations. It leaves the standards ambiguous, by partly incorporating the two positions on residential care in its text parallelly one to the other rather than converging them, or explicitly recognizing differing standards to children with and without disabilities, if applicable. Considering that the CRPD prescribes more restrictive obligations to states (alternative care only in a family settings) this resolution ultimately adopts the position of implicit permission of residential care.

[195] Id. at.

Another layer of confusion is added by strong and explicit reiterations of the GACC, which may be read as if the present resolutions is just a repetition of the GACC with frequent references to the CRPD.

However, given the simultaneous incorporation of CRC and CRPD provisions and their interpretations, it suggests that different standards might apply to disabled and non-disabled children. In this way, the parallel expression of divergent positions, only legally speaking, would not be problematic if they were targeting different populations, i.e. the *ratione personae* would not overlap. On the other hand, the CRC relates to all children including CWD, and any demarcation was not drawn. However, it can be debated if such more far-reaching protection of family life for CWD would be a viable solution. This and other possible solutions are explored under the section

3.5. HRC Resolution on CWD (2019)

The HRC adopted Resolution 40/14, 'Rights of the Child: Empowering CWD for the Enjoyment of Their Human Rights, Including Through Inclusive Education,' on 22 March 2019.[196] The HRC expressed deep concern about the institutionalisation of CWD (Preamble) and advocated for replacing institutionalisation with family-based care (para. 16), explicitly omitting any recognition of residential care as a viable alternative. It also reiterates Article 23 (5) CRPD in regard to the provision of alternative care within the community in a family setting (para. 16). The second part addresses the inclusive education for CWD (para. 18-31) and the third part the follow-up.

The present resolution prioritized CRPD over non-binding resolutions, such as the GACC, in addressing the question of alternative care. Unlike the UNGA Resolution on the children without parental care (2019), adopted only several months later, it did not refer to the GACC in any way and did not mention any standards that recognize and endorse the role and use of residential care for children. Given that this resolution specifically addresses CWD, it raises questions about differing state obligations and standards for alternative care between CWD and other children, a topic explored further in the section ‘Possible solutions to the discord’.

[196] A/HRC/RES/40/14.

3.6. Conclusion on UN resolutions and alternative care for children with disabilities

While the non-binding nature of UNGA and HRC resolutions is acknowledged, their potential to shape norms and perform other significant functions is also recognized. The role in the development of law was already mentioned above and taken into consideration in the present case. The question posed here is whether the examined resolutions evidence or promote emergence of convergent standards and recommendations on the role and permissibility of residential care, or another solution, by drawing from the CRC and the CRPD.

The resolutions reviewed do not resolve the divergences between the CRC and CRPD concerning the permissibility of residential care. The GACC had clearly neglected the CRPD in that regard, while the Resolution on children without parental care (2019) paid due regard to the CRPD by reiterating its provisions parallelly to that of the CRC and the recommendations of the GACC, again without actually solving the existent divergence, but even introducing an additional layer of confusion as previously explained. The two resolutions mentioned here (66/141 from 2011 and the HRC resolution from 2019) could be understood as attempts to promote the implementation of articles 19 and 23 (5) CRPD, which contain a more far-reaching obligation of states. Those resolutions had seemingly not had much impact even on the resolutions coming right after. Currently, as exemplified by the 2019 Resolution on the Rights of Children without Parental Care, there are parallel recommendations: one advising states to provide quality alternative care, including family-based and small-group residential care to all children (para. 35(g)), [197] and another urging care for disabled children specifically within family settings (para. 35(h)).[198]

To resolve the divergence between the CRC and CRPD and clarify confusion in some resolutions, further efforts from UN bodies, treaty bodies, member states, and non-state stakeholders are essential. In order to address the issue, the two Committees came together to

[197] Id. at.
[198] Id. at.

produce a joint statement on the rights of CWD after conducting a study, which is explored in the section 'Joint statement of the CRC and the CRPD Committees on the rights of '.

Resolutions from the GACC (2009) through to Resolution 76/147 (2021)[199] consistently recommend abandoning care in large institutions in favour of other alternative care forms, including certain types of residential care, with a pronounced preference for family-based care. Resolution 66/141 (2011) urged states to consider commitments for replacing institutions with family-based care. Meanwhile, the HRC Resolution (2019) took a step further by advocating for replacing institutionalisation with family- and community-based services, specifically providing family-based care for CWD, aligning closely with Article 23(5) CRPD, and leaving no room for any form of residential care.

All those documents evidence a strong pull towards (incomplete) DI, primarily by prioritizing care in family settings. This, however, cannot be understood as an advancement, or a development of law as the relevant CRC and CRPD provisions already contain provisions that favour family care (in the case of the CRPD only family care). Rather, they can be understood as the promotion of CRC provisions, with some clarifications on their implementation, especially in the case of the GACC which provides a number of policy and practice recommendations. The same goes for the invite to where residential care is provided it should be in small groups and appropriate. This cannot be regarded as evidence or a call for the evolution of law, as the CRC already prescribes that such care should be provided in 'suitable institutions for the care of children'. Therefore, the call for the provision of residential care is merely an elaboration of the suitability prescribed by the CRC, and it does not depart from any aspect of that provision.

The series of resolutions on DI and the use of small residential care, where states repeatedly participate in creating and adopting these documents without objection, could speak to the agreement of states on the interpretation of Article 20 CRC. Thus, those resolutions promoting the transition to family-based care and the use of SSRC might be understood as a subsequent agreement of states on the interpretation of Article 20 of the CRC. However, the CRPD must be taken into account too.

[199] A/RES/76/147.

The GACC also called for the abolishment of residential care for children under 3 years of age, i.e. that the care for those children should be provided only in family settings. To support this recommendation, the document referred to a 'predominant opinion of experts' that residential care has detrimental effects on children of that age (para. 22). This recommendation can be understood as an evolution, especially considering that the GACC stemmed from the CRC whose provisions do not contain such a meaning. Although, its normative value seems to be substantial, as a number of countries in the world have at least incorporated this standard in their legislation, this was not the case before the adoption of the GACC.

The authoritativeness of the GACC is also evidenced through frequent references in almost all resolutions adopted after 2009. Unlike other resolutions on the rights of the child whose processes of drafting and adoption can be described as alienated from the states parties, the drafting process of Guidelines was characterized as a states-led process (although initiated and strongly influenced by UNICEF and NGOs). Perhaps those characteristics of the content of the GACC – a long needed elaboration of how to implement CRC provisions, and the basis in scientific evidence (in case of the recommendation to abolish residential care for children under three), and conditions of the adoption – initiated by UNICEF and NGOs but led by states, with an emergence of a groups of states who were particularly interested in backing up this resolution, have rendered it more authoritative than the other resolutions on the rights of the child and increased the potential for the normative value of its recommendations. A similar pathway should probably be used when solving the divergence between the treaty interpretation and emergence of new standards to increase their authority.

NGOs, DPOs, and service providers have established at least two transnational issue networks, which may also function as interpretive communities, particularly if associated with treaty bodies. A transnational issue network primarily focused on the rights of the child and service provision to children without parental care participated in the creation of the GACC and some earlier documents. On the other hand, a network of DPOs and disability-rights oriented NGOs has emerged during and before the drafting of the CRPD but got engaged on the issue of standards related to CWD in the UN framework late, and their impact is only evident in more recent UN resolutions.

4. Jurisprudence and recommendations of the CRC and the CRPD committees

4.1. Committees' competence

The CRC and CRPD committees play important roles in implementing their respective treaties, primarily focusing on monitoring, and facilitating treaty implementation. The purpose of this chapter is to uncover how the treaty bodies have approached the issues of family-based care, residential care, and DI, and if and how they have addressed the divergence between the treaties, to help grasp the meaning of international rules and standards on the right to family life for CWD. Despite their involvement in interpreting and developing IHRL, treaty bodies rarely detail the legal methodologies, interpretive rules, and techniques used to formulate the positions expressed in their general comments. While potentially dense and complex for the general public, such detailed elaborations could enhance the documents' authoritativeness and promote legal cohesion within the IHRL regime and across international law regimes. On that note, Keller, Grover, and Ulfstein contend that treaty bodies should adopt clear legal methodologies and reasoning techniques to enhance their legitimacy and influence on legislative bodies and courts.[200]

The two treaty bodies are obliged to cooperate on overlapping issues. The CRC Committee is to be invited when the implementation of provisions in the scope of its mandate is considered, and it is entitled to consult other bodies that it finds appropriate (Article 45 (a) CRC). The CRPD Committee 'shall consult' other human rights bodies established by human rights treaties 'to ensure consistency of their respective reporting guidelines, suggestions, and general recommendations, and avoiding duplication and overlap in the performance of their functions' (Article 38 (b) CRPD). Therefore, the CRPD Committee is obligated to cooperate with the CRC Committee, while the CRC Committee may do so or may not, but it is certainly recommended, as visible from the CRC provision. This chapter will also evaluate how these treaty bodies cooperate on this overlapping issue.

[200] Helen Keller & Leena Grover, *General Comments of the Human Rights Committee and their legitimacy*, *in* UN HUMAN RIGHTS TREATY BODIES: LAW AND LEGITIMACY (Helen Keller & Geir Ulfstein eds., 2012), p. 120; Geir Ulfstein, *Law-making by human rights treaty bodies*, (2014), p. 2.

To monitor and facilitate implementation effectively, treaty bodies use various tools, including General Comments (GCs). GCs, non-binding documents, are used to elaborate on treaty provisions, further develop the international law and provide parties with guidance on how to implement the respective provisions. They are commonly described as documents that summarize treaty bodies' positions enshrined in their Concluding Observations (COs) and Views on individual communications (Views).[201] Apart from GCs, COs and Views, treaty bodies issue reports on the examination of potential violations of rights in states parties, guidelines on the implementation of treaties' norms and other documents that serve the function of facilitating the implementation.

Keller and Grover argue that the competence of treaty bodies to issue GCs is derived from established subsequent practice of the states, in accordance with Article 31 (3) (b) VCLT.[202] This subsequent practice can be understood to be related to the interpretation of CRC and CRPD provisions regarding the work of the committees (Article 45 (c) CRC; Article 39 CRPD). While these articles do not explicitly mention GCs, they authorize the CRC and CRPD Committees to make 'suggestions and general recommendations based on information received pursuant to Articles 44 and 45 of the present Convention' (Article 45 (d) CRC) and 'suggestions and recommendations based on the examination of the reports and information received from states parties' (Article 39 CRPD). The practice that establishes the competence of the CRC Committee and the CRPD Committee to issue GCs where they interpret, elaborate and guide the implementation of their treaties is the lack of objection of their legality by the states parties and states parties' involvement in drafting processes - similar to practices observed with the HRC's GCs, as Keller and Grover explain.[203]

Indeed, states parties have participated in the drafting of GCs of the CRC Committee and the CRPD Committee and no states parties have officially objected to this competence, which should be understood as their recognition of the committee's competence to publish GCs, and consequently as the recognition of the GCs legitimacy and authoritativeness. The General Rules of Procedure of the CRC Committee and the CRPD Committee (in accordance with Article 43 (8) CRC; Article 34 (1) CRPD) contain identical rules prescribing that the bodies

[201] Keller & Grover. 2012, p. 123.
[202] Id. at, p. 127.
[203] Id. at.

may publish GCs that shall be included in their reports to the UNGA.[204] Although an interpretative function of GC is not mentioned either in the treaties' texts or the committees' rules of procedure, the committees regularly engage in such practice.

Moreover, state parties nominate individuals for committee membership as per Article 43(3) CRC and Article 35(5) CRPD. These nominees are then elected during a Conference of States Parties through a secret ballot requiring the presence of at least two-thirds of the states parties (Article 43(5) CRC; Article 34(5) CRPD). These nomination and election processes ensure that committee members hold legitimacy and authority among state parties, which ideally extends to the documents they produce. Conversely, GCs sometimes have poor acceptance by the states and their persuasiveness might be improved with the clarity of language and the quality of techniques applied.

No legal rules or standards exist in isolation - they continually interact with other international rules, standards, and even different legal regimes.[205] Therefore, interpreters, in this case the CRC Committee and the CRPD Committee, need to follow general rules of treaty interpretation and avoid creating conflicts and divergences through interpretation and development of law as much as possible. The committees and the Secretariat, a body that participates in drafting processes of such documents, shall uphold general rules of treaty interpretation, and should avoid conflicts with other rules and standards, while accepting and incorporating views and preferences of a broad range of actors that participate in these processes directly or indirectly. According to the ILC's view, deviations from older rules on the same subject matter should be seen not as technical errors but as intentional legal developments.[206] In that light, deviations from the treaty provisions and previously developed UN secondary law sources are hereby treated as dynamic interpretations.

The following sections revisit several GCs from each committee, with a detailed analysis of General Comment 9 from the CRC Committee,[207] and General Comment 5 from the CRPD Committee.[208] General Comment 9 addresses a spectrum of issues related to the rights of CWD, including Articles 20 and 23 of the CRC. General Comment 5 tackles institutionalisation and

[204] CRC/C/4/Rev.5. Rule 77. Rules of Procedure CRPD/C/1/Rev.1, Committee on the Rights of Persons with Disabilities, 2016. Rule 47.
[205] A/CN.4/L.682, International Law Commission, 2006, para. 120.
[206]Id. at, para. 16.
[207] General comment no. 9 The rights of children with disabilities, CRC/C/GC/9, Committee on the Rights of the Child, 2006.
[208] CRPD/C/GC/5.

social exclusion by promoting the right to independent living and community inclusion, encompassing CWD's right to family life under Article 19 of the CRPD. Since these GCs were adopted in 2006 and 2017 respectively, more recent COs and Views are revisited to capture and analyse potential changes in the Committees' positions.

Drafting processes for GCs and resolutions are becoming ever more inclusive of many stakeholders who have various views on the issues at hand. Needless to say, these stakeholders often prioritize the perceived meanings of treaty provisions and international standards - often driven by moral imperatives and various interests - over strict legal methodology and coherence. This is not surprising as both the CRC and the CRPD are conventions addressing rights of some of the most marginalized groups in contemporary societies and through the history too. For that reason, stakeholders participating in the process, especially organisations and individuals with lived experience of discrimination and other human rights violations, might not think of coherency of international human rights regime first but of the reforms needed to address historical injustices. This form of impact on international lawmaking is also described as 'bottom-up' lawmaking[209] and should be generally seen as a positive occurrence, as it manages to capture lived realities (human rights violations or more broadly injustices) better than states apparatuses or overly bureaucratized inter-governmental bodies and is indispensable for effective interpretation of treaties. While the ILC acknowledges the importance and influence of non-state actors in treaty interpretation, it cautions that documents produced by these actors must undergo critical review.[210]

Conversely, states can have different understandings of how a new treaty, a GC or a resolution should look like based on their political, economic, and social contexts, again having less regard for purely legal issues of an international legal order. The perspectives of NGOs on these issues also vary, influenced by factors such as the type of organisation, its leadership, membership, mission, and vision - ranging from disabled people's organisations and human rights organisations to service providers, faith-based organisations, and humanitarian aid groups. All these stakeholders contribute their views and positions to international documents, which may or may not fully reflect these diverse perspectives in the final text.

[209]Levit, THE YALE JOURNAL OF INTERNATIONAL LAW, (2007), p. 409
[210] Yearbook of the International Law Commission. Report of the International Law Commission on the work of its seventieth session (30 April–1 June and 2 July–10 August 2018), A/CN.4/SER.A/2018/Add.1 (Part 2), United Nations, 2022, p. 42.

4.2. CRC Committee

4.2.1. General Comment No. 9 on CWD

General Comment No. 9 (2006) the Rights of CWD (GC 9) is an important source of information for this analysis, as it contains interpretations of the CRC articles related to CWD, primarily Article 23 on CWD and Article 2 that prohibits discrimination on the basis of disability.[211] The CRC Committee did not detail the interpretive techniques and methods it used to develop GC 9. In explaining the reasons for adopting GC 9, the CRC Committee highlighted widespread rights violations against CWD and noted that 80% of these children live in developing countries.[212] It also recognized increased disability-oriented advocacy by NGOs, which has highlighted the rights violations experienced by children and adults with disabilities. It is later evidenced in this thesis that an increased advocacy by DPOs and disability-rights oriented NGOs brought more balance between the CRC and the CRPD into UNGA resolutions on the rights of the child and into the work of the CRC Committee itself.[213]

GC 9 was adopted in September 2006, whereas the CRPD got adopted in December the same year, hence GC 9 preceded the CRPD by only several months. This timing is curious for the adoption of a GC focused on the rights of CWD, especially as the CRPD - a treaty specifically addressing the rights of CWD - was about to be adopted. Adopting the non-binding GC 9 on the same subject matter just before the CRPD might indicate the CRC Committee's intent to provide an updated interpretation of the CRC, given that the CRPD prescribes higher human rights standards for persons with disabilities than previous treaties. Furthermore, by drafting and adopting GC 9 before the CRPD's adoption, the CRC Committee was not yet legally bound by the CRPD's provisions, as it had not yet become a rule of international law in the sense of Article 31(3)(c) of the VCLT.

Firstly, the CRC Committee adopted a definition of disability present in the CRPD and emphasised the problem of barriers to the full realisation of rights of CWD.[214] By recognizing the issue of barriers, specifically social, cultural, attitudinal, and physical, the Committee

[211] CRC/C/GC/9, para. 6.
[212] Id. at. para 1.
[213] See 'UNGA Resolution on Children without Parental Care (2019)'; 'Day of General Discussion on children's rights and alternative care (2021)'.
[214] CRC/C/GC/9, para. 5, 7.

adopted an approach to disability that focuses on the societal factors which in interaction with impairment hinder disabled persons' participation in the society. This approach, embraced by the CRPD and outlined in its Preamble, led the Committee to align its discourse with the yet-to-be-adopted CRPD.[215] This shift marked a departure from the CRC's previous approach, which arguably resembled an individualistic or medical model, moving towards a human rights-based approach to disability.[216]

Recognizing and addressing these barriers did not contradict the CRC's approach but significantly enhanced it, vital for achieving the CRC's goal for CWD as stated in Article 23(1) CRD: 'enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'.

4.2.1.1. Family environment and alternative care

Chapter VI of GC 9 focuses on a central theme of this analysis: the issue of family environment and alternative care. As explained above, Article 20 of the CRC clearly emphasizes the primary role of family environment in the care of all children and gives institutional care a marginal role amongst alternative care options, indicating its undesirableness too.[217] GC 9 reiterates the primary role of family environment for CWD but with an important qualifier:

'CWD are best cared for and nurtured within their own family environment *provided that the family is adequately provided for in all aspects*.' [218] (emphasis added)

his statement marks a significant departure from the original text of the CRC and as such deserves attention. Namely, the detour taken is reflected in the second part of the sentence, which qualifies the care in the family environment for CWD only best when certain requirements are fulfilled, that is when families are provided with adequate support and means. This can imply that the family environment may not be optimal when families lack comprehensive support, a significant consideration given the inadequate support and services for families with CWD in many states, not to mention the poverty. The CRC Preamble

[215] Convention on the Rights of Persons with Disabilities, UNTS, 2515, p. 3, A/RES/61/106, 2006.Preamble (e).
[216] See note 13.
[217] See 'Marginal role and undesirableness of institutions'.
[218] CRC/C/GC/9, para. 41.

recognizes that care in a family environment is best for all children and that families should be provided protection and assistance, while Article 20 (1) prescribes special assistance to children '…in whose own best interests cannot be allowed to remain in that (family) environment…'. Paradoxically, the CRC Committee's statement in paragraph 41 of GC 9 might have inadvertently weakened the protection of family life for CWD by suggesting that, in the absence of adequate family support, alternative care settings could be preferable, despite the CRC Committee's probable intention to emphasize the importance of assistance provided to families with CWD.

GC 9 strongly emphasised the importance of using institutions only as a measure of last resort due to a number of issues related to institutional care such as the sub-standard quality of care, violence and abuse etc.[219] Reiterating the position of institutions as a last resort measure the CRC Committee does not depart slightest from the text of the CRC, as explained above. The marginal role of institutions and their inherent undesirableness is maintained in GC 9 without further development of the standard. Also, although the CRPD deals with family life and care for CWD, GC 9 does not refer to the CRPD standards, unlike in relation to issues of social inclusion, international cooperation, education, accessibility etc. Considering this regard for other CRPD provisions that the CRC Committee had had, it is surprising that it did not refer to the CRPD in relation to alternative care and family life. Furthermore, GC 9 advocated for the reform of institutional care by proposing the development of 'small residential care' facilities as alternatives to large institutions.[220] The CRC Committee thereby elaborates on standards which institutional care should upheld, a question that remained completely open in the CRC text. GC 9 first proposes transforming large institutions into SSRC facilities before calling for DI programmes in state parties that should transition children into '…their families, extended families or foster care system…'.[221] It is not completely clear whether the states parties should focus on the improvement of quality of institutional care, or the DI. Judging by the wording and the order in which those observations and recommendations are expressed, the CRC Committee gave a greater prominence to the former.

For all the above said, it seems that the CRC Committee did not engage in an evolutive interpretation of the norms related to family life and alternative care for CWD. Omitting

[219] Id. at, para. 47.
[220] Id. at.
[221] Id. at, para. 49.

reference to the CRPD in this aspect signified dissonance between the CRPD norms and the CRC Committee's views on the same subject.

4.2.1.2. Article 23 CWD

The CRC Committee identifies Article 23 as a 'leading principle' of the CRC concerning CWD, emphasizing the aspirations set out in paragraph 1 of this article as goals to strive toward.[222] The comprehensive and aspirational nature of this paragraph elevates it to a leading principle. The first indicator of an evolution in understanding Article 23 is reflected in the use of a noun 'inclusion' instead of the noun 'integration' originally used in Article 23 (3). Although the CRC Committee did not detail this change, it likely stemmed from the influence of the Draft CRPD, which consistently uses the term 'inclusion' and emphasizes full societal inclusion and participation as a core principle. Years later, the CRPD Committee defined 'inclusion' and distinguished it from 'integration.' The committee argued that integration allows placing CWD in mainstream schools provided they can adapt to the existing system, whereas inclusion involves making structural changes to eliminate barriers 'to provide all students of the relevant age range with an equitable and participatory learning experience and environment that best corresponds to their requirements and preferences'.[223] Therefore, in terms of rights and duties, 'inclusion' involves, among other things, a duty to adapt existing structures, such as schools, health and social services, public spaces, and administrative bodies, to accommodate CWD. Conversely, according to the CRPD Committee's explanation, 'integration' simply involves a duty to include CWD in these structures to the extent that each child can adapt to the existing conditions.

For these reasons, by merely replacing 'integration' with 'inclusion,' the CRC Committee engaged in an evolutive interpretation of the CRC. Such a development serves the purpose of CRC regarding CWD, as achieving the aspiration from Article 23 (1) is unthinkable without a responsibility of parties to undertake various structural changes to accommodate to the needs and preferences of CWD.

[222] Id. at, para. 11, 14(a).
[223] General comment No. 4 (2016) Article 24: Right to inclusive education CRPD/C/GC/4, (Committee on the Rights of Persons with Disabilities), 2016.

GC 9 also advocated for inclusive education for CWD, referencing the Draft CRPD—even though the CRC does not mention this. It acknowledged the challenges of achieving full inclusion and suggested alternative educational options, deviating from the original CRC text influenced by the Draft CRPD. However, GC 9 did not fully endorse the Draft CRPD and recommended the development of other forms of education.

4.2.1.3. Shift in the approach to disability

Byrne suggests that that the use of the term ‘special care’ in art 23 CRC reflects the dominant disability-related language of the time.[224] 'Social integration' is another term that reflects the dominant approach to disability in the CRC. The terms 'special care' and 'integration' suggest disability is an individual issue or personal tragedy, necessitating special protection aimed at social integration. This view overlooks the myriad 'disabling' factors in an individual's environment that also need addressing.[225] Effectively, such an approach situates a disability inside an individual, giving little to no regard to social contexts and disabling and enabling factors coming from those contexts. Consequently, laws and public policies are created to reflect this individual-oriented understanding of disability. Typically, such policies focus on biophysical aspects of disability, prevention, treatment, and alleviation of impairments, and to the provision of specialised systems of education and employment. In contrast, the CRPD uses 'inclusion' instead of 'integration,' aligning more closely with the social model of disability. This model emphasizes society’s responsibility to adapt to disabled individuals. Overall, it is widely acknowledged that the CRPD was significantly influenced by the social model of disability, and for this reason, it is sometimes referred to as a transformative treaty.[226] The individualistic discursive model is further reflected in Article 23 (3) CRC with the recognition of ‘special needs’ of CWD, which is a result of the focus on personal deficiencies that should be addressed by providing the extended care.

Article 23 CRC reflects a particular disability-related discourse both through the use of specific terms (social integration, special care, special needs) and substantively, by focusing on

[224] Byrne. 2019, p. 871-872.
[225] USING THE HUMAN RIGHTS FRAMEWORK TO PROMOTE THE RIGHTS OF CHILDREN WITH DISABILITIES: DISCUSSION PAPER AN ANALYSIS OF THE SYNERGIES BETWEEN CRC, CRPD AND CEDAW (UNICEF.), p. 8.
[226] E.g. Oliver Lewis, *The expressive, educational and proactive roles of human rights: an analysis of the United Nations Convention on the Rights of Persons with Disabilities*, RETHINKING RIGHTS-BASED MENTAL HEALTH LAWS (2010).

biophysical aspects of disabled children's lives, prescription of special-track services and the lack of intention to address the disabling societal factors. Therefore, Article 23 CRC is correctly understood to originally reflect the so-called individualistic approach to disability and consequently the lack of intention of drafters to address societal factors that contribute to the disablement of individuals with impairments. This is particularly important as Article 23 CRC is understood as a guiding principle regarding CWD, its comprehensiveness is cemented in the paragraph 1 of this article. It should be noted that the non-discrimination article of the CRC prohibits discrimination on the basis of disability and that all rights and duties in the CRC relate to CWD as much as all other children. However, one of the troubles of the individualistic approach to disability is that anti-discriminatory norms will fail to protect individuals with disabilities from discrimination by justifying different treatment based on disability as necessary, even when it deprives a disabled person from his/her rights. For example, placement of a disabled child in an institution can be seen as a necessary action to meet the child's 'special needs' when seen through a lens of an individual approach, or as a form of discrimination and a failure to provide appropriate care and support for the child in a family environment, effectively depriving the child of his/her right to family life, privacy etc, when seen from a human rights perspective.

Despite the CRC's predominantly individualistic approach, the CRC Committee's endorsement of 'inclusion' in GC 9 signaled a significant shift. Such a shift in terminology is more than just a semantic issue, it signalled a change in the approach to the subject-matter, and departure from the original approach in the CRC. This shift by the CRC Committee stems from an evolutive interpretation approach, as outlined in Article 31(1) of the VCLT. It was influenced by the drafting of a new treaty on the same subject and by emerging values and concepts that were uncommon among the treaty drafters in the 1980s. Although discussions on the social model of disability that focuses on society as a disabling factor and insists on society-oriented reforms were very much alive during 1980s, its main ideas did not find a way to the text of the CRC. This might have been a consequence of the lack of participation of DPOs and disability-oriented NGOs in the drafting process.

4.2.1.4. Conclusion on CRC Committee General Comment 9

This analysis has revealed two distinct paths through which the CRC Committee dynamically interpreted the CRC in GC 9. Firstly, the discourse adopted a new approach to CWD. Although this did not yield concrete recommendations, it indicates the direction of the CRC Committee's future interpretations, likely moving towards harmonisation with the CRPD. This leads to another curious conclusion, that the CRC Committee considered the text of the Draft CRPD, a document that had not yet become part of the IHRL. Interpreting the CRC with reference to such a document cannot be strictly considered as grounded in Article 31(3)(c) of the VCLT. The treaty body used a document that was yet to become an applicable rule of international law, signifying some flexibility in interpretation for the sake of future coherency of international rules related to the same subject-matter. Therefore, the CRC Committee's interpretation can be said to be grounded in Article 31 (1) VCLT and the good faith principle.

The harmonisation was selectively applied across different provisions. The CRC Committee's choice to refer to the Draft CRPD in some instances but not others was left unexplained. For example, the standards related to family environment and alternative care for CWD, although enshrined in the CRPD through provisions that ultimately protect the life in family environment for CWD to a higher degree than the CRC, are omitted in GC 9. Instead, the CRC Committee decided not to engage in an evolutive interpretation of the relevant standards but merely elaborated vague CRC terms. Furthermore, the CRC Committee fully embraced the CRPD's definition of disability, which is crucial as it frames disability as the interaction between persons with impairments and environmental barriers - a vital perspective for shaping international and national policies. Also, in relation to mainstreaming the rights of CWD in all national policies and programmes GC 9 refers to the CRPD and entirely adopts its standards. Regarding inclusive education, the CRC Committee referenced the CRPD to guide its evolving interpretation. However, it did not fully affirm the CRPD's obligations, arguably diluting them by endorsing the development of special education systems and acknowledging some states' inability to immediately fulfil these obligations.

In summary, the CRC Committee applied evolutive interpretations to certain CRC norms while merely elaborating on others. Although it consistently adhered to the treaty's purpose and objectives in its dynamic interpretations, it frequently deviated from the CRC's text. It took into account the Draft CRPD, but in a non-consistent manner, which left plenty of space and need for future work on overlapping issues.

4.2.2. Other CRC Committee's General Comments

General Comment No. 24 (2019), addressing children's rights within the child justice system, discusses residential care as early intervention for young children below the age of criminal responsibility who have committed acts that would be criminal for older individuals.[227] The CRC Committee stresses that supporting these children in their families should be 'an absolute priority.' However, it notes that residential care, offering a range of professional services, may be more suitable for some children but only as a last resort and for the shortest possible duration (para. 11). Although this is not a disability-specific recommendation, it could be related to CWD who committed such acts and speaks to the permissibility of such care in general. The CRC Committee names the provision of professional array of services that can be provided in residential care as a justification for placement. Unfortunately, the Committee does not elaborate on the specific services. The question arises whether the residential care is permitted only when such services cannot be provided in a family setting. Judging by the wording of the para. 11, such a meaning is indeed very likely. The CRC Committee also called for the establishment of small residential care facilities where necessary, as one of specialised services that should be available (para. 108), in line with the GACC.

GC 24 replaces General Comment 10 (2007), which also focused on children's rights within juvenile justice.[228] The CRC Committee acknowledged that the reason for this revision is the advancement in international and regional standards, acquired knowledge about the child development, evolution of the committee's jurisprudence and evidence of good practices (para. 1). Interestingly, the older version, GC 10, stated that the aim of residential care was rehabilitation (para. 89), whereas GC 24, in a nearly identical paragraph, shifts this aim to reintegration (para. 89). This change is a testimony to the advancement made by the CRC Committee in the direction of protecting family life.

Considering that the year of adoption of GC 24 is the year of the Resolution on children deprived of parental care (2019) it would be interesting to compare the content of these two documents. Unlike GC 24, the Resolution on the rights of children without parental care does

[227] General comment No. 24 (2019) on children's rights in the child justice system, Committee on the Rights of the Child, 2019.
[228] Id. at, para. 1.

not read that the placement in residential care should be for the shortest possible period of time (same as the GACC). This could be understood in two ways – either the CRC Committee intended to promote a standard of provision of such care only for the shortest period of time despite the Resolution and the GACC, or the CRC Committee held that such standard should be applicable specifically to children under the age of criminal responsibility who committed acts that would otherwise be an offence. The former option is more likely, as the restoration of family living in shortest possible time was also insisted both by the child rights community and disability rights community of NGOs in their submissions for the Resolution on children deprived of parental care, without mentioning any particular group of children. Hence, the CRC Committee may have been more receptive of such requests, which then should be understood as an attempt to advance the protection of family life for all children.

General Comment 17 (2013) on the right of the child to rest, leisure, play, recreational activities, cultural life and the arts reiterates that the goal for states is DI, but recommends certain measures to realise this right for children in residential care, before DI is fully achieved.[229] In this case the CRC Committee used the term 'institution' to encompass a wide array of establishments such as 'residential homes and schools, hospitals, detention centres, remand homes and refugee centres' (para. 51). This is inconsistent (but a more appropriate use) with some previous uses of this term in the context of residential care, where it denoted only large, traditional institutions for the care of children, such as in the GACC (para. 23).

General Comment 13 (2013) on freedom from violence acknowledges that children are often be victims of violence perpetrated by staff in 'residential and other institutions and persons who have power over children' (para. 23, 36).[230] It recommends using institutionalisation only as a last resort and when in the best interest of the child, specifically to prevent violence (para. 47(d)(iii)). It could be said that the CRC Committee maintained the character of undesirability of residential care, in the same way it was expressed in the CRC text, by assessing it in the context of violence which had been found more prevalent in such establishments. Furthermore, the CRC Committee recognized a higher potential for violence in all forms of residential care, without endorsing smaller group settings over larger ones.

[229] General Comment No. 17 (2013) on the right of the child to rest, leisure, play, recreational activities, cultural life and the arts (Article 31), Committee on the Rights of the Child, 2013.
[230] General comment no. 14 on the right of the child to have his or her best interests taken as primary consideration, CRC/C/GC/14, Committee on the Rights of the Child, 2013.

General Comment 14 (2013) emphasizes the child's best interests as a primary consideration (Article 3(1) CRC) and reaffirms CRPD Article 23(4), stating that a child with disabilities must not be separated from parents due to the child's or parents' disability (para. 61). It recognizes 'the right to family life' of a child contained in Article 16 of the CRC. GC 14 also echoes para. 15 of the GACC, upholding the necessity principle of alternative care and stipulating that institutionalisation should only occur when necessary, after assessing the child's best interests (para. 62, 79). Seemingly the CRC Committee did not engage in any sort of dynamic interpretations in relation to the permissibility of residential care, although it did include the CRPD provision from Article 23 (4).

General Comment 21 (2017) on children in street situations highlights the importance of a 'continuum of care,' which includes 'temporary residential care' as a component (para. 17, 44).[231]

4.2.3. CRC Committee Concluding observations

An analysis of twenty-eight CRC Committee Concluding Observations from 1 January 2020 to 1 July 2022 provides insights into recent interpretations of relevant provisions. This analysis is significant, especially since GC 9 on CWD was adopted in 2006, and interpretations may have evolved since then. Considering that General Comments are formulated from committee activities and integrate findings from Concluding Observations, analyzing these elements helps clarify the committee's current stance and interpretations in the absence of a recent General Comment.

In many cases, the CRC Committee urged states to implement DI, consistently emphasizing family-based care in nearly all examined countries. The care in a family environment is prioritized in every CO, and forms of residential care rarely mentioned in the context of establishing and expanding such care. This is in line with the CRC and UNGA resolutions analysed above, however it might even go beyond the Guidelines, as a reference to even small residential care was usually omitted. The CRC Committee, however, did call for the use of residential care in small groups in its report on Czechia 'when necessary and appropriate', in

[231] General comment No. 21 (2017) on children in street situations, CRC/C/GC/21, (Committee on the Rights of the Child), 2017.

line with the recommendations in the Guidelines. [232] Conversely, in case of Chile, the Committee emphasised the problem of the replication of practices from large residential care to small residential care and noted the abuse of girls.[233] Similarly, the Committee was 'seriously concerned' about the institutionalisation of CWD in, *inter alia*, SGHs in Hungary.[234] This and frequent reminders to states to implement the GACC evidence that the CRC Committee's approach is in line with the Guidelines and has not much changed since.

In several occasions the Committee expressed concerns about institutionalisation of CWD, indigenous children, Romam and children in street situations, recommending that states prioritize family-based care and DI for these groups.[235] One recommendation to Zambia was to stop institutionalisation on the basis of disability, while the Committee recommended Belarus to pay 'particular attention' to DI of CWD.[236] The CRC Committee praised Poland for its commitment to ending institutionalisation for children under ten years old and urged Croatia to accelerate DI for children under seven, including CWD.[237] Previously the GACC recommended prohibiting the institutionalisation of children under three years of age that the CRC Committee often reiterated. The situations in Croatia and Poland illustrate the CRC Committee's support for raising the age limit for residential placements, reflecting an overarching approach to residential care, which is the fewer the better.[238] However, the CRC Committee does not seem to be ready to call states to completely avoid such care, and it has stayed devoted to the promotion of the GACC that call for the use of SSRC when necessary and appropriate.[239]

[232] Concluding observations on the combined fifth and sixth periodic reports of Czechia, CRC/C/CZE/CO/5-6, 2021, para. 31(f)
[233] Concluding observations on the combined sixth and seventh periodic reports of Chile*: Committee on the Rights of the Child, CRC/C/CHL/CO/6-7, 2022, para. 20.
[234] Concluding observations on the sixth periodic report of Hungary**: Committee on the Rights of the Child, CRC/C/HUN/CO/6*, 2020, para. 29 (a).
[235] Concluding observations on the combined fifth and sixth periodic reports of Croatia*, CRC/C/HRV/CO/5-6, (Committee on the Rights of the Child), 2022, para. 31 (d); CRC/C/CHL/CO/6-7, 2022, para. 25(d); Concluding observations on the combined fifth to seventh periodic reports of Zambia*, CRC/C/ZMB/CO/5-7, (Committee on the Rights of the Child), 2022, para. 30(f); Concluding observations on the combined fifth and sixth periodic reports of Poland*, CRC/C/POL/CO/5-6, (Committee on the Rights of the Child), 2021, para. 31 (b, c). Concluding observations on the combined fifth and sixth periodic reports of Rwanda*, CRC/C/RWA/CO/5-6, (Committee on the Rights of the Child), 2020, para. 29 (a), 32 (c), 33 (c);
[236] CRC/C/ZMB/CO/5-7, 2022, para. 30 (f); Concluding observations on the combined fifth and sixth periodic reports of Belarus*, CRC/C/BLR/CO/5-6, (Committee on the Rights of the Child), 2020, para. 28.
[237] CRC/C/POL/CO/5-6, 2021, para. 31 (b); CRC/C/HRV/CO/5-6, 2022, para. 28 (a)

[239] See UNGA Guidelines for the Alternative Care of Children (2009)

Analysis of the CRC Committee's Concluding Observations on residential care indicates a strong preference for family-based care. However, the Committee also recognizes the necessity and benefits of care in small residential facilities 'when necessary and appropriate,' thus endorsing an 'incomplete' (DI or a partial transition to family-based care. This DI is considered incomplete because, even at full implementation, it leaves some children in residential care, albeit in smaller facilities, despite a predominant reliance on family-based care systems. The transfer from large institutional care to smaller facilities is termed trans-institutionalisation and cannot be regarded as DI.

Importantly, the CRC Committee recommended that particular attention is paid to DI of CWD due to their specifically hard position in those countries. This speaks to the sensitivity of the Committee to often harder position of some groups of children and implementation of additional efforts to remedy the problem, which opens a question of potential for the development of international standards that will specifically address the most disadvantaged children in a wider framework of rules and standards on the protection of all children.

4.2.4. Acknowledgment of the problems of SSRC

Concluding Observations on Hungary and Chile highlight two significant issues with SSRC, emphasized by the disability-rights community: the replication of practices from large to small residential facilities, and the continued institutionalisation of CWD in small facilities even after replacing larger institutions. Those are some of the main concerns of the proponents of the 'complete' DI, in opposition to an 'incomplete' DI which also results in trans-institutionalisation. Firstly, harmful practices from large institutions are likely to be replicated in small residential care, which was evidenced by Disability Rights International in their report on Bulgaria's small group homes,[240] and also noted by the CRC Committee in relation to girls in such care in Chile. Secondly, considering that CWD were historically institutionalised in much higher rates than other children[241], it is assumed that they will be placed in small residential care instead of family care.[242] Another issue of residential care that is the inability

[240] E.g. ERIC ROSENTHAL, et al., A DEAD END FOR CHILDREN: BULGARIA'S GROUP HOMES (Disability Rights International. 2019).
[241] MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 189
[242] UN Disability and Child Rights Groups On Behalf of Children without Parental Care: Key Recommendations. 2019.

of children to form stable and deep attachments with their primary caregivers, which according to scientific evidence, leads to developmental issues[243] - the main reason why the CRC Committee and the Guidelines have instructed states not to place children under three years of age in residential care.[244] This indicates that the CRC Committee is aware that small group care can perpetuate patterns of human rights violations and have similarly detrimental effects on CWD as seen in large-scale residential care.

The CRC Committee has emphasised the need for quality alternative care, same as the Resolution on children without parental care (2019),[245] recognizing that it is not enough to scale down the size of institutions but actually uphold high quality standards, in order to improve outcomes. The feasibility of providing high-quality small residential care raises significant concerns. This includes the replication of entrenched, harmful practices, the resources required to ensure high quality, and the challenges associated with monitoring and assessing care quality. What is likely, however, is that many states will be able to construct SGHs, even those with limited resources, including with the help of external aid from public and private donors or faith-based organisations. As a result, quality may be relegated to a secondary concern, overshadowed by the appearance of newer, smaller, and more home-like facilities, which states may tout as successes in moving away from large institutional systems. Furthermore, despite the CRC Committee's and the GACC's strong emphasis on family-based care, there are no strict limitations preventing states from expanding small residential care. This expansion could eventually accommodate as many children as the larger institutions, albeit across a greater number of facilities. Coupled with historically rooted practices of institutionalisation of CWD, the CRPD Committee's and disability-rights organisations' concerns about SGHs continuing to discriminate and segregate CWD are well-founded.

4.2.5. Inquiry reports and Views

No views were adopted on the issue of CWD right to family life and alternative care. Also, no relevant Inquiry reports were adopted by the CRC Committee.

[243] Rutter, HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS, (2008).
[244] See 'UNGA Guidelines for the Alternative Care of Children (2009)'.
[245] See 'UNGA Resolution on Children without Parental Care (2019)'.

4.3. CRPD Committee

4.3.1. General Comment No. 5 on living independently and being included in the community (2017)

The CRPD Committee' General Comment No. 5 (2017) on living independently and being included in the community (GC 5) addresses one of the most critical issues of the CRPD. GC 5 interprets Article 19 of the CRPD and elaborates its relationship with CWD. GC 5 outlines the historical exclusion of persons with disabilities from local communities and their denied right to self-determination, [246] clarifying that true autonomy involves living outside of 'residential institutions of all kinds'.[247]

In relation to children, GC 9 holds that the placement in alternative care on the basis of disability is discrimination.[248] To support this, GC 5 reiterates General Comment No. 4 (1994) on persons with disabilities[249] of the Committee on Economic, Social and Cultural Rights, that recognizes segregation of persons with disabilities due to physical and social barriers as a form of discrimination.[250]

GC 5 makes two critical assertions regarding children:

'For children, the core of the right to live independently and be included in the community entails a right to grow up in a family.' (para. 37)

'Large or small group homes are especially dangerous for children, for whom there is no substitute for the need to grow up with a family. 'Family-like; institutions are still institutions and are no substitute for care by a family.' (para. 16(c))

[246] CRPD/C/GC/5, para. 1-5
[247] Id. at, para. 16(c)
[248] Id. at, para. 11
[249] E/1995/22, para. 15
[250] Ibid, para. 13

On the first look, it is obvious that the intention of the CRPD Committee was to address the issue of small residential care as a priority and without hesitation. Unlike other documents analysed above (resolutions and CRC Committee's GCs) that address institutionalisation, mostly implying that this means only large residential care, while small residential care is either not mentioned at all or implied as a viable form of alternative care, these focusses specifically on the inadequacy of small residential care. This emphasis by the CRPD Committee likely responds to various documents up to 2017 that permitted and even favored such care, particularly the GACC. It may represent the first public documentation of the significant divergence between the CRPD and CRC Committees' stances on small-group residential care.

DI is frequently mentioned throughout the document (13 times) similarly to all other documents analysed here. However, the CRPD Committee advocates for 'complete' DI, a term not commonly found in academic literature but introduced in this dissertation to highlight the substantive differences between the two committees' perspectives on DI. The CRPD Committee emphasised DI is not only the closure of institutions, but a 'structural reform' that among other things means the establishment and provision of different support and services CWD and their families.[251]

4.3.2. CRPD Committee and interpretation

The CRPD Committee's handling of family life for CWD under Article 19 illustrates the applied approaches and interpretation techniques. Although Article 19 does not explicitly mention children, alternative care, or residential care, the CRPD Committee interpreted it as highly relevant to alternative care for CWD. The CRPD Committee did not depart from the wording, but rather elaborated on its meaning, considering that the article explicitly applies to 'all persons with disabilities'.

The CRPD Committee did not interpret this provision expansively, but rather with an emphasis on the context and object and purpose. The purpose of the right to independent living and being included in the community is to reverse the rooted practices of segregation, social exclusion, and the denial of self-determination, similarly to Article 23 (5) in relation to CWD. In fact, limiting the provision of Article 19 only to adults would be restrictive and contrary to the good

[251] CRPD/C/GC/5, para. 16 (c), 33, 41, 58

faith principle of interpretation, as the wording is broad enough to accommodate such understanding, and both children and adults experience segregation and social exclusion due to disabilities.

The CRPD Committee paid special attention to the provisions of Article 23, which focus on preventing institutionalisation and providing alternative care in family settings for children when necessary.[252] The Committee asserts that community living for CWD entails life in a family (as opposed to living in a residential care that is integrated into the community for example).[253]

The CRPD Committee took into consideration the external context in the sense of applicable rules of law, such as articles 9 (1), 18 (2), Article 20 (1,2), Article 23 (1) of the CRC. The omission to mention Article 20 (3) CRC that names institutions as a form of alternative care that countries could provide to children was expected as the CRPD Committee strongly condemns any form of residential care. The UDHR Article 29 (1) on the duties towards and participation in the community for 'free and full development' of an individual's personality is named the fundamental in relation to Article 19 CRPD. Then the right to the right to liberty of movement and the freedom to choose one's residence of the ICCPR Article 12, the right to adequate standard of living of the ICESCR Article 11 and other treaties.[254] A number of other instruments, namely the UNGA resolutions analysed above, might have been omitted for the reason of suggesting the use of residential care. Still, GC 5 reiterates the CRC Committee's GC 9 on CWD in relation to the concern for high levels of institutionalisation but does not mention the recommendation contained in the same paragraph which called states to provide institutional care (only as a last resort).[255]

In summary, the CRPD Committee closely followed the general rules of interpretation, primarily emphasising the internal context, wording, and purpose. The Committee also considered the external context, but only in relation to the CRC's prescriptive provisions. Moreover, the misalignment of GC 5 with CRC Article 20 (3), as it excludes institutional care

[252] See 'Article 23 CRPD – Respect for the home and family'.
[253] CRPD/C/GC/5, para. 37.
[254] Id. at, para. 9 – 14.
[255] General comment no. 9 (2006), The rights of children with disabilities, CRC/C/GC/9, Committee on the Rights of the Child, 2007, para. 47; CRPD/C/GC/5, para. 12

as a form of alternative care, should not be considered a conflict. This is because the CRC provision neither imposes an obligation nor establishes a right, as explained above.[256]

Despite their non-binding nature, the number of resolutions advocating for some use of residential care, adopted before GC 5, could have served as supplementary interpretative tools, particularly the GACC due to their perceived normativity.[257] As previously explained, residential care contradicts the purposes of Articles 19 and 23 and the overall CRPD objectives. Thus, the CRPD Committee's disregard for such external contexts aligns with the general rules of treaty interpretation. The CRPD Committee cannot be faulted for this divergence, as it originates from the conventions themselves and is closely linked to their purposes.[258] Nevertheless, while GC 5 did not resolve the divergence between the treaties, it made the differences more apparent, marking a preliminary step towards addressing the issue. The first attempts to address the discord were seen in the Resolution on children without parental care (2019) and the DGD 2021 of the CRC Committee.[259]

4.3.3. Other CRPD Committee general comments

The CRPD Committee dedicated a substantial part of General Comment No. 6 (2018) on equality and non-discrimination (GC 6) to addressing institutionalisation as a form of discrimination, reinforcing its stance on a "complete" DI. The document srtongly emphasised that: 'States parties should address violence and institutionalisation of CWD, who are denied the right to grow up in their families as a matter of discrimination' (para. 38). Furthermore, the Committee elaborated that policies and laws that justify institutionalisation and separation of CWD from their families on the basis of impairment are discriminatory (para. 8, 30, 38),[260] that such measures correspond with the so-called medical model of disability, while they disregard the human rights approach to disability promoted in the CRPD (para. 8). The document describes institutionalisation of CWD as a denial of the right to grow up in families as a consequence of the discrimination (para. 38, 62). The discrimination is found in the failure of responsible authorities to ensure support and services in the family and the community, due to

[256] See 'The nature of compared norms and overlaps'.
[257] See notes 127, 128.
[258] See 'Conflict of purposes'.
[259] See 'UNGA Resolution on Children without Parental Care (2019)'; 'Day of General Discussion on children's rights and alternative care (2021)'.
[260] CRPD/C/GC/6.

which persons with disabilities are forced to abandon family and community living for institutions (para. 58). A similar approach was advocated by a group of DPOs and NGOs in their 2019 submission for the Resolution on the rights of children without parental care, calling for the recognition of institutional placement as a human rights violation.[261]

The CRPD Committee argued that Article 23 (5) prohibits the placement of CWD in institutions based on their impairment, viewing it as discriminatory, and mandates that states ensure support and services for parents and children (para. 62). This interpretation of Article 23 (5) is for the good part in line with the understanding offered in this dissertation.[262] The wording of the provision is ambiguous and can accommodate different interpretations. The CRPD Committee put an emphasis on the purpose and the objective of the provision and the CRPD in general, which then produced the interpretation of the norm seen here. However, the CRPD Committee also stated that Article 23 (5) prohibits institutionalisation which could be seen as an expansive interpretation, as the obligation to provide alternative care only in family setting does not necessarily mean the prohibition of institutionalisation. This prohibition can be rather derived from Article 19 (that has a more prescriptive wording than Article 23 (5))[263] which in conjunction with Article 5 on non-discrimination and Article 23 (5) can produce a prohibition of institutionalisation of CWD.

In relation to DI, the CRPD Committee advocated for processes enabling CWD to live with their families or in 'alternative family care' within the community (para. 38). GC 6 is very clear about the institutionalisation and other forms of segregation on the basis of disability.

General Comment No. 1 (2014) on equality before the law called for DI and the problem of pervasive institutionalisation of persons with disabilities and human rights violations that occur in relation to institutional placements (para. 40, 46).[264] General Comment No. 3 (2016) on women and girls with disabilities notes a number of human rights violations in relation to

[261] See
Drafting process and the divide.
[262] See Article 23 CRPD – Respect for the home and family
[263] See Characteristics of obligations.
[264] General comment No. 1 (2014) Article 12: Equal recognition before the law, (Committee on the Rights of Persons with Disabilities), 2014.

institutionalisation.[265] General Comment No. 4 (2016) states that 'institutionalisation is incompatible with inclusive education,' requiring states to implement well-organized and funded DI, supported by family and community services (para. 64).[266]

4.3.4. Conclusion on CRPD Committee's General Comments

For the CRPD Committee, addressing institutions and DI is central and forms the backbone of the CRPD. The Committee has consistently addressed the issues surrounding the right to family life for CWD by interpreting the relevant provisions as prescribing a DI, excluding any form of residential care for CWD. It interprets Articles 19 and 23 as mandating that states provide alternative care for CWD exclusively in family settings, thereby prohibiting institutionalisation. In terms of the rules of interpretation, the CRPD Committee places an emphasis on the object and purpose, followed by the wording and the context to interpret critical provisions. There is no evidence of dynamic interpretation concerning the right to family life and provision of alternative care in their General Comments. This may be because the CRPD, as a relatively recent treaty introducing a progressive paradigm into IHRL, has not yet required evolutionary interpretation. However, a critique of expansive interpretation as a consequence of 'teleological effectiveness' in relation to the permissibility of residential care for CWD can be expected. On the other hand, tendencies of human rights treaty bodies, including ECtHR, to interpret treaties with an approach termed as teleological effectiveness has been well established, and sometimes might be necessary to provide meaningful protection to individuals.[267]

4.3.5. CRPD Committee Concluding observations

An analysis of thirty COs by the CRPD Committee, adopted between March 2018 and July 2022, aims to capture potential shifts in the interpretation of Articles 19 and 23(5) regarding the permissibility of residential care as alternative care for CWD and DI since GC 5's adoption

[265] General comment No. 3 (2016) on women and girls with disabilities, (Committee on the Rights of Persons with Disabilities), 2016.
[266] CRPD/C/GC/4.
[267] Çalı. 2020, p. 540

in 2017. The CRPD Committee used different wordings to express concerns and recommendations in relation to residential care for children. The COs to France and Switzerland are particularly illustrative of the Committee's stance on care in small-scale residential facilities or family-type settings. France received a recommendation to 'end the institutionalisation of children and adults with disabilities, including in small residential homes(…)'.[268] In Switzerland's case, the recommendation included ending institutionalisation 'in small residential homes, with measures to prevent trans-institutionalisation'.[269] The term 'trans-institutionalisation', also used in the CO to Hungary, denotes the transition from one institutional setting to another, in this case from larger residential facilities to smaller ones, usually called small group homes (and many other names). The Committee also expressed concerns about the use of small residential care and trans-institutionalisation in North Macedonia. In the CO to Estonia, the Committee notes 'that institutionalisation on the basis of disability persists in the form of alternative care homes and new small-scale 'family type' or 'special care villages' (…)'.[270]

In its COs to Switzerland and France, the CRPD Committee underscored its interpretation of Article 23(5) to mandate the provision of alternative care to CWD exclusively in family settings. In many other COs the Committee urged DI and provision of alternative care in family settings, but without the use of words such as 'solely', 'exclusively' or 'only' (e.g. Cuba, Poland, Kuwait and Rwanda).[271] A different wording was used in a CO to Algeria, where the Committee 'encouraged' authorities to provide alternative care in a family setting for CWD.[272] Such a wording is close to the wording of the CRC Committee and does not strictly exclude other forms of care, which is a curious occurrence. Given that this formulation appears uniquely in the Algerian CO, and the CRPD Committee did not suggest or explicitly call for the

[268] Concluding observations on the initial report of France*: Committee on the Rights of Persons with disabilties, CRPD/C/FRA/CO/1, 2021, para. 41 (a)
[269] Concluding observations on the initial report of Switzerland*, CRC/C/CHE/CO/5-6, (Committee on the Rights of Persons with Disabilities), , 2022, para. 40 (a)
[270] Concluding observations on the initial report of Estonia*, CRPD/C/EST/CO/1, (Committee on the Rights of Persons with Disabilities), 2021, para. 38 (b), 39 (b)
[271] Concluding observations on the initial report of Rwanda*, CRPD/C/RWA/CO/1, (Committee on the Rights of Persons with Disabilities), 2019, para. 14 (e); Concluding observations on the initial report of Cuba*, CRPD/C/CUB/CO/1, (Committee on the Rights of Persons with Disabilities), 2019, para. 18 (b); Concluding observations on the initial report of Poland*, CRPD/C/POL/CO/1, (Committee on the Rights of Persons with Disabilities), 2018, para. 12 (e); Concluding observations on the initial report of Kuwait*, CRPD/C/KWT/CO/1, (Committee on the Rights of Persons with Disabilities), 2019, para. 45 (b)
[272] Concluding observations on the initial report of Algeria*, CRPD/C/DZA/CO/1, (Committee on the Rights of Persons with Disabilities), 2019, para. 17 (e).

provision of alternative care in settings other than family settings in other COs, this does not indicate a shift in the Committee's position or interpretation.

The COs issued by the CRC and CRPD Committees on Hungary's state reports (adopted in 2020 and 2022, respectively) show striking similarities concerning CWD. Both Committees expressed concerns over institutionalisation, including the use of small group homes. The sole difference lies in the CRC Committee's directive to close institutions 'that do not comply with the required standards', contrasting with the CRPD Committee's call to 'discontinue the institutionalisation of CWD and ensure their right to a family life'.[273]

The CRC Committee's recommendation implies that institutions meeting the 'required standards' may continue operating, corroborated by the reiterated GACC advocating for small residential care when necessary and appropriate. Conversely, the CRPD Committee's recommendation excludes the provision of such care. In their COs to Poland, adopted in 2021 by the CRC and in 2018 by the CRPD, both Committees issued nearly identical recommendations for providing 'safe alternative care in family settings' for CWD.[274]

4.3.6. CRPD Committee Inquiry reports and Views

In 2019, the CRPD Committee conducted an inquiry in Hungary. Pursuant to Article 6 of the Optional Protocol to the Convention on the Rights of Persons with Disabilities (OPCRPD), when the CRPD Committee receives reliable information on grave or systematic human rights violations it must invite the state party in question to cooperate in conducting examination of the alleged violations.[275] The Committee investigated alleged breaches of Articles 4(1), 5, 12, and 19 of the CRPD and identified grave and systematic violations of the rights of CWD. The report emphasized that placements in any institution, from small-scale group homes to large-scale facilities, fail to meet Article 19 CRPD's requirements.[276] It specifically addressed this issue by noting that: 'The strategy of moving persons with disabilities from large- to small-

[273] CRC/C/HUN/CO/6*, 2020, para. 30 (b); Concluding observations on the combined second and third periodic reports of Hungary*, CRPD/C/HUN/CO/2-3, (Committee on the Rights of Persons with Disabilities), 2022, para. 41 (a).
[274] CRPD/C/POL/CO/1, para. 12 (a); CRC/C/POL/CO/5-6, 2021, para. 31 (c)
[275] Optional Protocol to the Convention on the Rights of Persons with Disabilities, U.N.T.S, 2515, 3, UN General Assembly, 2006.
[276] Inquiry concerning Hungary under Article 6 of the Optional Protocol to the Convention: Report of the Committee, CRPD/C/HUN/IR/1, (Committee on the Rights of Persons with Disabilities), 2020, para. 100

scale institutions perpetuates and expands institutionalisation, and there are no measures in place to prevent their institutionalisation from extending any further'.[277]

The report categorizes as 'direct discrimination' the law allowing the institutionalisation of children under 12 based on impairment.[278] The existence of grave and systematic violations in relation to CWD is reflected in 'extremely harmful and discriminatory effects', perpetuation of segregation and marginalisation, and combined effects of laws, policies and stereotypes against CWD.[279] Among other recommendations, the Committee urged Hungary to prevent further institutional placements, revise the current strategy of transitioning individuals from large to small-scale institutions, and ensure the realisation of CWD's right to family life.[280]

4.3.7. Guidelines on DI, including in emergencies

Since its inception, the CRPD Committee has issued two guiding documents for state parties on implementing the CRPD. The first document focuses on implementing Article 14, concerning the right to liberty and security, while the second, addressing DI during regular times and emergencies, was adopted in 2022. The CRPD Committee stated that it developed Guidelines on DI on the basis of inputs from hundreds of disabled people worldwide, and other interested actors, after a transparent and inclusive process.[281]

The document explicitly states that: 'States parties should abolish all forms of institutionalisation, end new placements in institutions and refrain from investing in institutions'.[282] The CRPD Committee also sought to clearly define what constitutes institutionalisation for CWD:

All forms of institutionalisation of CWD – that is, placement in any non-family setting – constitute a form of segregation, are harmful and violate the Convention. (para. 12)

Also:

[277] Id. at, para. 101 (f)
[278] Id. at, para. 103 (c)
[279] Id. at, para. 109.
[280] Id. at, para. 114 (a), (b), (d)
[281] CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 1 – 3.
[282] Id. at, para. 8.

‘An ‘institution’, in the context of children, is any placement that is not family-based.’ (para. 43)

And:

’Institutionalisation of persons with disabilities refers to any detention based on disability alone or in conjunction with other grounds such as ‘care’ or ‘treatment’.’

The latest guidelines clearly articulate the CRPD Committee's stance against residential care, or any form of out-of-family care for CWD. The document came after a report of the CRC Committee on the Day of General Discussion and the UNICEF ECARO’s White paper. The latter designated some role of SSRC for children, which might indicate that the CRPD Committee’s Guidelines on DI come as a reply to that document. Importantly, the COVID-19 pandemic highlighted severe issues in institutions housing people with disabilities, described as 'hotbeds' of infection with higher death rates than other settings, reinforcing the stance against any form of institutionalisation.[283]

4.3.8. Guidelines on Article 14 the right to liberty and security

In the 2015 Guidelines on Article 14, the CRPD Committee asserted that the deprivation of liberty of persons with disabilities (including children) on the basis of disability, as well as other reasons such as perceived risks, dangerousness, treatment, and other disability-linked reasons, violates Article 14. Such practices are discriminatory and constitute arbitrary deprivation of liberty.[284]

Both the Subcommittee on the Prevention of Torture and the Committee for the Prevention of Torture classify social care institutions and orphanages as places of detention under Article 4 of OPCAT. The HRC has stated that the ’placement of a child in institutional care amounts to deprivation of liberty within the meaning of article 9’. Thus, relevant bodies and experts

[283] E.g. Ciara Siobhan Brennan, *Disability rights during the pandemic: a global report on findings of the COVID-19 Disability Rights Monitor,* (2020). Lazar Stefanović, *Implications of Anti-pandemic measures of Serbian Authorities on the Right to Life for Persons with Disabilities*, *in* YEARBOOK HUMAN RIGHTS PROTECTION: RIGHT TO LIFE (Zoran Pavlović ed. 2021).
[284] Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, CRPD Committee, 2015.

recognize the institutionalisation of CWD as a deprivation of liberty.[285] This perspective reinforces the right to family life, given the scarcity of alternatives to family-based care that do not amount to *de facto* deprivation of liberty.

4.4. Joint statement of the CRC and the CRPD Committees on the rights of children with disabilities

The CRC and CRPD treaty bodies are obligated to cooperate on overlapping issues, avoid duplication of work and conflicts.[286] In 2018, a Joint Working Group on CWD was established by the two committees to address and harmonize approaches on overlapping issues. After several years of exploring interactions between the conventions concerning CWD and the right to family life, the treaty bodies adopted a Joint Statement (JS) on CWD in May 2022.[287] As part of this process, Jorge Cardona, a former member of the CRC Committee, conducted an analysis of the CRC and CRPD. The JS encompassed the question of alternative care and DI, and addressed several issues: non-discrimination, best interests of the child, respect for the views of children, elimination of violence, abuse and exploitation and the right to inclusive education.

The committees avoided to directly address the contested issue – the use of some types of residential care (small residential care) for CWD. The JS neither explicitly states nor implies the use of any specific form of alternative care; instead, it advocates for clear, adequately funded, and time-bound DI strategies, along with the development of support and services for CWD within family settings. The goal of these DI strategies is to end 'all forms of discrimination and segregation of CWD'.[288]

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[285] In general: NOWAK. 2019; Manfred Nowak, *Detention of Children for the Purpose of Educational Supervision*, *in* EUROPEAN YEARBOOK ON HUMAN RIGHTS 2020 (Gerd Oberleitner, et al. eds., 2020).
[286] See ‘

Jurisprudence and recommendations of the CRC and the CRPD committees’.
[287] *The Committee on the Rights of Persons with Disabilities and the Committee on the Rights of the Child Hold Panel Discussion on the Rights of Children with Disabilities*, OHCHR, (2022), accessed: 19th July, 2022, *available at* https://www.ohchr.org/en/press-releases/2022/03/committee-rights-persons-disabilities-and-committee-rights-child-hold-panel.; Committee on Rights of the Child & Committee on the Rights of Persons with Disabilities, 2022.
[288] Committee on Rights of the Child & Committee on the Rights of Persons with Disabilities, 2022.

Additionally, the committees emphasised the vulnerability of children with intellectual or psychosocial disabilities and children requiring high levels of support to institutionalisation.[289] The text does not imply the use of residential care by using some of the common words and sentences (e.g. such as in the case of the Resolution on children without parental care (2019)).[290] Conversely, it could be understood to imply that CWD should be cared for only in families, especially due to the statement that the goal of DI is 'to eliminate all forms of discrimination and segregation of CWD' While the CRPD Committee views the placement of CWD in any out-of-family care as discriminatory, the CRC Committee, aligning with the GACC, considers small residential care as sometimes necessary and appropriate. Consequently, while the JS does not provide definitive answers about permissible forms of alternative care for CWD, it reflects a noticeable shift in the CRC Committee's stance, now exhibiting greater caution regarding small residential care without explicitly recommending it.

Indeed, the CRC Committee's COs, adopted after the JS during its 2630th meeting on 3 June 2022, expressed concerns about SSRC and advocated for strengthening family care to end the institutionalisation of young children.[291] For Croatia and Zambia, the CRC Committee advocated for DI, without implicitly or explicitly approving SSRC, while emphasising the development of family-based options.[292] Conversely, in most COs issued after the JS, the CRC Committee referenced the GACC, which explicitly recommend SSRC. The most recent instance of the CRC Committee openly advocating for small-scale residential care was in its COs for Czechia, adopted in September 2021.[293] Therefore, while the joint document by the CRC and CRPD Committees does not explicitly resolve the contested issue, it demonstrates a broad consensus between the two bodies on matters concerning family life and highlights the CRC Committee's tendency to refrain from explicitly endorsing SSRC.

[289] Ibid.
[290] See UNGA Resolution on Children without Parental Care (2019)
[291] CRC/C/CHL/CO/6-7, 2022.
[292] CRC/C/ZMB/CO/5-7, 2022.; CRC/C/HRV/CO/5-6, 2022.
[293] Concluding observations on the combined fifth and sixth periodic reports of Czechia*: Committee on the Rights of the Child, CRC/C/CZE/CO/5-6, 2021, para. 31 (f)

4.5. Day of General Discussion on children's rights and alternative care (2021)

The CRC Committee organized the Day of General Discussion on children's rights and alternative care (DGD 2021), drawing numerous stakeholders, including DPOs and NGOs focused on the rights of persons with disabilities. The adoption of a resolution on this issue in 2019 followed by a DGD in 2021 underscores the growing importance and existing discord among stakeholders that requires resolution. Indeed, the CRC Committee stated that DGD 2021 aimed to review 'normative discussions between the CRC Committee and the CRPD Committee'.[294] In the same period (2018-2022), the CRC and the CRPD committees also commenced a study on interactions of the two conventions with the intention to jointly address overlapping issues. The product of that initiative is a joint statement of the two committees on the rights of CWD issued in March 2022.[295]

At DGD 2021, submissions were received from 22 states, 13 NHRIs, four IGOs, 99 NGOs and NGO coalitions, along with several submissions based on children's inputs and numerous others from various stakeholders.[296] The substantial and diverse participation underscores the issue's importance, as well as the process's transparency and inclusivity. Moreover, this highlights the expanding role of non-state actors in international human rights lawmaking, albeit within the framework of traditional international law structures.[297]

The DGD 2021 report emphasizes that DI for children, including CWD, must be a 'worldwide priority', urging states to implement time-bound and adequately funded DI policies.[298] Funds for institutional care should be redirected to family- and community-based care and national and international donors, whether public or private, should not support institutionalisation.[299] It is also recommended that states prioritize family-based options when alternative care is necessary.[300] Regarding indigenous children, the report recognizes the historical injustice of

[294] *2021 day of general discussion: Children's rights and alternative care*, UN OHCHR, (2021), accessed: 10th March, 2023, *available at* https://www.ohchr.org/en/events/days-general-discussion-dgd/2021/2021-day-general-discussion-childrens-rights-and.
[295] Committee on Rights of the Child & Committee on the Rights of Persons with Disabilities, 2022.
[296] *Submissions to the Day of General Discussion 2021*, accessed: 10th March, 2023, *available at* https://owncloud.unog.ch/s/j0qk6e5tZMjghsK.
[297] Pauwelyn, et al., EUROPEAN JOURNAL OF INTERNATIONAL LAW, (2014).
[298] 2021 Day of General Discussion Children's Rights and Alternative Care: Outcome Report, Committee on the Rights of the Child, 2022, para. E (2).
[299] Id. at.
[300] Id. at, para. A (1,2), B (1), D (1), E (1)

their separation from families and communities, recommending that 'any placement should be with a member of the child's family, as defined by local custom and practice, or community as the first priority'.[301]

Notably, the recommendations do not explicitly address residential care. This is an indicator that the consensus on this type of care was not reached, and that the issue of discord stayed unresolved after this forum.[302] However, this also speaks to the increased recognition of the CRPD and the influence of the CRPD Committee and NGOs that advocate for the complete DI, where residential care is not an option. Nevertheless, the report calls on states to 'prioritize' family-based care when alternative care is necessary, aligning with CRC guidelines, yet this phrasing does not explicitly exclude certain forms of residential care.

Moreover, Kenya's submission called for the complete DI, by providing alternative care only in families where it is not possible to provide care in the immediate family, for which it provided arguments, including the possibility (in family-based care) to acquire cultural and religious identity, which in institutions is not attainable, and a number of other issues of institutional care.[303] Conversely, Portugal argued that appropriate residential care should remain an important option within the spectrum of alternative care available.[304] Rosemary Kayess, Chairperson of the CRPD Committee, asserted that placing CWD in residential care denies their right to family life and constitutes discrimination.[305] The point of the placement of CWD in residential care as a form of discrimination is explored further in relation to the possible ways of addressing the divide in the section 'Possible solutions to the discord'.

Compared to the previous DGD report on children without parental care,[306] the DGD 2021 deals with substantive questions of alternative care in much greater detail. It was also a product of the participation of a larger number of different stakeholders, including 22 states, thus its impact on the development of international law might be significant. The presence and regard

[301] Ibid. Id. at, p. 33, para. D (2).
[302] Ann Skelton, CRC Committee member, noted the lack of consensus on this issue in the opening meeting: id. at, p. 11
[303] Kenya's submission to the CRC Committee for DGD 2021, accessed 16th April 2024, available at: https://owncloud.unog.ch/s/j0qk6e5tZMjghsK?path=%2F1.%20States#pdfviewer.
[304] Portugal's submission to the CRC Committee for DGD 2021. accessed 16th April 2024, available at: https://owncloud.unog.ch/s/j0qk6e5tZMjghsK?path=%2F1.%20States.
[305] Committee on the Rights of the Child, 2022, p. 25.
[306] See 'Day of General Discussion on children's rights and alternative care (2021)'.

for the CRPD in the report is much higher than in previous documents, although not completely aligned with it, as explained.

4.6. Conferences of states parties

Conferences (or meetings) of states parties to the CRC are convened every two years, and to the CRPD annually. These meetings are organized under the auspices of the Secretary-General of the UN. For the CRC, the meetings of states parties are procedural and primarily focus on electing new members biennially. Reports on these meetings from 2008 to 2020 do not mention discussions on alternative care of children.[307] The current format does not facilitate discussion on the implementation or interpretation of specific CRC articles. The CRPD Conference of states parties, an annual event, foresees dialogues between the parties on the implementation of the CRPD. However, an examination of all reports from 2008 to 2021 revealed no relevant information on aspects pertinent to this study.[308] States parties to the CRPD have not yet addressed issues of alternative care and institutionalisation of CWD in their conferences.

Therefore, the major discussions on the issue are between different non-state stakeholders, including the treaty bodies and NGOs with sporadic involvement of states parties. Analyses of UNGA resolutions and treaty bodies' works confirmed this. Potentially, these meetings could yield non-binding recommendations on implementing the conventions, focusing on alternative care, family life, and institutions for CWD. Nonetheless, the parties could use conferences to authoritatively interpret CRPD norms if they choose to.

4.7. Conclusion

The CRC Committee has been adjusting its approach to the issues surrounding alternative care and CWD, including by dynamically interpreting some of the CRC provisions, in its more than 30 years of existence. This analysis reveals that the CRC Committee addressed issues

[307] Reports available at: https://www.ohchr.org/en/treaty-bodies/crc/meetings-states-parties-elections
[308] Reports available at: https://www.un.org/development/desa/disabilities/conference-of-states-parties-to-the-convention-on-the-rights-of-persons-with-disabilities-2.html. Last accessed on 16th April 2024.

overlapping with the CRPD as early as in its GC 9 on CWD. Although adopted several months before the CRPD, GC 9 considered numerous CRPD provisions, even though the CRPD was not yet an applicable rule of law at that time. Hence, the CRC Committee was not obligated to do so but acted in good faith. However, GC 9 overlooked CRPD provisions directly related to the right to family life and alternative care (Articles 19 and 23), making the approach seem ambivalent and inconsistent.

GC 9 also addresses the use and quality of SSRC, a theme that was later upheld in the GACC, to which the CRC Committee continues to refer in its COs to the present day. However, the CRC Committee's GC 24 on access to justice (2019), which replaced an old GC on access to justice from 2007, did indicate a slight change in the approach to residential care, by naming goal of such placement the reintegration, while the older GC spoke of rehabilitation.[309] Although these GCs did not directly address alternative care for CWD, they reflected increased protection of children's right to family life. In the last several years (2019-2022) the CRC Committee rarely explicitly recommended the residential care in its COs, and after the adoption of JS on CWD together with the CRPD Committee, the CRC Committee did not recommend such care, whilst in a couple of cases it expressed concerns over trans-institutionalisation in SSRC. Importantly, the CRC Committee endorsed Poland's commitment to banning residential care for children under seven and ten years of age, supporting further restrictions on such care. Still, the GACC, a resolution calling for the use of SSRC among other things, stayed a regular reference in most of the COs. The CRC Committee based its dynamic interpretation (in relation to the prohibition of residential care for young children) on the scientific evidence of the harm of residential care.

The CRPD Committee addressed the issue of SSRC for CWD in its GC 5 on living independently and being included in the community, by asserting that it is an inappropriate form of care and dangerous for CWD. The CRPD Committee stayed mostly consistent in its approach to this form of care in the years after the adoption of GC 5, with slight differences in wording used to condemn the use of such care and recommend the provision of alternative care in family settings. The CRPD Committee did not dynamically interpret the critical provisions, however its approach to the interpretation can be described as teleological effectiveness - i.e. the flexible wording of Article 23 (5) was interpreted having in mind the purpose of such a norm and the background justification – to end historical and widespread institutionalisation

[309] See 'Other CRC Committee's General Comments'.

of CWD. It is important to note that this interpretation did not come on the expense of wording and context, but it rather placed emphasis on the object and purpose without neglecting the wording and context. Moreover, it was shown that the internal context (CRPD text and the Preamble) is especially conducive to the interpretation expressed by the CRPD Committee – CWD should be provided alternative care only in family settings.[310]

The Joint Statement on CWD demonstrates possible consensus between the Committees on the right to family and provision of alternative care, aligning their approaches significantly, though it omits explicit discussion of small residential care, highlighting ongoing disputes. Regardless, it can be assumed that the trajectories of interpretations and general approaches to alternative care of both treaty bodies move in a direction of alignment, which could be supported by further scientific evidence and knowledge.

The following section explores how this alignment can be reached by dynamically interpreting the treaties and applying other techniques for the resolution of norm conflict in international law in order to reach a legitimate and valid standard that will have a high level of authority and normativity, despite the non-binding nature of treaty bodies' decisions and UNGA resolutions.

[310] See 'CRPD Committee and interpretation'.

5. Divergence resolution and the future for the right to family life

Several techniques and rules can help avoid or resolve conflicts. The ILC's report on the fragmentation of international law addresses this issue, drawing on the work of scholars like Joost Pauwelyn, Jenks, Pulkowski, and Simma, who have notably influenced the report. Techniques, principles, and rules examined in the section are the use of dynamic interpretation to resolve conflicts, the presumption against conflict principle, the better law should prevail principle of human right treaties, *lex posterior* and *lex specialis* principles and termination or suspension of norms in successive treaties.

Pauwelyn argues that if a conflict is not solved with conflict-avoidance techniques ‘an apparent conflict’ becomes ‘a genuine’ one. The author further explains that conflicts in applicable law exist when exercising a right or obligation under one norm breaches another and that such conflicts can be ‘necessary’ or ‘potential’. Since this situation presents a 'potential conflict', this section will explore suggestions for resolving it.[311]

In a situation of conflict in applicable law, in the trade law sphere, Pauwelyn argues that the real question is which of the two conflicted norms apply in each case, which is an issue of hierarchy of international law norms.[312] In the IHRL regime such an approach would yield unsatisfying results. One reason this approach is inadequate is that the potential conflict (or a divergence) in this case is an intra-regime issue. Secondly, there is no centralized international adjudicator that would rule in such a situation which of the norms prevails. It was argued above that the resolution through the hierarchy of norms is not the best approach as it is not sensitive to differing level of normativity that can carry a norm that is not an obligation, or soft law norms.[313] Also, the vagueness of all the provisions concerned makes them more conducive to the harmonisation through interpretation.

Rules of treaty interpretations and techniques for conflict resolution should guide and facilitate the harmonisation. After all, states and non-state stakeholders will be the ones who will, by reaching a sort of an agreement, promote a certain solution that will harmonize the treaties. Where a number of legal arguments point into one direction more than the other, this forms a

[311] See ‘Identifying a conflict’.
[312] PAUWELYN. 2003, p. 5-6.
[313] See ‘The nature of compared norms and overlaps’.

strong guidance for stakeholders in reaching the solution and increases the normativity of such a solution.

5.1. Dynamic interpretation as a resolution technique

Analysis of the CRC and CRPD using VCLT treaty interpretation tools revealed a divergence regarding the permissibility of residential care as a form of alternative care and, more broadly, the right to live in a family environment.[314] It was further argued that this divergence is a product of different background contexts and thus purposes of the respective norms. The purpose of Article 20 CRC is to primarily offer protection to children deprived of their family environment due to an unlimited variation of reasons for the deprivation. On the other hand, one of the primary issues CRPD addresses is the eradication of institutionalisation, which is a backbone of this treaty (arguably together with articles on non-discrimination and equality before the law). The CRPD sought to persuade states to end the omnipresent institutionalisation of CWD by providing alternative care for in family settings.[315] It was argued that the treaty bodies will most likely create interpretations of the respective norms that will be in a starker divergence than the original CRC and CRPD meanings, due to differing purposes and the treaty bodies' interpretations often putting emphasis on a teleological approach (unless they work together to close the gap and bring forward unison solutions).[316]

Firstly, the analyses of UNGA resolutions on the rights of the child and persons with disabilities, and secondly, the doctrine of the two treaty bodies, confirm this. After the CRC Committee's GC 9 on CWD and the UNGA Resolution Guidelines for Alternative Care of Children (2009) there was a significant difference between the CRPD and the newly developed standards for alternative care that were based on Article 20 CRC. During this period, DPOs and NGOs advocating for the rights of children and adults with disabilities participated minimally in the drafting of these documents, coinciding with the CRPD Committee's recent establishment in 2008. Perhaps the stakeholders' relative absence, including the CRPD Committee, and the CRPD treaty's recentness led to its minimal consideration in those resolutions. Therefore, despite its status as an applicable international law rule, the CRPD was

[314] See 'Conclusion on the norm divergence'.
[315] See 'Conflict of purposes'.
[316] See 'Why interpretations create more divergence'.

side-lined due to insufficient advocacy by transnational norm entrepreneurs and issue networks to integrate it more thoroughly into those resolutions.

This occurrence shows that respect for general treaty interpretation rules (and cooperation provisions in the treaties) may be overshadowed by the influence of stakeholders, especially non-state ones as seen in this case. Later resolutions and documents, emerging from drafting processes, show greater stakeholder participation closely aligned with the CRPD Committee's positions, resulting in more balanced but sometimes confusing outcomes.[317] These findings are in line with the TLP's approach that emphasizes the importance of non-state stakeholders, especially NGOs.

The resolutions and the two committees have interpreted relevant norms dynamically on several occasions. A dynamic interpretation is not always easy to discern from an interpretation that clarifies ambiguities but does not necessarily advance the rights or obligations, such as in the case of the GACC (2009) which called for the development and use of small residential care instead of large residential care. Arguably, this is not dynamic interpretation because Article 23 (3) CRC states that authorities can provide alternative care in 'suitable institutions for the care of children.' Thus, the new resolution merely clarifies this in light of current understandings of suitable institutions, without introducing new standards. Conversely, according to Pauwelyn, such an interpretation could be regarded as evolutive, as the document asserted a specific interpretation of an important concept, and thus effectively restricted and specified how states should implement it.[318]

In case of a recommendation to prohibit the provision of residential care to children under three years of age, the GACC had without a doubt resort to a dynamic interpretation and the advancement of standards.[319] In this case the document did not dynamically interpret a single CRC term, but rather created a new standard from scratch, unlike in the previous example of an appropriate form of residential care. To justify this, the GACC cited scientific evidence and practical knowledge about the harmful effects of residential care on young children. Therefore, the constantly expanding knowledge and science were regarded as solid enough basis for the evolution of the CRC, which is a well-known, but not an only mechanism of a human rights

[317] See '
Drafting process and the divide'.
[318] PAUWELYN. 2003, p. 266.
[319] See 'UNGA Guidelines for the Alternative Care of Children (2009)'.

treaty evolution. The temporal nature of treaty interpretation is embedded in the VCLT Article 31 (3)(c), and has been widely used by international and regional courts and interpreters. Pauwelyn elaborates on cases of ICJ where this court asserted that an evolutive interpretation of a concept 'exhaustible natural resources' was necessary 'in the light of contemporary concerns of the community of nations about the protection and conservation of the environment (not as it was understood in 1947)'. Thus, the ICJ did not narrow down the justification to a scientific knowledge and practice that had emerged in the meantime, but also the 'concerns of the community of nations', indicating a rather broad scope of justifications that could be used to legitimize an evolutive interpretation, that is not limited to 'any relevant rules of international law applicable in the relations between the parties', as Article 31 (3)(c) VCLT stipulates.

Pauwelyn elaborates that dynamic interpretation can be successfully employed to resolve a conflict of norms too, but only 'apparent conflicts' not 'genuine conflicts'. An apparent conflict in Pauwelyn's terms, shares a lot with a notion of norm divergence of Jenks. According to Pauwelyn, apparent conflicts exist where the interpretation can solve them. He proposes that effective interpretation may be a tool for resolving an apparent conflict.[320] We explained that an effective interpretation of Article 23 (5) CRPD renders a meaning that obligates states parties to provide alternative care only in a family setting (and not in any type of institution).

Considering that interpretation to harmonize the two treaties could go in two directions – to give 'full effect' to the CRC norm or to give full 'full effect' to the CRPD norm, it raises the question of which outcome would be the most effective for both norms. In case full effect was given to the CRC norm, the CRPD norm would be simply redundant, and the *status quo* regarding the permissibility of the provision of institutional care (when necessary and in suitable institutions) maintained. Hence, such an outcome would clearly go against an effective interpretation of the CRPD and largely undermine the purpose of the treaty. On the other hand, if the full effect was given to the CRPD norm to harmonize interpretations, the CRC would need to be interpreted to exclude the possibility of provision of any form of residential care to CWD. This would not go against the effectiveness of the CRC norm, as the CRC in general including Article 20, clearly favours the provision of care in a family setting for all children. To achieve such a result, certain generic terms susceptible to dynamic interpretation would have to be identified and interpreted. CRC terms and phrases that are particularly prone to dynamic interpretation due to their generic nature or their vagueness include 'if necessary',

[320] PAUWELYN. 2003, p. 247.

'placement', 'suitable institutions' (Article 23 (3) CRC). For instance, one could clarify the necessity of institutional care for CWD by limiting it to minimal cases. This would practically exclude the provision of any form of residential care in all cases, unless it is absolutely necessary to eliminate a real and imminent danger to a disabled child, and only for the time needed to eliminate such danger, after all measures have been taken to place the child in an emergency family care. Special Rapporteur Catalina Devandas-Aguilar called stakeholders to 'review' Article 20 (3) CRC regarding the meaning of 'suitable institutions' and update the GACC to uphold the more advanced standards of the CRPD.[321]

Nonetheless, some solutions could be criticized as revising the CRC or undermining the continuity of this treaty. Likewise, it could be argued that the CRPD should be interpreted in a way that avoids conflict with the CRC, applying the principle of the presumption against conflict.

5.2. The presumption against conflict

This principle in legal interpretation aims to avoid conflicts between overlapping older and newer treaties. Based on the 'presumption of continuity', this principle requires treaties to be interpreted in light of applicable rules of international law, as outlined in VCLT Article 31 (3)(c).[322] Applying this principle in the current case would likely lead to interpreting the CRPD as allowing states to provide alternative care for CWD outside families (in some form of residential care), after exhausting family-based options, similar to the CRC.[323] In this scenario, the CRPD norm would become redundant and lose its effectiveness, as described above. In other words, the presumption of continuity would prevent a newer treaty from furthering rights of its target group. This likely represents the main flaw of the presumption against conflict, particularly within the context of IHRL. International and regional human rights instruments and human rights bodies are famous for the development and application of a doctrine of a dynamic treaty, a treaty as a living instrument. In IHRL it is considered an inherent characteristic and is more or less present in other branches of IL.

[321] A/HRC/40/54, UN Human Rights Council, 2019, para. 51.
[322] PAUWELYN. 2003, p. 240.
[323] See Article 23 – special assistance and protection of CWD and their families'.

Interestingly, VCLT Article 31 (3)(c) can both support the presumption of continuity and evolutive interpretations. This norm is commonly regarded as a legal basis for evolutive interpretations of international treaties and the reflection of temporal nature of treaty interpretation. Similarly as in human rights law, Pauwelyn claims that in the WTO law evolutionary interpretation is a norm, while the contemporaneity in interpretation is an exception.[324] The vague terms and open-ended wording of provisions suggest that drafters intended these provisions to remain open to further interpretation and evolution, as seen in CRC Article 20 (3) and CRPD Article 23 (5).[325] Thus, an older treaty, in this case the CRC, should not forestall the advancements of rights promoted in the overlapping instrument.

Therefore, the continuity presumption in the present case would not stand, due to the principles of treaty dynamism commonly applied in human rights law (and in other branches of IL),[326] then the development of IHRL, and more specifically due to the provision of the CRC which prescribes its provisions shall not stand in a way of more conducive provisions of international and domestic law (Article 41). Highlighting flaws in the presumption against conflict principle, Pauwelyn specifically addresses the issue of legal stagnation.[327] The need for stability in IL is not disregarded in this case, as the changes promoted by the CRPD fit well into its context, including the CRC. It simply advances the protection of rights in the direction already established by the CRC.

5.3. Better law dilemma

The CRPD prescribes that it shall not affect any provisions of other treaties (and domestic law) that are more favourable to the rights of CWD (Article 4 (4)). Almost identically, the CRC prescribes that its provisions shall not affect others that are more conducive to the rights of all children (Article 41). These articles embody two critical principles: the principle of non-retrogression and the application of more favourable provisions. This means that the conventions shall not regress already achieved levels of protection of the rights of children and that a more favourable norm to the rights of children should apply. Della Fina acknowledges

[324] PAUWELYN. 2003, p. 268
[325] Id. at, p. 267
[326] Pauwelyn makes a point about the WTO interpretation where evolutionary interpretations is a norm while contemporaneity is an exception: id. at. P. 268
[327] Id. at, p. 242

the dual function of these 'saving clauses'.[328] Equivalent provisions are found in other UN human rights instruments.[329]

Accordingly, if a CRPD provision better serves the rights of CWD compared to a CRC provision, it should take precedence (and *vice versa*). If we unpack further those norms, it can be argued that a conflict does not exist in a case where a human rights treaty norm overlaps with a norm that is more favourable to the rights of their mutual beneficiaries. Although those provisions are not conflict clauses in a strict sense, they could function as such in a specific case. So, potential conflicts or the divergence as this one (where one norm prescribes a more far-reaching obligation to states parties in order to better protect the rights of beneficiaries) can never be in a conflict with a less reaching norm of a human rights treaty (or another rule of international and domestic law) that is not as effective. The provision regarded as the better law will prevail.

Another critical question concerning the better law clauses in the present case is 'which law is actually better'? An issue of normative dissonance may always arise, as different perspectives, or 'observational standpoints' in the words of TLP scholarship, can give different views of what law ought to be, and this certainly is the case here. The overall issue can be described as a dissonance of normativity, though the discussion should not be limited to a single factor (e.g. scientific findings about the impact of such care on children). Looking for an answer only in e.g. developmental psychology can be one of elements in discussions needed to reach stakeholders' consensus in a form of (soft) law. Still, international law scholarship and practice, and legal theory have ways of dealing with norms divergences as this one. Hence, an array of different legal arguments (supplemented with empirical evidence) is needed to reach a solid argumentation on how to solve the present issue.

The normative dissonance in the present case is easily detected in stakeholders' position papers (and other advocacy tools): one interpretive community holds that residential care in any form should not be provided to any child, whilst the other community holds that such a form of care can be appropriate and should exist in an alternative care system. We have already named these groups interpretive communities, as their dissonance can be framed as one pertaining to treaty interpretation and that 'members' of those communities include treaty bodies. They could be

[328] VALENTINA DELLA FINA, et al., THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY (Springer. 2017).
[329] Article 23 CEDAW, Article 81 ICPRMW, Article 50 ICCPR, Article 28 ICESCR.

also called transnational issue networks, normative or advocacy communities or epistemological communities and none of the meaning would be lost. Their divide was elaborated in the section ‘

Drafting process and the divide’ where the inputs for a new resolution on the rights of the child were analysed.

To further reflect on the issue of normative divide a discussion between UNICEF and other stakeholders is revisited here that some forms of residential care are better for children, aligning with the GACC. The 2020 White Paper issued by UNICEF ECARO made this point.[330] Firstly, it stated that a consensus among actors, based on empirical evidence, holds that large institutions are unsuitable for children's care.[331] This view is also reflected in the GACC, which recommend transitioning from large institutions to family and small residential care. Despite this consensus, the White Paper introduces 'a new and important discussion' on whether small residential care is appropriate for children.[332] The White Paper made a case for the use of small residential care as one of the services in the ‘continuum of care’.[333] It argued that this form of care 'can at best play a marginal role' in care systems and does not fulfil children's right to a family environment, warning against over-reliance.[334] Emphasising the marginal role for such care, UNICEF ECARO aligned with the intention of parties who drafted Article 20 CRC as it was elaborated above.[335] Nevertheless, UNICEF ECARO promoted it as an important addition to child care systems and argues against its abandonment. Importantly, the White Paper has addressed the issue in relation to all children, not only CWD. In a later document, UNICEF (not UNICEF ECARO) omits any mention of residential care, focusing instead on measures to end institutionalisation and strengthen family-based care for disabled children, with an emphasis on the criticality of Article 19 of the CRPD.[336]

Conversely, some DPOs and international NGOs have claimed the opposite – that leaving a space for the use of such care in domestic child welfare systems will particularly harm CWD, as they were the ones who were historically placed out of families and left behind in some DI

[330] Stela Grigoras, White paper. The role of small-scale residential care for children in the transition from institutional to community-based care and in the continuum of care in the Europe and Central Asia Region (UNICEF Europe and Central Asia Regional Office 2020).
[331] Id. at, p. 5.
[332] Id. at.
[333] Id. at.
[334] Id. at.
[335] See section *Suitability of institutions* and *Marginal role and undesirableness of institutions*.
[336] UNICEF Disability Inclusion Policy and Strategy 2022-2030, UNICEF, 2022.

processes.[337] They support this claim with the present evidence of CWD being disproportionately represented in institutional care around the world. These organisations offered evidence, including a human rights monitoring report detailing Bulgaria's heavy reliance on small group care in its childcare system. According to that report, hundreds of small-scale residential institutions, called small group homes, have housed hundreds of CWD who did not benefit much or not at all from abandoning old and large institutions.[338] The replication of institutional culture, including cases of neglect have surfaced. The CRC Committee also noticed the issue with SSRC in some states parties.[339] Another concern is that states would redirect resources to small residential care instead to the development of support and services to families and family-based care.[340] This group of organisations has adopted the CRPD Committee's position on small group care but it has also widened its scope to all children, not only CWD. Despite basing argumentation at least partly on the historical and contemporary issue of institutionalisation of CWD in a much higher rate than other children, and also that CWD are left behind in DI processes, a group of DPOs and NGOs has actually called the UNGA to recognize the right to family for 'all children' and take measures to enable 'any child' to live in a family.[341]

Moreover, a coalition of child-rights NGOs and UNICEF, advocating for the conditional use of small residential care, has urged state parties to prioritize the protection of family life rights for CWD.[342] They argue that such measures are necessary to address social contexts that often discriminate against CWD and disproportionately deprive them of family life. UNICEF's White Paper also highlights expert consensus that small residential care should serve only as a transitional phase from institutional to family-based care, expressing concerns about its potential as a long-term solution, particularly for CWD.[343]

The White Paper made another critical point, which is the existence of an 'enormous gap' between the idealised image of high-quality, temporary, small residential care, which often replicates large institutional care and becomes a dead end for many children.[344] That is also the

[337] Allen, et al., THE LANCET CHILD & ADOLESCENT HEALTH, (2020).
[338] ROSENTHAL, et al. 2019.
[339] See section 4.2.4
[340] Eric Rosenthal, Position paper: The right to live and grow up in a family for all children Revised (2019).
[341] UN Disability and Child Rights Groups On Behalf of Children without Parental Care: Key Recommendations. 2019.
[342] Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care. 2019.
[343] Grigoras. 2020, p. 12-13
[344] Id. at, p. 13.

concern shared by the abovementioned disability organisations and experts. Moreover, the business of small group care seems to be blooming in some parts of the world, which is a special and grave concern for the wellbeing of the children with and without disabilities in those areas.[345] Finally, UNICEF's White Paper concludes with several recommendations, including ceasing all residential care for children under six and that CWD 'should always be prioritized when it comes to the placement in family-based care'.[346] During implementation, this approach would require states to develop policies that prioritize DI of CWD over other children, the development of support and services for families of CWD and the development of foster care for CWD. A question whether it is legitimate and possible to reach a consensus on differing international standards in the relation to residential care and alternative care for CWD and all other children, or if standards for all children should be advanced arises here. This issue is explored in the section 'Possible solutions to the discord'.

With regards to treaty interpretation, it should be noted that the CRPD is a treaty on the rights of persons with disabilities and interpreting this treaty as pertaining to other groups of people might be seen as expansionism. The interpretation of the CRPD offered above seeks to stop institutionalisation of CWD and restore their right to live in a family environment. The CRPD Committee, an authoritative body composed of experts nominated by states parties, upholds this interpretation and claims that small residential care is particularly harmful for children.[347] Such an interpretation is in the spirit of the CRPD, the wording, the context and most prominently its purpose. The CRPD rules do not protect non-disabled children, and the CRPD Committee has not attempted to widen the scope of the beneficiaries of the Convention, although it did express that such care is not harmful only to CWD.

Following that, searching for a solution for the divergence needs to be restricted only in relation to CWD, as the critical CRC and CRPD norms overlap only when it comes to this group of children and not all children.[348] Indeed, an expansive interpretation of the CRPD would go *contra legem*, which is an 'inherent limitation of interpretation'.[349] Certainly, human rights advocates are not restricted by such rules and may demand what they consider appropriate.

[345] See for example: Tess Guiney, *"Hug-an-orphan vacations":"Love" and emotion in orphanage tourism*, 184 184 THE GEOGRAPHICAL JOURNAL (2018).
[346] However, in another recommendation the author wrote that 'all children, including those with disabilities, are prioritized for family care'. In Grigoras. 2020, p. 30, 33.
[347] This sentence of GC5 text does not read 'CWD' or 'all children'.
[348] See The nature of compared norms and overlaps
[349] PAUWELYN. 2003. p. 245.

However, their positions might lack robust legal support in such cases. This does not imply that the harmonisation of interpretations cannot take various forms, independent of the legal methods examined here, provided a consensus among all relevant stakeholders is achieved. Consequently, interpretative communities could converge on a solution that favours an expansive interpretation; if the state parties responsible for implementation accept this, then there would be no cause for concern.

The previous examination of conflict avoidance techniques, namely the presumption against conflict and the better law, has not rendered satisfying results. In other words, the matter has not been settled in a manner that is solid enough to withstand much criticism. On the other hand, an interpretation to give full effect to the CRPD, which at the same time increases effectiveness of the CRC, is a solid legal argument. In that case, the CRPD which prescribes the provision of alternative care only in a family setting for CWD is given full effect and the CRC interpreted having this in mind. At the same time, the effectiveness of the CRC would increase as this document strongly favours family care and institutional care is allowed more as an exception than a rule. The interpretation of the CRC, however, would need to be limited to CWD only. However, if stakeholders agree, this scope could expand to include all children. This is hard to expect considering that there is no such consensus between stakeholders anywhere in the sight.

5.4. Termination or suspension of a norm

Article 59 VCLT prescribes rules for treaty termination and suspension of operation.[350] The provision of Article 59 VCLT does not help in the present case for several reasons. The VCLT prescribes that an earlier treaty shall be considered terminated if a newer treaty is related to the same subject matter and it appears that the matter should be governed by the newer treaty (para. 1 (a)). In the CRC and the CRPD it is not possible to come to such a conclusion, although they do relate to the same subject matter. This ambiguity primarily stems from the wording of CRPD Article 23 (5), which allows various interpretations and does not clearly indicate an intention to terminate the corresponding CRC provision. Also, in cases where provisions of treaties are so significantly incompatible that the application of two treaties is not possible at the same time

[350] Vienna Convention on the Law of Treaties UNTS, 1155, p. 331., A/CONF.39/11/Add.2, 1969. Article 59.

(para. 1(b)), an older norm shall be regarded terminated. As previously explained, the critical norms can be applied at the same time without breaching any of the norms.[351]

Finally, there is no sign of the intention of parties to suspend the later treaty's norm, neither in the text of the treaty or in preparatory works (para. 2). However, the intention to advance the protection of the family life for CWD in the CRPD as compared to the CRC is well-established and explained. Hence, this idea of a later, more focused, and presumably more advanced treaty as one that prevails is worth of pursuing further. Article 30 VCLT is closely related to Article 59 VCLT and applies when it is not possible to determine whether one treaty is supposed to terminate or suspend operation of an earlier one, that regulates the same subject matter.[352] Giegerich describes Article 30 (3) VCLT as the codification of *lex posterior* principle.[353] A VCLT commentary by the ILC explains that Article 30 comes to the scene only when Article 59 does not apply in a specific case, in other words – when it cannot be determined that parties intended to abrogate or suspend the operation of a previous treaty.[354] Here, a question of the application of *lex specialis* and *lex posterior* principles in the present case becomes particularly relevant.

5.5. Lex specialis

The concept of *Lex specialis derogat legi generali* dictates that one (or more) of the treaties' provisions should prevail over another provision of a more general treaty or a norm of general international law. This doctrine of legal reasoning, which has a long history, was not codified in the VCLT. The common understanding is that special law should prevail over general law because it is more specific and effective, and more accurately reflects the parties' intentions.[355] Pauwelyn contends that this represents a subjective element of legal interpretation, similar to *lex posterior*, aimed at explicating the most recent and relevant intentions of the parties.[356]

[351] See 'Conflict in a strict sense'.
[352] Thomas Giegerich, *Article 59. Termination or suspension of the operation of a treaty implied by conclusion of a later treaty*, *in* VIENNA CONVENTION ON THE LAW OF TREATIES: A COMMENTARY (Oliver Dörr & Kirsten Schmalenbach eds., 2018), p. 1084.
[353] Id. at.
[354] Yearbook of the International Law Commission Vol. 2, A/CN.4/SER.A/1966/Add.l, (1967), United Nations, p. 256.
[355] PAUWELYN. 2003, p. 387; A/CN.4/L.682, International Law Commission, 2006, p. 40, para. 67.
[356] PAUWELYN. 2003, p. 387-388.

The ILC describes *lex specialis* as an 'interpretative guideline' and elaborates that its use should have more of a supplementary character.[357] As such, it should be 'taken into account' rather than used as the main tool in interpretation. To discern if this principle is applied in a particular case as an interpretive tool or a conflict-resolution tool might not be as easy since those functions can overlap. Moreover, the ILC contends that resolving such a question may not be crucial.[358] The use of *lex specialis* is appropriate also when solving conflicts that are not characterized as conflicts in a strict sense or genuine conflicts, according to the ILC.[359] On this point, Giegerich argues that *lex specialis* serves best as a conflict-resolving tool in broader conflicts and among treaties of the same regime, as in this case.[360]

Similarly to the identification of a conflict, in order to have two provisions in a *lex generalis – lex specialis* relationship there needs to be some overlap between them. This study demonstrates a vast overlap between the treaties and their relevant provisions. They overlap in regard to the subject matter, beneficiaries and timewise.[361] A prerequisite for this examination is that states in question have already ratified both treaties, otherwise if a state has ratified only one of those two the overlap and the conflict will not exist for that state. The overlap of the relevant norms concerning the two former elements (matter and time) is complete. In other words, those CRC and CRPD norms regulate states' behaviour in relation to the provision of alternative care and are applicable at the same time. The overlap *ratione personae*, or concerning the beneficiaries of the norms is, however, only partial. CRC Article 23 relates to all children, whilst Article 23 (5) and Article 19 CRPD relate only to disabled children. The CRC provision thus covers a broader range of beneficiaries, whilst the CRPD one is more specific.

CRC beneficiaries encompass CWD and all other children. It could be argued that the CRPD is more specialised in addressing the needs of persons with disabilities than other human rights treaties, due to its explicit focus on disability issues. As such, the CRPD should take precedence over other human rights treaties in matters concerning persons with disabilities, unless those treaties provide more favourable provisions. After all, the need for the CRPD came from the ineffectiveness of previous human rights treaties in addressing the rights of children and adults

[357] A/CN.4/L.682, International Law Commission, 2006, p. 40, para. 67.
[358] Id. at, p. 51, para. 92.
[359] Id. at, p. 50, para. 91.
[360] Jasper Finke, *Regime-collisions: tensions between treaties (and how to solve them), in* RESEARCH HANDBOOK ON THE LAW OF TREATIES (Cristian J. Tams, et al. eds., 2014).
[361] See 'Identifying a conflict.'

with disabilities. The CRPD is in a way more relevant to persons with disabilities than other human rights treaties as it is more 'contextually sensitive'.[362] he need for Article 19 CRPD arose from the pervasive institutionalisation of children and adults with disabilities, while Article 23 responded to the widespread placement of CWD in residential alternative care. Those issues have not been successfully remedied with any prior human rights treaty. Therefore, the CRPD is supposedly a more effective, contextually accommodated treaty to address issues faced by CWD. It is useful to remind readers of differing underlying justifications for CRC Article 20 and CRPD Article 23 (5) and Article 19 that have, after all, generated the diverging interpretations.[363]

Another important feature of this relationship is that the CRPD prescribes a more far-reaching obligation than the CRC in Article 23 (2). In that sense, the CRPD provision is also stricter in stipulating what states parties shall achieve. ILC reminded of the ECtHR doctrine of *lex specialis*, where a more detailed and stricter provision (Article 5 (4) ECHR) was identified as *lex specialis* to an overlapping provision (Article 13 ECHR).[364] The strictness of the *lex specialis* provision (Article 5 (4) ECHR) was found in the fact it prescribes a more far-reaching right, and its contextual sensitivity (in relation to the lawfulness of detention).[365] The aforementioned relationship was established between non-divergent provisions of the same treaty, hence *lex specialis* acted as an application of a more general provision in a specific type of situations.

In this case, Article 23 (5) and Article 19 of the CRPD prescribe stricter, more detailed obligations than Article 20 (2) of the CRC, making them lex specialis when care in a child's immediate family is not possible. The general rule of Article 20 (2) CRC is already contained in Article 23 (5) CRPD – the obligation to provide alternative care.[366] Thus, two crucial characteristics of this relationship are: the CRC provision includes beneficiaries of the CRPD provision (and all other children), and the CRPD obligation encompasses and extends beyond the CRC's obligation (the provision of alternative care only in a family setting). This analysis brings to a comfortable conclusion that the CRPD Article 23 (5) together with Article 19 is *lex*

[362] A/CN.4/L.682, International Law Commission, 2006, p. 48, para. 87.
[363] See 'Conflict of purposes'.
[364] Convention for the Protection of Human Rights and Fundamental Freedoms, ETS No. 5, 1950.; A/CN.4/L.682, International Law Commission, 2006; De Jong, Baljet and Van Den Brink v. The Netherlands, European Court of Human Rights, Application No. 8805/79, 8806/79, 9242/81, para. 60; Brannigan and McBride v. The United Kingdom, European Court of Human Rights, Application No. 14553/89, 14554/89, para. 76.

[366] A/CN.4/L.682, International Law Commission, 2006, p. 51, para. 91.

specialis to Article 20 (2) CRC. In that sense, Article 23 (5) together with Article 19 CRPD functions as application of the more general CRC provision (Article 20 (2) CRC).

However, the relationship becomes complicated with Article 20 (3) of the CRC, despite its guideline nature and lack of formal prescriptiveness. It was argued that the normativity of Article 20 (3) CRC goes beyond its non-prescriptive wording, especially thanks to UNGA resolutions that have upheld and elaborated further on the provision of institutional care (principles of necessity and suitability) and arguably 'hardened' its character.[367] When Article 20 (2) is taken in conjunction with Article 20 (3) CRC and its varying, but not negligent normativity, then Article 23 (5) together with Article 19 CRPD cannot mere be seen as application of the more general CRC provision. Article 23 (5) together with Article 19 CRPD stays *lex specialis* to Article 20 (2) CRC, they are both applied concurrently, but Article 20 (3) CRC is then partly set aside.

Despite its supplementary character, applying lex specialis here impacts the normativity of Article 20 (2, 3) of the CRC. The guideline paragraph (20 (3) CRC) is partly set aside in the sense of removing the possibility to provide alternative care in institutions for disabled children. The normative consequence on Article 20 (2) CRC is that it becomes stricter. The ILC discussion on the functions of *lex specialis* as the one of 'application', 'modification', 'exception', 'setting aside' or 'derogation' of a general rule is useful, but hardly a straightforward question. The ILC recognised that *lex specialis* functions often overlap and that even the use of a special rule as application of a general rule has some impact on the normativity of the latter.

Considering that the two provisions are considerably aligned and in the relationship of slight divergence, the application of *lex specialis* only slightly departs from the normative content of the general rule. In other words, when providing alternative care to CWD states should have in mind that Article 23 (5) together with Article 19 CRPD do modify Article 20 (2) CRC in the way that it prescribes the provision of alternative care for CWD only in a family setting. The CRC Article 20 (2-3) is still applied in that case but in the way determined by the *lex specialis*.

[367] See '

UN Resolutions'.

However, as observed, lex specialis is a subjective element intended to clarify the most relevant and detailed intentions of state parties.[368] Here, the question of all resolutions on the rights of the child, adopted by UNGA, as mirrors of states' understanding, and interpretation of the relevant treaties becomes relevant. Could UNGA resolutions calling for the development of some forms of residential care for all children, including CWD, be seen as state expressions that override the treaty-based *lex specialis*?

The fact that UNGA resolutions are not binding is relevant; however, their normative potential should not be overlooked, as already elaborated above. It has been demonstrated that, until relatively recently, UNGA resolutions largely disregarded the CRPD rules and interpretations by the CRPD Committee. Notwithstanding, with UNGA Resolution on the rights of children without parental care (2019), the CRPD provisions found their way into the text of this resolution. Also, language that explicitly mentions development of some forms of residential care was avoided. This indicates that the CRPD Committee and stakeholders advocating for an effective interpretation of the CRPD have increased their influence, and that the CRPD status as *lex specialis* is becoming recognised, whether intentionally or not. Also, it should not be neglected that UNGA resolutions on the rights of the child had not specifically address disabled children where they called or developed standards for the provision of residential care. Hence, this could be understood as staying in line with the general rule, and leaving other stakeholders with a task of developing further and promoting standards of the other treaty, hence of the *lex specialis.* This scenario seems plausible, as we have seen that the CRC Committee and the CRPD Committee had not cooperated on their overlapping issues until 2019, despite being obligated to do so.

It has been established that the *lex specialis* principle should not be applied automatically but should rather serve as a supplementary means for interpretation and resolving conflicts or divergences. Adding to that regard the unquestionable existence of some level of normativity when it comes to the provision of residential care as a form of alternative care (which was largely solidified through a series of UNGA resolutions) the consideration of *lex specialis* as a tool that unequivocally solves all the issues would be naïve. However, the undeniable relationship of the CRPD and the CRC provisions as one of a special and a general rule, and

[368] See note 356.

its characteristics, is an important aid in understanding and suggesting how the divergence should be tackled in the future.

5.6. Lex posterior

Lex posterior derogat legi priori principle is another tool that can help in finding a solution for the present issue. The basic assumption behind this principle is that a later law supersedes an earlier law, as it is a more recent expression of parties' will. The VCLT sets out several rules regarding successive treaties, such as the CRC (1989) and the CRPD (2006), in Article 30. The VCLT identifies two scenarios: treaties with identical parties and those without. In the present case, the CRC and the CRPD do not have identical parties. For instance, the European Union is a party to the CRPD but not the CRC, while Lebanon has ratified the CRC and only signed the CRPD.[369] Still, a large majority of UN members have ratified both treaties.[370]

When determining temporal points of relevance for this analysis, three categories arise – time of adoption of a treaty, time of the entry into force and time of accession to a treaty by a party. From the perspective of human rights evolution, the dates of treaty adoption appear to be the most relevant. Naturally, more recently negotiated treaties better reflect the current intentions of the negotiating parties. They are negotiated within a context that considers new knowledge and circumstances relevant to the subject matter since the negotiation of previous treaties. The ILC endorsed the view, held by many scholars, that the time of treaty adoption is most significant.[371] Following this standard, there is no doubt that the CRC is an earlier treaty.

Given that this dissertation explores the interaction between the two treaties and that countries examined in the parts II, III and IV of the dissertation have accessed both treaties, the *lex posterior* analysis should be approached in accordance with Article 30 (4)(a) VCLT. This provision prescribes that where parties to both treaties are non-identical, Article 30 (3) VCLT will apply to those that are parties to both treaties. Prior to that, it is important to establish if the CRPD, the later treaty, contains clauses specifying if it is subject or not incompatible with

[369] As of the 12th May 2024.
[370] Ratification Status for CRC - Convention on the Rights of the Child, 2022, Date, 2022) UN Treaty Body Database).; Ratification Status for CRPD - Convention on the Rights of Persons with Disabilities, 2022, Date, 2022) UN Treaty Body Database).
[371] A/CN.4/L.682, International Law Commission, 2006, para. 232.

the CRC, in accordance with Article 30 (2) VCLT. Such clauses are not explicitly mentioned in the text of the CRPD. It can be safely said that the CRPD is not subject to the CRC, as the CRPD was not created in connection to the conclusion of the CRC, or in relation to the interpretation and application of the CRC provisions.

Addressing incompatibility, the ILC contends that absent a specific derogation clause, interpreters must determine whether the parties intended to derogate from or supplement the earlier treaty.[372] The fact that the CRPD text recalls all previous UN human rights treaties, including the CRC in its Preamble, indicates there was no intention to derogate any of those, but rather build on them.[373]

Examining the relationship's characteristics reveals that the CRPD supplements rather than derogates the CRC. The relevant norms are not in conflict, but rather a divergence as explained earlier. Essentially the earlier and the later norms point in the same direction, hence there is no need to derogate from earlier norms (from Article 20 CRC). The later norm (Article 23 (5) CRPD) is more far-reaching, and thus it only supplements the earlier (CRC) norm. Moreover, the nature of the UN human rights law is one of interdependence, indivisibility, and interrelatedness.[374] All UN human rights treaties constitute one comprehensive human rights regime where treaties supplement and reinforce each other.

It is established that in the present case Article 30 (3) VCLT applies, in accordance with the rule of Article 30 (4)(a) VCLT, primarily due to the fact that the two treaties do not have the same parties. Under these circumstances, the CRPD norm, as the later treaty, should prevail since it presumably better reflects the parties' current will concerning CWD. If this is the case, then there is substantive overlap of a *lex specialis* and a *lex posterior* principles when applied here. They both point into direction and create a synergy in favouring the CRPD over the CRC concerning the specific subject matter – the characteristics of the obligation to provide alternative care for CWD.

[372] Id. at, para. 230.
[373] A/RES/61/106. Preamble (d).
[374] Vienna Declaration and Programme of Action, A/CONF.157/23, 1993, para. 5.

5.7. CRPD as an *inter se* agreement (treaty)

Given the conclusion that CRPD norms are more specific than the corresponding CRC norms and not all parties that ratified the CRC have also ratified the CRPD, a position of the CRPD as an *inter se* agreement/treaty should be considered. Parties to a broader multilateral treaty conclude *inter se* agreements to modify that treaty among themselves, as per Article 41(1)(b) VCLT. For a treaty to qualify as an *inter se* agreement, the older treaty must not prohibit the modification, and the modification must not affect the rights or performance of obligations of other states under the older treaty, nor derogate from the older treaty in a way incompatible with its object and purpose.[375]

First, since the CRC does not prohibit such modifications, this requirement is satisfied. Second, the performance of obligations by states parties to the CRC who are not parties to the CRPD remains unaffected. States that are not parties to the CRPD simply do not have the obligation to implement it. Lastly, as discussed elsewhere in this dissertation, the CRPD does not threaten the object and purpose of Articles 20 and 23 of the CRC. I However, it remains questionable whether the CRPD can be considered an *inter se* agreement given that some CRPD parties are not CRC parties. The VCLT does not provide sufficiently specific wording to resolve this question. The ILC, however, dealt with this matter intensively in relation to norm conflict matters and clarified that only subsequent treaties that do not have parties other than those that participate in the earlier treaty are covered by Article 41(1)(b) VCLT.[376] Moreover, an *inter se* treaty must notify the other parties about the modification of the prior treaty, per Article 41 (2) VCLT.[377] Consequently, neither the CRPD nor any of its provisions can be considered as constituting an *inter se* agreement.

5.8. Complexities in explicating will of parties

Although the application of these two principles yields fairly robust results based on solid legal arguments (that CRPD applies to CWD and partly sets aside Article 20 (3) CRC), they could

[375] A/CONF.39/11/Add.2. Article 41(1)(b).
[376] A/CN.4/L.682, International Law Commission, 2006, para. 295.
[377] See more: Kerstin von der Decken, *Article 41. Agreements to modify multilateral treaties between certain of the parties only, in* VIENNA CONVENTION ON THE LAW OF TREATIES: A COMMENTARY (Oliver Dörr & Kirsten Schmalenbach eds., 2018).

be further challenged. Potentially, the will of the parties could be explicated by examining recent UNGA resolutions on the subject at stake. Nevertheless, it is important to remember that the process of drafting and adopting UNGA resolutions differs significantly from that of human rights treaties, beyond the formal hard–soft law distinction between treaties and UNGA resolutions. The relevant UNGA resolutions have already been analysed above. Moreover, it is evident that UNGA resolutions on the rights of the child contribute to the ongoing development of standards and should be viewed as a process, not a static fact. Over time, as CRPD-oriented NGOs and other actors increase their influence, UNGA resolutions on children's rights increasingly reflect the CRPD. Therefore, the results of applying legal techniques and principles should be used as authoritative arguments rather than as definitive solutions.

5.9. Possible solutions to the discord

Considering that the development and implementation of human rights law norms is a continuous process, which was evidenced through the analysis of UN soft law and treaty bodies' work, possible solutions should be tailored to take the process into account. The unquestionable influence of international NGOs and other organisations must be taken into account, in fact all actors that constitute interpretive communities. However, it is the states that are parties to the treaties responsible for implementation. For this reason, any interpretation and development of human rights law must, in some way, be approved by the parties. Çalı argues that the reactions of states to interpretations by treaty bodies and courts are important indicators of whether a certain interpretation is accepted.[378] Conversely, Pauwelyn, Wouters, and Wessel explain that achieving a 'thick stakeholder consensus' is crucial for the authoritativeness of non-binding instruments, where explicit consent of all states parties is not required.[379] Findings from country studies suggest that UNICEF and international and domestic DPOs and NGOs can be significant contributors to the implementation of the CRC and the CRPD, including specifically the right to live in a family environment.[380] Therefore, not only would the authoritativeness of such a document increase with a broad consensus of non-state

[378] Çalı. 2020, p. 541.
[379] See note 124.
[380] See Part III Serbia, Chapter 4.2 Internalisation journey; Concluding chapter, 2.7 International and domestic organisations.

stakeholders (although not excluding states parties either), but the consenting non-state subjects would be motivated to promote the implementation of such standards in states parties.

Such substantive harmonisation could be reached through adoption of a series of UNGA resolutions and documents by treaty bodies. Ideally, these documents should meet several procedural and substantive requirements, including: transparency in the process which takes into account views of many stakeholders, reconciles disagreements and lacks 'sustained opposition' on substantial issues; inclusivity of various state and non-state actors; the substantive quality and consistency with the treaties;[381] ensuring that a substantive solution is grounded in international law principles and general treaty interpretation rules. Arguably, the substantive harmonisation, from the perspective of the quality and content of such documents can be achieved in several ways as portrayed in the following sections.

The present section does not elaborate on how states should implement the proposed solutions but focuses solely on the substance of these solutions. These are based on legal principles and rules of international law, and on the characteristics of the interpretive communities and their interactions.

5.9.1. A universalist approach

Rosenthal, a disability rights scholar and advocate, proposed a single-standard solution that establishes any placement in residential care as a violation of the right for children to live in a family environment.[382] In other words, Rosenthal argues that an effective interpretation of the CRPD, which yields an obligation to states parties to always provide alternative care for a child with a disability in a family-setting, expands to non-disabled children too. In that light, the GACC must be changed to conform with the CRPD, as a legally-binding document.[383] He supports this argument with scientific findings and human rights monitoring reports that detail the harmful effects of residential care on all children.[384] Rosenthal further argues that GACC have to conform to the CRPD and that the CRC Committee should revise GC 9 on CWD (2006). Finally, placing a child in out-of-family care violates their right to live in a family

[381] PAUWELYN, et al. 2012, p. 155-156.
[382] Rosenthal, BUFF. HUM. RTS. L. REV., (2019).
[383] Id. at, p. 184.
[384] Id. at, p. 114-115, 180.

environment, a right that must be immediately restored. Placements as 'last resort' solutions are a failure of social service systems to provide conditions for a child to live in a family.[385]

DPOS and NGOS for the rights of children and adults with disabilities, that submitted contributions to the drafting of recent UNGA resolutions on the rights of the child without parental care and participated in the 2021 DGD of the CRC Committee, advocate for this position.[386] The view that any placement in residential care is a violation of the right to live in a family environment was reiterated by Rosemary Kayess, chairperson of the CRPD Committee, confirming that the CRPD Committee is a part of the interpretive community which promotes the position promoted by Rosenthal. Also, Kenya's submission upheld this position and that all efforts need to be taken to ensure family-based alternative care for children when a child cannot stay in the family of its origin. The Kenya's submission also lists a number of arguments against institutional care, and does not leave any space for a constructive approach to institutional care.[387]

There are several issues and advantages of a universalist approach - a single standard that states must provide family-based care for all children, and where a child is placed in out-of-family care this is violation of their rights, and life in a family environment must be immediately restored. From an aspect of conflict resolution techniques, such outcome is attainable through dynamic interpretation, in this case of the CRC. The CRC would need to be interpreted to prohibit out-of-family care for all children, which then would need to be promoted by the CRC Committee, including through the body's jurisprudence, and its corresponding interpretive community/transnational issue network. Following that, the CRPD Committee and their community should promote such interpretation too. A series of resolutions, supported as widely as possible by states, would be necessary to enhance the normativity of this standard and increase the chances of its implementation by state parties. However, due to differing background justifications for the relevant norms, and thus differing observational standpoints of interpretive communities and states, a consensus would be challenging to reach in a near future.[388]

[385] Id. at, p. 182.
[386] See section UNGA Resolution on Children without Parental Care (2019).
[387] See section Day of General Discussion on children's rights and alternative care (2021).
[388] See section 'Why interpretations create more divergence'.

There are several potential counterarguments to the universalist approach. Firstly, states might view such an interpretation of the CRC as overly expansive, creating obligations they did not agree to under either the CRC or the CRPD, particularly because it would extend CRPD norms, which address the rights of CWD, to all children. Although dynamism in IHRL is well-established, it certainly does have limits that become apparent in specific cases and are more frequently identified by states than NGOs.

Secondly, if the placement of children in out-of-family care is a violation of their rights, the legitimacy of such services provided by states and other entities would be questionable in the first place. In other words, a state would provide a service (temporary residential care) that violates children's rights. For that reason, the concept of temporary placement in out-of-family care, where residential care is not allowed, would need to be further examined and adjusted.

Thirdly, an issue of practicality and enforceability of such standards could be questioned. It is a fact that the vast majority of CWD have at least one living parent, and their institutionalisation is a consequence of poor service and support provision and other factors from the child's environment. However, one might argue that in cases where there is a high population of children who do not have living parents, which more commonly occurs in conflict or disasters-impacted countries, providing family-based care for every child could be hard to achieve.

Moreover, the issue of costs of family-oriented support and services and potentially massive foster care systems is likely to arise, although family-based care has shown to be more cost-effective than institutional care.[389] For instance, 2021 data from the Serbian Republic Institute for Social Protection reveals that family-based care for 5,474 children cost only 85% more in total than institutional care for 557 children.[390] This means that the family-based alternative care was 5,3 times cheaper per child than institutional care. Another research on Central and Eastern Europe showed that family-based care is six times cheaper than care in traditional large institutions and three times cheaper than care in small group homes, which are commonly proposed by proponents of 'suitable' residential care for children.[391]

[389] Fact Sheet: Children with Disabilities. 2022, p. 49-50.
[390] Deca u sistemu socijalne zaštite 2021, (2022), REPUBLIC INSTITUTE FOR SOCIAL PROTECTION, p. 72.
[391] R Carter, Family Matters: A Study of Institutional care in Central and Eastern Europe and the former Soviet Union, Every Child, UK (2005). in KEVIN BROWNE, THE RISK OF HARM TO YOUNG CHILDREN IN INSTITUTIONAL CARE (Save the Children London. 2009).

Still, some countries with especially developed institutional care would be likely to oppose such standards. For instance, Austria has an astonishingly massive system of residential care in the form of SGHs primarily, based on a longstanding policy that seems unchallenged.[392] Portugal argued that appropriate residential care is an important option in a range of alternative care options that should be available, suggesting that without it, some children might not receive the most appropriate care for them. A similar, but more nuanced and layered position was promoted by UNICEF ECARO, which is explored in the section 'A mixed approach'. A dilemma of which law is better law was addressed in one of the previous sections, based on the assumption that two interpretive communities are in a relationship of normative dissonance, that they essentially do not agree on what is best for children. In that light, for such a universalist approach to be successful a significant shift in seeing what is best for children would be needed on one side.

On the other hand, a solution according to this universalist approach presents a total harmonisation of the CRC and the CRPD, and promotes advanced human rights standards that maximize the effectiveness of the CRPD. It is based on scientific research and informed by human rights monitoring reports for different forms of residential care. It also maximizes the observation of the CRC Preamble and the CRC Committee's positions that all children are best cared for in a family environment, which is essential for their development.

Perhaps most Importantly, the proposed solution does not leave legal loopholes through which CWD could fall through – this might be one of the biggest fears of the disability rights interpretive community. In other words, any standards that allow even temporary placement in institutional care are dangerous for CWD as such placements often become long-term or permanent, especially in states where there are no adequate investments in family-based care, support and services.[393] Therefore, this interpretive community seeks to close any gaps or exceptions, which can be used to justify institutionalisation of CWD.

Lastly, family-based care is not only more cost-effective but also cheaper than institutional care. However, such a reform should never be seen as a cost-cutting action because in the period of complete transition to family-based care state will have double costs of running both systems. Hence any DI plan implicitly or explicitly based on austerity could result in a

[392] See Part II, Austria, Chapter 2.3 Contemporary social protection.
[393] Allen, et al., THE LANCET CHILD & ADOLESCENT HEALTH, (2020).

catastrophe, as in South Africa's 'Life Esidimeni Tragedy', or in poorly developed support and services to families and eventually re-institutionalisation of children.[394]

5.9.2. A legalist approach

Another possible approach to solving the divergence in interpretations relies solely on norm conflict resolution techniques and methods. Removing dynamic interpretation, which previous sections relied on, leaves a legal scholar with various legal arguments about which norms should prevail, the implications for states and beneficiaries, and in which cases.

Namely, in the section on what is better law, the non-retrogression clauses were briefly explored as conflict-solving or conflict-avoiding tools. It was said that the CRC should not 'stay in the way' of the CRPD since the CRPD is better positioned to protect the rights of CWD than the CRC – it is a specialised treaty which addresses issues specifically faced by children (and adults) with disabilities, hence it is justified to assume that the CRPD is the carrier of a better law. Therefore, the CRPD should prevail regarding CWD, a stance that UNGA resolutions and other UN Human Rights system soft law or policy documents should reflect.

The *lex specialis* principle logically imposes itself in the present discussion. One of the previous sections analysed the application of this principle in the CRC-CRPD relationship and concluded that CRPD norms constitute special law for two reasons. Firstly, the CRPD is narrower *ratione personae*, as it is only related to CWD, who are also encompassed in the more general CRC. Secondly, the CRPD norms are more effective for the protection of the rights of CWD since they are contextually sensitive. This was evident in the inability of CRC standards to persuade states to redress the pervasive institutionalisation of CWD which, *inter alia*, generated the need for a disability-specific treaty in the first place. It was concluded that CRPD does not set aside Article 20 (1-2) CRC, but CRPD norms function as rules of how those CRC provisions are applied in relation to CWD. It also partly sets aside the non-prescriptive Article

[394] See Part IV, South Africa, ch. *Lessons learnt from the Life Esidimeni tragedy*; Lazar Stefanović, *Trans-institutionalisation of disabled people. A critical appraisal of some deinstitutionalisation strategies in South Africa and Europe*, *in* YEARBOOK PROTECTION OF HUMAN RIGHTS (Zoran Pavlović & Ivana Stevanović eds., 2022).

20 (3) CRC, since this provision lists institutions as one form of care that states could provide to children.

Lex posterior derogat legi priori is another relevant tool for the present case. The application of this principle was examined in one of the previous sections and it was concluded that the CRPD is a *lex posterior* to the CRC, which should mean that it reflects will of parties better than the CRC when it comes to the rights of CWD. Here, *lex specialis* and *lex posterior* principles work in conjunction and point in the same result – the CRPD norms prevail over the corresponding CRC norms, in relation to CWD.

Although the application of those techniques and principles do not provide a result where the CRC is set aside or modified in relation to all children, those standards can still be replicated to all children if stakeholders agree to that. However, those techniques provide solid legal arguments that the more far-reaching CRPD obligations should prevail in relation to CWD over more general CRC provisions. For that reason, a legalist approach, if strictly applied, would result in the existence of standards that might be seen as protecting the right to live in a family setting for CWD to a higher degree than non-disabled children. In other words, states parties would be obligated to provide family-based care to CWD, while such an obligation would not exist concerning non-disabled children (although family-based alternative care would be prioritized per the CRC nevertheless).

One issue with this approach is the potential for 'double standards', which may appear unfair, although disabled children are more likely to be placed in institutional care due to their disabilities. Moreover, article 23 (3) CRPD prescribes ‘state parties shall ensure that CWD have equal rights with respect to family life’. One could argue that this rule prevents granting CWD greater family life protection than other children. By contrast, approaching institutionalisation of persons with disabilities as an issue of discrimination against children and adults with disabilities is well-founded.[395] In that light, it can be argued that more stringent obligations of states concerning protection of the right to family for CWD are needed to address historical and widespread injustice. This substantive equality, in terms of the Committee for Economic, Social and Cultural Rights, through laws, policies and practice seeks to address ‘the inherent disadvantage that particular groups experience’.[396] Following that, it might be asked

[395] See section ‘Article 5 Equality and non-discrimination and residential care’.
[396] General Comment No. 16 (2005) The equal right of men and women to the enjoyment of all economic, social and cultural rights UN Committee on Economic Social and Cultural Rights, 2005, para. 7.

if the alleviation of the present issue is attainable through the laws, policies and practices that are same for all children, or different, more far-reaching ones are needed for CWD.

5.9.3. A mixed approach

A mixed approach represents a middle ground between two interpretive communities, drawing primarily on arguments from a legalist approach. Essentially, this approach advocates strongly for family-based care for all children and specifically promotes it for CWD, along with affirmative actions to address their widespread institutionalisation. It is based on the CRC, CRPD, anti-discrimination measures, and the quest for de facto equality for CWD. Importantly, any standards developed in this way would likely not be permanent, given the dynamism of human rights law, but only a potential next phase in the development of standards in relation to family life and alternative care for children that should be grounded in international law rules and principles, effective and achievable.

The analysis of the 2019 UNGA Resolution on the rights of children without parental care revealed a strong emphasis on family-based care for all children. In the context of the strong emphasis of family-based care for all children, such care for disabled children should be especially prioritized, and any form of residential care for disabled children opposed, as is the case with children under 3 years of age in the GACC.[397]

While the standard to not place children under 3 is supported only (and most importantly) by scientific evidence and practice, the standard not to place disabled children in such care is based on the CRPD and the principle of non-discrimination too. UNICEF ECARO recommended prioritising family-based care for CWD due to 'their complex needs'.[398] The prioritisation of the most disadvantaged is also ingrained in the UNGA resolution on Sustainable Development Goals within the principles to 'leave no one behind' and to 'reach the furthest behind first'.[399] This prioritisation also aligns with the obligations under Article 19 and Article 23(5) of the CRPD and the fundamental human rights principle of non-discrimination. The focus on the complex needs of children that should be met through family-based care should be at least

[397] A/RES/64/142*, para. 22.
[398] Grigoras. 2020, p. 30.
[399] A/RES/70/1, para. 4.

supplemented if not substituted, with the focus on what the society and states owe to CWD to redress historical and ongoing injustice.

The protection of family life of CWD should be put at the forefront. This is an approach taken by the UNICEF in their Disability Inclusion Policy and Strategy 2022-2023. This document highlights that CWD are 17 times more likely to be institutionalised than other children, often staying longer and experiencing more abuse and neglect.[400] The UNICEF's policy document strongly prioritizes family-based care and does not mention any forms of out-of-family care, and upholds Article 19 CRPD as critical in relation to obligations of states to provide necessary support and services for disabled children to live with their families.[401] The CRC Committee has also shown that it recognizes a specifically hard position some countries, where DI of disabled children should be particularly attended.[402]

Future UN soft law instruments on children's rights should guide state actions to implement the CRC and CRPD by urging countries to abandon residential care for CWD, prioritise support and services for disabled children and their families, and facilitate the transition to family-based care within the broader context of prioritising DI for all children. Given the dynamism in the development of the standards in childcare and rights, this does not preclude complete convergence of standards in any way.

For interpretive communities, lawmakers, and other stakeholders, this approach offers increased flexibility in tailoring standards to suit a wide range of situations and the needs of children in varied circumstances. Simultaneously, this would integrate CRPD norms by asserting that only family-based care is suitable for CWD and proposing methods to achieve this goal. Stakeholders, such as UNICEF ECARO, who hold that SSRC should have some role in a continuum of care could further develop and adjust those standards in relation to non-disabled children. For example, UNICEF ECARO proposed in 2020 that the age under which children should not be placed in residential care should be 6 years, and that the number of children in each unit should be 4-6.[403] They also detailed the temporary nature of such placements, the limited development of small residential care units, and aspects of quality control.

[400] UNICEF, 2022, p. 16.
[401] Id. at, p. 26.
[402] See note 236.
[403] Grigoras. 2020, p. 33.

Generally, exceptions for placing disabled children in residential care should not be allowed, as these are often used to justify the institutionalisation of CWD, echoing the critiques from disability-rights NGO leaders.[404] In that light, so called 'family-like' or 'family-type' care should be considered an out-of-family, residential type of care, which is a position shared by the CRPD Committee, the disability-rights interpretive community and UNICEF ECARO alike. Similarly, the placement of adolescents with disabilities in any form of residential care, including small-scale, should not be allowed, as it can serve as a pathway to life-long institutionalisation when adulthood is reached. For adolescents, forms of supported independent living should be arranged, aligning with the CRPD Committee's stance, [405] UNICEF ECARO's White Paper, [406] and with both interpretive communities' stances.[407]

However, this does not mean that some forms of SSRC could not be considered for emergency situations, when such care is absolutely necessary to eliminate any real danger to a disabled child, and after all measures have been taken to place the child in emergency family care. This approach mirrors, yet tightens, the standards set for children under three years of age.[408] Instead, emergency foster care should be prioritised for CWD. It also means that residential care can never be an option as a place of living for CWD. If alternatives to emergency group care are unavailable, or if a child remains there beyond a few days, this should be recognised as disability-based discrimination and a violation of the right to a family environment, which must be immediately rectified.

Possibly the main issue that the interpretative community of DPOs and disability-rights NGOs could have with a policy approach based on the prioritisation is the concern whether states will actually prioritize CWD in national laws and policies. UNICEF ECARO observed that many countries had not prioritised children under three years of age and CWD in DI programmes, leading to a higher proportion of disabled children in institutional care, a trend also noted in Serbia.[409] However, the UN soft law on children's rights had not convincingly or at all reflected CRPD norms at the time. The prioritisation should be clearly and unequivocally reflected in a series of UN soft law documents and treaty bodies' documents, supported by legal arguments

[404] Allen, et al., THE LANCET CHILD & ADOLESCENT HEALTH, (2020).
[405] CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 49.
[406] Grigoras. 2020, p. 31.
[407] Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care. 2019.para. 3(m); UN Disability and Child Rights Groups On Behalf of Children without Parental Care: Key Recommendations. 2019.
[408] A/RES/64/142*, para. 22.
[409] Grigoras. 2020. See Part III, Serbia, 2.3 Chapter Family-based alternative care.

to increase its normativity and authority. Importantly, it should be supported by international agencies, including UNICEF, that work directly with states on the improvement of childcare.

5.10. Concluding remarks on the CRC – CRPD discord

The resolution of the discord can take several forms from a perspective of the procedure and the substance of a solution. A consensus among stakeholders appears plausible, particularly based on the 'mixed approach' described above. Any solution must be of high substantive quality, and its drafting and adoption procedures must achieve a 'thick stakeholder consensus', as Pauwelyn, Wouters, and Wessel argue. Otherwise, new solutions might lack broad support and normativity, remaining overshadowed by the authoritative GACC. Importantly, influential stakeholders, such as UNICEF, but also international NGOs and international service providers, are necessary elements in reaching a solution. Otherwise, new solutions might lack broad support and normativity, remaining overshadowed by the authoritative GACC.

In his paper for the Buffalo Human Rights Law Review, Rosenthal argued that the GACC 'must conform' to the CRPD.[410] He also proposed that the CRC Committee revises its GC 9 on CWD. Rosenthal, however, called for the total convergence of standards, which is only one of the proposed solutions here, and the one less likely to be reached soon. Alternatively, a series of UN resolutions that assert new standards could enhance the normativity of any solution or precede the revision of the GACC.

However, expecting immediate effects from the alignment of standards in state parties would be naïve. After all, the question of implementation of IHRL is a hard one, and sometimes the characteristics of norms and standards only marginally impact the implementation, while determining factors are to be found within the states parties. Consequently, the second part of the thesis examines the factors that drive and hinder the internalisation of norms and standards concerning the right to family life and alternative care for CWD.

[410] Rosenthal, BUFF. HUM. RTS. L. REV., (2019), p. 183-184.

6. Regional Human Rights Mechanisms

The following section delves into the regional protection of the right of live in a family environment for CWD, and the right to alternative care within the European and African contexts. his focus on regional mechanisms arises from the study's specific examination of norm implementation within two European countries and one African country.

According to the TLP, transnational human rights norms are shaped not only by interactions between international and domestic jurisdictions but also by regional human rights protection systems. The African Charter on the Rights and Welfare of the Child was inspired by the CRC and other IHRL instruments.[411] Scholars like Shelton and Carozza argue that the frequent referencing of international human rights norms by regional bodies and courts evidences IHRL's influence on regional human rights law.[412] Similarly, Viljanen discusses the impact of the European Court of Human Rights on IHRL.[413] Given their objectives of promoting compliance with human rights norms and standards among state parties, regional human rights systems utilize context-sensitive instruments and mechanisms, making them pertinent to the present study. Moreover, regional mechanisms may facilitate but also impede the implementation of IHRL.

This chapter adopts a descriptive approach to analyse both binding and non-binding norms within these instruments. The study applies the VCLT methodology, considering all treaty interpretation aspects, including wording, context, purpose, and preparatory works when necessary. Major differences between relevant regional and international norms are identified, as those may hinder the domestic implementation of corresponding IHRL norms in a respective region. The study analyses jurisprudence, recommendations, opinions, and other pertinent documents from bodies tasked with monitoring instrument implementation and human rights court decisions to deepen understanding of these norms and their interpretation.

[411] African Charter on the Rights and Welfare of the Child, CAB/LEG/153/Rev. 2, Organization of African Unity, 1990. Article 46.
[412] DINAH SHELTON & PAOLO G. CAROZZA, REGIONAL PROTECTION OF HUMAN RIGHTS (OUP Second edition ed. 2013).
[413] Jukka Viljanen, *The role of the European court of human rights as a developer of international human rights law*, CUADERNOS CONSTITUCIONALES DE LA CÁTEDRA FADRIQUE FURIÓ CERIOL (2008).

6.1. European system of human rights protection

Established in 1949, the Council of Europe (CoE) is a key regional organisation dedicated to human rights protection in Europe. Currently, the CoE comprises 46 member states, with the notable exceptions of Belarus and the Russian Federation. The Russian Federation ceased its membership in the CoE in 2022.[414]

At the core of the CoE's human rights framework lies the European Convention of Human Rights (ECHR).[415] Adopted in 1950, this legally binding instrument is fundamental to safeguarding civil and political rights. Of the 48 European countries, 47 have ratified the ECHR, with Belarus remaining the only country not to have done so. Notably, the Russian Federation declared its intention to withdraw from the ECHR, however, as of May 2023, it has not yet executed the withdrawal process.[416]

In addition to the ECHR, the CoE has adopted several other legally binding instruments that play a significant role in the protection and promotion of human rights in Europe. Among these instruments is the European Social Charter (ESC),[417] which complements the ECHR by enlisting a range of protected social and cultural rights. Initially adopted in 1961, the ESC was revised in 1996.

Another important convention is the European Convention against Torture, adopted in 1987. This convention aims to prevent and combat torture and other forms of ill-treatment. It establishes a framework for the prohibition, investigation, and prosecution of torture within the member states of the CoE.

These legally binding instruments, along with their accompanying protocols, hold significant relevance in the present topic. Their provisions and principles are specifically analysed and considered due to their impact on the protection and promotion of human rights in Europe. Further, decisions of the European Court of Human Rights (ECtHR), the European Social

[414] Resolution CM/Res(2022)2 on the cessation of the membership of the Russian Federation to the Council of Europe, CM/Res(2022)2, (Committee of Ministers), Council of Europe, 2022.
[415] ETS No. 5.
[416] CM/Res(2022)2, Council of Europe, 2022.
[417] The European Social Charter (revised), ETS No.163, Council of Europe, 1996.

Committee (ESC Committee), and relevant documents of other CoE bodies are hereby analysed.

6.1.1. European Convention on Human Rights and the European Court of Human Rights

The ECtHR is mandated with adjudicating complaints from individuals, groups of individuals or NGOs who claim to be the victims of violations of the rights contained in the ECHR, and also performs an advisory function.[418] The Committee of Ministers, a political body of the CoE, oversees the enforcement of ECtHR decisions.[419]

The ECHR protects a list of civil and political rights, including the right to be free from torture, inhuman and degrading treatment and punishment, the right to family life, the right to liberty, and non-discrimination. Institutionalising CWD may breach these rights, as such institutionalisation constitutes a de facto deprivation of liberty, a position endorsed by the UN Global Study. The Experts of the Global Study faced obstacles when defining the deprivation of liberty in the case of children, especially infants, considering that their personal liberty is more often than not limited in usual circumstances (e.g. young children are typically not allowed to leave the house at their will, but upon permission by parents or another person that looks after them). Finally, to recognize a certain living arrangement of a child as a deprivation of liberty, prior engagement of governmental agencies leading to the deprivation of liberty is needed.[420] Therefore, in the case of institutionalisation, CWD are deprived of their liberty.

On the other hand, the ECHR explicitly prescribed a list of cases in which a person can be deprived of their liberty, in accordance with the procedure prescribed by law, including the 'lawful detention (…) of persons of unsound mind'.[421] This provision permitted governments to deprive persons with intellectual and psychosocial disabilities, including children, of their liberty. However, this provision and its terminology are considered obsolete today. In line with its view of the convention as a living instrument, the ECtHR has refined these standards, including in cases involving rights violations against CWD.

In Article 3, the ECHR prohibits torture, inhuman or degrading treatment or punishment. The exposure of CWD to care and treatment in living conditions that may amount to inhuman and

[418] ETS No. 5. Articles 19, 34.
[419] Id. at. Article 46 (2).
[420] NOWAK, UN Global Study on Children Deprived of Liberty. 2019, p. 12.
[421] ETS No. 5. Article 5(1)(e).

degrading treatment and cases of punishment have been well-documented by numerous stakeholders, including the CoE's Committee for the Prevention of Torture (CPT) in their country visits.

The ECtHR also found a violation of Article 3 in the case L. R v. North Macedonia. In this case, the court found the violation of the rights of an 8-year-old with intellectual and physical disabilities, who was under state guardianship and who was placed in an institution for person with speech and hearing impairments.[422] The court identified violations due to L.R.'s placement in an inadequate institution and the substandard treatment received there. The (last resort) placement in 'adequate' institutions is also prescribed by the CRC, although it was not cited by the Court. On the other hand, Article 15 CRPD on the prohibition of torture was cited in the judgement.

The case was brought before the ECtHR by an NGO, which, according to the Government, did not have a legal standing to do so, considering that the organisation did not have a power of attorney or a written authorisation from the applicant or his/her guardian. However, the Court made a significant advancement toward more inclusive human rights law by accepting the NGO's legal standing, despite it never having contact with the underage applicant and lacking authorisation from the guardianship authority, given the applicant's vulnerability, the exceptional circumstances, and the severity of the allegations.[423] Previously, in the case Valentin Câmpeanu v. Romania, the Grand Chamber acknowledged the Centre for Legal Resources as the 'de facto representative' of the deceased Câmpeanu, an adult with disabilities who lived and died in a Romanian institution.[424]

In relation to the right to life, probably the most notable is the case of Nencheva v. Bulgaria, where the Court found a violation of Article 2 ECHR.[425] Specifically, 15 CWD died during a 3-month period in 1996-1997, due to appalling living conditions, and despite the authorities being aware of the situation. The investigation was focused on three employees of the institutions and did not include the investigation of the responsibility on higher levels. Therefore, the Court concluded that the state failed to fulfill its positive obligation under Article

[422] L.R. v. North Macedonia European Court of Human Rights, Application No. 38067/15, para. 6.
[423] Id. at.para. 47.
[424] Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania, European Court of Human Rights, Application No. 47848/08.
[425] Nencheva and others v. Bulgaria, European Court of Human Rights, Application No. 48609/06.

2 of the ECHR to protect the right to life of the deceased and to conduct a proper investigation.[426]

In the 2016 case Blokhin v. Russian Federation, the Grand Chamber found violations of Articles 3, 5(1), and 6 of the ECHR, focusing on the detention of a child for educational supervision. Nowak elaborates that, following this judgment, the ECtHR's stance is that detaining a child for educational supervision is permissible if the institution is appropriate, well-resourced, provides education, and aims to reintegrate the child into society.[427]

The caselaw of the ECtHR is not particularly rich concerning the institutionalisation of CWD and children in general. A study by Lewis investigating the ECtHR's engagement with the CRPD up to 2016 revealed that the Court had not 'seriously' engaged with this international instrument.[428] Lewis explains that the ECtHR, as a CoE body, is not required to apply the CRC, CRPD, or other IHRL instruments in its decisions, nor does it have guidelines for using these instruments when the ECHR is vague or ambiguous.[429] Still, the Court has regularly used IHRL to support its dynamic interpretations of the ECHR.[430]

The cases discussed, including those involving adults, scrutinize the suitability of institutional settings, focusing on the types of institutions and their capacity to provide adequate care, treatment, or education. This approach broadly aligns with GACC, which advocate for care in settings that are constructive for the child's development.[431] It has been argued that this standard diverges significantly from the CRPD and the CRPD Committee's stance against all forms of institutional care. Lewis argues that the sparse citation of the CRPD in ECtHR cases until 2016 may partly result from litigators' cautious approach to avoid setting negative jurisprudential precedents.[432] This may even more be the case with the litigation concerning CWD, especially considering *locus standi* standards, that were made more inclusive only very recently with the case L.R. v. North Macedonia.

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[426] CLAIRE FENTON-GLYNN, CHILDREN AND THE EUROPEAN COURT OF HUMAN RIGHTS (OUP, USA. 2021), p. 323.
[427] Nowak, Detention of Children for the Purpose of Educational Supervision. 2020, p. 192.
[428] Oliver Lewis, *Council of Europe*, *in* THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES IN PRACTICE: A COMPARATIVE ANALYSIS OF THE ROLE OF COURTS (Ana Lawson & Lisa Waddington eds., 2018). Abstract.
[429] Id. at, p. 91-92.
[430] Id. at, p. 92-93.
[431] See 'UNGA Resolution on Children without Parental Care (2019)'.
[432] Lewis, Council of Europe. 2018, p. 129.

6.1.2. Revised European Social Charter and the European Social Committee

The Revised European Social Charter (RESC) protects a list of social and economic rights, including the rights of children and persons with disabilities. The ESC Committee oversees the implementation of this instrument and is authorized to receive collective complaints from organisations in states that have ratified the additional protocol concerning collective complaints, issuing conclusions about the states' adherence to the RESC.[433] The procedure, outlined in Articles 4-10 of the Additional Protocol, culminates with the Committee of Ministers inquiring about the measures taken by the concerned state to implement the recommendations. The state party must then respond in its subsequent regular report to the Secretary General.[434] Unlike the ECtHR, neither the ESC nor the Committee of Ministers can order a state party to take a specific action.

The Preamble of the RESC acknowledges the rights of persons with disabilities to independence, social integration, and the participation in a community, as well as the rights of children and families to social, legal, and economic protection.[435] Article 15 RESC specifically addresses the right to independence and community participation, in a way to an extent similar to Article 19 CRPD, but with some significant differences. The article starts with the recognition that all persons with disabilities regardless of their age and type or origin of disability shall enjoy this right and proceeds with obligations of states with an aim to ensure the realisation of the right. The provision of general or specialised services and support is one of three central obligations, much like the ones found in Article 19 (2, 3) of the CRPD. Other obligations concern access to employment, assistive technology, housing, transport, culture and leisure.[436]

The RESC prescribes that children should grow up in 'an environment which encourages the full development of their personality and of their physical and mental capacities', without specifying any further characteristics of that environment or of the special care and support that the children 'temporarily or definitively deprived of their families' support' should be entitled

[433] Additional Protocol to the European Social Charter Providing for a System of Collective Complaints, ETS No. 158, 1995. Articles 1, 8.
[434] Id. at. Articles 4 – 10.
[435] ETS No.163.
[436] Id. at. Article 15.

to.[437] However, the ESC Committee issued an important Statement of Interpretation for Article 16 and 17 (1) in 2011, where it further elaborated on the separation of children from families and appropriate forms of alternative care. Firstly, the Committee argues that separation from the family is an exceptional measure and done only when staying in his/her family is dangerous to the child. Further, in any case, alternatives to placement in alternative care should be first explored, considering the views and wishes of the child, parents, and other family members. The alternative care should be temporary, and placement in a foster family or 'family-type environment' should be prioritized over institutions, 'whenever possible'.[438]

This interpretation by the ESC Committee was crucial in addressing significant gaps in the RESC regarding the characteristics of alternative care and the prioritisation of family-based and family-like environments over institutional settings. It came two years after the adoption of GACC, and although it does not refer to that or any other international document, it echoes standards of the GACC including the temporary character of alternative care placements and the prioritisation of family-based and family-like care over institutions.

An additional interpretative statement from 2003 reaffirms the indivisibility of Article 15 of the RESC, which covers independence, social integration, and community participation, with the prohibition of discrimination under Article E.[439] In other words, the denial of those rights is a form of discrimination on the basis of a disability. The ESC even changed the terminology from the term 'integration' to 'inclusion'. The latter is common in the human rights approach to disability law and scholarship as opposed to the welfare approach and segregation of persons with disabilities, which were mentioned by the ESC as obsolete disability policies.

The search for ESC Committee's jurisprudence was conducted in the HUDOC online database, focusing on merits and statements of interpretation in English, concerning Articles 15, 16, and 17 of the RESC, up to 30th April 2023. The search retrieved 37 results. An analysis of the Conclusions found no cases addressing specifically the institutionalisation of children as a problem in itself. On the other hand, several cases concerned violations of the right to education of CWD who are institutionalized. Other cases were related to the prohibition of corporal

[437] Id. at. Article 17.
[438] Statement of interpretation - Article 16, 17-1, 2011_163_03/Ob/EN, (European Committee of Social Rights), 2011.
[439] Interpretative Statement - Article 15, 2003_Ob_1-1/Ob/EN, (European Committee of Social Rights), 2003. European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, ETS No. 126, Council of Europe, 1987; European Convention on the Exercise of Children's Rights, ETS No. 160, Council of Europe, 1996.

punishment, child trafficking, the rights of migrant children to social protection, housing, and education. Relevant Statements of interpretations were already mentioned above.

6.1.3. Other CoE instruments and documents

Several binding and non-binding documents issued by the CoE are revisited here, to capture the CoE's understanding and policies and their potential impact concerning the right to life in a family environment for CWD. Those instruments are the Convention on the Exercise of Children Rights, European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the European Convention on the Adoption of Children, documents of the Committee of Ministers on the rights of children living in institutions and inclusion of children with disabilities and CoE's strategies for the rights of the child and disability strategies.[440]

In 2005, the Committee of Ministers, the CoE's highest political body, adopted a Recommendation on the rights of children living in institutions. The CoE emphasized that placement in residential care should only be an exception, limited in duration, with the goals of reintegration into the family or society, ensuring families receive all necessary support.[441] In the section on the GACC, it was already elaborated that this position of the CoE supported the CRC's negative approach to institutional care, that was later to an extent abandoned by the GACC. Additionally, the CoE recommended providing 'small family-style living units' for children in institutional care.

The CoE, however, did not recommend DI or reduction of reliance on institutional care, or the development of family-oriented services. This could be explained by the moment in which the document was adopted and that is before the adoption of the CRPD, before the adoption of UNGA resolutions which called for such measures, including the GACC (2009), and even before Europe was shaken by reports on the position of CWD in institutional care, for example in Bulgaria and Serbia (2007).

[440] ETS No. 160; European Convention on the Adoption of Children (Revised), CoETS No. 202, Council of Europe, 2008; ETS No. 126.
[441] Rec(2005)5, 2005.

A 2010 Recommendation specifically addressed DI and community living for children with disabilities. The document states that 'all disabled children should live with their own family, which is the natural environment for the growth and well-being of a child, unless there are exceptional circumstances which prevent this'.[442] The document provides guidelines or a roadmap for Member States on key steps and measures in the DI process. It emphasizes the provision of support and community-based services, prevention of family separation, and specific measures like a moratorium on new admissions of CWD to institutional care, and advises stakeholders against funding new institutional projects.[443] Finally, the Committee of Ministers proposes that only in exceptional cases such as abuse and neglect, and where a child cannot be provided foster care, a child can be placed in a 'small, homely settings, that are as near to a family environment as possible'.[444]

The 2022-2027 Strategy for Children observes that the rate of institutionalisation 'remains too high in Council of Europe Member States' and recommends continued promotion of DI.[445]

The CPT establishes the CPT Committee, which serves as a preventive mechanism by visiting places of liberty deprivation, including orphanages and social care institutions for CWD, in states parties.[446] The CPT Committee issues reports on its visits with findings and recommendations to state parties. The body recommended to Serbia to promote the DI of CWD, reduce the number of children in institutions, develop community-based services, and it commended those efforts in other countries.[447]

The same body does not approach the 'family-type' or 'family-like' care the same way it was proposed in the Recommendation from 2005. Contrarily, it described the transformation of residential care in Bulgaria—where smaller units replaced large institutions at the same locations - as 'at best, trans-institutionalisation'.[448] Nevertheless, the CPT Committee advocated for the development of more personalized small group living units within the community for

[442] Recommendation CM/Rec(2010)2 of the Committee of Ministers to member states on deinstitutionalisation and community living of children with disabilities, (Committee of Ministers), Council of Europe, 2010, para. 1.2.
[443] Id. at, para. 3, 8.
[444] Id. at.para. 12.
[445] Strategy for the Rights of the Child 2022-2027, Council of Europe, 2022, p. 22-23.
[446] ETS No. 126. Article 1.
[447] Report to the Serbian Government on the Visit to Serbia Carried out by the European Committee For The Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 9 to 19 March 2021 CPT (2022) 03, (European Committee For The Prevention of Torture and Inhuman or Degrading Treatment or Punishment), 2022.
[448] 31st General Report of the CPT, (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)), 2021. p. 56.

adults. Therefore, while the CPT Committee views the transformation of large institutions into smaller 'family-type' units as inappropriate, its stance on SSRC for CWD remains unclear. A Recommendation from 2013 on the inclusion of CWD expressed that DI should be the main goal in promoting the full inclusion of CWD.[449]

Thomas Hammarberg issued a position paper on the rights of persons with disabilities, recommending that states adopt a no-admissions policy for institutional care, develop DI plans aimed at phasing out such care, create community-based services, and provide support to families of CWD. The former Commissioner for Human Rights also warned against SSRC and that such a form of care does not fulfil the requirements of Article 19 CRPD.[450]

6.1.4. European human rights protection mechanism and the right to family life of children with disabilities

The ECtHR and the ESC Committee, along with other bodies like the CPT Committee, have engaged in protecting the rights of CWD. A number of binding and non-binding documents touch upon the rights of CWD including the rights to social inclusion (or integration), the right to family life and alternative care. However, an analysis of ECtHR's caselaw reveals that the right to family life for CWD has not been adjudicated before this body. Generally, the slow integration of the CRPD into ECtHR jurisprudence and a lack of a harmonized approach may impede the realisation of the right to live in a family environment for CWD in Europe.

The cases which concerned CWD in institutional care were related to violations of Articles 2 and 3 ECHR, and the right to education. Lewis argued that the ECtHR has not yet fully embraced the CRPD and CRPD Committee's interpretations, for which there could be a number of reasons.[451] Nevertheless, in the recent case of L.R. v North Macedonia, the Court achieved a significant breakthrough in recognizing the status of a legal representative to an NGO that has never before been in touch with the deceased victim, primarily on the basis of

[449] Recommendation CM/Rec(2013)2 of the Committee of Ministers to member States on ensuring full inclusion of children and young persons with disabilities into society, (Committee of Ministers), Council of Europe, 2013, para. ii.
[450] The right of people with disabilities to live independently and be included in the community, (Council of Europe Commissioner for Human Rights), 2012.
[451] See note 428.

the victim's vulnerability due to disability and exceptional circumstances.[452] In this case, the court focused on the appropriateness and resourcefulness of an institution to care for a child with severe disabilities and not to the institutionalisation itself. Therefore, the caselaw of the Court does not provide much information on its position on CWD in residential care beyond cases of abuse and exclusion from education.

The RESC is more disability-sensitive and prescribes the right to independence, social inclusion, participation in the community and stipulates that children should grow up in an adequate environment. The ESC Committee provided further interpretation of those norms by asserting that alternative care is temporary, that children are first placed in family-based care, and only exceptionally in institutional care.[453] The timing of this interpretation and its content echoed the GACC.

The later and non-binding documents became more specific in relation to forms of alternative care and DI. Some of those documents were specifically aimed at CWD and DI, providing guidance to Member States and reflecting the CRPD by recommending the provision of community-based services and making general services accessible to CWD. Even moratoria on further placements of CWD in institutions were recommended, as well as the denial of funding for the expansion of institutional care. These documents were adopted after the adoption of the CRPD and indicate some impact of the international instrument. The Recommendation from 2005, that is before the CRPD, omitted to recommend the DI-related measures, unlike the ones after 2010.[454] The CPT's work in promoting DI is notable as well.

Finally, various bodies of the CoE are dedicated to the promotion of family living for all children including CWD and the promotion of DI. Conversely, different CoE bodies have noted that SSRC should be provided exceptionally, when the family-based placement is not available, apart from the Commissioner for Human Rights who warned that such a form of care is not compliant with Article 19 CRPD.

[452] See note 422.
[453] See note 438.
[454] See 'Other CoE instruments and documents'.

6.2. African system of human rights protection

The Organisation of African Unity (OAU) was formed in 1963, and based on the principle of non-interference as one of the main pillars of the organisation.[455] Adopted in 1981 by the OAU's Assembly of Heads of State and Government, the African Charter on Human and Peoples' Rights (ACHPR) marked a fundamental shift from non-interference to the protection of rights through a supranational, regional mechanism amid democratic changes across the continent.[456] All African countries are members of the AU, while the ACHPR is ratified by all except Morocco.

The African Commission on Human and Peoples' Rights (African Commission) was established in 1987 as a quasi-judicial body mandated with monitoring the implementation of the ACHPR.[457] The African Charter on the Rights and Welfare of the Child (ACERWC) was adopted in 1990, it came into force in 1999 and is almost universally ratified in the continent (50 ratifications of 55 states). The ACERWC established the African Committee of Experts on the Rights and Welfare of the Child (the African Committee) mandated with the promotion, monitoring, and interpretation of the ACERWC.[458]

In 1999, the OAU was transformed into the African Union (AU) to advance continental integration, and the African Court on Human and Peoples' Rights (African Court) began operating in 2006.[459] The African Court was established with the Protocol to the ACHPR, which was adopted in 1998 and came into force in 2004.[460] The African Disability Protocol

[455] GUIDE TO THE AFRICAN HUMAN RIGHTS SYSTEM. CELEBRATING 40 YEARS SINCE THE ADOPTION OF THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS 1981 - 2021 (Centre for Human Rights and the African Commission ed., Pretoria University Law Press PULP. 2021). SHELTON & CAROZZA. 2013.
[456] SHELTON & CAROZZA. 2013; Guide to the African Human Rights System. Celebrating 40 years since the adoption of the African Charter on Human and Peoples' Rights 1981 - 2021. 2021, p. 74.
[457] African Charter on Human and People's Rights, CAB/LEG/67/3/Rev 5, Organisation of African Unity, 1981. Article 30.
[458] CAB/LEG/153/Rev. 2. Articles 32 - 43.
[459] Guide to the African Human Rights System. Celebrating 40 years since the adoption of the African Charter on Human and Peoples' Rights 1981 - 2021. 2021.
[460] Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, , Organisation of African Unity, 1998. *Basic Information*, African Court on Human and Peoples' Rights, accessed, *available at* https://www.african-court.org/wpafc/basic-information/#:~:text=The%20Protocol%20establishing%20the%20African,by%20more%20than%2015%20countries.

was adopted in 2018, has not entered into force as of April 2024, with only one ratifications still lacking.[461]

6.2.1. African Human and Peoples' Charter and African Children's Charter

The ACHPR does not explicitly address the rights of the child or persons with disabilities, apart from directly prescribing that states are obligated to protect the rights of children as stipulated in 'international declarations and conventions'.[462] It recognizes that a family is a basic unit of the society and entitled to assistance and protection by the state and that people with disabilities have the right to special protection.[463] The absence of specific children's rights provisions in the ACHPR and the CRC's limitations in addressing child rights in an African context necessitated the development of a child-specific African charter.[464]

The ACERWC Article 18 prescribes that a family is the natural unit and basis of society and that it enjoys protection. Article 19 (1) ACERWC, much like Article 7 (1) CRC, prescribes the right to be cared for by one's own parents, whenever possible. The states are obligated to provide material and other support and assistance to families, 'in accordance with their means and national conditions'.[465] States are also obligated to ensure the 'development of institutions responsible for providing care of children'.[466] Although the provision does not specifically mention residential care and institutions, its wording allows for the development of such facilities, alongside social welfare bodies tasked with providing assistance and care to children and families in the community.

Article 13 ACERWC specifically addresses the rights of CWD, by granting them the right to special protection and assistance. States are obligated to provide protection and assistance, subject to available resources, with a view to facilitate full social integration and development. However, unlike the CRC, the ACERWC does not prescribe that such assistance should be free whenever possible. The Article 13 ACERWC is for the largest part identical to Article 23 CRC,

[461] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, OAU, 2018.
[462] CAB/LEG/67/3/Rev 5. Article 18 (3).
[463] Id. at. Article 18.
[464] Guide to the African Human Rights System. Celebrating 40 years since the adoption of the African Charter on Human and Peoples' Rights 1981 - 2021. 2021, p. 75-77.
[465] CAB/LEG/153/Rev. 2. Article 20 (2).
[466] Id. at. Article 20 (2)(b).

thus it is not further dissected here. The ACERWC does not protect the right to social security like the CRC (Article 26) and the CRPD (Article 28), however elements of social security protection for CWD are integrated in Article 13 ACERWC.

The non-discrimination clause of Article 3 does not mention disability as a protected personal characteristic, but the list of characteristics is open. The absence of disability as a specific ground of prohibited discrimination might reflect a lower awareness of the challenges faced by CWD at the time the ACERWC was drafted. This likely reinforced the need for a disability-specific document, such as the African Disability Protocol.

Article 23 ACERWC on the separation from parents, prescribes the obligation of states to provide 'alternative family care, which could include, among others, foster placement, or placement in suitable institutions for the care of children'. This provision echoes Article 20 CRC, with minor differences. Apart from the obligation to provide alternative care to children deprived of a family environment, the facultative options for the type of such care are also found in the ACERWC as in the CRC. The difference is that amongst these options there is no adoption and that the provision of institutional care is not qualified with the term 'if necessary'. The term 'alternative family care' is confusing considering that it includes institutional care, which clearly is not a form of family care. The principle of the suitability of institutions for the care of children is to be found in the ACERWC too.

A purely textual interpretation of this provision might suggest that family-based foster care and institutional care are somewhat equivalent, with no clear preference for one over the other. However, considering the internal context of the provision and the high regard and strong protection for the family as a basic unit of society, it could be argued that family-based care should be prioritized over institutional care. Such a dilemma does not exist in the CRC, considering that institutional care can be provided only if necessary, and judging by the order of alternative care options in the provision, as argued. Given that the CRC forms part of the external context for the ACERWC, this supports interpreting the ACERWC as prioritizing family-based alternative care over institutional care. In fact, Article 46 ACERWC refers to the CRC as a source of inspiration for this Charter. Moreover, the knowledge of child development and the potential harms of institutional care that are higher than in family-based care is another layer of circumstances supporting the prioritisation of family-based alternative care. Despite the solid argumentation based on the VCLT rules on treaty interpretation and the sensitivity of human rights instruments to real-life circumstances, it is best to analyse the position and

approach of the Committee of Experts through their resolutions, concluding observations, general comments, communications, and investigations, which they are mandated with in accordance with the ACERWC.[467]

6.2.2. African Disability Protocol

As of April 2024, the African Disability Protocol (ADP) is one ratification short of coming into force and is not yet an applicable rule of law. Regardless, considering it is a disability-specific, legally binding document, it is briefly analysed here with a focus on the right of CWD to life in a family environment.

The document was created with the intention to address the issues of children and adults with disabilities which are not addressed with the ACHPR and the ACERWC, although those documents also relate to persons with disabilities and prohibit discrimination. However, the ACHPR and the ACERWC do not explicitly prohibit discrimination on the grounds of disability.

Article 14 of the APD is a counterpart of Article 19 of the CRPD. It prescribes the right to choose one's own place of living and with whom they want to live.[468] Further, states are obligated to provide support and services in the community, facilitate personal mobility with as much independence as possible, offer rehabilitation services that facilitate community living and ensure accessibility of general services to persons with disabilities.[469] One major difference from the CRPD are 'community living centres organised or established by persons with disabilities' which states are obligated to support and provide services to.[470] Article 9 (2)(b) ACDP prohibits confinement or another form of concealment of persons with disabilities 'by any person or institution'.

Article 28 ADP on CWD opens similarly to Article 23 CRC by stipulating that a child should live in conditions that ensure dignified living, promote self-reliance and facilitate participation in the community.[471] States are, *inter alia*, obligated to provide age, gender and disability-

[467] Id. at. Articles 42-45.
[468] OAU, 2018. Article 14 (2) (a).
[469] Id. at. Article 14 (2).
[470] Id. at. Article 14 (2) (f).
[471] Id. at. Article 28 (1-2).

appropriate assistance and to 'protect children who require more intensive support'.[472] Also, states are supposed to protect CWD from the separation from their parents, carers or guardians on the basis of disability.[473]

Unlike in the CRPD, there are no references to family-based care for CWD and protection of their family life.

6.2.3. African Committee of Experts on the Rights and Welfare of the Child

The African Committee was constituted in 2001, as a 'regional quasi-judicial treaty body', and it is comprised of 11 experts. Experts are nominated by state parties and elected by the AU's Assembly of Heads of State and Government. The mandate of the African Committee includes monitoring the implementation and interpretation of the ACERWC, formulation of 'principles and rules' for the protection of children's rights, collecting data and research, receiving communications from individuals, NGOs, Member States, UN agencies or any other group, and conduct investigations.[474] The Committee fulfils its interpretive mandate by issuing General Comments. State parties are obligated to report periodically to the African Committee, which then issues Concluding observations (or Concluding recommendations) to facilitate the implementation of the ACERWC in state parties.[475]

The Committee of Experts has not issued any General Comments on Articles 13 and 25 (children with disabilities and separation from parents respectively). However, General Comment No. 1, focusing on children of incarcerated or imprisoned parents, stipulates that such children should be provided alternative care consistent with the GACC.[476] A comprehensive review of all communications submitted to the African Committee, accessible via its website, did not yield any cases relevant to this discussion.[477]

[472] Id. at. Article 28 ¶4 (b), (h).
[473] Id. at. Article 28 ¶4 (g).
[474] CAB/LEG/153/Rev. 2. Articles 42, 44, 45.
[475] Id. at. Article 43.
[476] General Comment No. 1 (Article 30 of the African Charter on the Rights and Welfare of the Child) on "Children of Incarcerated and Imprisoned Parents and Primary Caregivers", (African Committee of Experts on the Rights and Welfare of the Child), 2013, para. 40.
[477] *Communications*, African Committee of Experts on the Rights and Welfare of the Child, accessed: 22nd May, 2023, *available at* https://www.acerwc.africa/en/communications/table?page=0.

The African Committee also undertakes country visits and issues reports on their findings. An investigative mission to Malawi, led by the Working Group of the African Committee on Children with Disabilities, focused on children with albinism. However, the Working Group did not address issues related to life in a family environment or alternative care.

A similar mission was carried out in Tanzania concerning children with albinism temporarily placed in institutions (Temporary Holding Centres), also described as 'safe houses', to protect them from harmful practices that can result in killings and mutilation.[478] The Working group was concerned that the placement of children was not temporary but long-term, and that it facilities resembled more of detention centre than safe houses.[479] The recommendations included discontinuation of institutionalisation and reunification with families as immediate measures.[480]

An analysis of Concluding observations provides an insightful account of the work of the African Committee. This analysis includes all 35 Concluding Observations issued in English by the African Committee to 30 state parties from its inception until May 2023 (Table I.1). The aim of this analysis is to increase the understanding of the body's position and approach to the right to life in a family environment and the right to alternative care for CWD, and relevant CRC and CRPD norms where possible.[481] For nine countries Concluding observations are available only in the French language, and those are not included in this analysis (Burkina Faso, Chad, Comoros, Cote D'Ivoire, Guinea Bissau, Madagascar, Mali, Niger, Tunisia). Given that this analysis covers almost 80% of all Concluding Observations issued by the African Committee since its inception, the exclusion of documents in French is unlikely to significantly affect the quality of the analysis. That especially taking into account that a treaty body normally aims to harmonize interpretations of a respective treaty, and that any differences in recommendations should be captured in the pool of 35 Concluding observations on reports of 30 state parties.

[478] Report on Investigative Mission on the Situation of Children with Albinism in Temporary Holding Centres - Tanzania, (African Committee of Experts on the Rights and Welfare of the Child), 2016.
[479] Id. at, p. 27.
[480] Id. at, p. 29.
[481] These Concluding observations were issued to: Guinea, Lesotho, Liberia, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Senegal, Seychelles, Sierra Leone, Sudan, Tanzania, Zambia, Zimbabwe, Egypt, Benin, Eswatini, Kenya, Burundi, Angola, Algeria, Cameroon, Rep. Congo, Eritrea, Ethiopia, Gabon, Ghana 2016

Table I.1 Analysed Concluding observations of the African Committee of Experts on the Rights and Welfare of the Child.

State party	Year of Concluding observations	State party	Year of Concluding observations
Algeria	2015	**Liberia**	2014
Angola	2017	**Malawi**	2018
Benin	2019	**Mauritania**	2019
Burundi	2018	**Mozambique**	2014
Cameroon	2017	**Namibia**	2015
Egypt	2008	**Nigeria**	2006 and 2019
Eritrea	2017	**Rep. Congo**	2017
Eswatini	2019	**Rwanda**	2019
Ethiopia	2022	**Senegal**	2019
Gabon	2015	**Seychelles**	2022
Ghana	2016	**Sierra Leone**	2017
Guinea	2014	**South Africa**	2014 and 2019
Kenya	2009, 2014 and 2020	**Sudan**	2012
Lesotho	2015	**Tanzania**	2010 and 2017
Zambia	2019	**Zimbabwe**	2015

The analysis of 35 Concluding observations for 30 countries showed that the African Committee has frequently explicitly commended or recommended the prioritisation of family-based care over institutional care (for example to Liberia, Lesotho, Sierra Leone, Zimbabwe, Tanzania, Benin, Algeria, Kenya, Republic of Congo, and Gabon). DI efforts were also often applauded and further work on DI advised (for example to Lesotho, Malawi, Rwanda, Tanzania, Zambia, Eswatini, Kenya, Burundi, Angola, and Ethiopia). Support to biological families and reunification is another recurrent recommendation (e.g. to Sierra Leone, Tanzania, Zimbabwe, Zambia, Kenya, Ethiopia, Eritrea, Rwanda). The need for strong and quality foster care has been persistently asserted by the African Committee (e.g. to Rwanda, South Africa, Seychelles, Eswatini, Ethiopia, Angola, Tanzania). Moreover, states are frequently directed to adhere to the GACC when implementing various family-based alternatives (e.g. Guinea,

Mozambique, Namibia, South Africa, Zimbabwe, Kenya, Ethiopia). These frequent recourses to the GACC indicate the relevance and authoritativeness of the UN document.

All those recommendations signify a strong prioritisation of family-based care as well as the prevention of separation. Conversely, the treaty body has also recommended to state parties to build new institutions, expand the capacities of existing institutions, or commended placements in institutions in several states (e.g. Mauritania, Nigeria, Sudan, Algeria). For example, placements of children in institutions were praised in Nigeria and Mauritania, while at the same time, reunification of children with living parents and development of foster care was recommended.[482]

One could assume that such mixed recommendations may be the consequence of the perception that some states' and communities' socio-economic contexts preclude ensuring family-based care for all children or reducing institutional care to a marginal role, amidst large numbers of parentless children. Still, knowing the standards developed in the last 10 to 20 years which are based on scientific evidence and practice, as well as the (higher) costs of institutional care when compared to family care, it is not entirely clear why those countries are not advised to redirect efforts that would be otherwise invested in the expansion of institutions to the provision of family-based care. The current method of textual analysis of Concluding Observations does not fully reveal the reasoning behind the African Committee's experts' recommendations. A more comprehensive understanding might be gained through interviews with African Committee experts and interdisciplinary country-specific studies, though these are beyond the scope of this study, except for South Africa.

Importantly, CWD were rarely mentioned in direct connection to the forms of alternative care. In Concluding observations to Rwanda, a high number of CWD in institutional care was criticized and the reduction through placements in foster care was recommended.[483] In Ghana, the placement of CWD in prayer camps and psychiatric facilities raised concerns for the

[482] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) to the Government of the Federal Republic of Nigeria on its Periodic Report on the Implementation of the African Charter on the Rights and Welfare of the Child, (African Committee of Experts on the Rights and Welfare of the Child), 2019.

[483] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Second Periodic Report of the Republic of Rwanda on the Status of Implementation of the African Charter on the Rights and Welfare of the Child, (African Committee of Experts on the Rights and Welfare of the Child), 2019, para. 31.

African Committee..[484] In Concluding observations to South Africa (2019) the African Committee did not express concern with institutionalisation of CWD, unlike the CRPD Committee a year before.[485] Furthermore, concerning children with albinism, the ACERWC's Working Group on the Rights of Children with Disabilities recommended that Tanzania immediately halt institutionalisation and take steps to reunite institutionalized children with their families.

CWD were consistently addressed and probably in most detail in relation to inclusive education (e.g. Mozambique, Namibia, Rwanda, South Africa, Senegal, Seychelles, Sierra Leone, Tanzania, Kenya, Zambia, Burundi, Algeria, Republic of Congo, Ethiopia, Gabon, Ghana), access to health care, the accessibility of general services, non-discrimination and occasionally in relation to material social benefits.

6.2.4. African human rights protection mechanism and the right to family life of children with disabilities

The regional protection of children's rights in Africa is centred on the ACERWC and the African Committee, which holds a broad mandate to monitor ACERWC's implementation, adjudicate, and investigate both alleged and systemic violations of children's rights.

The examined documents suggest that the African Committee is committed to preserving families and prioritizing family-based care, with institutional care recommended only as a temporary solution. Despite this, the treaty body has also recommended expanding institutional capacities, indicating a less stringent commitment to family-based care, particularly for children without living parents. Concerns about institutional care typically arise only in contexts of overcrowding and reported abuse within these facilities. The institutions themselves, as it is in the contemporary international standards on the rights of the child and the CRPD, seem to be much less of an issue for the African Committee.

[484] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of Ghana Initial Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child, (African Committee of Experts on the Rights and Welfare of the Child), 2016, para. 29.
[485] Concluding observations on the initial report of South Africa, CRPD/C/ZAF/CO/1, (Committee on the Rights of Persons with Disabilities), 2018, para. 12(c).

When it comes to the GACC, recommendations of the African Committee sometimes go beyond some of its standards such as the temporary placement in institutional care, which according to the UN document does not need to be only temporary. In other cases, it falls behind the GACC's standards. For instance, the committee omits any reference to the institutionalisation of children under three or to recommending the cessation of such practice, despite this being a critical point in the UN document.

The DI and the promotion of family-based care were only in a couple of cases explicitly recommended in relation to CWD. Although recommendations concerning all children also encompass CWD, the lack of reference and specific address of their situation indicates that CWD are not in the focus of state or NGO, nor in the African Committee's Concluding Observations. It is reasonable to infer that the African Committee does not uphold Article 19 and 23(5) CRPD, while it does uphold the CRC Article 20 to a large extent in its recommendations. Still, the treaty body recommended an immediate cessation of institutionalisation of children with albinism in Tanzania, sending mixed signals concerning their approach to institutionalisation of CWD.

Part II Austria

1. Context

Austria, officially the Republic of Austria, is a landlocked country of 83.870 square kilometres, situated in the region of Central Europe, with a population of 8.969.068, according to a register-based census of 2021.[1] The number of inhabitants in Austria has been steadily increasing throughout the 20th and the 21st century, largely thanks to immigration. The number of persons 0-18 years old amounted to 1.570.222 in 2021.[2]

The Republic of Austria was founded in 1918, and again after the World War II in 1945. The Republic of Austria was interrupted by the fascist Federal State of Austria between 1934 and 1938, when the Federal Chancellor eliminated the Parliament in breach of the Constitution. The German Reich occupied Austria from 1938 to 1945. In 1945, the Federal Constitutional Law (B-VG) from 1920 was reinstated.

The federal capital is Vienna, which is also a constituent state. The country is divided into nine constituent states (Länder), also referred to as provinces.[3] These are Vienna, Burgenland, Lower Austria, Upper Austria, Carinthia, Salzburg, Styria, Tyrol, and Vorarlberg. As explained by Gamper, the territories of the provinces are based on historical grounds, rather than any other factors (e.g., ethnicity, language).[4] Austria has been described as a 'federation without federalism' due to a lower level of decentralisation of powers in comparison to other federations, including Germany and Switzerland.[5] As will be discussed later, Austria highly decentralises the legislative powers and the provision of child welfare services, including those for persons with disabilities.

Competences are divided between the federal level and provinces and are determined by the B-VG. Importantly, provincial responsibilities include enforcement of legislation related to social welfare, including most services for persons with disabilities, public social care

[1] *Independent statistics for evidence-based decision making*, Statistics Austria, (2023), accessed: 30th October, 2023, *available at* https://www.statistik.at/.
[2] Kinder- und Jugendhilfestatistik 2022, (2023), Bundeskanzleramt. Table 12.1.
[3] In this thesis, the term 'province' is used when referring to a constituent state of Austria.
[4] Anna Gamper, *Republic of Austria*, LEGISLATIVE, EXECUTIVE, AND JUDICIAL GOVERNANCE IN FEDERAL COUNTRIES (2006).
[5] Gerhard Lehmbruch, *Sub-Federal State-Building and the Origins of Federalism: A Comparison of Austria, Germany and Switzerland*, *in* CONFIGURATIONS, DYNAMICS AND MECHANISMS OF MULTILEVEL GOVERNANCE (Nathalie Behnke, et al. eds., 2019).

institutions, maternity, infant and adolescent care, hospitals and nursing homes, and adoption.[6] The division of competence for education is mixed, whereby in some spheres there is a sole responsibility of the Federation (e.g. tertiary education), and in other it is the Federation which sets the framework and provinces which enact detailed legislation and execute it (e.g. the kindergarten system).[7] The competence for personal assistance (PA) is shared, as the Federation is responsible for PA at work and sometimes education, while the provinces are responsible for PA in all other spheres of life.[8]

Austria is described as democratic republic, with a multiparty system, fair elections, and strong rule of law.[9] It is a high-income country,[10] with a very high human development index in 2021 (ranked 25th in the world), and with a low unemployment rate.[11] It is ranked among the least unequal countries in the world by Gini coefficient. By the distribution of wealth, it is one of the least equal among OECD countries.[12] Regional disparities inside Austria were assessed to be low, and different regions are more equal than in most other OECD countries.[13]

Austria's expenditure for social protection is almost 32.3% of its gross domestic product (GDP) in 2021, which is the second highest in the EU, according to Eurostat.[14] By function, almost half of the expenditure is for pensions, 27.2% for sickness and healthcare, 5.4% for disability, and 8.5% for the social protection of families and children.

The country borders with eight EU member states (Hungary, Slovenia, Italy, Switzerland, Liechtenstein, Germany, Czech Republic, and Slovakia). It is a member state of the EU since 1995, and a number of international and regional organisations, including the Council of Europe (since 1956), the Organisation of Economic Co-operation and Development (OECD) (since 1961), the Organisation for Security and Co-operation in Europe (OSCE) (since 1973), and the World Health Organisation (since 1945).

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[6] The Federal Constitutional Law (B-VG), BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 12(1).
[7] Id. at. Article 12(a), Article 14(3)(b).
[8] National Action Plan on Disability 2022–2030 Austrian Strategy for the Implementation of the UNCRPD, (2022), BMSGPK.
[9] E.g. BETH A. SIMMONS, MOBILIZING FOR HUMAN RIGHTS: INTERNATIONAL LAW IN DOMESTIC POLITICS (2009).
[10] *World Bank Open Data*, The World Bank Group, (2023), accessed, *available at* https://data.worldbank.org/.
[11] *Human Development Reports*, UNDP, (2023), accessed: 31st October, 2023, *available at* https://hdr.undp.org/.
[12] E.g. Policy Insights, (OECD WISE Centre), 2021.
[13] Regions and cities at Glance: Country note Austria, (2020), OECD.
[14] *Social protection statistics - social benefits*, Eurostat, (2024), accessed: 24th January, 2024, *available at* https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Social_protection_statistics_-_social_benefits#Expenditure_on_social_protection_benefits_by_function.

Additionally, this section of the thesis provides an in-depth examination of the CRC and the CRPD implementation regarding the right to live in a family environment for CWD in Vienna. Similarly, as in the case of South Africa where the country study focused on Gauteng, this selection enables a concentrated analysis on a major administrative centre. Vienna, serving both as the capital city and a federal state, is selected because it houses the largest population and the principal governmental bodies. The research primarily focuses on federal legislation and public policies in Austria (and state-level legislation in South Africa), and also considers judicial actions from other Austrian federal states. This approach allows for a thorough exploration that would be impractical to achieve within a feasible timeframe if it were to include all nine provinces of Austria.

1.1. Legal System, the Constitution, and international treaties

The Austrian legal system is based on Roman law. The legal order is hierarchical and lower legal acts must comply with higher legal acts. Stelzer explains that the rank of legal sources is determined by the complexity of the procedures to amend or create a norm, and sometimes, by the B-VG itself.[15] As a result, basic principles of the B-VG are the highest ranked norms, which are even above other provisions of the B-VG. Hence, the Constitutional Court may decide on the constitutionality of other constitutional provisions, or their compliance with the basic principles of the B-VG. The basic principles of the B-VG include, among others, democracy, the rule of law, federalism, and human rights.[16]

The B-VG was adopted in 1920 and has seen dozens of amendments until 2022.[17] The large number of amendments results from structural characteristics and political circumstances.[18] Specifically, amending the B-VG requires a two-thirds majority in Parliament. A referendum is mandatory only if general constitutional principles are to be abolished, in addition to a two-

[15] MANFRED STELZER, THE CONSTITUTION OF THE REPUBLIC OF AUSTRIA : A CONTEXTUAL ANALYSIS (Hart Publishing 1st ed. 2011), p. 24.
[16] Id. at.p. 32 - 36; Konrad Lachmayer, *The Constitution of Austria in international constitutional networks: Pluralism, dialogues and diversity*, *in* NATIONAL CONSTITUTIONS IN EUROPEAN AND GLOBAL GOVERNANCE: DEMOCRACY, RIGHTS, THE RULE OF LAW: NATIONAL REPORTS (Anneli Albi & Samo Bardutzky eds., 2019), p. 1274.
[17] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022.
[18] Lachmayer. 2019, p. 1273.

thirds parliamentary majority.[19] Lachmayer argues the Constitutional Court influences the B-VG considerably, contributing to its exceptional dynamism.[20]

The constitutional framework of Austria consists of many different acts. Those include ordinary constitutional acts, over 300 constitutional provisions in ordinary statutes, regional and international treaties with constitutional rank, alongside the B-VG.[21] There is no bill of rights in the B-VG, but its body of fundamental rights is composed of a number of documents and provisions, starting with the State Basic Law of 1867. The ECHR is part of the constitutional law, it was ratified in 1958, and in 1964 the Parliament declared its constitutional status.[22] Unlike other international human rights instruments, the ECHR can be directly applied and can be invoked before the Constitutional Court.[23]

1.1.1. Status and effect of international treaties

Lachmayer posits that the B-VG adopts a moderately monist stance in integrating IL with domestic law.[24] Additionally, Lachmayer holds that the division between the monism and dualism is decreasing in relevance, and that the reality is more complex, which is also the case in Austria.[25] The generally recognised rules of international law are part of federal law, in accordance with Article 9 B-VG. One major aspect of the Austrian legal system is its membership to the EU. Austria's accession to the EU necessitated the 'total revision' of the B-VG, and the decision was made after a referendum. This results in different understandings of the position of the EU law in the Austrian legal system. Stelzer explains a broad academic discussion on this issue which seems unresolved.[26] However, the European Court of Justice (ECJ) holds that the EU law has primacy over domestic law of the member states.[27]

On the occasion of the ratification of the CRPD by the National Council, it was declared that the CRPD has to be implemented through law and is not directly applicable, in accordance with

[19] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 44 (3).
[20] Lachmayer. 2019, p. 1274.
[21] Id. at, p. 1273.
[22] 59. Federal Constitutional Law: Amendment and supplementation of provisions of the Federal Constitutional Law of 1929 on state treaties., BGBl. No. 59/1964, 1964.
[23] Id. at.
[24] Lachmayer. 2019, p. 1313.
[25] Id. at.
[26] STELZER. 2011.
[27] Lachmayer. 2019, p. 1277.

Article 50 (4) of the B-VG. The same was the case with the CRC. The CRPD was published in the Federal Law Gazette III in October 2008.[28]

This dualistic approach, that Austria has with international human rights treaties in general (except the CAT), was criticised by the Austrian Council of Disabled Persons (Österreichischer Behindertenrat) (ACDP) and the European Disability Forum (EDF). Both groups reiterated that such treaties are considered primarily for interpreting domestic legislation and only when invoked by a party.[29] The established legal principle stipulates that treaties that require implementation through legislative acts initially have no internal legal impact; they are not directly enforceable, do not create individual rights, and cannot serve as the standard for assessing the legality of other legal actions.[30]

Each of the nine provinces is subject to the Federal Constitution and its own provincial constitutional law. In the hierarchy of legal sources, the B-VG is above provincial constitutions, which must be in line with the B-VG. Competences of the Federation and provinces for legislative and executive tasks are set out in the 'competence articles' of the B-VG (Articles 10 - 15). The legislative and executive authorities are classified into four distinct categories: exclusive federal law-making and implementation as per Article 10 of the B-VG, legislation at the federal level with execution by the provinces (Article 11 B-VG), federal framework legislation enacted and enforced by the provinces (Article 12 B-VG), and legislation and implementation exclusively under the purview of the provinces (Article 15(1) B-VG).

The implementation of international law falls under the jurisdiction of both the Federation and the provinces, contingent on whether the subject matter pertains to the competencies of the Federal Government or those of the provinces.[31] This depends on the specific matter of a treaty and each provision. In the case of the right to live in a family environment for CWD, there are issues that are the competence of the Federation and those that are competence of provinces. Social protection, support to families with CWD, prevention of separation, alternative care and

[28] Convention on the Rights of Persons with Disabilities and the Optional Protocol to the Convention on the Rights of Persons with Disabilities, BGBI. III Nr. 155/2008.d
[29] Joint Submission of the Austrian National Council of Disabled Persons (OeAR) and the European Disability Forum (EDF) on Austria to the Pre-sessional Working Group of the UN Human Rights Committee, 113th session, Austrian Disability Council, 2015.
[30] Legal sentence RS0131279, Supreme Court.
[31] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 16 (4).

DI are for the most part the competence of provinces.[32] However, family allowance and long-term care (LTC) allowance are under the direct federal administration.[33,34]

The Federation and provinces can enter into a legally binding '15a agreement'. The Federation and provinces may agree on the implementation of matters from the sphere of their competence, in accordance with Article 15a B-VG. Crucially, if a province fails to implement a treaty within its competence, authority shifts to the Federation, especially in law-making, as stipulated by Article 16(4) of the BV-G. The Federation supervises the implementation of treaties, also regarding those measures that fall into the provincial competence.[35] Where a province does not fulfil its obligations under a treaty, the Federation can issue binding instructions to the provincial government.[36] According to Bußjäger, that has never been done before.[37]

1.1.2. Judicial system

The courts are exclusively regulated by federal law.[38] In the jurisdiction of the courts of law (ordinary courts), there are 113 district courts, 20 regional courts, 4 higher regional courts, and the Supreme Court. Outside the jurisdiction of the courts of law, there are administrative courts and public law courts. In the former, there are 9 regional administrative courts, the Federal Fiscal Court, the Federal Administrative Court, and the Supreme Administrative Court. The public law courts include the Austrian Supreme Court, the Constitutional Court, and the Austrian Supreme Administrative Court. Formally, case law is not a source of law, but decisions from other courts can be considered.

The Constitutional Court is, *inter alia*, competent to review ordinances, laws that are enacted, international treaties, and to resolve conflicts of competence between the Federation and a province or between provinces.[39] Furthermore, an application for a constitutional review can

[32] Id. at. Section 12(1)(1).
[33] See note 103.
[34] Family Burdens Equalisation Act (FLAG), BGBl. Nr. 376/1967, last amend. BGBl. I Nr. 200/2023
[35] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 16 (5).
[36] Id. at.
[37] Peter Bußjäger, *Austria: The Implementation of the CRPD in the Austrian Federal System*, *in* FEDERALISM AND THE RIGHTS OF PERSONS WITH DISABILITIES: THE IMPLEMENTATION OF THE CRPD IN FEDERAL SYSTEMS AND ITS IMPLICATIONS (Delia Ferri, et al. eds., 2023), p. 68.
[38] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Articles 82, 83.
[39] Id. at. Articles 89 (2), 139 (1), 138 (1) subparagraph 3), 140 (1), 140a.

also be submitted by a natural person whose rights were infringed directly due to the unconstitutionality of a law.[40]

1.1.3. The Parliament

The Parliament, the National Assembly, consists of two chambers, the National Council, and the Federal Council. The National Council is the main legislative body, while the Federal Council represents provinces. Draft laws are, in practice, introduced by the Federal Government.

The Austrian Parliament operates as a bicameral system, consisting of the National Council (Nationalrat) and the Federal Council (Bundesrat), designed to facilitate a comprehensive legislative process within the framework of a parliamentary republic. The National Council, comprising 183 members, is elected directly by the citizens through a proportional representation system. Its primary role includes drafting and passing laws, overseeing the executive branch, and ratifying international treaties. After a bill is passed by the National Council, the President of the National Council transmits it to the Federal Council, which has eight weeks to decide whether to reject the bill's enactment. If there is no objection, the Federal President authenticates the bill, which is also signed by the Federal Chancellor. In the end, the bill is published in the Federal Law Gazette (Bundesgesetzesblatt BGBL).[41]

The Federal Council serves as the representative body of Austria's nine federal states, with its membership based on the population size of each state. Although its legislative influence is comparatively limited, especially in constitutional matters where its consent is mandatory, the Federal Council plays a crucial role in safeguarding the interests of the federal states within the legislative process, thereby embodying the federal structure of the Austrian state.

[40] Id. at. Article 140 (2)(c).
[41] See more: CHRISTOPH GRABENWARTER, INTRODUCTION TO THE LAW OF AUSTRIA (Christoph Grabenwarter & Martin Schauer eds., Wolters Kluwer. 2015), p. 7.

1.2. International and regional human rights mechanisms' recommendations

This section provides an overview of relevant recommendations issued to Austria by regional and international human rights mechanisms, similar to the analyses for the other two countries in this dissertation. This includes recommendations issued by treaty bodies, UN special procedures, the UPR mechanism, regional human rights bodies, including the CPT Committee of the CoE. This overview serves as a starting point for the exploration of the implementation of relevant CRC and CRPD norms.

Austria is a state party to CRC (1992), CRPD (2008), OPCRPD (2008), CAT (1985), OPCAT (2012), ICCPR (1978), ICESCR (1978), CEDAW (1982), and to the regional treaties such as ECHR (1958), RESC (2011), and CPT (1989).[42] The country has not made relevant reservations or declarations to any of those UN treaties. Notably, Austria has not ratified the Optional Protocol to the CRC concerning a communications procedure, nor the Additional Protocol to the European Social Charter regarding collective complaints. The Charter of Fundamental Rights of the European Union (CFREU) is binding upon Austria as a member state of the EU, since the entry into force of the Lisbon treaty (2009).

1.2.1. CRC Committee

In 2020, the CRC Committee urgently called on Austria to phase out institutionalisation and enhance support for family-based care for all children.[43] The treaty body also recommended to harmonize rules of the placement of children across provinces and the introduction of quality standards of care.[44] Commenting on the rights of CWD, the treaty body expressed serious concern with the lack of DI and a comprehensive plan to conduct such a reform.[45] The CRC Committee noted that general public services, including inclusive mainstream education, were inaccessible and unavailable to CWD, potentially leading to their segregation into special

[42] Years of ratification are in the brackets.
[43] Concluding observations on the combined fifth and sixth periodic reports of Austria, CRC/C/AUT/CO/5-6, Committee on the Rights of the Child, 2020, para. 4.
[44] Id. at, para. 29.
[45] Id. at, para. 30 - 31.

systems.[46] To this end, the CRC Committee urged Austria to adopt a human rights approach to disability in the new strategy for the period 2021-2030 and to adopt a plan for DI. It also recommended merging social welfare systems for non-disabled and disabled children, and awareness raising campaigns to address the prevailing unfavourable picture of CWD in the public.[47]

The CRC Committee singled out both themes (family environment and alternative care, children with disabilities) as the ones deserving urgent attention of the authorities. All the issues underscored by the treaty body uncover some major barriers to the life in a family environment for CWD. Those are: the lack of plans for DI, insufficient support for the care in a family environment and measures for the prevention of separation, separate tracks in social welfare which contributes to segregation, a charity approach to disability and the lack of public awareness for the rights and agency of children and adults with disabilities.[48]

In the past, the CRC Committee expressed worry for the large number of CWD in institutions, the decision to attend mainstream schools for CWD resting solely on their parents, quality control in institutional care and poor data collection.[49]

1.2.2. CRPD Committee

In September 2023, the CRPD Committee issued concluding observations, expressing grave concerns about the provincial governments' disregard for the CRPD.[50] The committee criticised the uneven legislation across provinces and their medically oriented disability approach, notably reflected in the National Action Plan for Disability 2022-2030 (NAPD 2022).[51]

In relation to Article 19 CRPD, the CRPD Committee eventually criticised the lack of progress in implementing most of the provisions of this article. The lack of a comprehensive DI strategy

[46] Id. at.
[47] Id. at.
[48] Id. at, para. 29, 31.
[49] Concluding observations on the combined third and fourth periodic reports of Austria, CRC/C/AUT/CO/3-4, (Committee on the Rights of the Child), 2012, para. 44 – 45. Concluding observations: Austria, CRC/C/15/Add.251, (Committee on the Rights of the Child), 2005, para. 17.
[50] Concluding observations on the combined second and third reports of Austria, CRPD/C/AUT/CO/2-3, Committee on the Rights of Persons with Disabilities, 2023, para. 6 – 7.
[51] Id. at.

to ‘forcefully promote, coordinate and design the deinstitutionalization process’ in all provinces, was marked as one of major issues.[52] Then, the denial of the right to choose one’s own residence and the lack of budgetary allocations for PA, different regulations across provinces and the requirements for PA based on the medical approach.[53] Crucially, the committee highlighted the misuse of ESIF funds for renovating and constructing segregated institutions for persons with disabilities.[54] That issue is addressed in the section ‘ESI Funds and institutional care in Austria and the EU‘.

In relation to Article 23 CRPD, the CRPD Committee criticised the removal of CWD from their parents' care. It recommended an end to this practice and opposed the placement of CWD in institutions and residential special schools.[55]

The criticism for segregated education and institutionalisation in residential schools was expressed two more times. Commenting on the implementation of Article 7 CRPD, the treaty body expressed concerns with the link between institutionalisation and special education.[56] Namely, special schools in Austria provide residence, which effectively results in the institutionalisation of CWD. To that end, the body recommended Austria to end segregation in all spheres of life and improve separation prevention and support to families of CWD.[57] Also, in relation to Article 24 CRPD, the CRPD Committee communicated grave concern with the prioritization of segregated education over inclusive education, and a number of other deficiencies in the education system.[58]

The language used by the CRPD Committee in relation to the implementation of Articles 19 and 23 and the issue of segregated education, which sometimes results in institutionalisation, indicates the severity of the situation in Austria.

In summary, the CRPD Committee identified major concerns in Austria regarding the family environment for CWD. These include the lack of DI strategy, a preference for segregated over inclusive education, institutionalisation in residential schools, inconsistent regulations across

[52] Id. at, para. 45a(a).
[53] Id. at, para. 45 (a, b).
[54] Id. at, para. 45 (c).
[55] Id. at, para. 54 (b).
[56] Id. at, para. 20 – 21.
[57] Id. at.
[58] Id. at. 55, 56.

provinces, insufficient budget allocations for family support and separation prevention, and the renovation and construction of institutional settings, including with the help of the ESI Funds.

1.2.3. Other recommendations

In 2019, the CEDAW Committee highlighted concerns about the institutionalization of girls with disabilities and noted a trend towards strengthening special education rather than promoting inclusion in mainstream settings for children and adults with disabilities.[59]

Through the UPR mechanism, Austria received recommendations to enhance its inclusive education system from several countries, including Israel, Costa Rica, Slovakia, and Honduras.[60] Other relevant recommendations were not identified neither in the UPR mechanism nor the recommendations from the UN Human Rights Council's special procedures (independent human rights experts).

In 2021, the European Committee of Social Rights concluded that social services across various provinces were not adequately adapted to meet the population's needs.[61] In 2019 and 2015, the European Committee of Social Rights found that family benefits (Familienbeihilfe) in Austria were sufficient, affirming the country's compliance with Article 16 of the RESC.[62]

The European Committee for the Prevention of Torture has not visited social welfare establishments for children with disabilities in Austria until 2023. In 2012, Nils Muižinieks, then High Commissioner for Human Rights of the Council of Europe, reported on his visit to Austria, emphasizing the lack of clear targets and deadlines for DI and noting how the federal structure negatively impacts DI's implementation.[63]

[59] Concluding observations on the ninth periodic report of Austria, CEDAW/C/AUT/CO/9, Committee on the Elimination of Discrimination against Women, para. 30, 40.
[60] *UPR Info Database*, UPR Info, accessed: 2nd May 2023, *available at* https://upr-info-database.uwazi.io/en/.
[61] Conclusions 2021: Austria, European Committee on Social Rights, 2022.
[62] Conclusions 2019: Austria, European Committee of Social Rights, 2020.
[63] Report by Nils Muižnieks Commissioner for Human Rights of the Council of Europe Following his visit to Austria from 4 to 6 June 2012, CommDH(2012)28, Council of Europe, 2012, para. 29.

2. Situation of children with disabilities

2.1. Historical human rights violations and reform of institutional care

In the last several decades, Austria has had to grapple with a rather peculiar history of care and treatment of CWD. The period of World War II, arguably one of the darkest chapters in Austrian history, witnessed horrific treatment of children and adults with disabilities. This period included mass murders of CWD, and fatal medical experiments conducted at different locations, including the infamous child clinic, Am Spiegelgrund, and the Hartheim killing centre.[64] The murder of CWD was a part of the Nazi ideology promoting a 'pure Aryan race'. Numerous doctors and nurses were complicit in the murder and maltreatment of disabled and sick children; however, only a few were convicted. Post-1945 trials focused primarily on the most prominent figures involved in the crimes at Am Spiegelgrund, resulting in the imprisonment of two doctors and one nurse, and the death sentence for another doctor.[65] Erwin Jekelius, who served as the head of the hospital from 1940 to 1942, was sentenced to hard labour in Soviet Union, where he died several years later.[66] It is believed that many more individuals were involved but either did not face trials or evaded convictions.[67]

After the war, Pavilion 15 at Am Spiegelgrund, previously a site of systematic murder of CWD, disturbingly continued to house CWD, with many nurses from the National Socialist regime still employed.[68] Flieger reports that CWD were no longer murdered after 1945, but they continued to be completely segregated and ill-treated.[69] Some children were transferred to the Wilhelminenberg institution, which became notorious for grave rights violations, violence, and

[64] Petra Flieger, *Endstationen: oder Zum historischen Erbe des Nationalsozialismus im Umgang mit behinderten Menschen in Österreich*, STIMME. ZEITSCHRIFT DER INITIATIVE MINDERHEITEN (2017); Mattner Dieter (2000) as cited in: Gertraud Kremsner, et al., *Tracing the historical and ideological roots of services for people with intellectual disabilities in Austria, in* INTELLECTUAL DISABILITY IN THE TWENTIETH CENTURY (2019).
[65] EDITH SHEFFER, ASPERGER'S CHILDREN: THE ORIGINS OF AUTISM IN NAZI VIENNA (W.W. Norton & Company First edition ed. 2018).
[66] Id. at.
[67] Id. at, p. 292.
[68] Flieger, STIMME. ZEITSCHRIFT DER INITIATIVE MINDERHEITEN, (2017), p. 4.
[69] Id. at.

abuse of children for decades. In 2002, remains of over 600 children who died at Am Spiegelgrund were buried at the Vienna Central Cemetery, and a memorial site opened.[70]

In the period after the World War II, many children residing in public and private institutions, including children's and youth homes run by the federal government, the provinces and the churches, psychiatric institutions, hospitals and sanatoriums, were subject to violence and other rights violations.[71] According to Lueger-Schuster *et al.*, public exposure of these crimes began in 2010, fuelled by newspaper articles where adult survivors shared their experiences of abuse in institutions under the City of Vienna's administration.[72] The authors claim it was the media reports that ultimately generated the momentum for public awareness, which resulted in concrete institutional steps. An interviewee suggested a different understanding of why the issue became high-profile. They mentioned that the media picked up on it only after Friedrich Zawrel's fascinating and gut-wrenching testimony was published by Falter, indicating that the connection with the Nazi regime was the main reason for the popular interest.[73]

The political will to deal with the issue of the past was reflected in the acts of authorities but also expressed by high-ranking Viennese officials. On one occasion, Vienna's Mayor Michael Ludwig expressed: 'The victims have experienced the unbelievable; it is our duty as a city to assume our responsibility, to recognise the injustice that has occurred without relativizing it and to sincerely and deeply apologize for it.'[74]

Initially, the victims' organisation White Ring (Weißer Ring) was tasked with assessing compensation claims for approximately 2.700 individuals between 2010 and 2016.[75] A branch of the NGO was established in the Austrian Ombudsman Board's (AOB) premises in Vienna to process the claims. The White Ring expanded its work with institutional abuse victims to include victims who resided in establishments of the Protestant Church, its charitable organisation Diakonie, and institutions under federal jurisdiction.[76]

[70] SHEFFER. 2018, p. 302.
[71] Home Victims' Pensions Act - HOG, BGBL I, No. 69/2017, 2017.
[72] B. Lueger-Schuster, et al., *Child abuse and neglect in institutional settings, cumulative lifetime traumatization, and psychopathological long-term correlates in adult survivors: The Vienna Institutional Abuse Study*, 76 CHILD ABUSE NEGL (2018).
[73] V. O., Interview, 8th June, 2023.
[74] Abschlussberichthilfe Für Opfer Von Gewalt In Einrichtungen Der Wiener Jugendwohlfahrt (Final Report Assistance for Victims of Violence in Viennese Youth Welfare Facilities), (2019), Weißer Ring.
[75] Lueger-Schuster, et al., CHILD ABUSE NEGL, (2018).
[76] Tätigkeitsbericht 2012, (2012), Weißer Ring.

In 2017, the AOB took on the responsibility of Independent Pension Commission (IPC) (Heimopferrentenkommission), on the ground of the Federal Home Victims Pension Act.[77] The law prescribes that residents of institutions between May 9th 1945 and 31st December 1999 who were victims of violence are entitled to a pension.[78,79] Former victims who were residents of private institutions, are eligible for the pension if the referral was made by a child and youth welfare organisation.[80] The IPC is responsible for determining whether those individuals are eligible for the monthly pension as a form of compensation for their suffering.[81] The AOB receives hundreds of cases for assessment each year (as of 2022).[82]

The AOB reports systematic application of violence in municipal, regional, church, and private institutions, hospitals, psychiatric wards, and foster care.[83] Sexual violence was frequent, while the treatment and education were 'authoritarian and brutal'.[84] In the past, every province, except Burgenland had had special boarding schools for deaf children. Therefore, deaf children had been leaving their families and lived in institutions attached to those special schools *en masse*. The regime of living, institutional culture, involvement of authorities, shared personal characteristics of residents, and other factors undoubtedly testify that the housing in special boarding schools in Austria amounted to institutionalisation.

This study does not investigate the IPC mechanism further, considering that, by this point in time, only adults are eligible to benefit from the scheme and the study is focused on contemporary circumstances surrounding the right to family life for CWD. Regardless, the fact that the named act was adopted, and the IPC established speaks to the intention of Austria's authorities to break with their infamous history of serious human rights violations in alternative care, which children, including CWD, had experienced in both institutional and foster care in the past. Surprisingly, this study reveals that Austria did not see DI as a primary tool to sever ties with the legacy of institutional care and the associated human rights violations. Instead, as it will be shown, public policy and practice seem to focus on the fragmentation of institutional care, better quality of care in smaller units, and improved supervision.

[77] BGBL I, No. 69/2017.
[78] Id. at.
[79] Annual Report of the Austrian Ombudsman Board to the National Council and the Federal Council: Monitoring Public Administration, (2022), AOB, p. 17.
[80] BGBL I, No. 69/2017. Article 1(1).
[81] See note 79.
[82] AOB, 2022**, p.** 18.
[83] Id. at, p. 35.
[84] Id. at.

2.2. Reform of the long-term care system and institutional care

LTC is defined as the continuous provision of assistance to individuals of any age who need ongoing support due to chronic illness or disability.[85] In 1977, reflecting the prevailing medical and segregationist approach to disability, the Federal Ministry for Social Administration drafted a policy document centred on rehabilitation and sheltered workshops.[86] Trukeshitz *et al*. emphasise the reform of LTC during the 1980s and the 1990s, which resulted in the adoption of the Federal LTC Allowance Act (BPGG),[87] increased support for family care and the expansion of institutional care.[88] According to Österle, prior to the 1990s, the dominant model for providing LTC services was centred on residential care, primarily delivered by public authorities or private non-profit organisations, while community-based services were sparsely scattered around the country.[89]

Already in the 1980s and the 1990s authorities and other stakeholders saw the need for a more comprehensive approach to disability. According to Österle, the 1990s saw extensive stakeholder consultations, including with disability advocates and political parties, culminating in a consensus agreement in 1993.[90] This agreement focused on supporting LTC within families, introducing a tax-funded universal LTC allowance (the 'cash for care' programme), and expanding institutional care in smaller facilities.[91] The Austrian Federal Governments Disability Concept from 1992 provides a great insight into the intended (not necessarily realised) disability policy of that time.[92][93]

[85] August Österle, *Long-term care reform in Austria: Emergence and development of a new welfare state pillar, in* REFORMS IN LONG-TERM CARE POLICIES IN EUROPE: INVESTIGATING INSTITUTIONAL CHANGE AND SOCIAL IMPACTS (2012), p. 160.
[86] The Austrian Federal Government's Disability Concept, Federal Ministry for Labour and Social Affairs and Österreichische Arbeitsgemeinschaft für Rehabilitation, 1992. ch. 1.1.
[87] Federal Long-term Care Allowance Act (BPGG), BGBl. Nr. 110/1993, last amend. BGBl. I Nr. 170/2023.
[88] Birgit Trukeshitz, et al., *Austria's Long-Term Care System: Challenges and Policy Responses*, JOURNAL OF LONG TERM CARE (2022), p. 89.
[89] Österle. 2012, p. 159 - 160.
[90] Id. at.
[91] 866. Agreement between the federal and state governments according to Article 15 a B-VG on joint measures by the federal and state governments for people in need of care, including facilities, NR: GP XVIII RV 1069 AB 1331 S. 136. BR: AB 4660 S. 576
[92] See 'Other policy documents'.
[93] Federal Ministry for Labour and Social Affairs and Österreichische Arbeitsgemeinschaft für Rehabilitation, 1992.

A Federation-provinces agreement, one of the so-called '15a agreements', was signed to manage the new LTC system and to delineate responsibilities between the Federation and the provinces. Under this agreement, as Österle notes, the provinces committed to extending the range of services, including semi-residential and residential services.[94] The agreement among stakeholders was reached only after all parties involved were satisfied with the acknowledgment of their respective concerns and interests.[95] Österle contends that political parties were inclined to support the reform, partly due to market-oriented developments within the LTC system and the need for cost control.[96] More significantly, 1993 marked a crucial turning point in the evolution of the country's welfare system by recognising LTC as a separate sector within the social welfare system, a development Österle aptly terms a 'new welfare state pillar'.[97]

Different authors argue that another significant point in the LTC system development was in 2007, when the 24-hour care work of migrant workers in private households of persons in need of care was formally recognised and regulated.[98] Namely, this type of care emerged informally, in border areas, but spread throughout the country and the situation demanded regularisation for various reasons.[99] The regularisation was done with the adoption of the Home Care Act.[100] Potentially, CWD could also benefit from this type of around-the-clock care, and prevent admission in institutional care.[101]

In 2009, new amendments were made to the BPGG, by recognising the need for care for severely disabled children, and children and adults older than 15 with dementia and severe mental illness.[102] This was a significant change for the families of disabled children (and foster carers), which could then more effectively cover the costs of care of another person or any other service to prevent institutionalisation, as a 'hardship' supplement was added. In 2012, the

[94] Österle. 2012, p. 161.
[95] Id. at.
[96] Id. at, p. 164.
[97] Id. at.
[98] Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022); Österle. 2012.
[99] Österle. 2012, p. 168 - 169.
[100] Home Care Act (HBeG), BGBl. I Nr. 33/2007.
[101] See 'Support and services to children with disabilities and their families'.
[102] Amendment of the Classification Ordinance to the Federal Care Allowance Act (EinstV), BGBl. II Nr. 469/2008.

LTC allowance came under the exclusive competence of the Federation with the adoption of another BPGG amendment.[103]

In 2009, a significant policy shift occurred as the requirement for family members to fund residential care was discontinued across all provinces.[104] Up to then, family members participated in the funding of residential care, which was calculated on the basis of their income and assets. Due to funding challenges, some provinces later reinstated the policy requiring financial contributions from family members' assets. This arrangement was finally terminated in 2018 by the Federation, with funding for residential care in the provinces thereafter ensured by the central government.[105] In terms of DI, eliminating parents' financial contributions to their child's residential care might have eased the financial burden for some parents but could also have inadvertently encouraged more parents to opt for institutional care.

Perhaps, the monumentality of the LTC reform of 1993, which focused both on the expansion of family support and institutional care, cemented the trajectory of the development of care for CWD too. During the stakeholders' dialogue, contemporary standards such as the CRPD did not yet exist, and the CRC had only been ratified by Austria a year prior, in 1992. Consequently, the 1993 reform, not being grounded in these newer international standards, appears partly obsolete today, especially regarding CWD.

At this point, Degener's division of approaches to persons with disabilities in the context of the IHRL becomes handy for readers to understand the problem of an outdated policy, from the perspective of the contemporary human rights law. Degener outlines five distinct phases in the IHRL approach to disability: from viewing individuals as invisible citizens (1945–1970) to recognising them as subjects requiring rehabilitation (1970–1980), objects of human rights (1980–2000), and finally, as subjects with human rights since 2000.[106]

Considering the nature of the 1993 reform, which hinges on robust social protection, one could argue that the 1993 policy straddles the 4th and 5th phases of Degener's model. On one hand, the policy recognises the importance of increased autonomy and freedom of choice, as evidenced by the introduction of cash transfers. On the other hand, the expansion of

[103] Pflegegeldreformgesetz 2012, BGBl. I Nr. 58/2011.
[104] Österle. 2012, p. 171.
[105] Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022), p. 89.
[106] Theresia Degener, *Die UN-Behindertenrechtskonvention als Inklusionsmotor*, 57 RDJB RECHT DER JUGEND UND DES BILDUNGSWESENS (2009).

institutional care, where individuals with disabilities are expected to receive adequate care, aligns more with the phase where they are viewed as recipients of rights, rather than autonomous individuals with agency.

One may argue that the 1993 policy remains highly relevant due to the significant number of children in residential care, the ongoing expansion of SGHs, and the nearly unanimous support for SGHs for children, including endorsement by the AOB (as detailed in subsequent paragraphs). Indeed, any reforms that followed have been characterised as gradual, without causing major disruptions to the LTC system. This confirms that the practices established by the 1993 policy, particularly the continued reliance on and even expansion of institutional care, persist in the present.[107]

Surprisingly, even the AOB has consistently called for the expansion of SGHs, and the expansion of family-based support and services concurrently.[108] The fact that the AOB, an entity expected to be progressive in adopting international human rights norms and standards, does not prioritise DI, despite broad international support for it, highlights the deeply entrenched nature of institutional care in the Austrian social care system and society at large. Also, the special report by the AOB was published two months after the publication of the CRPD Committee's General Comment No. 5, which openly condemns family-like care and SGHs.[109] Moreover, the Independent Monitoring Committee (IMC), a federal, independent CRPD-implementation monitoring body, called for the development of family-like care (alongside the actual family care) for CWD in 2016.[110] This was published in the statement of the IMC regarding DI in Austria, which was developed after consultations with different stakeholders, a year before the adoption of the General Comment No. 5 of the CRPD Committee.

[107] Österle. 2012; August Österle & Karin Heitzmann, *Austrification in welfare system change? An analysis of welfare system developments in Austria between 1998 and 2018*, *in* ROUTLEDGE HANDBOOK OF EUROPEAN WELFARE SYSTEMS (Sonja Blum, et al. eds., 2020); Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022).
[108] Sonderbericht Kinder und ihre Rechte in öffentlichen Einrichtungen, (2017), Volksanwaltschaft, p. 30.
[109] General comment no. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, Committee on the Rights of Persons with Disabilities, 2017, para.16 (c).
[110] Stellungnahme De-Institutionalisierung, Monitoring Ausschuss, 2016, p. 6.

Table II. 2 Updated and adjusted timeline of significant LTC reforms in Austria, according to Österle. Source: Österle. 2012. Long-term care reform in Austria: Emergence and development of a new welfare state pillar, p. 166.

Year	Change	Level
1993	Introduction of the LTC allowance.	Central / Provincial
	Federation-provinces agreement on the development of the LTC system.	
2001	Elimination of the previous age limit (3 years) in the care.	Central / Provincial
1996	Regional development plans for residential, semi-residential, and community care services implemented (covering 1996–2010).	Provincial
2004	Financial support scheme for temporary respite care.	Central
2007	Regularisation of 24-hour in-home care and the introduction of financial support for 24-hour care.	Central / Provincial
2009	Abolishment of the participation of family in the costs of residential care.	Provincial
	Children with severe disabilities recognised in the BPGG and a 'hardship' supplement introduced.	Central / Provincial
2012	LTC allowance came under the competence of the central level.	Central
2018	Residential care funded by the central level.	Central

The reform of institutional care did not necessarily coincide with the reform of the LTC system, arguably because the motivations behind each were distinct. In Vienna, the reform of institutional care, which is a type of an LTC service, has had several phases by this point, according to the White Ring. Starting in 1971, guided by the Vienna Home Commission (Wiener Heimkommission), the first changes focused on restructuring institutions by placing children in smaller groups and relaxing the regime.[111] However, this was seemingly not good

[111] Ring, 2019**, p.** 38.

enough, and part of the institutional culture persisted for a long time, reportedly largely due to insufficiently trained staff, who perpetuated old practices.[112]

Reportedly, with the Home Reform 2000 and 2000+ (Heim 2000 and Heim 2000+) in Vienna (initiated in 1995), things changed significantly with the residential care in the capital, for institutions under the children and youth welfare department (residential facilities for CWD were not part of that reform). Large institutions were closed down, and children and adolescents placed in smaller residential care, of up to 8 residents.[113] Temporary placements of children and adolescents are now in provincial crisis centres, while the initial placement of babies and young children is only with foster parents and temporarily in crisis foster families (which is not always possible, due to the lack of crisis foster persons).[114] The staff/residents ratio improved as well as their training, according to White Ring.[115] Also, the approach regarding the length of placements in residential care changed. The current (declarative, and not necessarily achieved) goal of placements is to minimize their duration, swiftly reintegrating children with their biological families or placing them in suitable foster families, while also providing community- and family-based services and intensive family support measures to assist families in keeping their children at home whenever possible, claims White Ring.[116]

It could be argued that the need to address the historical repercussions of Nazi atrocities at Am Spiegelgrund and post-World War II abuses in children and youth homes across Austria catalysed these reforms. These reforms have manifested in a significant reduction in large residential care facilities, not only in Vienna but also in other provinces of the country. Nevertheless, the shift has been towards smaller residential care settings, improved oversight, supervision, and a higher quality of care. The emergence of the CRC, the CRPD and international standards in alternative care seemingly helped to further the development of alternative care at the beginning of 21st century, but not towards decisive DI. Also, the public image of CWD likely contributes to the continued segregation of CWD, which, according to the ACDP and a study commenced by public authorities, is utterly unfavourable and portrays CWD as objects of pity and charity.[117]

[112] Id. at.
[113] Id. at.
[114] Id. at.
[115] Id. at.
[116] Id. at, p. 39.
[117] Second Alternative Report on the implementation of the UN Convention on the Rights of Persons Disabilities in Austria, (2018), ACDP, p. 8 - 9.

Interestingly, it appears that the concept of smaller residential care facilities has not been perceived as a detriment to the well-being of children, the way it is seen by the CRPD Committee, and reflected in new relevant international soft law instruments. As a result, such facilities continue to be widely utilized in Austria. This situation prompts inquiries into the approach adopted by Austrian authorities in formulating their policies. It implies that these policies are largely influenced by the experiences of professionals working in institutional care and the evidence of violence within large residential settings. This approach diverges from the principles of the CRPD, the committee's recommendations, and recent developments in international human rights law and alternative care standards. The policy changes implemented since 1993 have been relatively minor and incremental in this aspect of social policy, as well as in the LTC as argued by other authors,[118] while a more substantial and transformative shift is required.

2.3. Contemporary social protection

The social protection for adults, children and families in Austria is often praised and widely recognised for its successes. Austria is often described as a welfare state, with a conservative character.[119] studies on Austria's social welfare system seldom address the social protection of CWD. This oversight is partly due to a lack of data, leaving even experts in the field often unaware of the specific challenges faced by these children. However, various aspects of the system and its subtle changes over time are well-researched, including by the previously mentioned August Österle and Birgit Turkeshitz, and are significant for the current analysis.

The AOB underscored the conflict of competencies between federal, provincial and local levels regarding the implementation of the CRPD.[120] Many stakeholders and academics cite federalism and policy fragmentation as primary reasons for unequal access to care, support, and services, contributing to the sluggish implementation of the CRPD.[121] It is reported that

[118] See notes 85, 88.
[119] E.g. Österle & Heitzmann. 2020.
[120] Volksanwaltschaft, 2017**, p.** 63.
[121] E.g. Country report on Living independently and being included in the community - Austria, The Academic Network of European Disability Experts (ANED), 2019. Vjenka Garms-Homolovà, *Austria*, *in* HOME CARE ACCROSS EUROPE (Nadine Genet, et al. eds., World Health Organization. Regional Office. 2013). Country Report on Austria for the Study on Member States' Policies for Children with Disabilities, (Policy Department C: Citizens' Rights and Constitutional Affairs Directorate General for Internal Policies), European Parliament, 2014.

provinces show little interest in implementing international laws ratified by the federal government, which itself lacks either the power or the incentive to enforce these laws at the provincial level (despite the constitutional competence to take over the implementation from provinces in certain cases or to issue binding instructions). Seemingly, the problem with federalism in this sphere comes down to the issue of funding (which government level takes the responsibility for the funding) and the lack of unified strategies, rules, and practices. Consequently, the 2020 transfer of all competencies in child and youth welfare from the Federation to the provinces has drawn significant criticism from child rights specialists, NGOs, and NHRIs.[122] While federalism scholars praise federal governance for its superior ability to contribute to the democratisation and better answer regional/local needs,[123] others, such as Belser, highlight federalism's tendency to impede the equal implementation of human rights in the country drawing from the experience of human rights advocates and international and national NGOs.[124]

Apart from general social protection measures, CWD and their families are entitled to disability-specific protection and support.[125] Social protection for CWD and their families includes material support, community-based services, in-home social care, and alternative care options for children deprived of their family environments.[126] Access to social services in Austria is often criticised for being overly bureaucratic, reliant on a medical model of disability, and unevenly distributed across the country.[127] Apart from the fragmentation of disability and child welfare policy on the federal-provincial level, there is also fragmentation of the competence within provinces, as the social protection for CWD is divided between the child and youth welfare department and the social welfare department. This may also impede the development of a unified policy and the availability of comprehensive data on the provincial level.

Bußjäger. 2023. Written Submission of the Austrian Disability Ombudsperson on the Occasion of the Second Constructive Dialogue with Austria in its 29th Session, (2023), AOB.

[122] E.g. *Massive Kritik an "Verländerung" der Kinder- und Jugendhilfe*, Der Standard, (2018), accessed: 5th March, 2024, *available at* https://www.derstandard.at/story/2000081991380/verlaenderung-der-kinder-und-jugendhilfe-laut-volksanwalt-schockierend.

[123] E.g. John Kincaid, *Values and value tradeoffs in federalism*, 25 PUBLIUS: THE JOURNAL OF FEDERALISM (1995).

[124] E.g. Eva Maria Belser, *Why the affection of federalism for human rights is unrequited and how the relationship could be improved*, STUDIES IN TERRITORIAL AND CULTURAL DIVERSITY GOVERNANCE (2021).

[125] See 'Support and services to children with disabilities and their families'.

[126] All forms of services and support are discussed in detail in the following sections.

[127] Annual Report on the activities of the Austrian National Preventive Mechanism (NPM), (2023), AOB, p. 85.

The social protection system for CWD is distinct from the system serving non-disabled children, a separation that has been criticised by various stakeholders, including the AOB.[128] An approach based on separate social protection system, and other systems such as a mainstream and special education, can impede the inclusion of CWD in all spheres of life. Provinces are responsible for family support and childcare; hence the data are collected by provincial authorities. In their report to the CRPD in 2018, Austrian authorities claimed that the data collection had been improved since 2012.[129] Child-related statistic is available since 2015, based on the Federal Child and Youth Welfare Act.[130] Despite improvements, significant gaps in data on CWD persist, drawing criticism from the CRPD Committee in 2023 and recommendations for the development of a comprehensive national database on children and adults with disabilities, which will include data on institutional care.[131]

As of 2023, the child and youth welfare statistical annual reports still exclude specific data on CWD, as confirmed by an official at the Austrian Statistics Office (Statistik Austria).[132] Provincial departments for social welfare are competent for persons with disabilities, including CWD, but they do not publish relevant statistics. Furthermore, much of the available data on persons with disabilities in Austria fail to specifically reference CWD or to disaggregate the data by age, blending children's data with adults. The National Action Plan on Disability 2022 – 2030 recognises the issue and sets an objective to drastically improve data on children and youth with disabilities.[133]

Amidst the lack of data about CWD, the state's reply to the CRPD Committee's List of issues prior to reporting (LOIPR) is one of rare sources of somewhat disaggregated data regarding CWD. The state's response to the LOIPR was submitted in 2019, primarily utilising data from 2018 and 2017. This not only renders the data outdated, but the absence of information from multiple time points also hinders any analysis of trends.

[128] Supplementary Report of the Austrian Ombuds Offices for Children and Youths on the 5th and 6th State Party Report of the Republic of Austria to the CRC, (2019), KIJA, p. 33.
[129] Combined second and third reports submitted by Austria under article 35 of the Convention pursuant to the optional reporting procedure, due in 2018, CRPD/C/AUT/2-3*, Committee on the Rights of Persons with Disabilities, 2019.
[130] Id. at, para. 40.
[131] CRPD/C/AUT/CO/2-3, para. 70
[132] Statistik Austria was contacted via email requesting information regarding CWD in different forms of alternative care and recipients of child and youth welfare support and services. The institution replied that such data does not exist with them.
[133] BMSGPK, 2022**, p.** 17.

Another source of (aggregate) data on children deprived of liberty, including in social care institutions, is a study by Desmond and Lu. The authors estimated the rate of institutionalisation of children in Austria between 501 and 1000 in 100.000 children. This rate places Austria among the countries with high levels of child institutionalisation, contrasting sharply with countries like Serbia and South Africa, where the rates are significantly lower (under 100 per 100.000 children).[134]

Unfortunately, the 2018 data provided by state authorities in response to the LOIPR are not comprehensive, failing to adequately depict the situation regarding family support, services, and the state of alternative care across the provinces. Specifically, the CRPD Committee requested data on the number of CWD in alternative care, including institutional settings. The authorities' underwhelming response drew criticism in the Concluding Observations for Austria's inadequate data collection practices.[135]

The following table shows aggregate data on children who received some kind of social welfare support and services, including out-of-home care (residential care and foster care) in Austria. It is not clear how many CWD are included in this statistic if any.

Table II. 3 The number of children using support and services in Austria in 2022. Source: Bundeskanzleramt.[136]

	All forms of care and support	**Residential care**	**Foster care**	**Residential & Foster care %**
Burgenland	1.556	325	126	28,98%
Carinthia	3.674	766	249	27,63%
Lower Austria	11.155	1.359	797	19,33%
Upper Austria	4.642	912	661	33,89%
Salzburg	2.618	472	204	25,82%
Styria	6.805	886	820	25,07%

[134] Chris Desmond, et al., *Prevalence and number of children living in institutional care: global, regional, and country estimates*, 4 THE LANCET CHILD & ADOLESCENT HEALTH (2020). Full data Group – 2. in MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 503.
[135] List of Issues prior to submission of the combined second and third periodic reports of Austria, CRPD/C/AUT/QPR/2-3, Committee on the Rights of Persons with Disabilities, 2018, para. 13.
[136] Bundeskanzleramt, 2023.p. 15, 25.

Tyrol	3.634	620	252	24,00%
Vorarlberg	1.990	251	205	22,91%
Vienna	6.899	2.402	1.748	60,15%
Austria	42.973	7.993	5.062	30,38%

Table 2 illustrates that Vienna is an outlier regarding the representation of residential and foster care amongst all support and services provided to children This variance is significant; including Vienna, the federal average ratio of children in residential and foster care is 30.38%, compared to 24.69% for the other eight provinces. This disparity may suggest either a lesser availability of support and services for children in their homes in Vienna compared to other provinces, or that authorities in Vienna are less inclined to apply the principle of providing the least intrusive services first. Furthermore, this might suggest that children in Vienna face unique circumstances compared to their peers in other provinces, affecting their need for and access to certain types of care. It is plausible that immigration has contributed to the heightened demands placed on Viennese child welfare authorities. However, this marked difference in support and services is unlikely to be entirely attributable to circumstantial variations concerning the children and their parents. Commenting on the high number of children in foster care in Vienna, an interviewee employed by the City of Vienna ironically concluded: 'We have got so many children in foster care (in Vienna), because we are doing our job too well!'.[137]

Lower Austria stands out as another notable outlier, with the highest number of children receiving support and services in their homes, and the lowest ratio of children in residential and foster care compared to other forms of support. For comparison, the number of children receiving support and services other than residential and foster care in Vienna was 2.749, compared to 8.999 in Lower Austria. It is noteworthy that in 2021, Lower Austria had approximately 11% fewer 0-18 years old inhabitants than Vienna.

The following sections attempt to paint the picture of family-based alternative care, institutional care, including boarding schools, and of available support and services in Austria, with a focus on Vienna, amidst the lack of data.

[137] H. E., Interview, 23rd January, 2024.

2.3.1. Support and services to children with disabilities and their families

Apart from data related to alternative care and institutional forms of care, the state's reply to the CRPD Committee's LOIPR provides a more nuanced data on support and services to families. While standardized processes for assessing care needs have been in place since 2016, the availability of support varies across provinces due to provincial jurisdiction.[138]

Material support and benefits to which children with disabilities and their families may be entitled in accordance with Family Burdens Equalisation Act (FLAG) include:[139]

- Family allowance;
- Increased family allowance to families with severely disabled children;
- LTC allowance;
- Tax deduction ('Family Bonus Plus').

Families with CWD are eligible for an increased family allowance, provided the child has a disablement assessed by a physician to at least 50%.[140] If a child's disablement is assessed at under 50%, they are still eligible for the regular family allowance. The amount of family allowance in 2023 started at €120.6 (increases depending on the age of the child and the number of children), while the supplementary family allowance was €164.9 per month on top of the general allowance.[141,142]

Previously, the increased family allowance was deducted from the LTC allowance, but this changed in 2023. Since then, a person can receive the increased family allowance on top of the LTC allowance. Also, foster parents, kinship carers and crisis foster persons of CWD are eligible, and not only the immediate family (biological or adoptive parents).[143]

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[138] Assessment Regulation of the Federal Long-term Care Allowance Act (EinstV), BGBl. II Nr. 37/1999, last amend. BGBl. II Nr. 211/2023, 2016.
[139] BGBl. Nr. 376/1967, last amend. BGBl. I Nr. 200/2023 §8 (5).
[140] Id. at. §§ 2, 5, 8.
[141] Id. at. §8 (4).
[142] In 2024, the family allowance started at €132.30 and the supplementary family allowance for families with severely disabled children was €180.90: *Höhe der Familienbeihilfe*, Government of Austria, (2024), accessed: 30th January, 2024, *available at* https://www.oesterreich.gv.at/themen/familie_und_partnerschaft/familienbeihilfe/Seite.080714.html#:~:text=F%C3%BCr%20sechs%20Kinder%20gew%C3%A4hrt%20wird,180%2C90%20Euro%20pro%20Monat.
[143] BGBl. Nr. 376/1967, last amend. BGBl. I Nr. 200/2023 §2 (3, 3a).

LTC allowance is aimed at offsetting additional costs of care, and both children and adults with disabilities may be entitled to it. This allowance is not means tested and is universal, with over 460.000 recipients in 2021.[144] As a result, it has the potential to reduce the reliance on residential care. The medical assessment for eligibility consists of examinations by a medical doctor and other medical personnel and the person is classified in one of seven levels of need for care, according to the regulation accompanying the Federal LTC Allowance Act.[145] The levels are dependent on the calculation of the total hours of care needed per month, while the carers of children with severe disabilities have hardship supplement hours added to the calculation.[146] In 2023, the remuneration starts at €175 for level 1 and increases up to €1,879.50 for level 7 of care needs.[147]

The LTC is tax-funded, and its administration is in the sole responsibility of the Federal government, which was introduced with the reform of the BPGG in 2012.[148] Before 2012, the LTC allowance administration was in the hands of the provinces. The transition to centralized financing and administration of LTC allowance was motivated by the goal of ensuring equal access across the entire country and improving the efficiency of LTC provision. This implies that the federal and provincial authorities are aware of all the issues with a highly decentralized system of social protection. Conversely, Trukeshitz *et al*. explain that unlike the LTC allowance, LTC-related services are solely the responsibility of provinces, which results in severe differences in availability and quality of services from province to province.[149]

Parents can take care leave for the maximum duration of 6 months.[150] Eligibility for care leave requires an agreement between the employer and the employee, or a collective agreement. Since 2014, a parent on care leave is entitled to the care leave allowance, based on the BPGG §21c. Parents, including the parents of CWD, are eligible for tax deduction on their annual income, and it is based on the number of children, in accordance with the Income Tax Act.[151] This scheme is called Family Bonus Plus and is linked to the family allowance.

[144] BMSGPK, 2022**, p.** 125.
[145] BGBl. Nr. 110/1993, last amend. BGBl. I Nr. 170/2023.
[146] BGBl. II Nr. 37/1999, last amend. BGBl. II Nr. 211/2023. §1 (5, 6).
[147] BGBl. Nr. 110/1993, last amend. BGBl. I Nr. 170/2023. §5 (1).
[148] See ' Reform of the long-term care system and institutional care'.
[149] Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022).
[150] BGBl. Nr. 110/1993, last amend. BGBl. I Nr. 170/2023. §21c. (1).
[151] Income Tax Act (EStG), StF: BGBl. Nr. 400/1988.

Trukeshitz *et al*. argue that families of CWD are prioritised in the LTC system, given the generosity of the LTC allowances and other benefits for which they may be eligible.[152] Also, since 2015, the possibility of switching caregiving responsibilities between family members was introduced, to allow more flexibility and increase the possibility for caregivers to retain jobs and find employment.[153]

Services that CWD may be entitled to, their nature, scope, and length differ from province to province. Services available in all provinces, according to the state report to the CRPD, are:[154]

- Outpatient clinics for developmental diagnosis and therapy which provides a wide range of therapies in all districts;
- Outpatient and mobile early support for children with delayed developments and hearing and visual disabilities;
- Psycho-social care and advice centres for children and young people with mental illnesses and psycho-social problems which offers diagnosis and treatment via a multi-professional team;
- Health Care for Children at Home provides support for families who cannot manage the care of their sick children alone.

Services for CWD available in Vienna according to the state report to the CRPD are:[155]

- Intensive support for families (average of 12 hours per week):
- Support to families on a low-threshold basis (maximum 9 hours per week);
- 24-hour care;
- Respite care;
- Day care;[156]
- Mobile early support.

Despite inconsistent reporting by the state on the availability of support and services, especially institutional care, websites of some provinces, including Vienna, provide such information on

[152] Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022), p. 91.
[153] Id. at, p. 94.
[154] CRPD/C/AUT/2-3*. Reply to paragraph 12 of the LOIPR.
[155] Id. at.
[156] Day care for CWD other than in kindergarten or in the school system.

an annual basis. This allows some comparison over the years. Viennese authorities have been publishing annual reports on children and youth since 2014.

Regulations for 24-hour care were established in 2006 and 2007, responding to political pressure to formalise the predominantly migrant worker-provided profession.[157] This service entails round-the-clock care provided at home, with eligibility extended to CWD. However, in 2018, only 23 positions were available for CWD caregivers in Vienna. This type of service can prevent institutionalisation of children CWD with the highest support needs.

Currently, the formalization of family members' roles as caregivers is being piloted in Burgenland and Upper Austria.[158] This means, that a long-term caregiver to a family member could be employed as a caregiver, receiving compensation and insurance. It is not yet clear whether such a model will be applicable to parents who provide long-term care for their disabled children.

The following table presents data on the number of users of several key services in Vienna, sourced from the Vienna Children and Youth Welfare Department (Magistrat 11 - MA11). Such data for other services is not available in the report by the competent department.

Table II. 4 Services for CWD and their families in 2014, 2017, 2020 and 2022. Source: MA11.[159]

Vienna	2014	2017	2020	2022
Consultations	116	115	98	154
Intensive support for families	87	96	140	189
Support to families on an outpatient, low-threshold basis for a maximum of 9 hours per week	86	51	52	61

[157] Trukeshitz, et al., JOURNAL OF LONG TERM CARE, (2022), p. 89.
[158] Id. at, p. 95.
[159] Jahresbericht 2014 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2015, p. 60; Jahresbericht 2017 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2018, p. 70; Jahresbericht 2020 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2021, p. 26; Jahresbericht 2022 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2023, p. 44.

Vienna	2014	2017	2020	2022
Respite care	14	67[160]	63	52[161]
24-hour care	/	23	/	/

Based on the reports of the MA11, significant change between 2014 and 2022 occurred in intensive family care and respite care.[162] The number of users of intensive family support increased from 87 to 189 (117.24 % increase) The number of families CWD who utilized respite care increased from 14 to 52 (271.43% increase). Both services have a high potential to prevent institutionalisation of CWD, considering that the inability of parents to meet child's need for intensive support on their own, and their fatigue over time amidst the lack of support, are some of the reasons for parents to give up the care of their disabled child. Similar to residential care, intensive support and low-threshold support for CWD are outsourced by the city to a private service provider, Caritas.[163]

On the other hand, it is not clear whether those service, particularly intensive family support, are available to all CWD in Vienna who need it, especially considering, what seems to be, a low number of users even in 2022. Moreover, the respite care, as it is organised and provided in Vienna – as short-term residential group care, is incompliant with the CRPD. Therefore, efforts to provide in-family care should be recognised, but its availability and coverage are questionable, especially with the rise of population in Vienna, which increased by approximately 134.000 from 2015 to 2022.[164] According to Statistik Austria, the sharpest increase recently happened between 2022 and 2023, approximately 50.000, due to the war in Ukraine.[165] This will likely further increase the need for family-based support and services for CWD in Vienna, a trend not yet reflected in publicly available statistics.

Until September 2023, children with disabilities other than physical disabilities (specifically those at care level 5 and above), were not entitled to receive PA at schools. However, this

[160] Average duration 19 days.
[161] Average duration 26 days.
[162] Jahresbericht 2014, Magistrat der Stadt Wien MAG ELF – Amt für Jugend und Familie, 2014. Magistrat der Stadt Wien MAG ELF, 2018. Magistrat der Stadt Wien MAG ELF, 2021. Magistrat der Stadt Wien MAG ELF, 2023.
[163] Magistrat der Stadt Wien MAG ELF, 2023, p. 44.

[165] *Bevölkerung zu Jahres-/Quartalsanfang*, Statistik Austria, (2024), accessed: 30th January, 2024, *available at* https://www.statistik.at/statistiken/bevoelkerung-und-soziales/bevoelkerung/bevoelkerungsstand/bevoelkerung-zu-jahres-/-quartalsanfang.

changed in March 2023 following a decision by the Vienna Commercial Court, prompted by a representative action (Verbandsklage) lawsuit filed by the litigation NGO Klagsverband.[166] The court ruled that federal legislation had been discriminatory in denying access to PA for CWD.[167] The recent decree issued by the Ministry of Education, Science, and Research, which rectifies the discriminatory rule and distinguishes between the services provided for children with autism and those with physical and sensory disabilities. Specifically, it labels the service for children with autism as 'school assistant', while it refers to the service for children with physical and sensory disabilities as 'personal assistant'.[168] Additionally, interpreting services are available from German and other languages to Austrian Sign Language, and vice versa.[169]

In 2018, the Equal Opportunities Advocate for Persons with Disabilities reported on the poor availability of support and services for families CWD and recommended a radical expansion of those.[170] The Children and Youth Ombuds (KIJA), reported that parents of CWD have troubles accessing support and services due to confusing procedures and divided competencies between children and youth departments on one hand and disability departments on the other.[171] Other criticism regarding accessing support and services is related to the medicalised approach to the assessment of eligibility, and lengthy procedures resulting in late interventions.[172] Additionally, LTC allowance is a precondition for some other forms of support and services, which means that the medical assessment on which the eligibility for LTC allowance is based on determines whether a child will access other services too.

2.3.2. Family-based alternative care

Forms of family-based care available in Austria and Vienna include foster care and crisis foster care. Kinship care is also recognised as a form of care, and kinship parents may be entitled to

[166] *Klagsverband: Bildungsminister hebt diskriminierendes Rundschreiben auf, Erlass bringt Verbesserungen für Schüler*innen mit Behinderungen*, Klagsverband, (2023), accessed: 30th January, 2024, *available at* https://www.klagsverband.at/archives/19808.
[167] See 'Representative action on personal and school assistance'.
[168] Erlass betr. Unterstützung für Schülerinnen und Schüler mit einer Behinderung in Bildungseinrichtungen des Bundes, Erlass reference no. 2023-0.480.776, 2023.
[169] Id. at.
[170] Bericht des Anwalts für Gleichbehandlungsfragen für Menschen mit Behinderungen 2020, Parlament Österreich, 2021, p. 50.
[171] KIJA, 2019**, p.** 33.
[172] E.g. AOB, 2023**.** Evaluierung des Nationalen Aktionsplans Behinderung 2012–2020, (2020), BMSGPK, p. 182.

foster care allowance, according to the B-KJHG.[173] In Vienna, kinship carers receive the foster care allowance on equal footing as other foster parents. Child and youth welfare authorities are tasked with suitability assessments and supervision.[174] Public child and youth welfare agencies and accredited private child and youth welfare organisations can provide counselling, support, and arrange placements in accordance with the law.[175]

Children may remain in foster care until they reach the age of majority, while crisis foster care is limited to emergency situations. Typically, children maintain ties with their immediate family, unless this is not in the best interest of the child. Additionally, parents may lose their parental rights completely, and foster parents can apply for full custody or pursue adoption.[176]

Table II. 5 The number of children in foster care in 2015, 2018, and 2022 in Austria. Source: Bundeskanzleramt.[177]

Province	2015	2018	2022
Burgenland	94	124	126
Carinthia	269	276	249
Lower Austria	775	761	797
Upper Austria	703	698	661
Salzburg	247	220	204
Styria	900	998	820
Tyrol	216	232	252
Vorarlberg	269	261	205
Vienna	1.689	1.755	1.748
Austria	5.162	5.325	5.062

Foster parents are entitled to family allowance, supplementary family allowance for CWD, to care leave, and foster care allowance to cover maintenance costs, which were generally assessed as generous. Already in 1972, the amendment BGBl 284/1972 of §2 (3) FLAG was

[173] Federal Child and Youth Welfare Act (B-KJHG), BGBl. I Nr. 69/2013, last amend. BGBl. I Nr. 105/2019.
[174] Id. at. §19 (1).
[175] Vienna Child and Youth Welfare Act (WKJHG), LGBl. Nr. 51/2013 last amend. LGBl. Nr. 2/2023. §39 (4).
[176] Civil Code (ABGB), JGS Nr. 946/1811 last amend. BGBl. I Nr. 182/2023 §§ 184, 194 (1).

[177] Kinder- und Jugendhilfestatistik 2015, (2016), Bundeskanzleramt, p. 15; Kinder- und Jugendhilfestatistik 2018, (2019), Bundeskanzleramt, p. 25; Bundeskanzleramt, 2023**, p. 25.**

adopted with an intention to completely equalise the position of foster children with other children in the sense of this Act.[178]

The large number of children in foster care, and the number of foster families, indicate a well-developed foster care network but also possibly the lack of adequate prevention of family separation, particularly given the number of children in residential care. A similar observation was made regarding Serbia - a large number of children in foster care, which is often a permanent solution, indicates poor prevention of separation.[179] Additionally, while Table II.4 shows the aggregate number of children in foster care, it remains unclear whether a well-developed network of foster carers for CWD actually exists. Based on the state report to the CRPD, in Lower Austria, approximately 10% of children in foster care had disabilities in 2018.[180] The data for other provinces was not provided. Another study reports that finding a suitable placement in a foster family for CWD is especially challenging, since foster families are mostly not willing or trained to care for them, which renders the placement in an institution the only option.[181]

In 2023 in Vienna, foster care allowance started at €554 for children 0-6 years old and went up to €640 for children over 15 years old. Crisis foster persons were remunerated with €1109.[182] According to the Vienna Child and Youth Welfare Act, the allowance can be increased on an individual basis on account of the disability or illness of the child.[183] Foster parents are also eligible for the family allowance and disability benefits, such as LTC allowance when a disabled child is in their care. In Vienna, foster parents may choose to be employed by the Children for Austria association as foster carers. In this case, foster parents are remunerated in accordance with a model of their employment, which can also include salary, social and health insurance.[184]

Additionally, according to an interviewee, 42% of the children from Vienna who are in out-of-home care, including residential and foster care, are actually placed outside of Vienna, in other

[178] Legal sentence RS E2174/2022 Constitutional Court.
[179] See Part III, Serbia Chapter 3.1.5. Enforcement Gap.
[180] CRPD/C/AUT/2-3*, para. 87.
[181] Stefan Wagner-Schuster, Pflegefamilie oder sozialpädagogische Einrichtung? Bestandsaufnahme über die Praxis der Platzierungsentscheidung in der Kinder- und Jugendhilfe (2018), (Master of Arts, Karl Franzens University Graz), p. 121.
[182] Foster Child Allowance Ordinance (WPKGVO), LGBl. für Wien Nr. 51/2013.
[183] LGBl. Nr. 51/2013 last amend. LGBl. Nr. 2/2023. §44 (4).
[184] *Wissenswertes für werdende Pflegeeltern*, City of Vienna, (2023), accessed: 23rd January, 2024, *available at* https://www.wien.gv.at/menschen/kind-familie/pflegefamilie/wissenswertes.html.

provinces.[185] However, those children are reflected in the statistics by the MA11, because they are under the Viennese authority's custody, as explained by the same interviewee.

As a rule, children 0-3 years of age are only placed in foster care, to avoid the negative effects of institutional care, in accordance with the UN Guidelines on Alternative Care.[186] Reportedly, there was a shortage of crisis foster persons in Vienna in 2018, which meant that some of the youngest children still had to be placed in crisis centres.[187] Also, CWD are placed in crisis centres on a more permanent basis, as evidenced in the case which was finally adjudicated before the Supreme Court, regarding the application of restrictive measures on a disabled child who resided in a Viennese crisis centre.[188] Furthermore, limitations concerning the number of residents in a residential facility under the administration of the MA11 do not always apply in the case of crisis centres, in accordance with the Vienna ordinance on socio-pedagogical facilities.[189]

Table II.6 The number of foster families and crisis foster families in Vienna 2015, 2018, 2022. Source: MA11.[190]

Vienna	**2015**	**2018**	**2022**
Foster families	629	797	863
Crisis foster families	41	47	37

2.3.3. Institutional (residential) care

According to the Federal Ministry for Social Affairs, Health, Care, and Consumer Protection (BMSGPK), residential care for CWD is provided in institutions governed by child and youth

[185] E., Interview Stefanović, 23rd January, 2024.
[186] Guidelines for the Alternative Care of Children, A/RES/64/142*, 2009.
[187] Annual Report on the activities of the Austrian National Preventive Mechanism (NPM) 2018, (2019), AOB, p. 73.
[188] 7 Ob 80/19v, Supreme Court.
[189] Vienna ordinance on socio-pedagogical institutions (SPEVO 2015), LGBl. Nr. 24/2015. §7(1).
[190] Jahresbericht 2015 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2016, p. 50; Jahrersbericht 2018 Wiener Kinder- und Jugendhilfe, Magistrat der Stadt Wien MAG ELF, 2019, p. 81; Magistrat der Stadt Wien MAG ELF, 2023, p. 41.

welfare departments, and those established under the laws pertaining to persons with disabilities.[191] The former are subject to the federal and provincial child and youth welfare laws. The fact that CWD reside in institutions under two different systems – child and youth welfare system, and a disability-specific system, further impedes the standardization of services, the collection and synthesis of data, research, planning and coordination. Therefore, apart from the federalism, the sequencing of services, particularly residential services for CWD, is another contributing factor to the *status quo*. The residential care for CWD is organized in the form of large residential care, SGHs, or 'family-like' small group arrangements.

The BMSGPK recently conducted the first study on the prevalence of violence against persons with disabilities.[192] The researchers found that persons with disabilities are exposed to violence to a significantly larger extent than their non-disabled peers, including the violence in a family, and structural and institutional violence. Interestingly, the study found that the exposure to violence does not depend on the size of institution, but it does depend on the number of employees at a residential facility.

According to the B-KJHG, several types of institutional care are provided in so-called socio-pedagogical facilities. Those are: care facilities for emergency situations (crisis centres); care facilities for the long-term care of children and youth; supervised living arrangements for youth; non-stationary forms of socio-pedagogy.[193] The latter, classified by the B-KJHG as semi-residential, do not include overnight stays and should not be considered a form of institutional care in terms of depriving children from their family life, although their compliance with the CRPD is doubtful.

The W-KJHG and a corresponding ordinance on socio-pedagogical institutions, further elaborate on this form of care in Vienna. Large residential care, under the child and youth welfare system, does not exist in Vienna, where an ordinance limits the number of residents to eight.[194] Large residential care is still present in Lower Austria, Carinthia, Styria, and Salzburg.

[191] BMSGPK, 2022.
[192] Erfahrungen und Prävention von Gewalt an Menschen mit Behinderungen, Federal Ministry for Work, Social, Health and Consumer Protection BMASGK, 2019.
[193] BGBl. I Nr. 69/2013, last amend. BGBl. I Nr. 105/2019. §17 (3).
[194] LGBl. Nr. 24/2015. §7 (1).

Although, there are no large residential facilities in Vienna, some of Viennese CWD may be housed in large institutions in other provinces, according to two interviewees.[195]

There are also residential facilities at special boarding schools. There is no consensus, either in Austria or globally, on the number of residents that constitutes a large residential institution. However, it is generally accepted that SGHs (SGHs) accommodate 12 or fewer residents, implying that facilities housing more than this number should be considered large institutions. It should not be forgotten, however that those institutions can house anywhere from a dozen to several hundreds of children.

In Vienna, the Residential and Nursing Care Act (WWPG) replaced the Vienna Social Welfare Act in 2005, regulating institutions for persons with disabilities.[196] The Vienna Equal Opportunities Act (CGW) regulates the institutional care too.[197] Neither of the two acts, WWPG and CGW, stipulates specific forms of residential care, size, or the age of residents. The FSW is responsible for institutional and other forms of care and support for persons with disabilities per CGW.[198]

Since 2015, child and youth welfare departments have meticulously published data on children in care, which, as explained above, does not encompass CWD. Considering that departments for social welfare do not publish similar data regarding CWD,[199] such data must be collected from various sources, of which none provides a comprehensive overview of the situation, nor do all those sources combined allow for such an overview. The following Table II.6 shows the numbers of children with and without disabilities in alternative care, by type of care, according to the state's reply to LOIPR in 2018. The data is scarce and not complete for any of the provinces. Moreover, the state has seemingly omitted to provide data on children in private institutional care, and only provided some data on children in public institutional care. In the same report, the authorities provide numbers of persons with disabilities in residential care in

[195] R. G., Interview, 8th June, 2023; E., Interview Stefanović, 23rd January, 2024.
[196] Vienna Social Welfare Act (WSHG), first last amend. LGBl. Nr. 38/1975, last amend. LGBl. Nr. 49/2018.
[197] Vienna Equal Opportunities Act (CGW), LGBl. Nr. 45/2010 last amend. LGBl. Nr. 49/2018.
[198] Id. at. §2.
[199] In Vienna it is the Department for social, welfare and health law (Soziales, Sozial- und Gesundheitsrecht MA40) that is competent for CWD, and Fonds Soziales Wien. However, the MA11 in Vienna publishes data about several in-home services for CWD in Vienna. The other two do not publish report with usable data regarding residential care for CWD.

each province and the number of residential institutions, but without disaggregation by age. Therefore, it is not clear whether those residential institutions house any and how many CWD.

Table II.7 Data from Austria's reply to the CRPD Committee LOIPR 2018. The number of children with and without disabilities in alternative care, by type of care.[200]

Province	Children in foster care	CWD in foster care	Children in institutions	CWD in institutions	CWD in boarding special schools
Vienna	/	/	/	130	/
Burgenland	/	/	/	/	/
Lower Austria	746	~75	/	/	/
Upper Austria	/	/	211	/	/
Styria	/	/	/	/	31
Carinthia	/	/	/	63 in full-time care (209 in total)	/
Salzburg	/	/	/	30[201] + 11 in other provinces and abroad	512 receiving nursing care at schools[202]
Tyrol	/	/	/	22	4 boarding homes, of which 3 attached to schools (No. of CWD undisclosed)
Vorarlberg	/	/	/	/	/

[200] CRPD/C/AUT/2-3*.
[201] Run by Salzburg support programme. It is not clear whether this is the only provider of institutional care for CWD in Salzburg or there are other providers not mentioned in the state reply to LOIPR.
[202] Nursing care at schools implies residential care attached to those schools.

In 2017, the AOB issued a report addressing children in public institutions, briefly mentioning the situation of CWD in residential care. The report highlighted concerns that the standards of institutional care did not align with the latest international standards and scientific knowledge, despite legal obligations to do so.[203] The report identified varying group sizes for care across Austria, ranging from eight in Vienna and Salzburg to 16 in Burgenland.[204] Additionally, the report advocated for the organisation of care in 'family-like' communities within institutions, as well as in smaller facilities.[205] The conflict between the CRPD Committee's approach to SGHs and family-like care and the AOB's stance on it was mentioned above.[206] However, the fact that the AOB also recommended to provide family-like care within larger facilities adds another layer to the doubt of the AOB's understanding of the issue of institutional care.

Moreover, the IMC in 2016 reported on the tactic that providers of residential care may use to create the illusion of care in small groups, while actually placing several small groups in one location, effectively resulting in much larger group care.[207] Such clusters of small residential groups, although organisationally and structurally forming a much larger group together, most likely have a high number of staff. This is because the standards of care, at least in socio-pedagogical facilities, prescribe a specific number of personnel per residential group. Such cluster care was also featured in a case before the Supreme Court in 2022, where a cluster consisted of 10 residential groups organisationally functioned as one institution, which was confirmed by the manager.[208,209]

According to the AOB report, there were no large residential institutions in Vienna, Vorarlberg, Styria, and Salzburg in 2017, while Tyrol was undergoing a transformation from large residential facilities to smaller institutional arrangements.[210] The information by the AOB conflicts with the information from ENIL, which claims that large residential institutions in

[203] Volksanwaltschaft, 2017.
[204] Id. at, p. 28 – 30.
[205] Id. at, p. 30.
[206] See ' Reform of the long-term care system and institutional care'.
[207] Monitoring Ausschuss, 2016, p. 9 - 10.
[208] 7 Ob 43/22g, Supreme Court, para. 15.
[209] See 'The Supreme Court'.
[210] Volksanwaltschaft, 2017.

2022 did exist in Styria and Salzburg.[211] The Ombud's Office for Children, despite the lack of data to confirm that, reported that most CWD are cared for in special institutions, which results in segregations and is a fertile context for structural violence.[212]

Statistik Austria publishes data on social welfare for children,[213] but those do not include CWD in residential care that does not fall under the child and youth welfare departments. In 2022, the largest number of children supported by the child and youth welfare departments lived in Lower Austria, despite the fact that most minors live in Vienna, which has the second highest number of minors in care on the evidence of this department.[214]

The Resident Representative (Bewohnervertreter), published that it was aware of 741 facilities for minors, including special schools in Austria in 2022.[215] The Resident Representative did not break down the data by disability. The first time this organisation mentioned the number of facilities for minors was in its 2018 annual report, when the number was 697, following the Supreme Court's ruling that facilities for children came under the scope of the HeimAufG.[216] In order to fall under the scope of the HeimAufG, a facility must either currently accommodate or have the capacity to accommodate CWD, as interpreted by the Supreme Court.[217] The increase in the number may indicate that new facilities were built in the meantime, or that the Resident Representative became aware of previously existing institutions. Additionally, it remains unclear how many of these, new or newly discovered institutions, actually house CWD.

[211] *Going into the wrong direction, Austria and the institutionalisation of children*, ENIL, (2023), accessed: 17th January, 2024, *available at* https://enil.eu/going-into-the-wrong-direction-austria-and-the-institutionalisation-of-children/.
[212] Bericht der Kinder- und Jugendanwaltschaften der österreichischen Bundesländer zum Sonderbericht der Volksanwaltschaft, Volksanwaltschaft, 2019, p. 12 - 13.
[213] In the entire Austria, persons under 18 are minors. However, Austria does not have a unified nomenclature, and the term 'child' is used to denote persons under the age of 14 and and the term 'youth' the persons from 15 to 17 in Styria, Carinthia, Tyrol and Vorarlberg. In Salzburg children are up to 12 years old, and youth 13 to 17. This study uses the term 'child' or 'minor' for persons under 18 to keep the consistence with the international law.
[214] *Child and youth welfare*, Statistik Austria, accessed: 13th January, 2024, *available at* https://www.statistik.at/en/statistics/population-and-society/social-benefits/child-and-youth-welfare.
[215] Jahresbericht 2022, VertretungsNetz, 2023, p. 13.
[216] Jahresbericht 2018, VertretungsNetz, 2019, p. 10.
[217] See 'Application of the HeimAufG'.

Table II.8 The number of children in full time care in residential and foster care in 2022. Source: Bundeskanzleramt.[218]

	Residential and foster care	Residential care	Foster care	Foster care %
Burgenland	451	325	126	27,9
Carinthia	1.015	766	249	24,5
Lower Austria	2.136	1.359	797	37,0
Upper Austria	1.573	912	661	42,0
Salzburg	676	472	204	30,2
Styria	1.629	886	820	48,1
Tyrol	857	620	252	28,9
Vorarlberg	444	251	205	45,0
Vienna	4.107	2.402	1.748	42,1
Austria	12.888	7.993	5.062	38,8

The observed data indicating a higher number of minors in socio-pedagogical institutions compared to foster care in Austria indicates over-reliance on institutional care. It should be emphasised that some CWD may be placed in socio-pedagogical institution, although mostly non-disabled children are placed in this type of residential care. Therefore, data from Table II.7 does not capture the full scope of institutional and residential care for all children in Austria. Regardless, the high number of children in formal alternative care suggests a significant displacement of children from their biological families. This could be interpreted as a consequence of inadequacy in family separation prevention measures, which is to an extent confirmed by the National Mechanism for the Prevention of Torture (NPM), who pleaded that preventive measures must be improved, which was also recognised by the CRC Committee (See '**Error! Reference source not found.**').[219] This situation demonstrates the actions of the Federation and provinces, which are non-compliant not only with the CRPD, which disallows residential care for CWD, but also with international standards of alternative care that prescribe only a marginal role for residential care, and only for the shortest necessary period. In Austria,

[218] Bundeskanzleramt, 2023**, p.** 25.
[219] AOB, 2019**, p.** 70.

residential care seems to play a major, rather than a marginal, role in the system of alternative care.

Table II.9 The percentage of children in foster care, compared to residential care in 2015, 2018, 2022. Source. Bundeskanzleramt.[220]

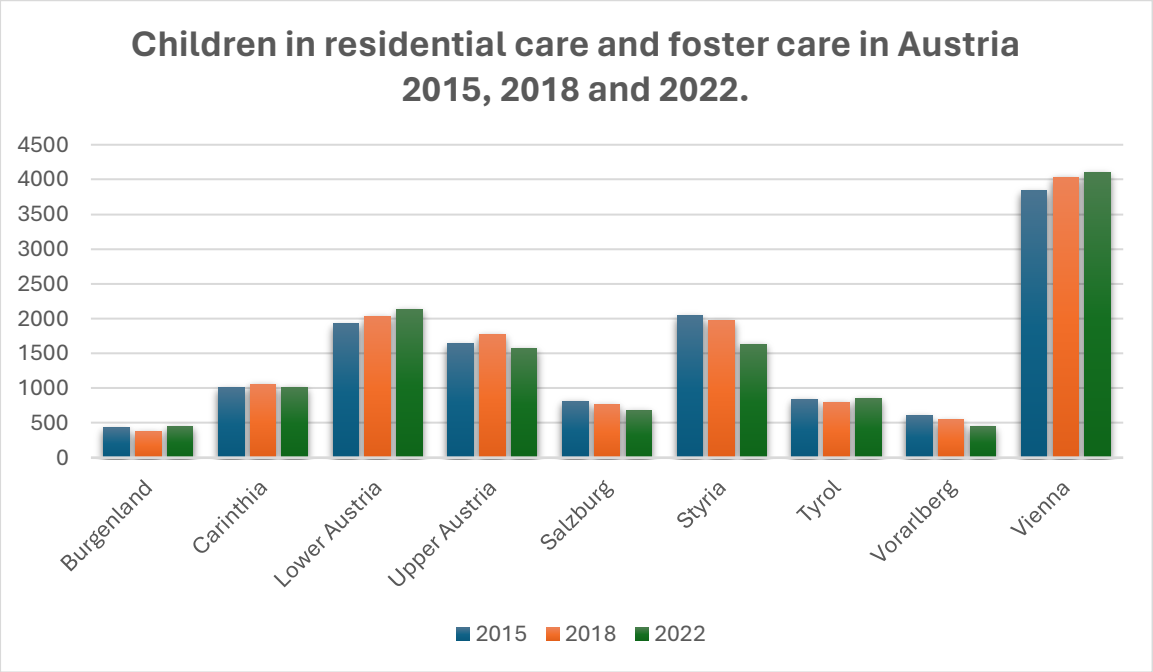
	2015	2018	2022
Burgenland	21,8	33,0	27,9
Carinthia	26,7	26,2	24,5
Lower Austria	40,3	36,7	37,0
Upper Austria	42,9	39,5	42,0
Salzburg	30,5	28,9	30,2
Styria	44,1	50,7	48,1
Tyrol	25,8	28,5	28,9
Vorarlberg	44,6	45,9	45,0
Vienna	44,0	43,3	42,1
Austria	39,3	39,6	38,8

Haider *et. al*, compared the prevalence of 'outpatient' services (in-home services/ family- and community-based services) to residential and foster care in Lower Austria.[221] They found that of the 14.000 services provided to children and their families in Lower Austria in 2021, 79% were family- and community-based, while the remainder included residential, foster care, kinship care, and crisis foster care. The authors argued this aligns with the legal requirement of the Federal Child and Youth Welfare Act that the least disruptive form of care is provided to a child and family in need.[222] In relation to that argument, the authors did not take into account that children who receive support and services at home may receive several such services at once, so the number of children who received outpatient services was actually lower. On the other hand, the number of cases where residential care was provided arguably corresponds better to the actual number of children in residential care, because one child can only be placed in one institution at a time. In turn, this means that the number of children

[220] Bundeskanzleramt, 2016**, p. 15**; Bundeskanzleramt, 2019**, p. 25**; Bundeskanzleramt, 2023**, p. 25.**
[221] Katja Haider, et al., *Why Are Child and Youth Welfare Support Services Initiated? A First-Time Analysis of Administrative Data on Child and Youth Welfare Services in Austria*, 10 CHILDREN (2023).
[222] Id. at, p. 9.

receiving services and support at home may be significantly lower than the number of provided services. While it may be true the authorities rely on displacement only when they have to in a given case, this is not enough to confirm that residential care plays only a marginal role, especially considering that residential care dominates over foster care in prevalence (Table II.8).

Chart II.1 Number of children in residential care (excluding CWD) in 2015, 2018 and 2022. Source: Bundeskanzleramt.[223]



Statistics on children receiving support from provincial child and youth welfare departments have been available since 2015. Although these statistics have only recently become available, they provide insight into the trajectory of reliance on residential care for children in Austria in recent years, but not for CWD. Arguably, a sensible public policy which includes DI of care for children would aim to decrease reliance on residential care over time. The desired reduction in the number of children in residential care over a period (e.g., 5% over two years) may depend on many factors. Regardless, a successful DI policy should be empirically verifiable over a seven-year period. A number of indicators should be used to assess the success of a DI policy, with the number of children in residential care being one of the primary indicators.

[223] Bundeskanzleramt, 2016, p. 15; Bundeskanzleramt, 2019, p. 25; Bundeskanzleramt, 2023, p. 25.

Table II.10 The number of children in residential care and foster care in Austria in 2015, 2018, 2022. Source: Bundeskanzleramt.[224]

Province	2015	2018	2022
Burgenland	431	376	451
Carinthia	1.006	1.052	1.015
Lower Austria	1.925	2.029	2.136
Upper Austria	1.638	1.765	1.573
Salzburg	810	760	676
Styria	2.041	1.968	1.629
Tyrol	836	796	857
Vorarlberg	603	543	444
Vienna	3.836	4.036	4.107
Austria	13.126	13.325	12.888

In Austria, however, there was a negligible increase in the number of children in residential care between 2015 and 2022, from 7.964 to 7.993 (Table II.10).[225] Based on this, there is no doubt that DI is not taking place in Austria as a whole. The data for some provinces, including Vienna, are even more concerning than for Austria as a whole, while a few others, such as Styria, have managed to decrease their reliance on institutional care. Several stakeholders have highlighted the issue regarding the absence of a comprehensive DI plan, while the AOB has asserted that there is not even an intention to implement DI on a national scale.[226] The NPM argued that the reason for the increase in Vienna, is the increase in the number of residents in the capital since 2015, which makes it challenging for welfare authorities to keep with the demand for family-based support and services.[227]

[224] Bundeskanzleramt, 2016, p. 15; Bundeskanzleramt, 2019, p. 25; Bundeskanzleramt, 2023, p. 25.
[225] Bundeskanzleramt, 2016. Overview 3, p. 15. Bundeskanzleramt, 2019. Overview 5, p. 25. Bundeskanzleramt, 2023. Overview 5, p. 25.
[226] Annual Report 2021 on the Activities of the Austrian National Preventive Mechanism (NPM), (2022), AOB, p. 106.
[227] Annual Report on the activities of the Austrian National Preventive Mechanism (NPM) 2020, (2021), AOB. p. 64.

Table II.11 The number of children in residential care in 2015, 2018 and 2022 in Austria. Source. Bundeskanzleramt.[228]

Province	2015	2018	2022
Burgenland	337	252	325
Carinthia	737	776	766
Lower Austria	1.150	1.314	1.359
Upper Austria	935	1.067	912
Salzburg	563	540	472
Styria	1.141	970	886
Tyrol	620	582	620
Vorarlberg	334	308	251
Vienna	2.147	2.301	2.402
Austria	7.964	8.110	7.993

In Vienna, the number of children in institutional care increased 11.88% (2.147 to 2.402) between 2015 and 2022, the most in Austria in absolute numbers. Of all children in institutional care in Austria, 26.96% were in Vienna, and 14.44% in Lower Austria in 2022.[229] Lower Austria saw the highest relative increase of 18.17% (1.150 to 1.359). Styria, Vorarlberg, Salzburg, Upper Austria, and Burgenland decreased the numbers of children in residential care 22.35%, 24.85%, 16.16%, 2.46%, and 3.56% respectively. Despite the significant decrease in percentage in three provinces (Styria, Vorarlberg, and Salzburg), two of those have small population (Vorarlberg and Salzburg), and their significant relative decrease is not enough to offset the absolute increase in other provinces.

The special report by the AOB highlighted the alarming statistic that over 1% of Vienna's under-18 population lives in institutional settings.[230,231] Those are SGHs, which accommodate up to 8 residents and have at least 7 employees. Vienna is divided into 6 regions, of which each

[228] Bundeskanzleramt, 2016, p. 15; Bundeskanzleramt, 2019, p. 25; Bundeskanzleramt, 2023, p. 25.
[229] Bundeskanzleramt, 2023, p. 22.
[230] Volksanwaltschaft, 2017.
[231] The AOB special report from 2017 indicated a rate of 1.02% for Vienna, whereas the NPM report from 2018, referring to the same publication, recorded 1.23% of children in out-of-home care in Vienna in 2017.

has 9-14 public SGHs for children, according to an audit report.[232] There are private SGHs, which were not encompassed by the report. Private providers with whom the MA11 works include Caritas Vienna, Vita Nova, ProSoz, Volkshilfe Wien and SOS Kinderdorf.[233] The latter runs 15 residential facilities for group care in Vienna.[234]

The vast reliance on out-of-home care in Vienna is reflected in the expenditure as well. While the proportion of expenditure on family support and services on one hand, and residential and foster care on the other is approximately 1:3 in Austria, in Vienna this proportion is 1:11.[235] In other words, in Vienna, the expenditure for support and services in families is approximately 11 times lower than for the residential and foster care. The report notes that personnel costs are not included in the calculation, therefore the comparison between the provinces may not be adequate. In Lower Austria 18.60% and in Styria 48.50% were spent for family support and services.[236]

Fonds Soziales Wien (FSW) is a company responsible for the provision of support and services, including residential care, to children and adults with disabilities. Although FSW is a company, it was established by the City of Vienna in 2000, and later it took over responsibilities of MA45 Care and Support.[237] According to an FSW annual report, the cost of institutional care in Vienna was €3.057 per month per person in 2022.[238] This calculation, however, likely encompasses institutional care for children, adults and the elderly, indicating that due to higher standards of care for children, costs may be even higher for that age group. The report shows that 1900 people were in (full) residential care in 2022 across 130 facilities, but it does not disaggregate this number by age of the clients.[239] In total, 6.690 persons with disabilities aged 0-19 received some form of support and services from FSW in that year.[240] The report also

[232] MA 11, Prüfung der Gewaltprävention und des Vorgehens der MA 11 - Kinder- und Jugendhilfe bei Verdachtsfällen von körperlicher, seelischer oder sexualisierter Gewalt an Kindern und Jugendlichen in eigenen Einrichtungen, StRH II - 12704-2023, (Stadtrechnungshof Wien), 2023, p. 11.
[233] Magistrat der Stadt Wien MAG ELF, 2023, p. 13.
[234] *Angebote und Programme in Wien*, SOS Kinderdorf, (2024), accessed: 31st January, 2024, *available at* https://www.sos-kinderdorf.at/so-hilft-sos/wo-wir-helfen/europa/oesterreich/wien.
[235] Bundeskanzleramt, 2023**, p.** 43.
[236] Id. at.
[237] *Die Entwicklung des Fonds Soziales Wien*, (2024), accessed: 2nd February, 2024, *available at* https://www.fsw.at/p/entwicklung-des-fonds-soziales-wien.
[238] Menschen mit Behinderung in Wien Grafiken und Daten zu Kund:innen, Leistungen & Partnerorganisationen, Fonds Soziales Wien, 2023, p. 8.
[239] Id. at, p. 3 - 4.
[240] Id. at.

shows the largest residential care providers in the city, which are Jugend am Werk, Lebenshilfe Wien, Caritas der Erzdiözese Wien.[241]

2.3.4. Adoption

Adoption in Austria is regulated by the Civil Code (ABGB), and the federal and provincial child and youth welfare acts. CWD may be eligible for adoption on the same terms as other children. Additionally, foster parents may adopt their foster children when specific conditions are met.[242] Although the ABGB favours adoptions in which prospective adoptive parents have already formed a relationship with the child, [243] such adoptions are infrequently realized in practice, according to Krutzinna and Križ.[244] Although there is no specific data on the adoption of CWD in Austria, aggregate data are available.

Table II.12 The number of adoptions in Austria in 2022. Source: Bundeskanzleramt.[245]

	Adoptions
Burgenland	1
Carinthia	7
Lower Austria	10
Upper Austria	7
Salzburg	2
Styria	17
Tyrol	3
Vorarlberg	3
Vienna	20
Austria	70

[241] Id. at, p. 5.
[242] JGS Nr. 946/1811 last amend. BGBl. I Nr. 182/2023
[243] Id. at. §194 (1).
[244] Jenny Krutzinna & Katrin Križ, *Adoption from care in Austria*, *in* ADOPTION FROM CARE (Tarja Pösö, et al. eds., 2021).
[245] Bundeskanzleramt, 2023**, p.** 53.

In 2018, the head of the MA11 department for adoption confirmed that finding adoptive parents for CWD was particularly challenging.[246] Considering this, along with the total number of annual adoptions in Austria, it can be confidently concluded that adoption does not play a significant role in fulfilling the right to live in a family environment for CWD deprived of parental care.

Table II.12 The number of adoptions in Vienna 2010 - 2022. Source: MA11. Wiener Kinder- und Jugendhilfe Jahresberichte 2015 and 2022.

Vienna	**2010**	**2013**	**2016**	**2019**	**2022**
Adoptions	25	32	22	17	9

2.3.5. Education

Austria employs a multiple-track approach to the education of CWD, encompassing special education in segregated settings (special schools), special education in mainstream schools, and education of CWD in mainstream school (with a mainstream curriculum).[247] Special schools can be independent or attached to mainstream schools, in accordance with the School Organisation Act.[248]

The special education in mainstream schools includes several forms such as education in small groups of CWD (5-7) in mainstream schools, but in separate classrooms (Integrationsklasse), then mid-size groups (around 10) CWD in a separate class inside a mainstream school but some classes are held together with non-disabled pupils (Kooperative Klassen), and individual classes, when one pupil with a disability is part of a mainstream class but with additional

[246] *Pflegekinder: Aufwachsen mit zwei Familien*, Der Standard, (2018), accessed: 23rd January, 2024, *available at* https://www.derstandard.at/story/2000081157854/pflegekinder-aufwachsen-mit-zwei-familien.
[247] All children assessed to have special educational needs in Austria have a disability, unlike in some other countries where children can be assessed as having special educational needs while not having a disability.
[248] School Organisation Act (SchOG), BGBl. Nr. 242/1962 idF BGBl. Nr. 267/1963, last amend. BGBl. I Nr. 37/2023. §25 (1).

assistance (Stützlehrerklassen).[249] Other forms of education of children with special education needs in mainstream schools emerge as pilot programmes and other initiatives.

Some forms of inclusive education began with a decree of the Ministry for Education in 1986, which allowed pupils with physical and sensory impairments were to be schooled in mainstream schools, while this privilege was not extended to children with intellectual and mental disabilities.[250] The right to education in mainstream schools emerged with legal amendments in 1993, according to Buchner and Proyer, but the access to mainstream education for CWD is subject to the availability of resources and the will of parents.[251] Currently, parents decide whether their child will attend a special or mainstream school, while the Education Directorate determines whether the child will follow the curriculum of a special or mainstream school, in accordance with the Compulsory School Act.[252]

This separate treatment of children with intellectual and psychosocial disabilities persists to this day, highlighted by the fact that only pupils with physical and sensory disabilities had the right to PA at school until 2023. This was changed with the decision of the Vienna Commercial Court in May 2023, following which the Ministry issued a decree that grants children with intellectual and mental disabilities the right to school assistance, comparable to the PA provided for pupils with physical and sensory impairments (see note 132).

According to the state report to the CRPD, 65.2% of pupils with 'special education needs' attended mainstream schools in the 2015/2016 schoolyear.[253] In the 2016/2017 schoolyear 61% of children with special education needs attended mainstream schools in, and 60% in 2019/2020.[254] The notable disparity observed between 2015/2016 and 2016/2017 could be attributed to a change in methodology. Under the revised approach, classes in mainstream schools with over half of their pupils having special education needs are now categorized as 'special classes' and included within the special schools category.[255] Conversely, children with

[249] Tobias Buchner & Michelle Proyer, *From special to inclusive education policies in Austria–developments and implications for schools and teacher education*, 43 EUROPEAN JOURNAL OF TEACHER EDUCATION (2020), p. 87.
[250] Id. at, p. 86.
[251] Id. at.
[252] Compulsory School Act, BGBl. Nr. 76/1985, last amend. BGBl. I Nr. 37/2023. §8 (1).
[253] CRPD/C/AUT/2-3*, para. 291.
[254] Nationaler Bildungsbericht 2021. Teil II Bildungsindikatoren., Ministry for Education, Science and Research, 2021, p. 272.
[255] Id. at.

special educational needs attending mainstream classes where over half of the pupils do not have special education needs are now classified as attending mainstream schools.

The rest of pupils with special education needs attend special schools, of which there were 240 in 2019/2020.[256] Buchner and Proyer argue that the ratio of CWD in mainstream schools increased after 2010, due to the increased interest in the development of an inclusive, or integrative, education for CWD after the ratification of the CRPD.[257] This intention was enshrined in the NAPD 2012-2020.

While some schools fall under the jurisdiction of the Federation and others under the provincial jurisdiction, kindergartens are always under the purview of provinces.[258] Under Vienna law, CWD can attend special kindergarten groups only for CWD, or integration groups with non-disabled children.[259] The Disability Ombudsman argues that the insufficient resources allocated for CWD in mainstream kindergartens in certain areas may necessitate these children attending specialised kindergartens, potentially located at a considerable distance from their place of residence and affiliated with a residential institution.[260] This is one of the channels which pushes CWD towards the special education system and the living in residential institutions, depriving them of the possibility to live in a family environment.

The AOB reports that mainstream schools and kindergartens are hesitant to take in CWD, including those with negligible additional support needs.[261] The IMC criticised the apparent poor investments in inclusive education and further strengthening of the special education system.[262] This monitoring body also highlighted that authorities are indifferent to the CRPD and Article 24.[263]

[256] Id. at, p. 271
[257] Buchner & Proyer, EUROPEAN JOURNAL OF TEACHER EDUCATION, (2020), p. 88.
[258] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 14 (4).
[259] Vienna Kindergarten Act (WKGG), LGBl. Nr. 17/2003, last amend. LGBl. Nr. 20/2023. §3 (2).
[260] AOB, 2023**, p.** 14.
[261] Additional Report and Response to the List of Issues Submitted by the Austrian Ombudsman Board on the occasion of the 29th Session of the CRPD (14 August–8 September 2023), (2023), AOB.
[262] Monitoring Report for the UN Committee on the Rights of Persons with Disabilities on the Occasion of the Second Constructive Dialogue with Austria, (2023), IMC, p. 22.
[263] Id. at.

3. Legal and Political Implementation

3.1. Legal Measures

As with the other two countries, the present section explores the implementation of the relevant CRC and CRPD norms through legal measures. Firstly, statutes are examined, which is followed by the examination of judicial measures of higher courts. The focus of analysis is on federal legislation and pertinent provincial legislation of Vienna.

A systematic review of federal and Vienna legislation, along with a desk review of academic and grey literature, has identified several laws particularly relevant to this study. The federal legislation examined includes:

- the Federal Constitutional Law B-VG,
- the Federal Constitutional Act on the Rights of Children B-RK
- the Federal Child and Youth Welfare Act B-KJHG,
- the Federal Disability Act BBG,
- the Federal Equality of Persons with Disabilities Act BBGStG,
- the Federal Residential Care Act HeimAufG,
- the Civil Code ABGB,
- the Federal LTC Allowance Act BPGG,
- the Family Burdens Equalisation Act FLAG,
- the Compulsory School Act, and
- the School Organisation Act SchOG.

The Viennese legislation under review includes:

- the Constitution of the Capital of Vienna WStV,
- the Vienna Child and Youth Welfare Act W-KGJH,
- the Vienna Equal Opportunities Act CGW,
- the Vienna Antidiscrimination Act,
- the Vienna Residential and Nursing Care Act WPPG, and
- the Vienna Social Welfare Act WSHG.

3.1.1. The Federal Constitutional Law B-VG

The B-VG lacks specific provisions aimed directly at children or persons with disabilities, apart from those prohibiting discrimination and relating to education. Instead, these constitutional provisions are dispersed across various legal documents and will be discussed in the context of the specific documents they are contained in, such as the Federal Constitutional Act on the Rights of Children B-RK.

The B-VG explicitly prohibits discrimination based on disability and mandates that all governance levels ensure equal treatment of disabled and non-disabled citizens in all aspects of daily life.[264] The prohibition on the basis of disability was introduced in the B-VG in 1997.

Some schools, including school hostels, are in the competence of the Federation.[265] Although it is prescribed that 'pupils are educated together', the right to admission to public schools is not universal and may be limited in accordance with statutes.[266] The B-VG only prohibits birth, sex, race, estate, class, language and religion as bases on which admission to a public school could be limited, effectively leaving the leeway to limit the admission to school based on disability.[267] One could argue that restricting admission to public schools based on disability contradicts the general prohibition of discrimination on the grounds of disability.

Other relevant provisions of the B-VG are those regulating the position of international law in the domestic law (Article 9 B-VG), the division of competences (Articles 10 – 15 B-VG), the provincial and the central government's responsibilities for the implementation of international treaties (Article 16 (4) B-VG), as well as the Federation's powers in relation to non-obeying provinces (Article 16 (4, 5) B-VG). Article 16 (4) B-VG prescribes the obligation of provinces to undertake measures to implement international treaties to which Austria is a party to. Where a province does not undertake those measures appropriately, the competences transfer to the Federation, especially regarding the legislation. Bußjäger explains that the Federation can issue obligating instructions to a province which fails to comply with its actions regarding a relevant

[264] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 7 (1).
[265] Id. at. Article 14 (1).
[266] Id. at. Article 14 (6).
[267] Id. at.

treaty.[268] Additionally, the Federation has a supervisory role concerning the implementation, even for matters within the competence of provinces, in accordance with Article 16(5) B-VG. Bußjäger asserts that these powers of the Federation have never been used before, implying a very low possibility that they are viable options in the case of the implementation of the CRPD.[269]

3.1.2. Federal Law

3.1.2.1. Federal Constitutional Act on the Rights of Children B-RK

The BRK is a constitutional act, and as such it has supremacy over all other domestic and international law that Austria is subject to. It is a rather short act, of only 8 articles, reflecting its constitutional character of regulating the most fundamental issues and leaving further regulation to statutes.

The BRK incorporates the CRC provisions on the special protection and support to children deprived of family environment (Article 20 CRC),[270] a child's right to be cared for by his/her parents (unless that is detrimental for the well-being of the child) (Article 7 (1) CRC).[271] The protection for CWD in accordance with their 'special needs'(Article 23 (1,2) CRC) is reflected in the BRK too.[272] However, it does not incorporate any CRPD norms.

3.1.2.2. Federal Child and Youth Welfare law B-KJHG

The Youth Welfare Act of 1989 (Jugendwohlfahrtsgesetz) was replaced by the B-KJHG in 2013. The B-KJHG is especially important as it regulates the fundamentals of child welfare (§§ 1 - 3), the duty to provide adequate family and child support and services (§ 16), institutional care (§ 17) separation (§ 28 (2)), foster care (§§ 18 - 21), adoption (§§ 31 - 34),

[268] Bußjäger. 2023, p. 68.
[269] Id. at.
[270] Federal Constitutional Act on the Rights of Children (BRK), StF: BGBl. I Nr. 4/2011. Article 2 (2).
[271] Id. at. Article 2 (1).
[272] Id. at. Article 6.

and the establishment, tasks and funding of the Ombuds Office for Children and Youth (KIJA) (§ 35). From 2020, legislative and enactment competence was transferred to provinces.[273] The 15a agreement prescribed minimum standards for §§ 1 – 7 and 9 – 36 of the B-KJHG. The legislation that provinces adopt in relation to those provisions has to comply with those standards.

The B-KJHG is a comprehensive law on child and youth welfare, yet it does not explicitly address or mention CWD. This reflects a well-established and documented legislative practice of addressing issues pertaining to children and adults with disabilities in separate, special laws. This further results in the separate tracks including in the social protection and education, which has already been identified as a feature of the Austrian state that hinders inclusion of CWD.[274]

The B-KJHG successfully incorporates different provisions of the CRC and expressly mentions this treaty.[275] The law prescribes several principles of child and youth welfare including that children have the right to be raised into individuals who are contributing to the community.[276] Although, such a wording resonates with the Article 23 (1) of the CRC, on the self-reliance and active participation in the community of CWD, it is likely that lawmakers did not have this CRPD provision in mind, considering that CWD are practically excluded from this act. Instead, the B-KJHG principle should be understood as the recognition of the preambular principles of the CRC about the full and harmonious development of the child, upbringing that should enable individual life and contribution to the community (preambular paragraphs 5 – 7 of the CRC).

The law ensures the support and services for children and parents and provides a list of services that must be available, including the promotion of care in the family, support in crisis situations, support for families and children who are facing issues.[277] It also prescribes the provision of alternative forms of care, which include institutional care, foster care, and kinship care. The types of both forms of alternative care are expressed above.[278]

The act, however, does not explicitly designate institutional care as a last resort. Moreover, the act prescribes that any alternative care (institutional, foster, or kinship care) is provided only when remaining in his/her family (or another environment) presents a risk for the child's

[273] 106th Agreement pursuant to Article 15a B-VG on child and youth welfare, BGBl. I Nr. 106/2019.
[274] See note 128.
[275] BGBl. I Nr. 69/2013, last amend. BGBl. I Nr. 105/2019. § 3.
[276] Id. at. §1 (1).
[277] Id. at.
[278] See 'Family-based alternative care' & 'Institutional (residential care)'

welfare.[279] Interestingly, the B-KJHG does not prioritise family-based alternative care options, essentially treating residential and family-based care equally. This is a suboptimal solution where the intention is to emphasise institutional care as a last resort option, and to exhaust the least restrictive measures first.

This is a similar solution to the UN Guidelines, which stipulate that a child should be separated from his/her family as a last resort option, but does not denote specifically residential care as a last resort option.[280] The CRC, which, as previously argued, does not explicitly designate institutional care as a last resort, should be interpreted to imply that such care is considered only as a last resort.[281]

3.1.2.3. Federal Disability Act BBG

The Federal Disability Act (BBG) stipulates the fundamentals of the implementation and monitoring of the CRPD, designates a federal contact point for the implementation (§ 13(f)), a monitoring committee (§ 13g), the Disability Ombudsman (§§ 13b – 13e), and the ACDP (§§ 8 - 12). The named bodies, tasked with the coordination, counselling, monitoring and human rights protection are addressed separately under the chapter 'National Human Rights Institutions, monitoring bodies and other structures to facilitate the implementation of human rights treaties'.

The objective of the act is to enable the highest possible participation in social life of persons with disabilities.[282] Importantly, the BBG provides a definition of disability, which is described as not temporary physical, mental or psychological impairment or impairment of sensory functions, which is likely to make participation in society more difficult and lasts more than 6 months. Clearly, the definition does not reflect the societal contribution to the disablement of an individual with an impairment, and as such it falls short of fulfilling the main elements of the definition of a person with a disability provided in the CRPD. Although the problems with the participation in social life are mentioned, the definition situates the issue within the person, in his/her impairments, which impede this participation. The National Action Plan on Disability

[279] Id. at. §26.
[280] See Part I, Chapter 3.2 UNGA Guidelines for the Alternative Care of Children (2009).
[281] See Part I, Chapter 1.1.1.4 Marginal role and undesirableness of institutions.
[282] Federal Disability Act (BBG), BGBl. Nr. 283/1990, last amend. BGBl. I Nr. 185/2022. §1.

2022 – 2030 (NAPD 2022) foresees legal changes to align the definition of disability with a social model of disability.[283]

The BBG also addresses the establishment of the Support Fund for Persons with Disabilities, which is a charitable organisation, according to the law. On the other hand, the act does not incorporate, for this study relevant, CRPD norms, apart from Articles 4 (3) and 33 on the coordination of implementation, participation of DPOs in monitoring and implementation of the CRPD, and the formation of an independent monitoring body.

3.1.2.4. Federal Equality of Persons with Disabilities Act BBGStG

The Federal Equality of Persons with Disabilities Act (BBGStG) serves as an anti-discrimination law that incorporates the prohibition of discrimination outlined in the CRPD and provides further elaboration. It is a key piece of legislation specifically focused on prohibiting discrimination against persons with disabilities in Austria. It reaffirms the definition of disability as defined in the BBG. An interesting aspect of this act is its provision for representative action lawsuits, which can be initiated by various entities, including the National Council on Disabled Persons, upon a majority vote in favour, as well as the NGO Klagsverband, and the Disability Ombudsman. This significant change occurred with an amendment in 2017. It expanded the entities authorized to file representative actions beyond the OeB, which was previously the sole entity with this authority, potentially enhancing the efficiency of such actions.

The Klagsverband has, indeed, won one representative action case before the Vienna Commercial Court in 2023, regarding the discrimination of pupils with disabilities in relation to their access to PA and school assistance, which is discussed in the chapter 'Representative action on personal and school assistance'.

Austrian law mandates that prior to pursuing legal action, all claims must undergo conciliation proceedings, during which the Austrian Disability Ombudsperson can assist discrimination victims.[284] While conciliation proceedings offer a flexible approach to resolving disputes,

[283] BMSGPK, 2022**, p.** 15.
[284] AOB, 2023**.**

enforceable legal claims primarily pertain to compensatory damages, with no provision for injunctive remedies or remedial actions under the law, which is seen as one of major barriers to the realisation of the rights of persons with disabilities in Austria by the Disability Ombudsperson and other stakeholders.[285]

General antidiscrimination laws do not specifically refer to the discrimination on the basis of disability. The Federal Equality Act (B-GIBG), in its last amendment from 2023, explicitly includes a reference to the denial of leave from work due to the care for a disabled child as a form of a discrimination on the basis of sex.[286]

3.1.2.5. Federal Residential Care Act HeimAufG

Federal Residential Care Act (HeimAufG) regulates the rights of persons who, according to the Act, are in need of care in institutional settings due to age, disability or illness, where their liberty may be restricted.[287] The object of the Act is not the reason why it is significant for this study, but rather its scope of application. The Act indirectly reflects the lawmakers' understanding of what residential/institutional care for persons with disabilities is. It does not directly define residential/institutional care, but it rather implies it through the scope of application of the Act. In §2 (1) the Act prescribes that it is applicable in homes for disabled people and in any other setting where three or more persons with intellectual or mental disabilities are permanently cared for.

A corresponding Viennese act, the Vienna Residential and Nursing Care Act (WPPG)[288] actually defined residential care explicitly, and not indirectly like the HeimAufG. It stipulates:

'Residential care homes are facilities in which at least three individuals are permanently or temporarily admitted, cared for, and, when necessary, nursed, and also receive occasional medical supervision.'[289]

[285] Id. at.
[286] Federal Equality Act (B-GIBG), BGBl. Nr. 100/1993, last amend. BGBl. I Nr. 117/2023.§4a (2)(e).
[287] Home Residence Act (Heim-AufG), BGBl. I Nr. 11/2004, last amend. BGBl. I Nr. 77/2023. §1.
[288] Vienna Residential and Nursing Care Act (WPPG), LGBI Nr. 15/2005, last amend. LGBl. Nr. 30/2020.
[289] Id. at. §1.

The HeimAufG, and the WPPG are therefore significant as they provide definitions of residential care. The acts equate, at least from the perspective of the scope of these laws, small and large residential/institutional care, and do not make substantive differences between the two.

Considering the scope of application of the of §1 (1) HeimAufG and the definition in the WPPG, Austrian law takes into account the group size when defining residential care for children and adults with disabilities, aiming to provide special protection for residents' rights. The law sets a relatively low group size, possibly influenced by the average household size in Austria, which is approximately 2.2 residents.[290] This further implies, that legislators recognise the position of residents of virtually any form of group care for children and adults with disabilities (other than the care by family members and relatives) as demanding specific regulation and increased protection. Conversely, it would likely be incorrect to say that lawmakers had in mind either the CRC or the CRPD when drafting the law Instead, their focus was likely on increasing the protection of persons with intellectual and mental disabilities in group care settings outside of individual households, where intellectually or mentally disabled persons' liberty can be restricted. Consequently, also SGHs, and family-like settings fall under the scope of this law.

In 2021, The Supreme Court interpreted §2 (1) HeimAufG expansively, by actually stipulating that three persons with mental disabilities do not have to be placed in a facility in order for it to fall under the scope of the HeimAufG. Instead, the possibility of carrying for three persons with mental disabilities in a facility would suffice.[291] The evaluation of whether an institution falls under the scope of the HeimAufG, concerning the care of at least three individuals with mental disabilities, should be grounded in its structural features.[292]

Importantly, the HeimAufG was seen as deficient and thus amended in 2017 to address its scope of application.[293] Previously, §2 (2) HeimAufG excluded any institutions for minors and special schools from the scope of application. This was perceived as unfair to CWD who, by residing in such facilities, had their rights less protected compared to those residing in facilities

[290] *Household Projections*, Statistik Austria, (2024), accessed: 5th February, 2024, *available at* https://www.statistik.at/en/statistics/population-and-society/population/families-households-living-arrangements/household-projections.
[291] 7 Ob 107/21t, Supreme Court, para. 13.
[292] Id. at.
[293] Amendment of the Home Residence Act, BGBl. I Nr. 59/2017, 2017.

covered by the HeimAufG. The Act was amended on 25 April 2017, repealing a provision that limited its scope of application, thereby effectively extending coverage to all institutions where children with intellectual or mental disabilities reside or spend part of the day, and where their liberty could be restricted. Contrary to that, the Supreme Court adopted a decision on 26th April, in which it confirmed that institutions for minors are outside of the scope of the Act.[294] As a result of the 2017 amendment, all facilities, regardless of their nature, fall under the scope of HeimAufG when there are children with intellectual or psychosocial disabilities being cared for there. However, the corresponding Viennese act, WPPG, still lists institutions, such as socio-pedagogical institutions, that are excluded from the provincial law.[295]

The expansion of the scope of the Act also meant that the Resident Representative has under their mandate the possibility to visit places where CWD are cared for on a permanent basis and represent persons whose liberty is restricted.[296] The Resident Representative can, after assessing an individual case of liberty restriction of a disabled child in an institution, bring the issue before the court.

3.1.2.6. Other federal legislation

The Civil Code (ABGB) includes provisions on the best interests of the child, detailing 12 key elements for consideration in individual cases.[297] These 12 elements entered the Austrian law in 2013 with the amendment of the ABGB. Although the CRC Committee acknowledged the introduction of this statutory 'checklist', it expressed scepticism about the law's impact and recommended an analysis of its effects.[298] The ABGB also regulates issues pertaining to the rights and duties of children and parents, including the care and upbringing, custody, legal representation, foster care, adoption and other. An atypical solution in comparative law is the provision allowing foster parents to adopt the child.[299]

The BPGG was mentioned several times above, in relation to the provision of LTC. This paragraph summarises the reforms introduced by the BPGG, assessing their effects and

[294] 7Ob33/17d, Supreme Court.
[295] LGBI Nr. 15/2005, last amend. LGBl. Nr. 30/2020. §2 (3).
[296] BGBl. I Nr. 11/2004, last amend. BGBl. I Nr. 77/2023. §§ 18, 19.
[297] JGS Nr. 946/1811 last amend. BGBl. I Nr. 182/2023 §138.
[298] CRC/C/AUT/CO/5-6, Committee on the Rights of the Child, 2020, para. 18.
[299] See note 244.

potential alignment with relevant CRC and CRPD norms. The BPPG was adopted in 1993 to mark the new era in the provision of social welfare to Austrian citizens, with the introduction of what Österle calls, a new pillar of the social welfare state.[300] The Act introduced the LTC allowance, for which parents of CWD are also eligible. In 2009, the Act was amended to include a hardship supplement, further strengthening protection for families of severely disabled children by more effectively covering additional care costs.[301] In 2012, the competence for the funding and administration of the LTC allowance was transferred to the Federation, which further improved the efficiency and ensured equal access to the LTC allowance for people in different provinces.[302]

Although this legislation does not directly reference the CRC or CRPD (unlike the B-KJHG), nor does it mirror their specific language, it could be inferred that primarily the CRPD's ratification might have influenced the strengthening of social protection via the BPGG. However, it is worth noting that the purely medical approach to disability assessment in the BPGG and its accompanying by-law is in clear contradiction to the CRPD, despite recommendations from the CRPD Committee.

The FLAG prescribes that families with severely disabled children have the right to an increased family allowance.[303] This is a measure that can contribute to the prevention of institutionalisation, by enabling parents to offset some of the additional costs regarding the disability, which is discussed in more detail above.[304]

The Compulsory School Act prescribes that 'children with special educational needs' can attend 'special schools' or general schools, depending on the assessment of the Education Directorate and the decision made by his/her parents.[305] The School Organisation Act prescribes that schools must take into consideration the 'social integration' of CWD, implying an obligation of mainstream schools to accommodate to CWD, but only to an extent. The use of the term 'integration' implies the school should make only limited adjustments while it will mostly depend on the pupil's characteristics whether he/she will be schooled in a general school. Also, the law prescribes that CWD who can follow the mainstream school curriculum

[300] See note 97.
[301] See note 102.
[302] See note 103.
[303] See note 140.
[304] See 'Support and services to'.
[305] BGBl. Nr. 76/1985, last amend. BGBl. I Nr. 37/2023. §8 (1).

without excessive need for support can be schooled under such curriculum, otherwise the special school curriculum will be applied.[306] The approach to schooling of CWD, enshrined in both acts examined here, is an approach that clearly falls short of the CRPD obligations and CRPD Committee's approach to inclusive education, which can contribute to the lack of social inclusion of CWD and institutionalisation.

The models of education of CWD are discussed in more detail above (See 'Education').[307]

3.1.3. Vienna law

The Vienna Constitution does not cover issues pertinent to this study but regulates the intra-provincial division of competences, including funding for out-of-school childcare and social services managed by the City of Vienna.[308] The following paragraphs revisit relevant Vienna law.

3.1.3.1. Vienna Child and Youth Welfare Act

The Viennese W-KJHG explicitly mandates that the least invasive and most effective measures be prioritised in the context of family- and community-based services as well as in alternative care settings (institutional, foster and kinship care).[309] The W-KJHG prescribes that the out-of-home care for youngest children, should primarily be in a family environment, with relatives or in a foster family.[310] This provision acknowledges the UN Guidelines' standard that children under three years of age should be placed in family-based care to avoid the potentially detrimental consequences of even short institutional placements.[311]

However, the provision's wording appears diluted. A firmer commitment to preventing the institutionalisation of very young children would include more decisive language such as 'whenever possible', coupled with a more stringent procedure for approving institutional

[306] BGBl. Nr. 242/1962 idF BGBl. Nr. 267/1963, last amend. BGBl. I Nr. 37/2023. §10 (4).
[307] See note 252.
[308] Constitution of the Capital of Vienna, LGBl. Nr. 28/1968, last amend. LGBl. Nr. 27/2023.
[309] Vienna Child and Youth Welfare Act (W-KJHG), LGBl. Nr. 51/2013, last amend. LGBl. Nr. 2/2023. §28.
[310] Id. at. §30 (3).
[311] See Part I chapter 3.2.1 The position of residential care.

placements. A comparable provision in the Serbian law stipulates that children under the age of three are, as a rule, not placed in institutions, but a following provision enables it in exceptional circumstances and upon approval of the competent Minister.[312] In fact, the provision of the Viennese act may be understood as a confirmation that for older children, placement in family-based alternative care is actually not prioritised over residential care.

The Ordinance on Socio-pedagogical Institutions, under §§ 46 – 48 WKJHG, stipulates requirements for residential care, including group sizes, staffing, and other operational rules. The groups cannot accommodate more than 8 residents, except in crisis centres and in exceptional circumstances.[313] The Ordinance also governs shared living apartments, where up to two older minors can reside, with no less than 20 square meters per person.[314] Although CWD are not specifically mentioned, they can be placed in this type of residential care.

Clearly, the WKJHG and the corresponding ordinance do not comply with the CRPD, though they do incorporate the CRC and UN Guidelines, particularly concerning the size of residential care, prioritisation of family-based care, and the avoidance of placing children under three in institutions. The W-KJHG ensures that kinship carers (relatives) can be granted the same amount of care allowance as foster carers.[315] Also, the act recognises the social insurance for foster carers, and that the foster care allowance can be increased on an individual basis, due to disability of the child.[316] A separated decree regulates the rules of residential care, including the limit of residential groups to 8. However, as it was evidenced by stakeholders, providers of residential care can in a way circumvent this obligation, by creating several residential groups inside one residential facility, eventually resulting in care in much larger groups than 8 children.[317]

Unlike the B-KJHG, the W-KJHG actually mentions CWD in relation to the support in the sense of family- and community-based services and alternative care.[318] This presents a legal integration of the social protection of CWD in the mainstream social protection system in Vienna. At the implementation level, support and services for CWD appear to be managed by the FSW, a company tasked with providing support and services for persons with disabilities,

[312] See Part III, Serbia, Chapter 3.1.3. Law on Social Protection.
[313] Id. at. §7.
[314] Id. at. §9.
[315] See 'Family-based alternative care'.
[316] Id. at. §44 (4).
[317] See note 207.
[318] LGBl. Nr. 51/2013, last amend. LGBl. Nr. 2/2023. §20 (10).

rather than MA11, the provincial department for child and youth welfare, suggesting a functional separation in the social protection of CWD from non-disabled children.

3.1.3.2. Vienna disability and antidiscrimination law

The Vienna Equal Opportunities Act (CGW), adopted in 2010, promotes equality for persons with disabilities.[319] The act addresses issues including the provision of services—such as in-home, community-based, and residential services, cost participation, and representation of Viennese disabled people at the Office of the Vienna Provincial Government. It obligates the City to provide special assistance and care to CWD in relation to their schooling and early intervention support and services.[320] Other aspects of family life, support, alternative care for CWD, are not covered by this act. The act prescribes PA, but only for adults with disabilities.[321]

The CGW does not stipulate the size, the age, the length, and other aspects of residential care that would be relevant for this study. The Act expresses that the goal of residential care is to help persons with disabilities to live as independently as possible once they reach the age of majority.[322]

The CGW establishes a representative council comprising 10 to 15 DPO representatives working in Vienna, at least eight of whom must be persons with disabilities.[323] The body's task is to represent the interests of disabled people in Vienna, participate in all matters affecting them, and advise the Provincial Government on such issues. Additionally, the chairperson can summon members of the Provincial Government, municipal employees, and FSW employees, and must ensure all resolutions adopted by the council are presented to both the Provincial Government and the Provincial Parliament.[324] The representative council was introduced before the CGW, with the Vienna Disability Act (WBHG), which was terminated by the CGW in 2010.[325]

The Vienna Antidiscrimination Act prohibits discrimination based on disability and mandates the establishment of an Office for Combating Discrimination within the Vienna Provincial

[319] LGBl. Nr. 45/2010 last amend. LGBl. Nr. 49/2018.
[320] Id. at. §§ 7, 8.
[321] Id. at.
[322] Id. at. §12.
[323] Id. at. §38.
[324] Id. at. §38 (6).
[325] Id. at. §41.

Government, tasked with promoting CRPD implementation and cooperating with the IMC.[326] The Act sets up a body to monitor the implementation of the CRPD in Vienna, which is independent in conduct, and consists of one person from the Office for Combating Discrimination, four representatives of DPOs, an NGO representative, and one person from academia.[327]

The existence of two statutory bodies, one tasked with representation and counselling, and the other with monitoring and promoting the CRPD, implies successful incorporation of Articles 4(3) and 33 CRPD into Vienna legislation.

3.1.3.3. Other Vienna legislation

The Vienna Social Welfare Act (WSHG) defines various support and services that Vienna residents may be entitled to. The act lists several types of services, including in-home care for sick, family assistance, and residential care.[328] The FSW, a company previously mentioned,[329] is responsible for providing these services.[330] Apart from the statutory recognition of those several services, the Act does not incorporate relevant CRC and CRPD norms to a satisfying degree. The Vienna Residential and Nursing Care Act (WPPG) is addressed together with the corresponding Federal law in the section 'Federal Residential Care Act HeimAufG'.

3.2. Judicial Measures

This section, like the other two country studies, examines court rulings related to the right of CWD to live in a family environment. I It aims to assess the courts' influence and strategic litigation on the realisation of this right and the adoption of relevant international standards within a family setting. Particularly crucial are cases related to the provision of residential and

[326] Vienna Antidiscrimination Act, LGBl. Nr. 35/2004, last amend. LGBl. Nr. 39/2018. §7 (2).
[327] Id. at. §7b (1).
[328] first last amend. LGBl. Nr. 38/1975, last amend. LGBl. Nr. 49/2018. §22 (2).
[329] See 'Support and services to'.
[330] Id. at. §34.

alternative care, community- and family-based services and support, and financial assistance for children with disabilities and their families.

The focus on decisions from the country's highest courts is due to their capacity to influence law and practice through highly authoritative rulings, although judicial decisions are not a source of law within the Austrian legal system. This is done by conducting a systematic review of caselaw in the publicly available Federal legal information system (RIS), provided by the Federal Ministry of Finance.[331]

For this review, the RIS online portal was utilised to search decisions from the Constitutional Court (VfGH) since 1980 and the Supreme Administrative Court (VwGH) from 1990. Under the RIS section *Justiz*, selected decisions of the Supreme Court (OGH), the Higher Regional Courts (OLG), the Regional Courts (LG), the District Courts (BG), decisions of the Supreme Patent and Trademark Senate (OPMS until the end of 2013) and foreign decisions (AUSL) can be found. Given that the RIS only contains selected decisions from the Supreme Court, this represents a limitation of this study. It is possible that certain decisions which would be valuable for this study are not available in the RIS.

The Constitutional Court's jurisdiction was mentioned above and will not be revisited here.[332] The Supreme Court is the highest court for civil and criminal law. The Supreme Court's case law plays a critical role in upholding legal consistency in the country. Despite the fact that lower courts are not legally obligated to adhere to its rulings, they typically conform to the precedent set by the highest court.

The Supreme Administrative Court oversees the legality of individual administrative decisions. This court's review is limited to the legal underpinnings of individual legal acts, whereas contentions involving infringements of constitutionally protected rights, or the enactment of illegitimate general legal acts are the domain of the Constitutional Court. The Supreme Administrative Court acts as a second instance in cases where the Federal Administrative Court (BVwG) serves as a first instance court. The administrative jurisdiction underwent significant reform on 1st January 2014. The BVwG was established to alleviate the burden on the VwGH,

[331] *Rechtsinformationnsystem des Bundes*, Ministry of Finance, accessed, 2024, *available at* https://www.ris.bka.gv.at/default.aspx.
[332] See 'Judicial system'.

and nine regional administrative courts were created to replace the administrative panels in the provinces.[333]

The Vienna Higher Regional Court is responsible for Vienna, Lower Austria, and Burgenland. It serves as the second instance court on appeals to the decisions of the regional courts and district courts, and as a first instance court for the entire Austria. In the first instance, it is responsible for anti-trust matters. The matters of law it decides include civil, labour and social law, and criminal law.

The RIS allows to search decisions by legal acts and norms on which decisions are based. The provisions of those acts, mentioned under the section 'Measures' were searched. The following pieces of legislation were under scrutiny: the B-VG, the Federal Constitutional Act on the Rights of Children B-RK, the Federal Child and Youth Welfare Act B-KJHG, the Federal Disability Act BBG, the Federal Equality of Persons with Disabilities Act BBGStG, The Federal Equal Treatment Act B-GBG, the Federal Residential Care Act HeimAufG, the Federal LTC Allowance Act BPGG, the Family Burdens Equalisation Act FLAG, the School Organisation Act (SchOG), the Compulsory School Act, the Constitution of the Capital of Vienna WStV, the Vienna Child and Youth Welfare Act W-KGJH, the Vienna Equal Opportunities Act CGW, the Vienna Antidiscrimination Act, the Vienna Residential and Nursing Care Act WPPG, the Vienna Social Welfare Act WSHG, the Vienna ordinance on socio-pedagogical institutions SPEVO, the Classification ordinance to the Federal care allowance act EINSTV, the CRPD, the CRC.[334]

The RIS allows search using keywords. The following keywords were used in the German language: the CRPD, the CRC, rights of persons with disabilities, child with a disability, children with disabilities, child with special educational needs, children with special educational needs, child with a disability in care, child in care, life in a family environment, socio-pedagogical institutions, children's home.[335]

[333] The Austrian Judicial System, The Federal Ministry of Constitutional Affairs, Reforms, Deregulation and Justice, 2018.
[334] Titles of the conventions in the German language were used - Übereinkommen über die Rechte von Menschen mit Behinderungen (Behindertenkonvention), and Übereinkommen über die Rechte des Kindes / Kinderrechtskonvention.
[335] All terms are searched in the German language: Übereinkommen über die Rechte von Menschen mit Behinderungen / Behindertenkonvention, Übereinkommen über die Rechte des Kindes / Kinderrechtskonvention, Rechte von Menschen mit Behinderungen, Kind mit Behinderung, Kinder mit Behinderungen, Kind mit

3.2.1. The Supreme Court OGH

3.2.1.1. Application of the HeimAufG

Between 2014 and 2022, the Supreme Court adjudicated at least six cases concerning the application of the HeimAufG involving CWD in special boarding schools, crisis centres, and socio-pedagogical facilities managed by child and youth welfare organisations.[336] These Supreme Court decisions neither directly nor indirectly addressed the realisation of the right for CWD to live in a family environment. However, for this dissertation, they are relevant as they contribute to understanding, amidst the lack of data, how alternative residential care for CWD is organised and how the country's highest court approaches care in SGH, especially when organised in clusters. Decisions from the years 2017, 2019, and 2022 are particularly noteworthy.

In 2017, The Supreme Court adjudicated on an appeal to the decision of the Innsbruck Regional Court as the court of appeal, on the review of the application of restrictive measures in a special boarding school, in accordance with the HeimAufG.[337] The question of the applicability of the HeimAufG was central, as the restrictive measures were applied on a disabled adult who lived in a residential institution attached to a special school since the age of 6. The appellant was represented by his relatives and the VertretungsNetz (VN), the association of resident representatives per the HeimAufG.[338]

The appellant argued that the HeimAufG also applies to special boarding schools, although the §2 (2) HeimAufG at that time explicitly excluded several types of facilities from its scope, including facilities for minors, as explained above.[339] The Court concluded that the Act was unambiguous and characterised the appellant's arguments as mere criticism of the existing

sonderpädagogischem Förderbedarf, Kind mit Behinderung im Pflege, Kind im Pflege, Pflegekind, Leben in einem familiären Umfeld, sozialpädagogische Einrichtungen, Kindheim, Jugendheim.

[336] 7 Ob 1/14v, Supreme Court; 7 Ob 33/17d, Supreme Court; 7 Ob 80/19v, Supreme Court; 7 Ob 107/21t, Supreme Court; 7 Ob 43/22g, Supreme Court; 7 Ob 34/23k, Supreme Court.

[337] 7 Ob 33/17d, Supreme Court.

[338] BGBl. I Nr. 11/2004, last amend. BGBl. I Nr. 77/2023. §8.

[339] See 'Federal Residential Care Act HeimAufG'.

law.[340] The Court, did, however, recognise as unfair the exclusion from the scope of the Act the facilities where CWD could be cared for, such as those under youth and welfare organisations' administration, and even claimed that legislators were not aware that CWD are also placed in such facilities.[341] Nevertheless, the Court strictly adhered to the legal boundaries, concluding that it was a policy decision to restrict the law's scope to exclude institutions for minors, special schools, and other facilities.[342] Consequently, the appeal was dismissed on the 26th April 2017.

Only one day earlier, on the 25th of April 2017, the HeimAufG was amended and the critical provision §2 (2) was removed from the Act. The amendment opened the space for the expansion of the application of the HeimAufG. The amendment of this crucial provision in the HeimAufG, just a day before the Supreme Court's decision, is particularly intriguing. However, the Court had no alternative but to base its decision on the law as it stood at the time of the disputed events, which occurred during 2016.[343]

This case was significant because it illustrated the essence of special boarding schools. The appellant, who had been attending such a school since the age of six, remained there for an additional year and a half after reaching adulthood, not for educational purposes but solely for care, pending transfer to an adult facility. Nearly all interviewees highlighted the issue of institutionalisation in these schools, yet no specific written and publicly available source showcasing this has been identified. Thus, while the information in the Supreme Court's decision is case-specific, it nonetheless sheds light on the nature of lifelong institutionalisation for children with disabilities in Austria, commencing with attendance at a special boarding school.

Similarly, in another decision from 2022, the judges of the Supreme Court expressed dissatisfaction with the current regulations on health insurance and urged legislators to change the law.[344] Nevertheless, they based the decision on the applicable law. The judges suggested that legislators introduce in-kind services for children who are severely disabled or ill and

[340] Supreme Court, 7 Ob 33/17d, para. II.2.
[341] Id. at, para. II.4.6.
[342] Id. at.para. II.5.3
[343] Id. at.
[344] 10 ObS 86/22b, Supreme Court, para. 18.

require 24-hour medical care at home, to mitigate the high market costs that parents would otherwise have to bear entirely or in part.

The decisions from 2022 and 2016 indicate that the judges of the Supreme Court are willing to criticize the applicable law and even suggest in which direction amendments should be made. Such practice can hardly be called 'judicial activism', which considers making decisions that are socially responsible but not based on the statutory or caselaw. The judges of the Supreme Court who adjudicated in those two cases, would be called by Schlessinger 'champions of self-restraint'. However, having in mind that going beyond applicable law is not common for legal systems based on written law, the behaviour can be described more positively as 'judicial advocacy'. The effects of this form of advocacy in Austria are not known.

Two years later in another decision, when commenting on the HeimAufG amendment from 2017, the Supreme Court explained that the materials confirm that the amendment aimed to broaden the HeimAufG's application scope, encompassing all facilities, whether public or private.[345] This includes entities under child and youth welfare organisations, special schools, after-school care, SOS Kinderdorf, and other day care and residential facilities, as elucidated in a 2019 Supreme Court decision.[346]

In 2022, the Supreme Court upheld a 'macro approach' to the assessment of the structure and organisation of small residential groups in Vienna, in relation to the fulfilment of conditions of §2 (1) HeimAufG.[347] Namely, the question of the application of the HeimAufG concerning the utilization of restrictive measures on a disabled child who was placed in a residential group, which was a part of a cluster of 10 such residential groups, was adjudicated. Instead of looking only into the conditions of the residential group where a disabled child was placed in, the Court held that the entire cluster had to be assessed for its possibility to accommodate and care for at least three children with 'mental disability or mental illness' (the term used by the Court). Therefore, the court understood that the functional and structural connectedness of residential groups forming a cluster, must not be neglected, at least in relation to the application of the HeimAufG. The approach of the Court to an extent confirms the criticism by the IMC of the

[345] 7 Ob 80/19v, Supreme Court, para. 2.
[346] Id. at.
[347] 7 Ob 43/22g, Supreme Court.

provision of care for children in *de facto* large groups,[348] such as in this case, where 80 children received care at one site.

3.2.1.2. Access to LTC allowance

In 2016, the Supreme Court adjudicated a case regarding access to the level 6 LTC care allowance, for a disabled child born in 2013.[349] There have been other cases regarding the calculation of care hours for different activities regarding the care of children with disabilities and access to lower levels of care allowance, which are not significant for the present study.[350] The case is descriptive of the Court's approach to the need for a high level of care for children with severe disabilities, as it may obstruct their access to the LTC allowance of such a level. The court recognised the child's multiple and severe impairments, which necessitated immediate attention at unpredictable times, particularly during the night, distinguishing this need from that of children without such impairments.[351] According to §4(2) BPGG, level 6 care allowance is awarded when care measures must be provided in an uncoordinated fashion regularly throughout the day and night, or a caregiver's constant presence is needed due to the likelihood of self-harm or harm to others.[352]

The first instance court granted level 6 care needs, citing the child's seizures that required immediate attention at any time, day or night. The Court of Appeal, on the other hand, maintained that a very young child must always be under the supervision of his/her carers, as there is an inherent danger to oneself regardless of disability. As a result, the Court of Appeal deemed the need for a parent to attend to a disabled child day and night - providing comfort during restlessness and assistance during seizures - as merely psychosocial support, not qualifying as care under the BPGG.[353]

The Supreme Court concurred with the decision of the Court of Appeal and dismissed the appeal.[354] In summary, based on §4(3) BPGG, the Court determined that the around-the-clock

[348] See 'Institutional (residential) care'.
[349] 10ObS33/16z, Supreme Court.
[350] Legal sentence RS0123197 Supreme Court
[351] 10ObS33/16z, Supreme Court. Head.
[352] BGBl. Nr. 110/1993, last amend. BGBl. I Nr. 170/2023.
[353] Id. at.
[354] 10ObS33/16z, Supreme Court, para. 1.

care required in the appellant's case was also age-related, a factor not considered when determining eligibility for care allowance under the BPGG.[355] The Supreme Court explicitly acknowledged that this policy prevents the youngest children with severe disabilities from accessing higher levels of care allowance, yet deemed it 'objectively justified' and not in violation of the non-discrimination clause in Article 7 of the B-VG.[356]

Therefore, there is no doubt that the youngest children with severe disabilities were put in a less favourable position with such an approach, but it was justified according to the Court. Moreover, the legislator added a hardship supplement in the BPGG in 2009, to better support parents of severely disabled children, that is also higher for persons over 15 years of age (children 15-17 years old and adults) than younger children.[357]

3.2.2. The Constitutional Court VfGH

The review of the Constitutional Court's practice did not retrieve results which would be relevant for the realisation of the right to live in a family environment for a disabled child.

Two cases involving young disabled adults were identified. The first case assessed the eligibility of a young disabled adult's aunt and uncle for an increased family allowance and self-insurance in the pension insurance scheme, due to their care for their nephew, who was a young disabled adult at that time.[358] The other case considered the right of a parent of two minor children and one adult disabled child to a single parent bonus and other benefits, in accordance with applicable law in Upper Austria.[359] Although relevant from the aspect of implementation of several CRPD provisions, including those in Article 23 CRPD, the cases involved adults and are thus excluded from further examination.

[355] Id. at, para. 1.
[356] Id. at, para. 1.
[357] See 'Support and services to'.
[358] E 2174/2022-14, Constitutional Court.
[359] E 2802/2021-16, Constitutional Court.

3.2.3. Supreme Administrative Court VwGH

3.2.3.1. Definition of institutional care in the context of the FLAG

A notable case from the Supreme Administrative Court focused on defining institutional care for children with disabilities within the context of the FLAG.[360] This 2009 case examined the eligibility for family allowance under the FLAG for a parent of a disabled person in institutional care. Under FLAG §6 (2, d), specific conditions are prescribed for the eligibility of a child without parental care for a family allowance.[361] When a child without parental care is in an institutional care and is disabled, he/she may be eligible for family allowance where his/her maintenance is not fully covered by public funds. Based on this provision, the VwGH defined 'institutional care' as per §6 (2, d) FLAG, to mean situations where an individual's care is directly and fully managed by public authorities.[362]

The VwGH in 2009 ruled that the understanding of institutional care in the sense of §6 (2, d) FLAG cannot be applied in the context of §2 (5, c) FLAG, which prescribes that parents may be eligible for family allowance when their adult child is in institutional care, and they still pay maintenance. The Court logically concluded that its interpretation of institutional care under §6 (2, d) FLAG would not apply to situations described in §2 (5, c) FLAG, thereby suggesting different definitions of institutional care depending on the specific provision within the same law. The Court determined that the definition of institutional care varies depending on the regulatory context, even when the provisions come from the same law and are interpreted by the same court. This indicates that the Court has not found value in developing one, coherent and universal definition of institutional care in its practice.

Conversely, the Court has explained its approach to interpreting the FLAG, focusing on the legislators' intentions and the Act's (and the provisions') objectives. Therefore, the judges applied a teleological interpretation of the relevant provisions to benefit families, aiming to reduce their financial burden or, in other words, to equalise burdens in the interest of families (§ 1 FLAG). Also, the interpretation that a person who is permanently in an institution is still considered a member of his/her parents' household if the parents pay for his/her maintenance

[360] 2006/13/0092, Supreme Administrative Court.
[361] BGBl. Nr. 376/1967, last amend. BGBl. I Nr. 200/2023
[362] Supreme Administrative Court.

in an institution, is rather broad, but adequate because this interpretation aligns with the family's interest regarding eligibility for family allowance, as highlighted by the Court. As a result, the child permanently placed in an institution can still be considered part of his/her household. Therefore, this indicates there could be many definitions and understandings of institutional care in Austria, depending on the regulatory context that applies to it, which is also confirmed with a different approach to the understanding of the notion of institutional care in the sense of HeimAufG.[363]

Considering the CRC and the CRPD are not directly applicable before the courts, the VwGH has not had an opportunity to interpret the notion of care in a family environment or the institutional care in the sense of those human rights treaties, or corresponding domestic law which incorporates those treaties.

3.2.3.2. CRPD interpretation

One case before the VwGH in 2012 considered the interpretation of the CRPD in relation to the obligations of states parties to provide PA to persons with disabilities. The case itself is not particularly relevant for the focus of this thesis, but it is informative regarding the VwGH's approach and interpretation of the CRPD. Although adults are involved in the case (and not children), access to disability assistance is essential for the realisation of the right to live in a family environment for CWD.

Namely, two complainants appealed a first instance decision of Salzburg Provincial Government from 2010, by which their applications for the assumption of costs for PA were rejected. The complainants argued that they are entitled to the assumption of costs for PA and used the CRPD to support their argumentation. At that time, the applicable Salzburg law did not explicitly recognise PA as a form of disability assistance. However, then prescribed 'integration assistance' in the provincial law also encompassed PA but did not specifically name it 'PA'. The Salzburg Disability Act (SbgBehG),[364] applicable at the time of the

[363] See 'Application of the HeimAufG'.
[364] Salzburg Disability Act (SbgBehG), LGBI Nr 93/1981, last amend. LGBl Nr 82/2018.

judgement, was later amended and the name of the law changed to the Salzburg Participation Act (S.THG) in 2019.[365]

Essentially, the VwGH declared the appeal unfounded, and concurred with the decision of the Salzburg Provincial Government, by which no specific type of integration assistance is guaranteed to persons with disabilities, and the experts must decide which type of assistance should applicants obtain, as prescribed by applicable provincial law. The appellants used the CRPD to support their argumentation in their appeal, specifically Article 19 CRPD, which prescribes that states parties shall take effective and appropriate measures to facilitate independent and community living, by ensuring, *inter alia*, access to PA.[366] Moreover, the complainants reiterated the CRPD's general principles of the recognition of human dignity and autonomy[367] as an argument in favour of their right to choose the type of disability assistance. The VwGH highlighted that these arguments were insufficient to warrant an interpretation of the provincial law contrary to its wording, as the law prescribes that experts must determine the type of assistance a person should receive, based on their medical examination and after consulting with the individual.

Arguably, even if the VwGH found the first instance decision unlawful, the Court would not need to deliver an interpretation contrary to the wording of the provincial law. Rather, the Court could guide its interpretation by the mentioned CRPD principles and provisions and find that medical experts should give due weight to the preferences of the person who requests disability assistance, since the experts were obliged by provincial law to hear the person when determining the form of assistance to be awarded.

Instead, the VwGH reiterated that the CRPD is not directly applicable, added that PA is not defined in the CRPD, and emphasised that the CRPD does not prescribe an obligation of states to allow disabled persons to claim specific forms of assistance. The VwGH therefore had clearly little regard for the CRPD and omitted to use the CRPD as an interpretive guidance of the provincial law. Lastly, while it was observed in some decisions of the OGH that judges would comment the dissatisfying quality of law, but eventually make a decision based on applicable domestic law,[368] this was not the case with the VwGH.

[365] Salzburg Participation Act (S.THG), LGBl. Nr. 64/2019.
[366] Convention on the Rights of Persons with Disabilities, UNTS, 2515, p. 3, A/RES/61/106, 2006. Article 19 (b).
[367] Id. at. Article 3 (a).
[368] See 'Application of the HeimAufG'.

3.2.3.3. Representative action on personal and school assistance

In March 2023, the Vienna Commercial Court deemed an ordinance on PA at federal public schools to be discriminatory.[369] The litigation was initiated following an unsuccessful mediation. As previously detailed, the ministerial ordinance in question restricted PA in schools solely to pupils with physical disabilities, specifically those assessed as requiring a care level of 5 or higher, thereby excluding all other disabled students from this service.[370] The Court determined that pupils with intellectual, psychosocial, and sensory disabilities, as well as those with physical disabilities but a care level below 5, were subject to discrimination under § 5 BGStG.[371] Furthermore, even pupils who received PA were discriminated, as they were not provided with assistance during all school classes, events, and free periods. The defendant did not appeal against the Court's decision but chose instead to revise the unlawful ordinance.

The new ordinance, which was adopted in September 2023, offers tailored services for children based on their specific needs.[372] Pupils with autism are eligible for 'school assistant' services, whereas those with physical and sensory disabilities are provided with 'personal assistant' services, alongside an interpreting service that facilitates communication between German (and other languages) and Austrian Sign Language.

This case is the only instance of anti-discrimination strategic litigation concerning CWD identified in this systematic review of Austrian caselaw. The case was a significant victory and the Court's decision undoubtedly helped the implementation of Article 24 CRPD. It is noteworthy that the defendant chose not to appeal the Court's decision, which likely expedited the resolution process. This was the first representative action under the BGStG, according to Theresa Hammer, a Klagsverband Managing Director.[373]

[369] 19 Cg 73/21p, Vienna Commercial Court.
[370] See 'Support and services to'.
[371] Id. at. paras. 1, 2.
[372] See note 168.
[373] *Theresa Hammer zum Verbandsklage-Urteil: Das ist ein großer Erfolg*, Bizeps.at, (2023), accessed: 8th March, 2024, *available at* https://www.bizeps.or.at/theresa-hammer-zum-verbandsklage-urteil-das-ist-ein-grosser-erfolg/.

Klagsverband is legally authorised to initiate representative actions regarding the rights of persons with disabilities, as stipulated by § 13 BGStG.[374] Disability Ombudsperson and the ACDP are two other organisations that are allowed to pursue representative actions. The BGStG determines that where the complainant seeks elimination of discrimination and injunctive relief, and where defendants are large companies, the competent court is the Vienna Commercial Court.[375] Theresa Hammer, of the Klagsverband, elaborates that legal grounds for NGOs to bring representative action before the court, specifically Klagsverband and the ACDP, was a result of the implementation of the EU equality directives.[376]

3.3. Strategic policy documents

In this section policy documents are examined to explore the implementation of relevant CRC and CRPD norms through the implementation of strategic and planning documents, as in two other country studies. The strategic documents examined here are:

- National Action Plan on Disability 2012 – 2020 (NAPD 2012);
- National Action Plan on Disability 2022 – 2030 (NAPD 2020);
- Government programme 2020 – 2024;
- Federal Government's Disability Concept 1992.

3.3.1. National Action Plan on Disability 2012 – 2020

The NAPD was valid until the end of 2021 and included 250 measures. The document received significant criticism from DPOs, NHRIs, and academics, primarily due to the exclusion of provinces from the negotiations and drafting process, which resulted in measures limited to federal competencies.[377] This represents a major deficiency in a comprehensive strategic document for a federation like Austria, where provinces hold competence over most social protection measures, including childcare, family support services, kindergartens, foster care,

[374] Federal Equality of Persons with Disabilities Act (BGStG), BGBl. I Nr. 82/2005, last amend. BGBl. I Nr. 32/2018.
[375] Id. at.
[376] Theresa Hammer, Interview, 12th March, 2024.
[377] Bußjäger. 2023.

and residential care (special education is the responsibility of the Federation, as well as LTC allowance and family allowance). However, the NAPD 2012 was repeatedly discussed in both chambers of Parliament and could have had indirect effects on provincial competencies, according to Bußjäger.[378] Another major deficiency of NAPD 2012 was the omission to explicitly state which human and material resources are allocated for the implementation of the plan, and the lack of target values for indicators.

Evaluators of the NAPD 2012 highlight the concern that disability policy may be considered a 'marginal issue' in Austria, particularly for persons with severe disabilities. They also point out that the drafting process did not ensure broad political participation and consensus, which ultimately led to poor implementation.[379]

The NAPD 2012 specifically addressed CWD in two chapters. Under the chapter 'Children with Disabilities', pertaining partly to the realisation of Article 7 CRPD and partly to Article 19 CRPD, the document set several objectives, including the early identification and therapy, support to families in order for a disabled child to stay in the family, availability of childcare facilities such as nursery schools and afternoon care, and increased family allowance for severely disabled children to continue.[380]

In general, the objectives were aligned with the CRPD and did not involve residential care. Conversely, measures that were supposed to lead to the realisation of those objectives were set rather restrictively. Specifically, the plan lacked measures aimed at providing a diverse range of individualised, in-home services for families with CWD. Also, the measures did not reflect dedication to family-based alternative care when CWD are separated from their immediate families, including the support to kinship and foster carers. Lastly, the measures did not include any DI-specific intentions, such as mapping residential care or developing a DI strategy.[381] This was a direct consequence of the exclusion of all matters pertaining to the competence of provinces from the NAPD 2012.

[378] Id. at, p. 76.
[379] BMSGPK, 2020**, p.** 693.
[380] National Action Plan on Disability 2012 – 2020 Strategy of the Austrian Federal Government for the implementation of the UN Disability Rights Convention, Federal Ministry of Labour, Social Affairs and Consumer Protection, 2012.
[381] E.g. Lazar Stefanović, Toolkit on Ending Deprivation of Liberty of Children in Institutions (Global Campus of Human Rights 2022), p. 23 – 24.

An evaluation of NAPD 2012, criticised, *inter alia*, the lack of coherence between objectives and measures, dubious effectiveness of awareness raising measures, and the lack of indicators.[382]

Under the chapter 'Independent living', the NAPD 2012 set objectives and measures regarding, *inter alia*, Articles 19 and 23 of the CRPD.[383] Namely, the need for a DI strategy was expressed, but it was followed by an expression that such a strategy should focus on breaking down large institutions and creating support services for people with disabilities. While the creation of in-home, family- and community-based services is indeed an essential part of any DI policy, the intention to 'break down' large institutions reflects decades long tendency to proliferate smaller residential care facilities on the expense of larger facilities. However, the NAPD 2012 does not mention CWD in this context and considering the lack of discussion on support to families and living in a family environment for CWD, it seems that authorities decided to address those issues only as part of Article 7 CRPD, as already explained above. Finally, the NAPD 2012 recognised that matters pertaining to DI and independent living are mostly in the competence of provinces and the only measure foreseen was support to self-advocacy organisations for their pilot projects.

In relation to PA, which is the competence of the Federation regarding the employment and education, the NAPD 2012 foresaw the expansion of PA in education to children with all disabilities. PA is a critical service that supports life in a family environment for CWD by facilitating social and educational inclusion and helping parents balance work and family life. Still, in order to be most effective, PA needs to be comprehensive and cover all spheres of life and not only education. In that sense, the lack of participation of provinces was another major impediment for an effective plan. The evaluation of the ministry competent for social affairs uncovered that the provinces might lack the motivation to conduct cross-state policies in relation to DI and PA.[384]

It was explained above that until September 2023, PA in schools was available only to children with physical and sensory impairments above a certain level of assessed care needs. The expansion of PA was not initiated by the ministry competent for social affairs, as it was stipulated in the NAPD 2012, but by the decision of the Vienna Commercial Court in a

[382] BMSGPK, 2020**.** p. 177 – 182.
[383] Federal Ministry of Labour, Social Affairs and Consumer Protection, 2012, p. 83 – 84.
[384] BMSGPK, 2020**, p.** 508.

representative action lawsuit by Klagsverband.[385] Other aspects concerning independent living such as expansion of social services in provinces, with the subsidies by the Federation, in accordance with the BPPG, was foreseen.[386]

3.3.2. National Action Plan on Disability 2022 – 2030

Prior to adopting the NAPD 2022, provinces and the Federation negotiated a common disability inclusion policy and the creation of an inclusion fund, notably without the involvement of DPOs, as reported by the OeB.[387] The negotiations reportedly failed, although the provinces were willing to undertake a common disability policy, if it were funded by the Federation.[388] Six months prior to the adoption of the NAPD 2022, the Federal Government adopted a resolution to form the aforementioned inclusion fund, from which the NAPD 2022 measures that are implemented by the Federation and provinces jointly, such as DI and PA in all spheres of life, are to be funded.[389] Therefore, the agreement on funding was finally reached.

Unlike the previous action plan, the NAPD 2022 was collaboratively drafted by federal and provincial authorities in what was initially a widely participative process, according to the OeB.[390] Recommendations of evaluators of the NDAP 2012 focused specifically on ensuring that the new NAPD overcomes the most obvious issue from the older strategic document – the lack of political participation of the provinces. [391] However, not all stakeholders adhered to the principles of participation of DPOs and CSOs, and, according to the OeB, some provinces, including Vienna, insisted on making their, province-specific plans.[392] The ACDP, a prominent DPO, criticised the NAPD 2022 for its overall neglect of children's rights.

One of the measures under the chapter ‘Disability Policy’ of the NAPD 2022 is the adoption of a Federation-provinces agreement on the uniform implementation of the CRPD in the entire country.[393] Such an agreement could be a crucial instrument for the implementation of the

[385] See ‘Support and services to’.
[386] Federal Ministry of Labour, Social Affairs and Consumer Protection, 2012, p. 87.
[387] ACDP, 2018**.**
[388] Id. at.
[389] BMSGPK, 2022**, p.** 10.
[390] Response to the List of Issues prior to submission of the combined second and third periodic reports of Austria (CRPD/C/AUT/QPR/2-3) by the Austrian Disability Council, (2023), ACDP, p. 2.
[391] BMSGPK, 2020**, p.** 693 – 696.
[392] ACDP, 2023**.**
[393] BMSGPK, 2022**, p.** 12.

CRPD and more specifically the realisation of the right to live in a family environment for CWD, as argued above. This claim is grounded in the historical context where the 1993 Federation-provinces agreement significantly influenced the expansion of both family and residential care, including the proliferation of SGHs to the present day. Therefore, perhaps another, country-wide, landmark agreement, negotiated under the contemporary IHRL context, could spark the decisive transition. The new Federation-provinces agreement on the implementation of the CRPD should be developed by 2027, according to the NAPD 2022.

The document directly targets institutional care for CWD by setting objectives to enhance violence prevention in these settings.[394] Other objectives include easier procedures to obtain the increased family allowance, increase the availability of community-based, non-residential services, to harmonize the quality and provision of services for CWD with the quality of children and youth welfare services. Also, the NAPD 2022 aims at the expansion of short-term accommodation, also known as respite care (in an institution), as well as the provision of all forms of residential care in an inclusive manner.[395]

In relation to Article 19 CRPD, the NAPD 2022 foresees 'deinstitutionalisation of residential facilities' urgently and in all provinces.[396] Such a phrase is not typical and not part of the CRPD or CPRD Committee's terminology. The phrase 'deinstitutionalisation of residential facilities' indicates that residential facilities will be reorganized or transformed in a way to provide residential care in smaller groups, which are sometimes viewed not as institutions, as already explained (Part I, chapter 3.2.2 DI in the UN Guidelines).

Another objective pertaining to Article 19 CRPD is to allow all CWD to live independently, in accordance with their age and support. Independent living of CWD is normally understood to be appropriate for some older minors.[397] Therefore, such a statement and the objective are not in conflict with the CRPD. However, the fact that the chapter on Article 19 of the CRPD lacks specific objectives and measures aimed at supporting CWD to live with their families suggests that the Austrian authorities did not understand Article 19 as inclusive of children.[398]

[394] Id. at, p. 17.
[395] Id. at.
[396] Id. at, p. 117 - 118.
[397] See Part I, Chapter 1.4.5 Article 19 and children.
[398] See Part I, Chapter 1.4.5 Article 19 and children.

Concerning PA, the NAPD 2022 stipulates harmonisation and expansion of this service across the country and in all areas of life.[399] In relation to PA in the context of education, the document only foresees commencement of discussions on the harmonization of this service from 2027.[400] Therefore, CWD are excluded from the expansion of PA service to all areas of life, and its harmonization between provinces, at this point. The plan includes expanding and harmonizing LTC services nationwide and reforming LTC allowance assessments to better meet the needs of individuals with intellectual and psychosocial disabilities.[401] The reason why the current assessment and conditions for the LTC allowance do not correspond adequately with the needs of children and adults with intellectual and psychosocial disabilities, is that, according to the Supreme Court, the LTC allowance is supposed to cover costs of physical care of persons with disabilities who are not able to care for themselves, with an aim to prevent neglect, according to the Supreme Court.[402] It is evident that this approach to the LTC allowance could place children and adults with intellectual and psychosocial disabilities at a disadvantage compared to those with certain physical disabilities. This is not justifiable, given that the former may require intensive support to prevent neglect, even in the absence of significant physical impairment.

It is planned to eliminate the deduction of the increased family allowance against the LTC allowance, and to increase the hardship supplement to the LTC allowance increased for persons with severe psychosocial disabilities from the age of 15.[403] Also, the NAPD 2022 foresees the expansion and introduction of benefits for persons who care for their relatives (including parents).[404]

In the realm of education, the further expansion, and a number of measures on inclusive education are planned, however, the NAPD 2022 does not address directly boarding schools for CWD.[405]

In sum, the NAPD 2022 contains a mix of much needed, CRPD-compliant measures, and non-compliant ones, from the perspective of the realisation of the environment for CWD. The CRPD-compliant are those measures focusing on the expansion of family- and community-

[399] Id. at, p. 121 – 122.
[400] Id. at.
[401] Id. at, p. 303.
[402] Legal sentence RS0107452, Supreme Court.
[403] BMSGPK, 2022.
[404] Id. at.
[405] Id. at, p. 76.

based services and support, as well as the material support for families with CWD, and foster carers too (LTC allowance and hardship supplement, increased family allowance, care leave etc.). Those are much needed measures, especially the in-kind support to families, considering that the financial support is already considered generous relative to comparable countries.[406] On the other hand, the expansion of institutional respite care is not CRPD-compliant, and the CRPD Committee expressed strong opposition to it,[407] although strictly speaking, it can contribute to the prevention of long-term institutionalisation. Also, the approach to Article 19 of the CRPD regarding CWD reflects the interpretation of that article, as explained above, which eventually weakens the obligation of the state to ensure that CWD grow up in a family environment,[408] by excluding that part of Article 19 CRPD from the conversation.

Moreover, the NAPD does not contain measures typical for a strategic document decidedly focused on DI, as argued above. Indicators that measure the number of CWD in institutional care were not set, further weakening the prospects for DI. Those indicators that are set, do not contain target values. Lastly, the authorities omitted to address some critical issues such as the expansion of foster care for CWD, while it only plans to commence the discussion on the harmonization of personal (and school) assistance for all CWD. Thus, it is reasonable to anticipate that, even with full implementation of the NAPD 2022, improvements in the realisation of the right to live in a family environment for CWD may be only marginal.

3.3.3. Other policy documents

The Government Programme for 2020–2024 anticipated several improvements in disability policy, focusing on inclusive education and employment.[409] A fundamental principle of the care policy set forth in the document is a preference for community care for as long as possible, resorting to residential care only when necessary.[410] In relation to family and youth policy, the Government aimed to reduce bureaucratic hurdles in accessing benefits and to expand services

[406] Costanzo Ranci, et al., *Coverage versus generosity: Comparing eligibility and need assessment in six cash-for-care programmes*, 53 SOCIAL POLICY & ADMINISTRATION (2019).
[407] Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 23.
[408] See Part I, Chapter 1.4. Article 19.
[409] Aus Verantwortung für Österreich. Regierungsprogramm 2020–2024, Bundeskanzleramt, 2020.
[410] Id. at, p. 173.

for children and their families.[411] The need for security of CWD after the death of their parents and the need for the support for a self-determined life is recognised, as well as the review of disability assessment procedure.[412]

The Government programme continues the decades-long exclusion of downright DI of care for CWD. This could be the consequence of a marginal status of disability policy in Austria, especially regarding children and adults with severe disabilities (who are also in the largest risk of institutionalisation), which was suspected by the NAPD 2012 evaluators.[413]

The Austrian Federal Government's Disability Concept of 1992 stands as a significant testament to the broader reforms of the 1990s.[414] The 1990s reforms included the changes in LTC and reinforced the dedication of authorities to the expansion of both family-based support and services but also residential care, which was discussed through this country study. The Disability Concept advocated against residential care wherever possible, favouring mobile, community-based, or semi-residential support.[415] It acknowledged the social dimensions of disablement and, to some extent, aligned its understanding of disability with the social model. This was specifically mentioned in relation to CWD, where the value of inclusive living for both disabled and non-disabled individuals was commended.[416] Furthermore, the document addresses concerns regarding the accommodation in special schools, which can isolate children from their social environments, among other issues associated with such educational settings.[417]

Concerning residential care, the Government's Disability Concept condemned the care in large residential facilities and expressed dedication towards full care in smaller residential groups, as well as community-based supported living.[418] The plan called for large facilities to be divided into smaller residential groups and individual flats offering assisted living. The

[411] Id. at.
[412] Id. at, p. 174 – 157.
[413] See note 379.
[414] Federal Ministry for Labour and Social Affairs and Österreichische Arbeitsgemeinschaft für Rehabilitation, 1992.
[415] Id. at. ch. 1.4.
[416] Id. at. ch. 3.
[417] Id. at. ch. 4. 1.
[418] Id. at. ch. 9. 2.

expansion of cash benefits and in-kind services was stipulated also as a way to avoid institutionalisation.[419]

The 1992 Government's policy document reflected an understanding of inadequacy of institutional care, but only in large facilities. It declared dedication towards cash and in-kind support for persons with disabilities, as well as descaling large residential facilities and providing residential care in smaller groups. The document, however, does not mention specifically CWD in relation to the named forms of care and support, but only in relation to education. The commitment to providing residential care in smaller groups, along with the failure to explicitly address support services and the challenges of institutional care for CWD, persists to this day, as it was explained in relation to NAPD 2012 and NAPD 2022. In fact, one of the criticisms of the evaluators of the NAPD 2012 was the lack of focus on children and women with disabilities. This was to an extent corrected in the NAPD 2022 in relation to CWD, but not when it comes to institutional care.

The Vienna Child and Youth Strategy 2020 – 2025 includes measures for CWD, such as the expansion of so-called low-threshold services.[420] Also, the services should be provided in multiple languages, which is a particularly important feature in multinational Vienna, considering that children whose mother tongue is not German are more often diagnosed with special educational needs. There are no studies that speak of prevalence of disability and/or institutionalisation relative to language or ethnic background in Austria. Other relevant aspects include accessibility of built environment and availability of medical expertise for early identification of developmental issues.[421]

3.4. National Human Rights Institutions, monitoring bodies and other structures to facilitate the implementation of human rights treaties

This section examines the work of NHRIs and federal and provincial monitoring bodies, assessing their impact on implementing the right to live in a family environment for CWD. The

[419] Id. at. ch. 13.
[420] The Vienna Children and Youth Strategy 2020 – 2025, Vienna City Administration, 2020, p. 34.
[421] The Vienna Children and Youth Strategy 2020 – 2025, City of Vienna.

analysis is done by reviewing the practice of these bodies, their publications, submissions to the UN human rights bodies and other activities from the scope of their mandates. In addition, three interviews were conducted with individuals who are directly involved in the work of independent national and provincial (Viennese) bodies that are tasked with the promotion of the rights of children and/or persons with disabilities and monitoring of the implementation of ratified international human rights conventions. Therefore, primary sources for this analysis are decisions/acts of those bodies, regulations governing their organisation and functioning, and interviews. Secondary sources, are publications of those bodies, including the bodies' submissions to the UN human rights bodies.

The bodies examined here are the AOB, IMC, Federal Disability Advisory Board (Bundesbehindertenbeirat), Disability Ombudsperson, KIJA Vienna (Kinder- und Jugendanwaltschaft Wien), Vienna monitoring body for the CRPD.

3.4.1. Austrian Ombudsman Board

The legal basis for the AOB is in the B-VG Article 148a to 148j, and the Federal Ombudsman Board Act.[422] The AOB has a mandate to visit all places of deprivation of liberty, and the B-VG explicitly includes visits to facilities and programmes for persons with disabilities as part of the AOB's mandate.[423] The AOB is, thus, also the NPM. A major deficiency in the AOB's powers is its inability to impose sanctions, a point of central critique by many stakeholders.

The role and the contribution of the AOB and the IMC were briefly explored under the chapter 'Situation of children with disabilities'. Notably, the AOB played a crucial role in the truth-finding process and the reparations programme for victims from child and youth centres.[424] This was one of globally rare examples where suffering of children and youth in care homes in the past was recognised and action taken to uncover the truth and offer reparations to the victims. Dealing with the past could have instilled the imperative of eliminating or cutting down to the minimum the availability of institutional care for children with and without disabilities and completely shift focus to family care. Instead, in order to prevent reoccurrence, the predominating idea, seemingly supported by most if not all stakeholders, including the

[422] Federal Ombudsman Board Act (VolksanwG), BGBl. Nr. 433/1982, last amend. BGBl. I Nr. 56/2021.
[423] BGBl. Nr. 1/1930 (WV) idF BGBl. I Nr. 194/1999 (DFB), last amend. BGBl. I Nr. 222/2022. Article 148 (3).
[424] See 'Historical rights violations and reform of institutional care'.

AOB, was to drastically improve the conditions and treatments within institutional care, rather than to pursue the transition to family-based care for all children, including CWD.

Such an approach was supported by the AOB and the IMC too. In the section 'Reform of the long-term care system and residential care', it was explained why the support by the AOB, but more so by the IMC was rather surprising. Especially for the IMC, the body with the only purpose to promote and monitor the implementation of the CRPD, it is surprising that it did not align its approach to the approach of the CRPD Committee. From the perspective of the implementation of the right to live in a family environment for CWD, such a situation could be described as discouraging. The IMC's position on residential care, and support for SGHs was expressed in their position paper from 2016.[425] A year later, the CRPD Committee's General Comment 5 on Article 19 explicitly expressed dissatisfaction with small group homes (SGHs) and advocated for the provision of family care for CWD.[426] In 2022, the CRPD committee issued DI guidelines further strengthening their position against such a form of care.[427] Perhaps, the IMC will align its position on small residential care for CWD in the near future, considering that it is currently at odds with the approach of the CRPD Committee.

The AOB has regularly included in their reports to the CRPD Committee information on the position of CWD, and family and residential care too. In their submissions, the AOB draw the attention of the CRPD Committee to the lack of family- and community-based services for CWD and their families, but it also emphasised the need for more residential facilities close to the homes of parents.[428] In their 2023 report to the CRPD Committee, the AOB acknowledged the preference for all CWD to live in family settings but recommended expanding small residential care facilities to ensure that CWD separated from their parents are not placed far from home. The AOB justified this position by stating the following:

'In such cases (where children needed intensive amount of care) 24-hour care at the parent's home might be difficult due to a lack of sufficient living space for the whole family. Although the AOB requests public administration to enable every child to receive the necessary care at

[425] See note 110.
[426] See note 109.
[427] See Part I, Chapter. 4.3.7. 'Guidelines on DI, including in emergencies'.
[428] AOB, 2023**, p.** 5.

home and ensure deinstitutionalization, this is, for the moment, not always possible due to infrastructure reasons.'[429]

In their report for 2021, the AOB wrote about the issue of the lack of institutional places for severely traumatised children, but it also called for urgent expansion of residential care for CWD, by stating the following:

'The expansion of specialised facilities for children and adolescents with severe mental stress, traumatisation and disabilities is also urgently necessary for ten to 18-year-olds and young adults.'[430]

The AOB's advocacy for DI is clear from their submissions, including their nominal dedication to the promotion of the family living for CWD. Conversely, the AOB's approach to residential care significantly deviates from the CRPD Committee's stance and the interpretation of the CRPD outlined in Part I of this thesis. Namely, the AOB recommends further investments in the expansion of residential care, seemingly without considering that instead of investing in the expansion of residential care, the authorities could invest in family- and community-based services and support and thus improve the 'infrastructure' that is currently lacking for the home care of disabled children. In other words, the further proliferation of residential care at least postpones the establishment of those family- and community-based support and services, resulting in less CWD living in a family environment at the present moment and in the foreseeable future. The CRPD Committee and the UN special rapporteurs criticised the expansion of residential care, even in a broader context of DI efforts, and offered the argumentation which was summarised above.[431]

[429] Id. at.
[430] AOB, 2022**, p.** 80.
[431] CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 20, 138; Visit to the European Union : Report of the Special Rapporteur on the rights of persons with disabilities, Gerard Quinn, A/HRC/52/32/Add.1, UN Human Rights Council, 2023, para. 21.

Therefore, the AOB, based on the latest submission to the CRPD, but also on previous publications, including the Special report on children in public institutions from 2017,[432] is supportive of high-quality, small residential care for CWD, and it that light, it is at odds with the full implementation of the CRPD in Austria.

3.4.2. Independent Monitoring Committee

Although not an NHRI in a strict sense, the IMC is an independent federal monitoring body established under §§ 13(g) to 13(l) of the Federal Disability Act and is therefore included in this analysis. The establishment of the IMC in 2008, and its functioning, presented an implementation of Article 33 (2, 3) CRPD in Austria. Article 33 (1) CRPD is implemented with the designation of the Federal Ministry for Labour, Social Affairs and Consumer Protection as a coordinating body for the implementation of the CRPD and with the establishment and the functioning of the Federal Advisory Board for the Disabled (Bundesbehindertenbeirat). In accordance with the Federal Disability Act, the IMC has responsibilities to obtain opinions from administrative bodies on the implementation of the CRPD, issue statements and recommendation on the implementation of the CRPD, maintain the dialogue with civil society, and report annually to the Federal Ministry for Labour, Social Affairs and Consumer Protection.[433]

The IMC's statement on DI, where the body recommended the use of small-scale residential care for CWD will not be repeated here.[434] In their 2023 submissions to the CRPD Committee, the IMC highlighted the problematic placement of CWD in specialized institutions alongside adults, and their exclusion from child and youth welfare facilities.[435] The issue of institutionalisation of CWD was not mentioned in relation to Article 19 CRPD, while Article 23 CRPD was omitted. In 2011, in their submission to the CRC Committee, the IMC criticised the fact that CWD are placed in institutions specifically designated for CWD, and not in

[432] See note 108.
[433] BGBl. Nr. 283/1990, last amend. BGBl. I Nr. 185/2022. § 13g (2).
[434] See 'Reform of the long-term care system and institutional care'.
[435] IMC, 2023**, p.** 7.

institutions under the youth and welfare department, which provide care to non-disabled children.[436]

The IMC criticised the NAPD 2022 for its approach to CWD-related measures, notably the lack of focus on the right to family life and community integration, implying that institutionalisation is still normatively accepted in Austria.[437] Commenting on the measures regarding Article 19 CRPD, the monitoring body emphasised that the transition to smaller residential care does not constitute DI.[438]

Taken together, seemingly the work of the IMC hardly focuses on the right of CWD to live in a family environment, despite sporadic mention of the issue of institutionalisation and the right to family life for CWD in available documents. Moreover, the IMC had previously called for the development of some forms of residential care, specifically small-scale residential care, and to make institutional care for children without disabilities accessible and inclusive of CWD.

3.4.3. Disability Ombudsperson

The Disability Ombudsperson, appointed by the Federal Ministry for Labour, Social Affairs, and Consumer Protection, serves a four-year term. The Ombudsperson is elected after a selection procedure involving all DPOs, and it is independent in its work, but its work is funded by the abovementioned Ministry. The body is responsible for counselling and supporting persons with disabilities to realise their rights.[439] This institution can issue recommendations, and it is also entitled to bring representative action.[440] Relevant representative actions of Disability Ombudsperson regarding CWD were not identified. The institution submitted a report to the CRPD Committee, but omitted to write about the position of CWD in institutional care or to advocate for DI of care for CWD.[441] Information on the work of the Ombudsperson in relation to life in a family environment and institutional care was not identified in the annual

[436] Statement on the implementation of the Convention on the Rights of the Child in Austria (Third Periodic Report in accordance with Article 44 CRC) for children and youth with disabilities, (2011), IMC, para. 39.
[437] Stellungnahme zum Nationalen Aktionsplan „Behinderung“ 2022-2030, (2022), Monitoringauschuss, p. 3.
[438] Id. at, p. 14 – 15.
[439] BGBl. Nr. 283/1990, last amend. BGBl. I Nr. 185/2022. § 13(c).
[440] BGBl. I Nr. 82/2005, last amend. BGBl. I Nr. 32/2018. §13(1).
[441] AOB, 2023.

activity reports of the institution, unlike the information on special and inclusive education which the Ombudsperson addresses regularly.

The Disability Ombudsperson issues opinions on draft laws too. The institution has on multiple occasions recommended the expansion of community-based services for persons with disabilities in general, in laws which regulate that area of social protection.[442] In 2022, in the process of amending the child and youth facilities ordinance in Upper Austria, the Disability Ombudsperson recommended that the number of children per facility is explicitly limited in the ordinance and that the institutions should be well equipped to care for CWD.[443] Similarly, the institution issued recommendations to authorities in Lower Austria in relation to the amendments to child and youth welfare law.[444] It recommended ensuring that specialised institutions for residential care for CWD offer the best quality service. The Disability Ombudsperson wrote that this is needed before the overriding goal of DI is achieved.

That recommendation follows the position of the AOB, which was explained and criticised above.[445] Although the AOB and the Disability Ombudsperson recognise that DI is an overriding goal, they are evidently engaged with the promotion of quality residential care and the expansion of such care, without recommending specific legislative, policy, and practical steps to reduce reliance on such care. Having that in mind, it is safe to conclude that the Disability Ombudsperson's work in the area of family living of CWD, as well as the AOB's work, are not aligned with the CRPD and the CRPD Committee's approach.

From the perspective of the CRC, it is less clear whether their approach would align with the interpretation of the CRC offered in the Part I. As a reminder, the CRC allows the provision of institutional care but only as a last resort option. In the documents reviewed, the bodies did not comment whether competent authorities resort to residential care only as a last resort, and before all other options are exhausted. When the latest developments in the UN soft law are taken into account, which stipulate, at best, the minimal use and the marginal role for small

[442] E.g. Betrifft: 2022-0.365.449 et al. – Stellungnahme des Behindertenanwalts zur Pflegereform, Anwalt für Gleichbehandlungsfragen für Menschen mit Behinderung, 2022.
[443] Betrifft: GS6-G-1000/070-2022 - Nö. Kinder- und Jugendhilfeeinrichtungsverordnung, Änderung; Begutachtungsverfahren Anwalt für Gleichbehandlungsfragen für Menschen mit Behinderungen.
[444] Betrifft: GZ: 2021-0.661.491 – Änderung des NÖ Kinder- und Jugendhilfegesetzes (NÖ KJHG); Stellungnahme, Anwalt für Gleichbehandlungsfragen für Menschen mit Behinderung, 2021.
[445] See 'Austrian Ombudsman Board'.

residential care in the continuum of care, the lack of criticism of the overreliance on residential is contentious as well.

3.4.4. Federal Disability Advisory Council

The Federal Disability Advisory Council (FDAC) is not an NHRI, but an advisory body established at the Federal Ministry of Labour, Social Affairs and Consumer Protection. It is legally based on §§ 8 – 12 of the Federal Disability Act. The FDAC advises the Ministry on certain issues regarding persons with disabilities, issues expert opinions, supports the Ministry in the implementation of the CRPD. The FDAC's membership comprises representatives from DPOs, the Disability Ombudsperson, the Chairperson of the IMC, parliamentary political parties, and selected ministries.[446]

A request was submitted to the Ministry for access to the reports, statements, opinions, or minutes from the meetings of the FDAC, to assess the FDAC's involvement with the topic relevant to this study. The Ministry replied that the question was forwarded to a specialist department and highlighted that the publication of the minutes from the FDAC's meetings is not foreseen.[447] A more substantive answer from the specialist department, as indicated by the Ministry, was not received by the conclusion of this dissertation.

3.4.5. Child and Youth Ombudsperson KIJA Vienna

KIJA operates as a province-based office dedicated to promoting and protecting the rights of children and youth. Each province has a KIJA office. The B-KJHG[448] obligated the provinces to establish and further regulate the KIJA in each province before the exclusive competence for child and youth welfare was transferred back to provinces. According to a KIJA report to the CRC in 2019, the B-RK was supposed to be amended to provide a federal legal basis for

[446] BGBl. Nr. 283/1990, last amend. BGBl. I Nr. 185/2022.
[447] Reply to Lazar Stefanovic by the Ministry for Social Affairs, Health, Care and Consumer Protection, Geschäftszahl: 2024-0.201.356, (BMSGPK - IV/A/7), 2024. The document can be requested from the author at: lazar.m.stefanovic@gmail.com.
[448] BGBl. I Nr. 69/2013, last amend. BGBl. I Nr. 105/2019. § 35.

the KIJA.[449] That has not been done before the submission of this dissertation. The W-KJHG[450] prescribes the legal basis for the KIJA and its tasks in Vienna. The KIJA offices have an association which represents all provincial offices and is tasked with the communication with UN human rights bodies.

The KIJA Vienna regularly publishes reports on the position of children and youth in Vienna, in which they call for much more support and services for CWD and their families. In 2022, the KIJA Vienna criticised the reliance on day care centres specifically for CWD, as they do not contribute to the personal and social development of children.[451] The office recommended significantly increasing support for families of CWD and simplifying the procedures for applying and receiving such support.[452] In 2019, the country-wide association of KIJA offices submitted an alternative report to the CRC Committee, where they draw the attention to the need for more community-based services to prevent institutional placements.[453]

From the reports and from an interview with a well-positioned key informant, it was concluded that the KIJA Vienna does not engage intensively with the rights of CWD in the sense of the realisation of the right to family life. KIJA employees can visit socio-pedagogical institutions and receive complaints from children in those facilities, but such cases regarding CWD were not identified in the work of the KIJA Vienna. Also, the body does not visit residential care institutions for persons with disabilities where CWD may reside. Still, the KIJA's approach to life in a family environment and residential care, in the sense of advocacy for the prevention of institutionalisation and expansion of family- and community-based services, is aligned both with the CRC and the CRPD.

[449] KIJA, 2019**, p.** 33.
[450] LGBl. Nr. 51/2013, last amend. LGBl. Nr. 2/2023. § 16.
[451] Jahresbericht 2022, (2023), Kinder- und Jugendanwaltschaft Wien KIJA, p. 36.
[452] Id. at, p. 78.
[453] KIJA, 2019**, p.** 33.

3.4.6. Vienna Monitoring body for the CRPD

The Vienna monitoring body for the CRPD was also addressed in brief above.[454] The legal aspects of its functioning are outlined in the section on the discrimination and disability law, while here only their engagement with relevant CRPD provisions is examined.

Members of the body address the implementation of specific CRPD provisions and issue recommendations in public sessions. Public sessions of the body are held at least once a year, according to the law. This, however, results in infrequent sessions, and a low number of addressed issues, according to an interviewee, who is well-positioned to comment on the work of the monitoring body.[455] Apart from promoting improved accessibility in Viennese hospitals, the visible impacts of the monitoring body's work are limited.[456]

The monitoring body criticised the lack of access to PA for CWD, particularly those with intellectual and psychosocial disabilities. The body recommended changes to FSW by-laws on PA to ensure CWD are treated equally under the law and can access this essential service. Other related issues, such as support for families, foster care, and residential care for CWD have not been addressed by the body, while their work on accessibility is abundant.

3.5. European Union

The EU ratified the CRPD in 2009, which took effect in January 2011. This ratification is noteworthy as it was the first time the EU joined a UN human rights treaty. Upon joining the CRPD, the treaty became a part of EU legislation and was made mandatory for all its institutions, as stated in Article 216(2) of the Treaty on the Functioning of the European Union (TFEU). The European Court of Justice (ECJ) has previously established that international treaties become a fundamental part of the EU legal framework.[457] Austria is a member state to the EU since 1995, and as such it is subject to the law of the EU.

[454] See ‘Vienna disability and antidiscrimination law‘.
[455] F. O., Interview, 7th February, 2023.
[456] Id. at.
[457] Case 181/73, Haegeman v. Belgian state, Court of Justice of the European Union, ECLI:EU:C:1974:41.

3.5.1. Status of the CRPD in the EU law

The EU and all its Member States ratified the CRPD in what is commonly referred to as a 'mixed agreement', due to the shared competences involved.[458] This means that the EU and its Member States have shared competences, which was enabled through the Article 44 of the CRPD. The CRPD provision was specifically designed so that the EU can ratify this treaty and declare which competences it undertakes with the ratification.[459] This will also apply to each regional integration organisation which decides to ratify the CRPD in the future.

The European Council decision from November 2009 concerning the conclusion of the CRPD contains an appendix that explicitly delineates exclusive and shared competences of the EU and its Member States.[460] Also, the decision contains a list of the EU legal acts regulating matters that fall into the competence of the EU regarding the implementation of the CRPD.[461] There are several acts pertaining to independent living and social inclusion, as well as the European Structural and Investment Fund (ESI Funds) regulation. The latter is relevant for the realisation of the right to live in a family environment for CWD, because the ESI Funds are, *inter alia*, used to strengthen social protection systems in the Member States.

The position of the CRPD in the EU law is a question of interest of legal scholars and practitioners. EU primary law holds supremacy over concluded international agreements, which in turn have primacy over EU secondary law. In that regard, the CRPD would be hierarchically positioned between the EU primary law and the EU secondary law. That means that all secondary law, regulations, directives, and decisions pertaining to the implementation of the CRPD must be interpreted in line with the CRPD, as far as possible.[462] The EU statutory law does not specify the position of the international agreements, but the ECJ has specified this in its case law.[463]

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[458] JONI HELISKOSKI, MIXED AGREEMENTS AS A TECHNIQUE FOR ORGANIZING THE INTERNATIONAL RELATIONS OF THE EUROPEAN COMMUNITY AND ITS MEMBER STATES (Kluwer Law International. 2001).
[459] Lisa Waddington, *The European Union*, *in* THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES IN PRACTICE: A COMPARATIVE ANALYSIS OF THE ROLE OF COURTS (Lisa Waddington and Anna Lawson ed. 2018).
[460] Council Decision of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities, 2010/48/EC, 2010.
[461] Id. at.
[462] E.g. Case C-485/20, Council of State, Belgium, ECLI:EU:C:2022:85, CJEU.
[463] Jan Klabbers, *Straddling the Fence: The EU and International Law*, *in* THE OXFORD HANDBOOK OF EUROPEAN UNION LAW (Anthony Arnull & Damian Chalmers eds., 2015), p. 55.

The question of direct effect of the CRPD in the EU is another one worthy of exploring. The EU is formally a monistic legal order, but Klabbers argues that a general opinion in the EU is that international agreements do not have direct effect and require translation into the EU law.[464]

Conversely, Delia Ferri argues that the CRPD has a special status in the EU law, and should actually be regarded as the EU primary law, since it reflects constitutional values of the EU Member States.[465] Moreover, the CRPD presents further elaboration and concretization of the norms contained in the Charter of Fundamental Rights of the European Union (CFREU) and the ECHR, regarding persons with disabilities, according to Ferri.[466] As the ECJ increasingly interprets the CFREU in light of the CRPD, due to the former's lack of specificity, the CRPD approaches the status of a 'primary constitutional benchmark' in EU disability law.[467]

The CFREU Article 26 recognises the right to of children and adults with disabilities to 'benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community'. The ECJ holds that Article 26 reflects a principle rather than a right.[468] The CRPD builds on Article 26 CFREU and concretizes its principle by prescribing a number of obligations to states parties in relation to the realisation of independence, integration and participation of children and adults, including through the wordings of Articles 19 and 23 of the CRPD.[469]

3.5.2. ESI Funds and institutional care in Austria and the EU

In another work, the author of this dissertation explored the position and influence of the CRPD on EU law, bearing in mind the tensions arising between the CRPD norms and the actions of

[464] Id. at, p. 62.
[465] Delia Ferri, *The Conclusion of the UN Convention on the Rights of Persons with Disabilities by the EC/EU: A Constitutional Perspective*, 2 EUR. YB DISABILITY L. (2010), p. 15; Delia Ferri, *The Unorthodox Relationship between the EU Charter of Fundamental Rights, the UN Convention on the Rights of Persons with Disabilities and Secondary Rights in the Court of Justice Case Law on Disability Discrimination*, 16 EUROPEAN CONSTITUTIONAL LAW REVIEW (2020).
[466] Ferri, EUR. YB DISABILITY L., (2010); Ferri, EUROPEAN CONSTITUTIONAL LAW REVIEW, (2020).
[467] Ferri, EUROPEAN CONSTITUTIONAL LAW REVIEW, (2020), p. 304 - 305.
[468] Case C-356/12, Wolfgang Glatzel v. Freistaat Bayern, CJEU, ECLI:EU:C:2014:350, para. 78.
[469] Lazar Stefanović, The commitment of the European Union to the Convention on the Rights of Persons with Disabilities and the right to live independently and be included in the community (UN Economic and Social Commission for Western Asia 2023), p. 158.

the EU and its Member States.[470] Notably, ESI Funds were utilised to construct new and expand existing residential care facilities for children and adults with disabilities throughout the EU, including in Austria.[471] The independent Living Austria (ILA) outlined that 7.5 million EUR from ESI Funds was allocated in Upper Austria for the renovation and construction of institutions and workshops for adults with disabilities; 3.2 million EUR in Tyrol, for facilities for persons with disabilities including a large residential facility for CWD; 1 million EUR for the construction of a facility for CWD from 5 to 17 years of age in Carinthia.[472]

Given that institutional care is in conflict with the CRPD and the stance of the CRPD Committee, the EC's funding for the construction of new and the expansion of existing institutional care capacities for children and adults with disabilities raises questions regarding the EC's compliance with EU law. In addition to the contentious funding for institutional care, ESI Funds contribute to the development of community-based social services for persons with disabilities.[473]

The importance of the ESI Funds regulation and the use of those funds from the perspective of implementing the CRPD in the EU is indisputable. This is evidenced by the repeated attention the CRPD Committee has drawn to ESI Funds regulations and their use. In 2015, the EU received commendation for aligning ESI Funds regulations with the CRPD's requirements. It was recommended that these funds should be utilised to develop support services for boys and girls with disabilities and their families in local communities. The goals included fostering DI, preventing new cases of institutionalisation, and promoting social inclusion along with access to mainstream, inclusive, quality education for CWD.[474] In the recent List of Issues Prior to Reporting, from 2022, the CRPD Committee enquired which measures were taken to immediately discontinue the use of ESI funds for the development and maintenance of institutional care for CWD (and others), including small residential care.[475] The EU's reply

[470] Id. at.
[471] List of issues prior to submission of the second and third periodic reports of the European Union, CRPD/C/EU/QPR/2-3, Committee on the Rights of Persons with Disabilities, 2022.para. 21 (b).
[472] Statement on the occasion of the 2nd and 3rd State review of Austria for the CRPD compiled by Independent Living Austria (SLIÖ) Vienna 28th July 2023, (2023), ILA.
[473] Commission Staff Working Document Evaluation of the European Disability Strategy 2010-2020 SWD(2020) 289 final/2, SWD(2020) 289 final/2, 2020, p. 31.
[474] Concluding observations on the initial report of the European Union*, CRPD/C/EU/CO/1, Committee on the Rights of Persons with Disabilities, 2015, para. 23.
[475] CRPD/C/EU/QPR/2-3, Committee on the Rights of Persons with Disabilities, 2022, para. 21 (b).

from 2023, explicitly stated that the use of ESI Funds for residential care is permitted, under certain conditions.[476]

In another work, the author noted that ESI Funds were used for the institutionalisation of children and adults with disabilities during the programming period 2007–2013, which elicited criticism, especially from NGOs.[477] This criticism led to the introduction of 'ex-ante conditionalities' (EAC) in the regulations for the 2014–2020 programming period.[478] Despite the EAC, the funds were still utilised to construct institutions, including in Austria,[479] and the EAC showed to be ineffective for the reasons that were explored by the European Court of Auditors.[480] The 2021–2027 programming period includes financial regulations with 'enabling conditions', which stipulate the existence of measures, among others, for the transition from institutional to family- and community-based care in national or regional strategic policy or legislative frameworks.[481]

Projects in which the European Agricultural Fund for Rural Development (EAFRD), a component of the ESI Funds, was allocated to construct facilities in Upper Austria for adults with disabilities and in Carinthia for CWD, faced challenges from NGOs. The ILA submitted three complaints to the EC, together with the ENIL, a Brussels-based disability advocacy NGO.[482] All complaints were unsuccessful, and the EC held that Austria did not breach EU law.

In 2018, the EC addressed the issue of whether using ESI Funds for institutional care in Member States was permissible. Specifically, the Legal Service evaluated whether such fund utilisation conflicted with the CRPD and the CRPD Committee's General Comment No. 5.[483]

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[476] Combined second and third reports submitted by the European Union under article 35 of the Convention, pursuant to the optional reporting procedure, due in 2021, CRPD/C/EU/2-3, 2023, para. 20, 21.
[477] Stefanović, The commitment of the European Union to the Convention on the Rights of Persons with Disabilities and the right to live independently and be included in the community. 2023, p. 159.
[478] Amended Regulation (EU) No 1303/2013 of the European Parliament and of the Council of 17 December 2013, The European Parliament and the Council of the European Union, 2013. Article 19.
[479] Stefanović, The commitment of the European Union to the Convention on the Rights of Persons with Disabilities and the right to live independently and be included in the community. 2023.
[480] SPECIAL REPORT: EX ANTE CONDITIONALITIES AND PERFORMANCE RESERVE IN COHESION: INNOVATIVE BUT NOT YET EFFECTIVE INSTRUMENTS (European Court of Auditors. 2017), p. 5.
[481] Regulation (EU) 2021/1060 of the European Parliament and of the Council of 24 June 2021, The European Parliament and the Council of the European Union, L 231/159, 2021. Annex III.
[482] *Rights of Disabled Children Ignored in Austria: Disability Rights Organisations Submit Third Complaint to the European Commission*, ENIL, (2022), accessed: 1st December 2022, 2022, *available at* https://enil.eu/rights-of-disabled-children-ignored-in-austria-disability-rights-organisations-submit-third-complaint-to-the-european-commission%ef%bf%bc/.
[483] Opinion of the Legal Service, ref. Ares(2018)2249997, European Commission, 2018.

The author dissected the Legal Service's expert opinion and the EC's responses to complaints, aiming to understand the EC's stance on institutional care and, more precisely, the use of ESI funds for developing and expanding such care for children and adults with disabilities.[484] The absence of authoritative interpretation of critical CRPD provisions by the ECJ, which holds exclusive competence for interpreting international agreements, creates room for uncertainties and ambiguities.[485] Furthermore, the author argues that, based on previous practices, the EU administration's proactive implementation and enforcement of the CRPD should not be anticipated, especially in the face of potential resistance by some Member States.[486] It was also discovered that the EC employed 'avoidance techniques' in addressing NGO complaints, frequently invoking the wide margin of appreciation argument and other methods.[487] The Legal Service disregarded the prescriptiveness of the CRPD by giving it only 'policy weight', while the interpretation of Article 19 CRPD offered by that department was described as not based in the general rules of treaty interpretation of the VCLT.[488] In 2022, the CRPD Committee asked the EU which measures were taken to revise the controversial Legal Service's expert opinion.[489] A year later, in 2023, Gerard Quinn, then Special Rapporteur on the rights of persons with disabilities, criticised the approach of the EC to the interpretation of the CRPD, as well as the understanding of the status of the CRPD in EU law.[490]

Despite the less favourable aspects of the EU's approach to the CRPD and DI, the author highlights progress within the financial regulations, specifically in the monitoring area, signalling a greater commitment yet still an incremental approach by the legislators to integrating the CRPD. [491] The author sees bringing controversial EC actions before the ECJ, despite its restrictive *locus standi* rules, as the most crucial path towards implementing the CRPD within the EU.[492] Gerard Quinn expects the EC to act independently and prohibit such controversial funding, arguing that awaiting the ECJ's verdict on whether institutionalisation constitutes *prima facie* discrimination (and thus is prohibited) is superfluous.[493] He holds this

[484] Stefanović, The commitment of the European Union to the Convention on the Rights of Persons with Disabilities and the right to live independently and be included in the community. 2023, p. 162.
[485] Id. at.
[486] Id. at, p. 168.
[487] Id. at.
[488] Id. at.
[489] CRPD/C/EU/QPR/2-3, Committee on the Rights of Persons with Disabilities, 2022, para. 21 (c).
[490] A/HRC/52/32/Add.1, UN Human Rights Council, 2023, para. 17 – 24.
[491] Stefanović, The commitment of the European Union to the Convention on the Rights of Persons with Disabilities and the right to live independently and be included in the community. 2023.
[492] Id. at.
[493] A/HRC/52/32/Add.1, UN Human Rights Council, 2023, para. 23.

view due to the prohibition of discrimination in the CFREU, suggesting that the EC should proactively act in accordance with it.[494]

3.5.3. Strategic policy framework

The European Disability Strategy 2021 – 2030 (EDS 2021) was adopted in 2021, as a continuation of the previous European Disability Strategy 2010 – 2020 (EDS 2010).[495]

In EDS 2021, the EC outlines how, over the past decade, the EU has made a significant contribution towards promoting and implementing Article 19 of the CRPD. This reportedly involves ceasing the funding of 'long-stay residential institutions' through ESI Funds.[496] Unfortunately, further details on the cessation of funding for long-stay institutions are absent, and additional sources do not corroborate this claim. The EU's flagship initiatives for the EDS 2021 include issuing recommendations on guidance for independent living within the EU by 2023 and establishing a Framework for Social Services of Excellence for persons with disabilities by 2024.[497] The guidance for independent living was not issued during 2023, raising questions about the timelines and prioritisation of such policies. The EC also invited Member States to implement good practices on DI and transition from institutional to community-based support, including for CWD. The previous EDS 2010 did not cover issues related to CWD, apart from the promotion of inclusive education.

The European Child Guarantee from 2021, recommends the promotion of 'quality community-based or family-based care'. Conversely, it adopts a rather constructive approach to institutional care for children (with and without disabilities), to an extent reflecting the UN Guidelines from 2009.[498] The document does not denote the institutional care as a last resort option, arguably falling short even of the CRC, of the recent UN resolutions on child rights,[499] and certainly it is not in line with the CRPD. From the wording of the document, there seems

[494] Id. at.
[495] Union of Equality: Strategy for the Rights of Persons with Disabilities, COM(2021) 101 final, (European Commission), European Union, 2021. European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe, COM(2010) 636 final, (European Commission), European Union, 2010.
[496] COM(2021) 101 final, European Union, 2021, p. 10.
[497] Id. at, p. 10 - 11.
[498] Council Recommendation (EU) 2021/1004 of 14 June 2021 establishing a European Child Guarantee, L 223/14, 2021, para. 24.
[499] See Part I, Chapter 3.4 UNGA Resolution on Children without Parental Care (2019).

to be not much emphasis on the prioritization of family-based care for children in need of alternative care. In other words, the family-based care and institutional care are almost equated.

3.6. Domestic and foreign organisations

A large number of inter-governmental organisations are based in Austria, specifically in Vienna. However, these organisations do not provide development work or humanitarian assistance in Austria because it is a developed, high-income country with a high HDI, stable democracy, and a well-established rule of law. In fact, Austria is among the 20 largest donors of 'official development aid', donating almost 2 billion US dollars in 2022, as reported by the OECD.[500] For example, although UNICEF Austria works on child protection issues within Austria, their agenda appears significantly narrower than in Serbia, and it fails to address CWD specifically.

In terms of domestic organisation, specifically DPOs, the ACDP is a leading association. The ACDP, previously known as the Austrian Rehabilitation Association until 2017, is an umbrella association comprising 85 member DPOs. Their work is frequently cited in this study, predominantly in relation to their submissions to the CRPD Committee. The BGStG stipulates that this organisation, alongside the Disability Ombudsperson and the Klagsverband, is authorised to pursue representative anti-discrimination actions. However, apparently the ACDP has never pursued an anti-discrimination representative action, despite the possibility to do so.

In a recent submission to the CRPD Committee, the ACDP draws the attention to the lack of services for CWD and their families and the consequent institutional placements.[501] It highlights the data deficiency and calls DI in accordance with the CRPD Committee's Guidelines.[502] Similarly, in 2018, the ACDP criticizes the overall societal position of CWD in Austria and the consequent institutionalisation.[503]

[500] *Data-explorer OECD*, OECD, (2024), accessed: 12th March, 2024, *available at* https://data-explorer.oecd.org.
[501] ACDP, 2023**, p.** 7 - 8.
[502] Id. at.
[503] ACDP, 2018**, p.** 8 - 9.

In their position paper from 2023, the ACDP called for authorities to implement DI and ensure that persons with disabilities can live a life in accordance with their wishes and preferences. The position paper, however, addressed CWD only in relation to inclusive education, while the support for CWD and their families is barely mentioned. Nevertheless, the association advocates for a 15a agreement between the Federation and the provinces to lay the groundwork for developing individualised support and services nationwide, including the expansion of 24-hour home care and mobile services, thereby potentially enhancing the realisation of family life for CWD as well.[504]

Apart from the umbrella DPO association, notable examples of CSOs regarding the promotion of the rights of CWD include the ILA, and their EU-oriented ally, ENIL. ILA and ENIL submitted three complaints to the EC regarding the development of residential institutions co-financed with the ESI Funds.[505] The ILA is a staunch promoter of the rights of persons with disabilities and of the implementation of the CRPD in Austria. In their submissions to the CRPD Committee, they draw attention to the institutionalisation of CWD and the use of EU funds for the construction of new institutions.[506]

When it comes to services providers, there are several leading organisations in the sphere of child and disability assistance and care. SOS Kinderdorf, a leading global provider of support and alternative care for children, operates in 138 countries and territories and was founded near Innsbruck, Tyrol.[507] It remains one of the major providers of various forms of alternative care in Austria, including foster and residential care. According to SOS Kinderdorf's annual report for Austria, 1.824 children were cared for in 2022 in typical residential groups, 'SOS Kinderdorf families', and assisted living arrangements.[508] When compared to 2017, roughly the same number of children are in 'full upbringing'(the abovementioned forms of living), while the number of children in 'SOS Kinderdorf families' almost halved, and the number of children in typical residential groups increased significantly.[509] In the same period, the number of children supported on a mobile basis almost tripled (1270 and 3590 respectively).[510]

[504] Positionspapier 2023, Österreichischer Behindertenrat, 2023, p. 23.
[505] See 'ESI Funds and institutional care in Austria and the EU'.
[506] ILA, 2023**, p.** 14.
[507] International Annual Report 2022, SOS Children's Villages International, 2023.
[508] Unser Jahresbericht 2022, (2023), SOS-Kinderdorf, p. 14 - 15.
[509] Unser Jahresbericht 2017, (2018), SOS-Kinderdorf. p. 10 - 11.
[510] Id. at; SOS-Kinderdorf, 2023**.**

‘SOS Kinderdorf families’ is a care model intended to replicate typical foster care; however, it is provided within SOS Kinderdorf’s facilities rather than in the homes of foster carers. Also, one carer (a ‘mother’ or a ‘father’) is a professional who cares for several children (usually 5). Therefore, a child is not placed in a family, but in a setting that should simulate a family setting or, at least, not resemble large-group care. This form of care, sometimes termed as family-like or family-type, was specifically deemed unacceptable by the CRPD Committee.[511]

In Austria, the SOS Kinderdorf provides residential care for CWD. However, the data about CWD in residential care at SOS Kinderdorf is confidential and not publicly disclosed, and the author was not granted permission to quote it in this dissertation. Considering that the data from SOS Kinderdorf regarding CWD were not found in the state report to the CRPD Committee, it is clear there is a communication issue between the authorities and some service providers regarding meaningful reporting.

The SOS Kinderdorf possesses potentially commendable advocacy and negotiating leverage, given the scale of their operations in Austria and their international relevance. Although this research did not examine in detail this organisation’s involvement in law- and policymaking, it should not be forgotten that massive and powerful providers of residential care can be significant factors in slowing down decisive DI, as highlighted by the CRPD Committee.[512] According to the SOS Kinderdorf’s report, they are increasingly looking to support families in risk and prevent separation. In 2022, 3600 families and children were supported, advised or accompanied, according to their report.[513]

Clearly, it is not only SOS Kinderdorf that can potentially slow down the DI process in Austria; any other stakeholder with a vested interest in maintaining widespread residential care for children, both with and without disabilities, can also have this effect. Other major private stakeholders, providers of residential care, include several organisations mentioned above (See ‘ Institutional (residential) care‘).

In sum, despite its developed status and hosting numerous international organisations, the issue CWD remains inadequately addressed, with a notable absence of concerted efforts of domestic and international organisations towards DI and comprehensive support to families. The ACDP

[511] E.g. CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 15.
[512] Id. at, para. 34.
[513] SOS-Kinderdorf, 2023.

and other CSOs, especially the ILA, have made some efforts to highlight these challenges, but actions remain limited mainly to advocacy without substantial progress in service provision or policy development, while the representative action lawsuits are not used despite by the ACDP despite the possibility. The situation is compounded by the lack of foreign organisations working specifically on CWD issues, a gap that, if filled, could advance the rights of CWD in Austria by introducing international best practices, enhancing advocacy, and improving data collection and policy formulation. This underscores an urgent need for a more integrated and international approach to support CWD in Austria.

4. Key Findings

4.1. The lack of data and resistance to change

A crucial finding is the persistent absence of comprehensive, up-to-date data on CWD across various care settings, recipients of community-based support, and other data categories. The absence of data is especially striking considering that Austria has the highest possible score regarding the 'data infrastructure (capability)', according to the World Bank.[514] Thus, this deficiency in comprehensive data on CWD likely stems from an apparent disregard by authorities to collect and analyse such information. This issue is compounded by the deep-seated secrecy among Austrian authorities.

The data gap hinders effective monitoring and research by state and non-state actors. The absence of specific data on CWD precludes a sound analysis of the realisation of their right to live in a family environment and the level of implementation of the CRPD. However, data from children and youth welfare organisations and aggregate data for all children do offer some analytical possibilities. In contexts where there is a deficiency of data on CWD, yet sufficient data on non-disabled children and aggregate data on all children, reliance on information from key informants and using available data as a proxy becomes a viable alternative.

Various stakeholders attribute the absence of data to the federalist organisation of the state. However, while the federalism may impede the synthesis of data from different provinces (e.g.

[514] *Statistical Performance Indicators (SPI)*, The World Bank, (2024), accessed: 14th March, 2024, *available at* https://www.worldbank.org/en/programs/statistical-performance-indicators/explore-data#1.

due to different methodologies or differences in the quality of data), it does not explain why none of the provinces possess and publish data for their own jurisdiction. Therefore, the persistent absence of data should rather be attributed to other factors, including the existing Freedom of Access to Information Act, which has been described as 'one of the weakest in the world'.[515] The new draft law to amend the official secrecy norm in the B-VG and introduce a new Freedom of Information Act was approved by the National Council in February 2024,[516] hopefully marking the end of secretive functioning of institutions, such as child welfare and social welfare departments, and educational authorities.

Amidst the absence of official data, it is necessary to turn to assessments. Global assessments suggest that approximately one in three children in institutional care has a disability, although this proportion varies significantly from country to country. For instance, in Serbia and Hungary, 77%, in France 66.7%, in the Netherlands 59.7%, in the Czech Republic 50.7%, and in Croatia 23.8% of children in residential care have a disability.[517] Therefore, while it is impossible to assess the actual number of CWD in residential care in Austria based on available data, we can rely on the well-established understanding that CWD are overrepresented in institutional care. Consequently, this implies that issues surrounding institutional care, including overreliance on it, disproportionately affect CWD. In other words, if a social protection system is overly reliant on institutional care for non-disabled children, it is likely at least as reliant, if not more, on such care for CWD. The ACDP, amidst the lack of reliable data, also assumes that institutionalisation of CWD is very high in Austria.[518]

This overview of the social protection system in Austria, specifically focusing on support and services for families and alternative care for children with and without disabilities, reveals both progressive strides and persistent challenges. However, the data highlight systemic issues, particularly concerning the overreliance on residential care, the proliferation of SGHs, the lack of family and community-based support and services (specifically in Vienna), and significant differences between provinces, which result from federalism's impact on policy implementation and planning. Moreover, in-state competence for the questions regarding CWD

[515] Legal Analysis of the Austrian Freedom of Information Act, (2021), Access Info.org.
[516] 5. Federal Law: Amendment of the Federal Constitutional Law and the Freedom of Information Act, BGBl. I Nr. 5/2024, 2024.
[517] NOWAK. 2019, p. 190.
[518] ACDP, 2023**, p.** 8.

is divided between several departments, which further jeopardizes coordination, data collection and planning even on the level of a province.

Recognition of past injustices has led to compensation efforts and attempts to reform the system in which these injustices occurred. Despite these developments, Austria's approach to DI was not straightforward. Instead of a complete shift from institutional care, reforms focused on improving care quality in smaller units and enhanced supervision. This aligns with the overall approach to social protection reform in Austria, which was described as 'more incremental and less path-departing' than in other EU countries.[519] Österle and Heitzmann argue that a paradigmatic change in the social protection system in Austria has not occurred, at least since the 1990s.[520] While the CRPD relies on the paradigm shift and DI represents a significant disruption in a system heavily reliant on residential care, the challenges posed by the tradition of continuity and concerns about the impact of disruptive measures could be major impediments.

It has been argued that the 1993 reform and the Federation-provinces agreement at that time did not take into account the CRPD or evolving UN standards on alternative care, including the UN Guidelines introduced much later.[521] Post-1993 reforms, while not disruptive, continued to rely heavily on institutional care, particularly small-scale residential care. The significance of the 1993 reform lies in the establishment of a new pillar of social protection in Austria and the inclusive negotiation process that led to the Federation-provinces agreement. This suggests that in the context of the Austria's conservative approach to changes, and amidst the federalism-related challenges in the realm of social protection, a radical shift would require consensus among the Federation, provinces, DPOs, NGOs, and public and private service providers (providers of family- and community-based services, residential care, foster care, education, and more). Ideally, this agreement would result in a binding Federation-provinces agreement committed to realizing the rights of CWD and implementing critical CRC and CRPD norms.

Secondly, the development of family- and community-based services, while still insufficient, especially in Vienna, represents efforts that contribute to the implementation of crucial CRC and CRPD principles. Lastly, in 2023, the Vienna Commercial Court made a significant

[519] Österle & Heitzmann. 2020, p. 27.
[520] Id. at.
[521] see Part I, Chapter 3 'UN Resolutions'.

positive impact on the availability of PA and schooling support for children with all types of disabilities. This was achieved by striking down discriminatory regulations from the Ministry of Education, Science, and Research. This suggests that, while gradual, such court decisions can drive substantial changes, although not necessarily paradigmatic or comprehensive in nature.

While some provinces have made efforts towards DI, the current state of alternative care indicates a strong reliance on small-scale residential care, while the prevention of separation appears barely sufficient, as evidenced by the availability of family support and services (in Vienna), and the overall high number of children in alternative care. This trend, although a shift from larger institutional settings, raises concerns about Austria's alignment with relevant international law and standards stipulating family-based care as the most conducive environment for the development and well-being of CWD, and indeed the only acceptable environment under the CRPD. Nonetheless, various stakeholders, including the AOB and the IMC, have advocated for the expansion of both community- and family-based services and residential care simultaneously, indicating the persistence and deeply entrenched support for such care, even on the side of an NHRI.

Vienna consistently exhibits the highest reliance on institutional care in Austria, along with a high number of children in foster care. The number of children in residential care has increased in recent years. However, it is important to note that a portion of this increase may be attributed to immigration, which is significantly higher in Vienna than in other provinces. Notwithstanding, the prevalence of residential and foster care in Vienna suggests challenges in effectively preventing family separation. In Vienna and some other provinces, residential care has a major role in alternative care, falling short of the international norms enshrined in the CRC, the CRPD and standards from relevant international soft law instruments.

Last but not least, researchers in the field of social welfare and employment might find worth exploring whether the situation in the employment market in Austria may have had an impact on the institutionalisation of care for children with and without disabilities. Österle and Heitzmann argue that the proliferation of day-care facilities for children during the 1900s and the introduction of a mandatory pre-school year had an aim to reconcile the employment and childcare, particularly for women.[522] Furthermore, according to them, the labour market policy

[522] Id. at.

was focused on the activation and reduction of passive benefits,[523] consequently inciting family members who did domestic work only, to get a job. Similarly, Ilinca *et al.* explain that high labour market participation jeopardized home care for older people in Austria.[524] The authors argue that despite several measures that were adopted to reconcile the employment and LTC, still 15% of carers leave jobs to care for their elderly when an extended care is needed, indicating that in a significant portion of cases work and care (for elderly) cannot be reconciled.[525] The authors did not consider the position of parents of CWD; however, it raises a question whether high labour market participation, especially among traditional carers in Austria – the women – combined with the lack of flexible, comprehensive, and individualised support at home, and the need for prolonged care for CWD (which sometimes extends into adulthood, particularly where support for independent living is lacking), contributes to the institutionalisation of CWD.

4.2. Internalisation journey

4.2.1. Differing levels of the CRC and the CRPD incorporations

The analysis of the Austrian legal framework reveals a notable commitment to integrating the principles of the CRC into national legislation, and some norms of the CRPD. However, the extent and manner of incorporation paint a complex picture, particularly regarding the right to live in a family environment for CWD, which remains significantly underdeveloped.

This study found that the Federal Constitutional Act on the Rights of Children (B-RK) and the Federal Child and Youth Welfare Act (B-KJHG) reflect a stronger alignment with CRC provisions than with the CRPD. The former underscores special protection for CWD but fails to explicitly incorporate CRPD norms. Similarly, the B-KJHG, while embodying CRC principles and acknowledging the right of children to be raised in a community-participating

[523] Id. at, p. 29.
[524] STEFANIA ILINCA, et al., FROM CARE IN HOMES TO CARE AT HOME: EUROPEAN EXPERIENCES WITH (DE)INSTITUTIONALISATION IN LONG-TERM CARE (European Centre for Social Welfare Policy and Research. 2015), p. 5.
[525] Id. at.

and contributing manner, fails to expressly include CWD, thereby side-lining them from its scope. This exclusion is characteristic of a broader legislative tendency to segregate issues related to CWD into separate, special laws, which perpetuates their marginalization and hinders inclusion.

Another important conclusion is that the regulatory framework concerning care, especially institutional care for CWD, is fragmented and confusing, further complicating the realisation of their rights. The analysis showed that the B-KJHG, for example, does not designate institutional care as a measure of last resort, nor does it adequately prioritise family-based care options. This lack of prioritization, coupled with the equal treatment of residential and family-based care, falls short of the intention to emphasize institutional care as a last resort and to exhaust less restrictive measures first. Such an approach is in conflict even with the CRC-related standards, which advocate for the family care of children and the minimization of institutionalization, and even more so with the CRPD.

Moreover, the legal framework's separate treatment of issues related to CWD, as observed in the division of social protection and education into separate tracks (mainstream and special), further exacerbates the challenge of inclusion. This separation not only reflects a legislative practice that is misaligned with the inclusivity objectives of the CRPD but also highlights a systemic reluctance to fully include CWD into mainstream legal and social protection systems.

In conclusion, Austria's legislative efforts to incorporate the critical provisions of the CRC are evident, whereas the incorporation of the CRPD is significantly less so. Significant gaps and inconsistencies persist, particularly in ensuring the right to live in a family environment for CWD, which appears not to be safeguarded by any legal norm. The current legal framework's fragmented and often ambivalent approach to incorporating CRPD norms, along with an inadequate focus on family-based care, underscores the need for comprehensive legal reform.

4.2.2. Provision and expansion of residential care does not reflect Austria’s interpretation of the CRPD

Considering the widespread use of different forms of residential care for CWD, and its expansion in the last 30 years (including after the ratification of the CRPD), one might think

that the state's practice reflects its understanding of the interpretation of Article 19 CRPD. However, this is not the case for at least two reasons. Firstly, the incorporation of primarily Article 19 (and Article 23 (5)) is notably poor in Austria's legal framework, as explained. If the incorporation were complete and in line with the CRPD Committee's interpretation, and the authorities continued providing and expanding residential care, a court would be potentially faced with the resolution of the legality of those actions. In the present case, given the lack of incorporation and the absence of direct applicability of the CRPD, the provision and expansion of residential care for CWD do not result from efforts to implement the CRPD.

Secondly, Austria was made aware of the meaning of the critical CRPD provisions via CRPD Committee's General Comment No. 5 on independent living, and its concluding observations on the implementation of the CRPD in Austria.[526] If Austria had intended to assert its own interpretation of the CRPD, it could have done so in the same manner as the EU (in a state party report to the CRPD Committee) or in another way. Therefore, the widespread provision and expansion of residential care do not reflect Austria's interpretation of the CRPD and cannot be regarded as conduct relevant for interpreting the CRPD, in the sense of Article 31(3)(b) of the VCLT.

4.2.3. Limited use of strategic litigation

The systematic review of Austrian case law reflects an intricate judicial landscape. The review, aimed at determining the influence of strategic litigation and court rulings on the adoption of the relevant CRC and CRPD norms, reveals several critical insights.

The Supreme Court (OGH) adjudicated several cases concerning the application of the Federal Residential Care Act (HeimAufG), yet these did not directly address the realisation of the right to live in a family environment for CWD. These decisions are nevertheless informative, as they illuminate the structuring of alternative care and the Court's approach to SSRC, particularly in cluster arrangements. Notable is the Court's willingness to critique the law and recommend

[526] See 'CRPD Committee'.

amendments, demonstrating a tendency towards 'judicial advocacy' (See 'Access to LTC allowance').

The Supreme Court's decisions suggest a limited awareness of the institutionalisation issues faced by CWD, particularly in special boarding schools, and in relation to the restrictive measures. The Supreme Court's decisions, where the Court criticised the positive law, while not qualifying as 'judicial activism', reflect a restrained approach to law interpretation, yet demonstrate a willingness to advocate for legislative changes.

The Supreme Administrative Court (VwGH), in its interpretation of institutional care in the context of the Family Burdens Equalisation Act (FLAG), has failed to develop a coherent definition of institutional care, indicating variability in its application depending on the regulatory context.[527] This lack of a unified approach underscores the Court's limited engagement with the concepts of care in a family environment or institutional care as outlined in human rights treaties, particularly in the CRPD.

Furthermore, the VwGH's handling of a case in 2012 concerning the PA for persons with disabilities illustrates the Court's reluctance to use the CRPD as a tool for interpretation.[528] The Court emphasised the non-direct applicability of the CRPD, refraining from allowing it to inform or guide its interpretation of provincial law. This stance indicates judicial hesitance to integrate CRPD principles proactively into domestic legal interpretations, which suggests a broader judicial and legislative reluctance to fully endorse the CRPD.

In summary, the judicial measures examined demonstrate a cautious judicial approach to the CRPD. While some decisions suggest judicial advocacy for legislative change, there remains a significant gap in the explicit realisation of CRPD rights through judicial practice. This reveals a potential area for further development and emphasis in strategic litigation and advocacy efforts aimed at the fulfilment of the rights of CWD in Austria. There is an evident need for strategic litigation and advocacy to bridge the gap between international standards and domestic judicial practice, encouraged by the one successful anti-discrimination representative action led by Klagsverband.[529] The absence of strategic litigation is closely linked to the ineffective domestic incorporation of CRPD standards, compounded by the inability to directly

[527] See 'Definition of institutional care in the context of the FLAG'.
[528] See 'CRPD interpretation'.
[529] See 'Representative action on personal and school assistance'.

apply human rights treaties in court. Additionally, the awareness among NGOs and potential litigators of the right for CWD to live in a family environment and of the CRPD more broadly, coupled with the absence of the *stare decisis* doctrine in the legal system, may contribute to the reduced use of strategic litigation.

4.2.4. NHRIs and other structures: Strong Frameworks, Limited Impact

The AOB has been instrumental in recognising and addressing historical injustices within child and youth care centres. Despite this forward momentum, the AOB's current stance, as revealed in their submissions to the CRPD Committee, leans towards a dual strategy of advocating for both the enhancement of SGHs and the expansion of family- and community-based services. Such a position, although intended to bridge gaps in care, positions the AOB at odds with the CRPD's unequivocal stance against residential care of any kinds, and is strategically unviable, as explained previously.[530]

The IMC has surprisingly endorsed SGHs in more than one occasion. This finding was unexpected and suggests that the IMC's work is to an extent misaligned with the CRPD Committee's approach, particularly General Comment No. 5 on Article 19 and the Guidelines on DI issued in 2022, which strongly advocate against SGHs and in favour of family-based care.

In this study, the KIJA emerges as the most aligned with the CRPD's vision, actively criticizing the reliance on day care centres for CWD and advocating for substantial support to families and the simplification of support processes. KIJA's recommendations point towards a systemic shift towards community-based services to prevent institutional placements, embodying the CRPD and CRC principles of prioritising family and community integration over institutional care.

While Disability Ombudsperson plays a crucial role in supporting persons with disabilities to realise their rights, its contributions towards the realisation of the right to live in a family environment for CWD reflect the broader national ambivalence towards DI. Recommendations

[530] See 'Austrian Ombudsman Board' in this country study; Part I, Chapter 4.2.4. Acknowledgment of the problems of small-scale residential care).

of the Disability Ombudsperson directed at legislators, somewhat unexpectedly, subtly reinforce a model of care that remains within the residential framework, albeit with a quality improvement focus. Such positions do not challenge the existing paradigm or advance a clear pathway towards the CRPD's vision of full DI. This stance, therefore, complements the observations regarding the AOB and IMC, wherein a cautious approach prevails over a radical reimagining of care systems to align fully with family-based care principles mandated by the CRPD.

4.2.5. Gaps in strategic public policy documents

Austria's approach to integrating the CRPD into its national disability policy documents, such as the National Action Plans on Disability and earlier policy initiatives dating back to the 1990s, demonstrates an initial step towards acknowledging the importance of the rights of persons with disabilities. However, this commitment often remains cursory, lacking the substantive engagement and concrete action plans necessary to effectuate meaningful change. The current investigation found that the strategic documents reflect a limited understanding of the CRPD's principles and fall short of incorporating the CRPD norms into Austria's legal and social welfare systems in a manner that fully realizes the rights of CWD. This is particularly clear through the ongoing, decades-long support for the expansion of institutional care (mostly in smaller facilities). The absence of an intention to plan and conduct a decisive DI is striking. It is one of the most unexpected findings of this investigation.

Arguably, the examined policy documents in Austria reflect the realities more accurately than strategic policy documents in Serbia and South Africa, which are characterized by wishful thinking and marred by significant implementation gaps (this is not to say there are no implementation gaps in Austria). In Austria, there is an apparent lack of intention to enact drastic changes, argued as necessary for the implementation of the CRPD, which is also visible in its strategic documents. Arguably, the disability policy from the early 1990s, enshrined in the Federal Government's Disability Concept from 1992, remains relevant, although the document itself may have been long forgotten. This supports the finding that the approach to LTC and social care policy reforms in Austria is more careful and incremental than disruptive and swift.

The enforcement of these policy commitments further highlights a significant challenge. The absence of robust mechanisms for monitoring, evaluation, and accountability reveals a critical issue in the enforcement, as argued by the evaluators of the NAPD 2012-2020. This enforcement deficit undermines the effectiveness of policy documents and the implementation of the CRPD. Moreover, the strategic documents scrutinised in this study suffer from fundamental design flaws. Notably, they lack detailed financial planning and fail to incorporate essential elements such as timelines, responsible entities, and specific, measurable objectives. Such omissions may be indicative of a broader systemic issue within Austria's policymaking. The federal structure significantly impacts the drafting and implementation of strategic documents and the realisation of the CRPD across Austria, as seen also with the absence of matters pertaining to provincial competences from the NAPD 2012-2020, and consequently the failure in bringing about the changes stipulated in the document.

This analysis, therefore, suggests that while Austria has made strides towards recognising the rights of persons with disabilities, significant work remains to bridge the gap between policy and practice. Also, there is a noticeable lack of focus on CWD (and women too). The journey towards implementing the right grow up in a family environment for CWD necessitates a comprehensive overhaul of the current policy framework. This includes a shift towards more actionable, costed, and enforceable DI policies, the development of rigorous enforcement mechanisms, cooperation between provinces and the Federation, and a commitment to genuine, participatory engagement with stakeholders, including CWD and their families.

4.2.6. European Union’s ambivalence

While the EU has undertaken significant steps to integrate the CRPD into its regulatory framework, its contribution to promoting a life in a family environment for CWD in Austria, and by extension in its Member States, has been inconsistent and at times contradictory. The EU is, at the same time, the only party to the CRPD in this study, which explicitly communicated that the development of residential institutions, under certain conditions, is aligned with the CRPD and the General Comment No. 5 of the CRPD Committee.[531]

[531] See note 476.

Furthermore, the EU's Legal Service's interpretation of the CRPD, which seemingly undermines the convention's prescriptiveness by affording it merely 'policy weight', indicates a lack of the will to approach the implementation of the CRPD decisively, and where it could cause resistance by some Member States. Still, in relation to the Legal Service's interpretation of Article 19 CRPD, the EU highlighted that the opinion was only for internal purpose, and was not supposed to be public, indicating that the EU did not intend to assert such an interpretation of Article 19.[532] Moreover, the EU could, at the moment of conclusion or at a later moment, issue a declaration on the interpretation of the CRPD, including Article 19, which it has not done yet.

The EU's ratification of the CRPD and the mixed agreement status which grants shared competences between the EU and its Member States underscores a formal commitment to the rights of persons with disabilities, including the provision of independent and family living, and social inclusion. However, the application of ESI Funds reveals a more controversial picture. Despite the CRPD Committee's recommendations and the EU's own strategic policies aiming at DI and the support of community-based services, significant portions of ESI Funds have been used for the construction and expansion of institutional care facilities before and after the conclusion of the CRPD by the EU. This approach directly conflicts with Article 19 of the CRPD.

Despite acknowledging progress in monitoring and the gradual integration of the CRPD within the EU's financial regulations, the continued use of ESI Funds for institutional care - coupled with the lack of evident benefits from EU financial contributions to family and community-based services in Austria - suggests that the EU has not effectively advanced the realisation of the right to a family environment for CWD.

Mechanisms that should have ensured compliance with the CRPD in the application of the ESI Funds were hardly effective, not least due to the EU's hesitance to halt funding to Member States that did not comply during the 2014-2020 programming period.[533] The analysis of the EU's policy documents reveals that the EDS 2021, while indicating a direction towards DI and support for community-based care, lacks substantive action and tangible outcomes that align with CRPD norms. Meanwhile, the Child Guarantee, appears to favour residential care without

[532] ILA, 2023**, p.** 21.
[533] Special Report: Ex ante conditionalities and performance reserve in Cohesion: innovative but not yet effective instruments. 2017, p. 8.

framing it as a marginal form or a last resort option.[534] This stance is at odds with more recent UN resolutions on the rights of the child, not to mention the CRPD.

In conclusion, the EU's engagement with the CRPD and its commitment to the rights of persons with disabilities, especially regarding the life in a family environment for CWD in Austria, demonstrates a misalignment with the CRPD Committee. This indicates a missed opportunity to create an 'issue linkage', in the terminology of the TLP scholarship, through a more dedicated application of conditionalities for the use of ESI funds.

Table II.13 List of facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in Austria.

Facilitators		**Impediments**
1.	a	The absence of all categories of data about CWD, likely due to a low priority by competent authorities to collect and analyse such data;
2.	Robust financial support system for families and for CWD;	A vast system of institutional care in small-scale and large residential facilities that is hard to significantly scale-down, partly due to the resistance of service providers and potentially employees, and due to the overall dependence of the social protection system on residential care;
3.	Access to ESI Funds for the development and expansion of support and services for families;	Widespread support for small-scale residential care, even from the structures tasked with the promotion and monitoring of the implementation of the CRPD;

[534] See note 498.

4.	Robust rights promotion and protection mechanisms, reflected in the number of state and independent bodies;	The long tradition of out-of-home care for disabled persons, including CWD;
5.	Potential to further expand existent community-based services, such as mobile early support, 24-hour home care, assisted living for adolescents;	Apparent contemporary relevance of trajectories for the social protection of persons with disabilities that were established during the 1980s and the early 1990s, which have resulted in the parallel expansion of community-based services and residential care.
6.	Possibility to conclude obligating agreements between (15a agreement) the Federation and provinces regarding the provision of social care, including the implementation of DI, the development of support and services to CWD and foster care;	The tendency to apply only incremental changes in social protection system, while the CRPD and the full realisation right to live in a family environment require paradigmatic changes;
7.	A robust foster care system for children without disabilities indicates a well-developed network and the existence of know-how in foster care.	Impossibility to directly apply the CRPD;
8.	Improvements in the cooperation between the Federation and provinces regarding the drafting of the National Action Plan on Disability 2021-2030;	Insufficient incorporation of the CRPD in domestic legal framework;
9.	Possibility for NGOs (Austrian Council of Disabled Persons and Klagsverband) to file anti-discrimination representative action lawsuit.	A federal structure in which provinces possess autonomy in the sphere of social services, including support and services for CWD and their families, as well as alternative forms of care, compounded by poor cooperation and coordination between the Federation and provinces;

10.	The full implementation of Article 33 (2) CRPD and the work of Independent Monitoring Committee, as well as provincial monitoring bodies for the implementation of the CRPD;	The reluctance of the Federation to exercise the powers granted to it by Articles 16(5) and 16(6) of the Federal Constitutional Law over provinces that fail to implement ratified international treaties;
11.	Awareness about the issue of institutional care of CWD amongst leading DPOs;	The issue of institutional care of CWD is a seldom topic when it comes to the rights of CWD;
12.	Commendable state of the rule of law and apparent readiness to deal with the crimes of the past committed by public and private organisations that provide health and social care;	Seemingly insufficient representation of the rights of CWD, especially in relation to institutional care, by DPOs and NGOs;
13.	Potential to further develop forms of inclusive education;	Secretive approach to the sharing of data pertaining to the number of underage users/pupils for research purposes by the Vienna social welfare and special education institutions;
14.	Announced new law on freedom of access to information of public interest;	Potentially impeding policy-making influence of private providers of residential care;
15.	An overall human rights culture and receptiveness for international human rights norms.	The use of ESI Funds for the development of institutional care;
16.		The EU's explicit support for the development of institutional care under certain conditions;
17.		Seemingly low regard of the provincial authorities for the implementation of the CRPD, while they carry crucial competence for the implementation of

		the support and services to families with CWD, foster care and residential care.
18.		At the moment, limited strategic litigation efforts for the rights of CWD in the sphere of family living and care.
19.		The absence of all categories of data about CWD, likely due to a low priority by competent authorities to collect and analyse such data;
20.		Two-track approach in the social protection and education system, including separate laws regulating matters pertaining to children with and without disabilities, and separate institutions (child and youth welfare, disability) with little or no coordination between those institutions;
21.		No 'issue linkages' identified;
22.		The reportedly poor public image of CWD and the predominantly charity-based portrayal of CWD in the media.

PART III Serbia

1. Context

Serbia has a population of approximately 6.5 million, with an unfavourable demographic trend. The number of live births in 2021 was approximately 20% lower than that in 2001, and the total number of children decreased by about 7.7% from 2011 to 2021.[1] According to the data from 2022 by the Republic Institute for Social Protection (RISP), the total number of children in Serbia in 2021 was 1.193.612.[2] The number of CWD is unknown, although the opening of a Registry of children with disabilities was scheduled for 2018.[3] Serbia is an upper-middle income country[4] with a very high human development index.[5] It is centrally located in the Balkans region, in South-east Europe.[6] Four of its eight neighbouring countries are EU Member States (Bulgaria, Romania, Hungary, and Croatia).

Serbia was part of Yugoslavia, a socialist one-party authoritarian country composed of six republics, established in 1945 and dissolved during the 1990s. The last decade of the 20th century was marked by a rule of an authoritarian, nationalist regime, with limited civil liberties and political rights.[7] It has often been categorized as a democracy in transition from a socialist regime that ended after a series of armed conflicts in the region and in Serbia, which makes it a post-conflict country too. The transition started in 2000 with the fall of Slobodan Milošević. However, the remnants of the authoritarian regime and the assassination of the democratic prime minister, Zoran Đinđić, impeded the process of democratic transition.[8]

The first decade of the 2000s was characterised by a high level of political instability, while from 2012 onwards the political situation is sometimes described as stabilitocracy, with a

[1] Prirodno kretanje stanovništva, Republic Institute for Statistics, (2023), accessed: 3rd May, 2023, available at https://data.stat.gov.rs/Home/Result/180304?languageCode=sr-Latn#. Procena stanovništva, po starosti i polu (početak, sredina i kraj godine), Republic Institute for Statistics, accessed: 3rd May, 2023, available at https://data.stat.gov.rs/Home/Result/18010403?languageCode=sr-Latn.
[2] Deca u sistemu socijalne zaštite 2021., (2022), RISP.
[3] SITUACIONA ANALIZA: POLOŽAJ DECE SA SMETNJAMA U RAZVOJU I INVALIDITETOM U REPUBLICI SRBIJI (Belgrade. NOOIS. 2017), p. 17.
[4] World Bank Open Data, The World Bank Group, (2023), accessed 23rd June 2023, available at https://data.worldbank.org/.
[5] United Nations Development Programme, Human Development Report 2020: The Next Frontier Human Development and the Anthropocene, (2020).
[6] RELIGION, MOTHER TONGUE AND ETHNICITY: DATA BY MUNICIPALITIES AND CITIES (Belgrade. Statistical Office of the Republic of Serbia 2015).
[7] Ivan Vejvoda, Serbia after four years of transition, THE WESTERN BALKANS MOVING ON, INSTITUTE FOR SECURITY STUDIES (ISS), CHAILLOT PAPER (2004).
[8] Id. at; Marija Babović, et al., Historical and Socioeconomic Context of Informal Relations Between Political and Economic Actors in Serbia, in INFORMAL POWER NETWORKS, POLICAL PATRONAGE AND CLIENTELISM IN SERBIA AND KOSOVO* (Slobodan Cvejić ed. Belgrade. SECONNS. 2016).

domination of Serbian Progressive Party (SNS), a right-wing party.[9] After 2012, a decline in media freedom, civil liberties, and political rights was detected.[10] The high personalization of political power is characteristic, which generates oscillations between a parliamentary and a presidential phase of a semi-presidential system.[11] The pervasive clientelism in the Serbian politics and society also impacts DPOs and potentially the realisation of their rights.[12]

Kosovo and Metohija, an autonomous province in southern Serbia, declared independence in 2008**.** The conflict and negotiations between the two are still ongoing as of the latest updates. This dissertation examines the implementation of the CRC and the CRPD in the territory of Serbia, excluding Kosovo and Metohija. Serbia is a member of the Council of Europe since 2003, and party to the Revised European Social Charter. It is an EU candidate country since 2012.

1.1. Legal system, the Constitution, and international treaties

1.1.1. Status and effect of international treaties

Serbia is a unitary parliamentary republic. The Constitution of the Republic of Serbia was adopted in 2006.[13] It is the highest legal act which regulates, *inter alia*, the status and effect of international law, ratified international instruments and agreements, the protection of human and minority rights, the protection from discrimination, the protection of children, [14] and the structure and function of NHRIs.[15] The Venice Commission stated that the number of provisions in the Serbian Constitution related to the protection of human rights is extraordinary.[16]

Prior to the adoption of the current Constitution in 2006, ratified international agreements were superior to domestic law, in accordance with the Constitutional Charter of the State Community

[9] Florian Bieber, The Rise (and Fall) of Balkan Stabilitocracies, Winter 2018 HORIZONS 176(2018).
[10] Nations in Transit 2021. The Antidemocratic Turn., (2021), Freedom House.
[11] Marko Mandić & Pavle Nedić, Karakteristike i funkcionisanje polupredsedničkog sistema u Srbiji, 15 GODIŠNJAK 2021 (2021).
[12] Keravica, Stefanović, Petri. Disabled peoples' movement in an eroding democracy – Serbia. 2023. (Unpublished study). For the research report, please contact the author via email at lazar.m.stefanovic@gmail.com.
[13] Constitution of the Republic of Serbia, "Official Gazette RS", Nr. 98/2006, 115/2021, 2006.
[14] Constitution of the Republic of Serbia, "Official Gazette RS", Nr. 98/2006. Articles 18 – 81.
[15] Id. at. Article 38.
[16] Opinion on the Republic of Serbia, CDL-AD(2007)004, (2007), European Commission for Democracy through Law (Venice Commission), para. 21.

of Serbia and Montenegro.[17] Article 16 (2) of the Constitution prescribes that general rules of international law and ratified international agreements are part of the internal legal system of the Republic of Serbia and are directly enforced. Furthermore, these agreements, under Article 167(2), are subject to constitutional review to ensure their compliance with domestic norms. The direct effect of ratified international law and human rights instruments means that those can be enforced without prior adoption of laws that translate international rules into the domestic system. In other words, an individual should be able to seek the protection of the rights contained in the CRC and the CRPD before the courts, and a judgment could be based on the CRC and the CRPD norms.

Apart from the CRC (2001), CRPD and OPCRPD (2009), Serbia ratified the CAT in 2001 and OPCAT in 2006, ICCPR in 2001, ICESCR in 2001, and CEDAW in 2001. The ECHR was ratified in 2003. Serbia ratified the RESC in 2009 but has not ratified an additional protocol to the RESC on collective complaints.[18]

Article 18 (2) prescribes direct enforcement of human and minority rights that are guaranteed in the Constitution, in general rules of international law and ratified international law and agreements. The law can prescribe only the way in which such a right is realized, if the nature of the right requires it, and must not interfere with the core meaning of the right (Article 18 (2)).[19] The Constitution also contains an important provision about the interpretation of human rights. Article 18 (3) of the Constitution obligates authorities to interpret human rights in line with current international human rights standards and practices of international bodies that are mandated with the monitoring of the implementation of those standards. Thus, instruments that are not ratified by Serbia or are not legally binding, yet contain human rights standards like UNGA resolutions on the rights of the child, guide interpreters. Also, general comments of the CRC Committee and the CRPD Committee constitute the practice of monitoring bodies, that interpretations must be in line with. Pajvančić argues those norms are principles and have a programmatic character.[20]

[17] Constitutional Charter of the State Community of Serbia and Montenegro, "Official Gazette S&M" Nr. 1/2003. Article 16.
[18] Yugoslavia, which Serbia was part of, ratified the CRC in 1991, the CAT in 1989, ICCPR and ICESCR in 1971 and CEDAW in 1981.
[19] For a discussion on Article 18 (2) of the Constitution: Marijana Pajvančić, Kontroverze ustavnog okvira zaštite ljudskih prava (Zoran Radivojević ed., Pravni fakultet u Nišu 2008).
[20] Id. at, p. 252

The Constitutional court decides about the compatibility of domestic laws with the Constitution and ratified international treaties (Article 167 (1)),[21] and about the compatibility of ratified international treaties with the Constitution (Article 167 (2)).[22] Although the ratified international agreements are part of the legal system of Serbia, they 'must be in conformity with the Constitution' and 'must not be contrary to the Constitution'.[23]

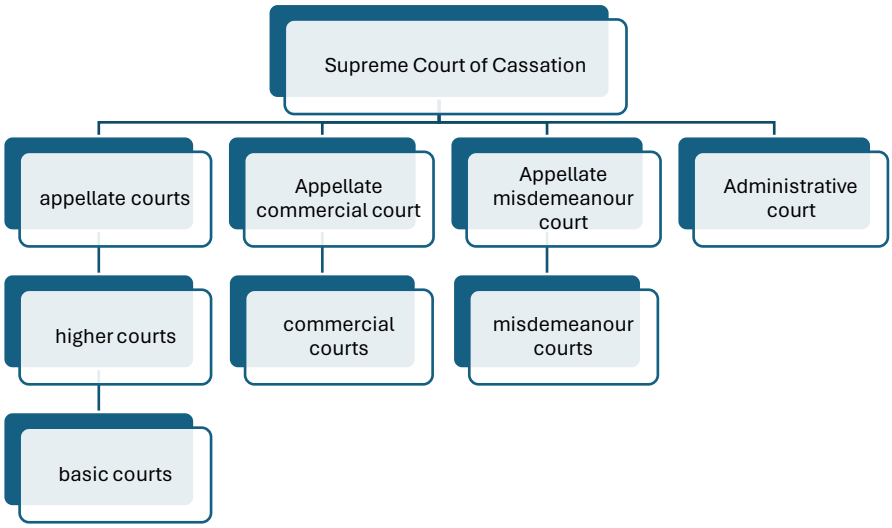
The Constitution prescribes sources of law, which are the Constitution, ratified international agreements, domestic laws, general rules of international law and other general legal acts adopted in accordance with the law.[24] Therefore, courts' decisions are not sources of law. However, the capacity of judicial decisions to constitute sources of law is contested. According to Ivošević, some scholars argue that courts' decisions are not sources of law, others that they are not in principle, but can be sources when there are gaps in statutory law, and the third group argues courts' decisions are a subsidiary source of law.[25] Ivošević, a former judge of the Supreme Court and retired professor of law, concludes that courts' decisions are not sources of law but are sources of a legal order in general.[26] In other words, judgments cannot be based on previous decisions, although all decisions constitute one legal order and judges sometimes have to create law in a specific case when there are gaps in statutory law or when statutory law has obvious flaws such as when it is not in line with a superior legal act.[27] This is a particularly relevant characteristic concerning the realisation of human rights through strategic litigation, which in such a system, has a more limited impact than in a common law system.

1.1.2. Judicial system

Although the Serbian legal system is monist as prescribed by the Constitution, the direct enforcement of the CRC and the CRPD has been rare before Serbian courts, which is assessed in the analysis of the impact of the judiciary on the implementation of the right to live in a family environment.[28] The judicial system comprises courts of general and special competence. The general competence courts are basic courts, higher courts, appellate courts, and the

[21] "Official Gazette RS", Nr. 98/2006.
[22] Id. at.
[23] Id. at. Articles 16 (2) and 194 (4).
[24] Id. at. Article 144 (2).
[25] Sudska praksa kao izvor pravnog poretka, (2021), accessed: 11th May, 2023, available at https://www.danas.rs/dijalog/licni-stavovi/sudska-praksa-kao-izvor-pravnog-poretka/.
[26] Id. at.
[27] Id. at.
[28] See 'Judicial measures'.

Supreme Court of Cassation.[29] The special competence courts are commercial courts, the Appellate commercial court, misdemeanour courts, the Appellate misdemeanour courts, and the Administrative Court.[30]



1.1.3. The Parliament

Serbia's Parliament, a unicameral National Assembly with 250 seats located in Belgrade, serves as the country's legislative body. Members are elected for four-year terms, during which they hold the responsibility for electing the Government and for the adoption and amendment of the Constitution and laws. Decisions within the Parliament are reached through a majority vote, a principle that applies to the quorum requirement as well. However, for constitutional amendments, a more stringent two-thirds majority is necessitated. Since 2012, the composition of the Parliament has been predominantly controlled by the right-wing SNS and its allies, which enables SNS to amend laws and even the Constitution without the support from parts of opposition. This dominance led to the opposition's boycott of the 2020 parliamentary elections, a move prompted by widespread dissatisfaction with the deplorable electoral conditions, which reportedly significantly undermine Serbia’s democracy.

[29] Law on the Organization of Courts. Article 11 (3).
[30] Id. at. Article 11 (4).

1.2. International and regional human rights mechanisms' recommendations

Serbia has received a considerable number of recommendations from different UN treaty bodies, special procedures, through the UPR mechanism and from the CPT Committee of the CoE, directly related to the institutionalisation of CWD, support to families, family-based alternative care, CBS (CBS) etc. The following paragraphs summarize the most relevant observations and recommendations. The review included documents issued in the past 30 years.

1.2.1. CRC Committee

In 2008 the CRC Committee was concerned about high numbers of CWD in institutional settings, the low quality of care and the insufficient number of foster parents for CWD in Serbia.[31] On that occasion, after an NGO uncovered harrowing conditions, the CRC Committee welcomed the moratorium on new placements of CWD in one of the institutions. It recommended that the state accelerate DI efforts and shift towards family-based care for CWD.[32]

The treaty body also issued Concluding Observations for Serbia in 2017 and condemned the inhuman and degrading treatment and high numbers of CWD, Roma children and children under three in institutions.[33] Furthermore, the body was concerned about the overrepresentation of CWD in institutions, the lack of safeguards in placement procedures and insufficient support to families of CWD.[34] It urged the state to reduce the placements of children under three including CWD and Roma children, and enable that CWD who are in need of constant care and assistance remain in their families and that parents who do not work in order to care for their children are provided with financial assistance.[35]

[31] Concluding observations: Republic of Serbia, CRC/C/SRB/CO/1, Committee on the Rights of the Child, 2008, para. 48.
[32] Id. at, para. 48.
[33] Concluding observations on the combined second and third periodic reports of Serbia, CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017. para 32, 39.
[34] Id. at.
[35] Id. at, para. 40, 43.

1.2.2. CRPD Committee

The CRPD Committee issued Concluding Observations on the initial report of Serbia in 2016, condemning the institutionalisation and the overrepresentation of CWD in institutions. It highlighted the insufficient CBS for CWD and their families, inappropriate placements of children under three in institutional care, and the complicated licensing for CBS providers.[36] The treaty body recommended to adopt a DI strategy, which the state did in 2021, to strengthen DI of CWD, stop institutionalisation of CWD under three, and to develop CBS on the local level.[37]

1.2.3. Other recommendations

The Human Rights Committee and the Committee Against Torture have recommended that Serbia intensify its efforts on the DI and the development of CBS for all persons with disabilities.[38] The Committee on Economic, Social and Cultural Rights specifically addressed the development of family-based care for CWD in 2014, while in 2022 the body called for DI efforts in general to continue in Serbia.[39] The Special Rapporteur on torture condemned the situation of CWD in residential institutions in 2015 and recommended to step up efforts on DI and the development of CBS.[40]

Through the UPR mechanism, New Zealand recommended that Serbia work towards the DI of CWD, while Montenegro emphasized DI for all children, particularly those under three.[41] In 2021 the CPT called the state to step up on DI in general, and it was concerned that the Draft Deinstitutionalisation Strategy (DIS) had not contained measures to prohibit building new

[36] Concluding observations on the initial report of Serbia, CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 13.
[37] Id. at, para. 14, 40.
[38] Concluding observations of the Committee against Torture Serbia, CAT/C/SRB/CO/1, (Committee Against Torture), 2009. Concluding observations on the second periodic report of Serbia, CAT/C/SRB/CO/2*, (Committee against Torture), 2015. Concluding observations on the third periodic report of Serbia, CCPR/C/SRB/CO/3, (Human Rights Committee), 2017.
[39] Concluding observations on the second periodic report of Serbia, E/C.12/SRB/CO/2, (Committee on Economic Social and Cultural Rights), 2014. Concluding observations on the third periodic report of Serbia, E/C.12/SRB/CO/3, (Committee on Economic Social and Cultural Rights), 2022.
[40] Visit to Serbia and Kosovo*. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/40/59/Add.1, (Human Rights Council), 2019.
[41] UPR Info Database, UPR Info, accessed: 2nd May 2023, available at https://upr-info-database.uwazi.io/en/.

institutions for children (the adopted DIS does not contain such measures either).[42] The same body condemned harrowing conditions in one of institutions for CWD and called for DI and development of CBS in 2016.[43] Following a 2007 visit, the CPT raised concerns about overcrowding and deplorable living conditions in an institution for children and adults with disabilities, noted the inadequacy of CBS, and recommended further DI efforts.[44] The CPT noted that some institutions need to be maintained for the most severely disabled people and requested further updates on the announced construction of a new facility for people with Down Syndrome.[45] A similar observation cannot be found in later CPT reports to Serbia, which indicates that the CPT might have ceased issuing recommendations supportive of institutionalisation due to the adoption of the CRPD and Serbia's ratification of the treaty in 2009.

The poor data collection on CWD, differing definitions of disability, and the lack of cooperation between institutions make tracing trends and comparisons challenging. This issue was also recognized by the Republic Institute for Social Protection (RISP). Still, there is several studies and assessments of primarily domestic DPOs and NGOs or international NGOs working in Serbia. The RISP publishes annual reports on children in the system of social care, including disabled children, which is an important source for policymaking and research. However, the data on children are sometimes not disaggregated by disability. Serbia lacks a unified definition of disability and developmental issues, with these terms often used interchangeably within legal and policy frameworks. Here, the term ‘child with a disability’ is used as an umbrella term.

2. Situation of children with disabilities

Alternative forms of care, primarily kinship and foster care, have a long tradition in Serbia, first being legally defined in the early 1800s. A century later, a legal act prioritized family-

[42] Report to the Serbian Government on the Visit to Serbia Carried out from 9 to 19 March 2021 CPT (2022) 03, (European Committee For The Prevention of Torture and Inhuman or Degrading Treatment or Punishment), 2022, para. 160.
[43] Serbia visit 2015, CPT/Inf (2016) 21 | Section: 54/61 | Date: 26/11/2015 E. Veternik Residential Facility / 1. Preliminary remarks, (2016), Council of Europe, para. 181.
[44] Report to the Government of Serbia on the visit to Serbia carried out from 19 to 29 November 2007, CPT/Inf (2009) 1, (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)), 2009, para. 148.
[45] Id. at, para. 163.

based alternative care over institutional care, anticipating the principles found in the CRC, which was adopted 70 years later.[46] Furthermore, these acts stipulated that a child without parental care should first be placed with a kinship family, if not possible, then with a foster family entitled to state compensation for costs, and if neither option is viable, in an institution.[47] By the 1920s and 1930s, first specialized establishments for the provision of foster care were formed as well as standards of such care. Subsequent laws on family-based care, influenced by the phenomenon of 'baby farming' in the United Kingdom, were adopted over the following decades, according to Žegarac.[48]

Conversely, the numerous wars on the territory of Serbia, including the Serbian-Ottoman wars and the First World War generated the need for residential care for children who lost their parents, states further Žegarac.[49] Another expansion of institutional care was seen after the Second World War, as a blueprint of the Soviet Union's system of care for children, when the number of children in institutions in Yugoslavia was the highest.[50] Brkić *et. al* claim that residential care was dominant throughout the 20th century and that CBS were non-existent.[51] The ratio of children in family-based care on the one hand and institutional care on the other fluctuated throughout the 20th century, culminating in a decline of the former and the domination of the latter in the final decade of the century. Authors elaborate that unemployment, a refugee crisis, internal displacement, sanctions, and inflation generated the need for alternative care of children, which at that time was mostly institutional. This occurred as the foster care system experienced a major decline, amidst underfunding and the cessation of payments to foster parents.[52]

At the onset of the 2000s, a reform of social protection was initiated, and significant changes were implemented in legal and policy frameworks and in practice. The following section

[46] DOBRILA GRUJIĆ, TEORIJA I PRAKSA HRANITELJSTVA U SRBIJI (Belgrade, Centre for family care and adoption Belgrade. 2017), p. 16.
[47] Id. at.
[48] NEVENKA ŽEGARAC, U LAVIRINTU SOCIJALNE ZAŠTITE. POUKE ISTRAŽIVANJA O DECI NA PORODIČNOM I HRANITELJSKOM SMEŠTAJU (Belgrade, University of Belgrade, Faculty of Political Science. 2014), p. 77-78.
[49] Id. at.
[50] M. VELJIĆ, DRUŠTVENA ZAŠTITA DECE BEZ RODITELJSKOG STARANJA (Belgrade, Institut političkih nauka. 1977). as cited in: ŽEGARAC. 2014.
[51] Miroslav Brkić, et al., Residential care for children with intellectual disabilities in the social protection system in Serbia, 17 EUROPEAN JOURNAL OF SOCIAL WORK (2014).
[52] ŽEGARAC. 2014, p. 78; GRUJIĆ. 2017, p. 17.

present the state of family-based care, institutional care, CBS, and social support to CWD and their families.

2.1. Community-based services and support for families

CWD are entitled to various forms of material and non-material support and services; this section exhibits the available data regarding their usage. The legal basis of support and services are discussed in another section.

The number of CWD using the 'personal companion of the child' service increased more than fourfold from 574 in 2017 to 2582 in 2021, and it was available in 59% of municipalities in 2021.[53] The number of 'day-centres' users nearly doubled between 2017 and 2021, from 132 to 259.[54] The 'help-in-home' service, providing in-home assistance for basic chores, was used by only 103 CWD and their families in 2021.[55] The number of CWD who use that service stands in stark contrast to the total number of users of the „help in home', which was 16.482 in 2021.[56] Respite care was used by 26 CWD in 2021, and it was provided by one provider.[57]

Parents of CWD with low income can benefit from increased child allowance, if personal financial and property requirements set in accordance with articles 7 and 8 of the Law on Financial Assistance to Families with Children are met.[58] The number of CWD receiving financial 'allowance for care and help of another person' increased from 6465 to 8819 between 2012 and 2021.[59]

[53] RISP, 2022, p. 60. Izveštaj o uslugama socijalne zaštite na lokalnom nivou koje pružaju licencirani pružaoci usluga u 2021. godini, (2022), RISP, p. 23.
[54] RISP, 2022, p. 60.
[55] Id. at, p. 61.
[56] Id. at.
[57] Id. at. p. 56-57.
[58] Law on Financial Assistance to Families with Children, "Official Gazette RS", Nr. 113/2017, 50/2018, 46/2021 - CC decision, 51/2021 - CC decision, 53/2021 - CC decision, 66/2021 and 130/2021.
[59] RISP, 2022, p. 59.

2.2. Institutional (residential) care

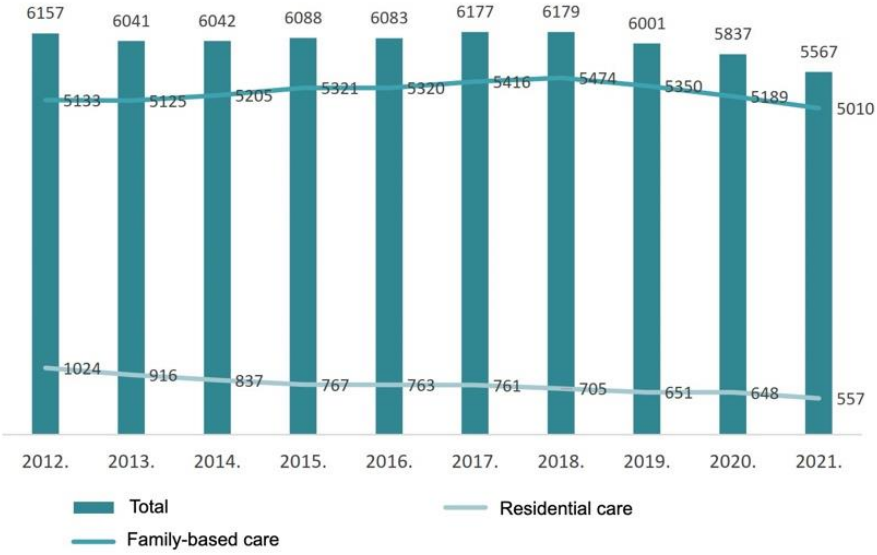
In 2021, 557 children were in residential care, translating to a rate of 46.7 per 100.000 children, as reported by the RISP. [60] This rate positions Serbia among the countries with the lowest usage of residential care for children globally, as per the UN Global Study on Children Deprived of Liberty.[61] The total number of children in alternative family-based care was around 5000.[62]

Between 2012 and 2022 the number of children in formal care (family-based care and residential care) decreased from 6157 to 5567, which is a decrease of 9.58%.[63] For the largest part the decrease was on the expense of residential care where the number of children was 1024 and 557 respectively, which is a decrease of 45.61% (Chart III.1).[64] A UNICEF database shows that the number of CWD in residential care decreased 43.5% between 2009 and 2018.[65] However, that data also included youth with disabilities (18-26).

During the year 2021, 128 children were placed in residential care and 636 in family-based care.[66] During the same year, residential care was ended for 51 children, meaning that the number of children in residential care increased, which according to the RISP, constitutes a trend.[67] In shelters for temporary accommodation, 132 children used this type of service, which can be provided for up to 6 months.[68]

[60] Id. at, p. 14.
[61] MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 503.
[62] RISP, 2022, p. 14.
[63] Id. at, p. 21.
[64] Id. at.
[65] Transformative Monitoring for Enhanced Equity (TransMonEE), 2021, Date, 2021).
[66] RISP, 2022, p. 14.
[67] Id. at.
[68] Id. at, p. 15

Chart III.1 Children without parental care in family-based care and residential care between 2012 and 2022. Source: Ministry for work, employment, veteran, and social affairs, in RISP. Deca u sistemu socijalne zaštite 2021. 2022.



In 2021, there were 397 CWD in residential care, [69] representing an 8.5% decrease from 2020, as illustrated in Chart III. 2.[70] A report by an NGO highlighted that 21 CWD under the age of 3 were in residential care.[71] According to RISP, 71.3% of CWD were in residential care, [72] positioning Serbia among the countries with the highest proportions of CWD in such settings, as noted in the UN Global Study.[73] In another report by the same agency, the share of CWD in residential care was 77% in the same year.[74] The decrease of CWD in residential care over a five-year period is significant and amounts to 154 children or 27.95%. During the same period the number of children without disabilities decreased from 210 to 160, or 23.81%.[75] The number of children placed in 'homes for children and youth with disabilities' in 2021 was 22, but there is no information on CWD placed in other types of institutions ('homes for children and youth without parental care and children and youth with disabilities' and 'institutions for

[69] Id. at, p. 59.
[70] Id. at.
[71] SNEŽANA LAZAREVIĆ, et al., POLOŽAJ OSOBA SA INVALIDITETOM. NULTI IZVEŠTAJ. (Belgrade, Inicijativa za prava osoba sa invaliditetom MDRI-S. 2022), p. 37.
[72] RISP, 2022, p. 56.
[73] NOWAK. 2019, p. 190.
[74] Izveštaj o radu ustanova za smeštaj dece i mladih za 2021. godinu, (2022), RISP, p. 17.
[75] RISP, 2022.

the upbringing of children and youth') in the same years.[76] The dominant reason for placements in residential care, according to the RISP, was the 'inability of parents to respond to the health needs of the child'.[77]

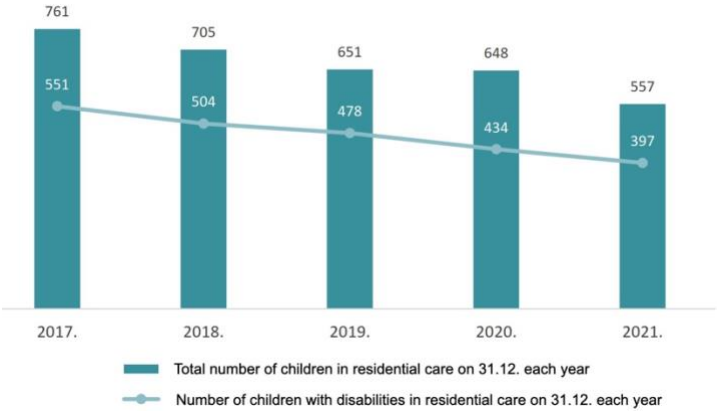


Chart III. 2 Children with disabilities in comparison to the total number of children in residential care. Source: reports of all residential care institutions, Ministry for work employment, veteran, and social affairs in RISP. Deca u sistemu socijalne zaštite 2021.

Currently, there are 18 residential institutions for children in Serbia, of which 10 are for the care of children and youth without parental care and children and youth with disabilities (CYWPC), 5 only for children and youth with disabilities (CYD), and 3 institutions for the upbringing of children and youth (UCY).[78] Three out of 5 CYD institutions also have units for the accommodation of adults with disabilities, but adults are placed in 5 of those institutions.[79] The use and the capacity of those institutions is determined in the Decree on the network of institutions for social protection.[80] The capacity of CYD institutions is 716 for children and 800 for adults, CYWPC institutions have a capacity of 924, and UCY institutions can accommodate 116.[81] According to the RISP report, the average occupancy rate for CYD institutions was 88% in 2021, with two institutions exceeding 100% capacity, indicating overcapacity.[82] At the same time, the occupancy of institutions for CYWPC was 50%.[83]

[76] RISP, 2022, p. 15.
[77] Id. at.
[78] Id. at, p. 5. Strategy for Deinstitutionalisation and the development of Community-based Services 2021-2026, "Official Gazette RS", Nr. 12/2022.
[79] RISP, 2022, p. 12.
[80] Decree on the network of institutions for social protection, "Official Gazette RS", Nr. 16/2012 and 12/2013. Article 9. RISP, 2022, p. 5.
[81] "Official Gazette RS", Nr. 16/2012 and 12/2013.
[82] RISP, 2022, p. 5.
[83] Id. at, p. 7

The number of CWD in so called 'small home communities' (a type of SSRC, also known as small group homes - SGHs) is not provided by the RISP, but the number of children and youth with disabilities in SSRC was 55 in 2021.[84] The SGHs are organizational units of CYWPC and data on CYWPC include SGHs. Five SGHs units were built between 2011 and 2012, as part of efforts to transfer disabled individuals from one large facility, with a capacity of 12 in each SGH.[85]

According to the RISP, institutions for CYD accommodate large numbers of adults, as a consequence of the process of DI.[86] The RISP notes a 21.9% decrease in the total number of users in CYD institutions (however the graph under the text shows the decrease of 8.57%).[87] The share of children in all three types of institutions for children and youth is only 29%, while the rest are youth (18-25 years of age) and adults (>26 years of age). [88]

The number of CWD in 6 institutions for CYD was 156 in 2021, or 11.6% of the total number of users of those institutions.[89] The RISP did not provide the number of CWD in 10 institutions for CYWPC for 2021. However, considering that the total number of CWD in residential care is 397,[90] 241 CWD must be accommodated in the other two types of institutions. Of all children in CYWPC, 53.4% have some kind of a disability, and in UCY 61.7% in 2021.[91] In 2015, the share of children and youth with disabilities in CYWPC was 51% and in 2010 42.9%. The RISP acknowledges changes in their data collection methods and that one entire institution was left out of the report for 2010 because all children were reported as disabled by that institution, making the comparability of data between years questionable.[92]

In SSRC all children have some kind of a disability.[93] In relation to contact with family members, the largest share of children and youth in SSRC does not have any contact (65.45%), compared to those in CYD (34.51%) and CYWPC (35.51%).[94] Also, children and youth in

[84] Id. at, p. 21.
[85] Podrška deinstitucionalizacije dece sa smetnjama u razvoju smeštenim u Kulini, Humanitarna organizacija Dečije Srce, accessed, available at https://decjesrce.rs/podrska-deinstitualizacije-dece-sa-smetnjama-u-razvoju-smestenim-u-kulini/.
[86] RISP, 2022, p. 11.
[87] Id. at.
[88] Id. at, p. 12.
[89] Id. at.
[90] See note 69.
[91] RISP, 2022, p. 17.
[92] Izveštaj o radu ustanova za smeštaj dece i mladih bez roditeljskog staranja za 2010. godinu, (2011), Republički zavod za socijalnu zaštitu, p. 17
[93] RISP, 2022, p. 17.
[94] Id. at, p. 21.

SSCR have the lowest share of those with regular contact (1.82%), compared to CYD (19.78%) and CYWPC (15.47%).[95]

When it comes to the type of disability, both in 2015 and 2021 most of the disabled children in residential care had intellectual disabilities, followed by multiple disabilities.[96] According to the RISP reports, there were no children with only physical disabilities in residential care.

Particularly alarming is the length of stay in institutions; in 2021, half of the children and youth with disabilities in CYWD institutions had been residing there for over 20 years. The data is not only for children, but also youth, thus the length of stay can be measured for a period longer than 17 years. In 2021 only one disabled child was transferred from CYD to foster care and none to the biological family.[97] No CWD were adopted that year from CYWD institutions.[98] In the same year 23 children were transferred from CYWPC to biological, kinship or foster family or they were adopted.[99] The same trends were observed in the years before 2021 – the dominant reason for leaving CYD was death, and the fluctuation of users in an out of institutions was „exceptionally small', according to RISP.[100] This data shows that CWD in those institutions are rarely, almost never, reunified with their families or transferred to foster care. They simply become adults in institutions where they were placed as young children, or they die.[101] If the number of placements is reduced this can result in decreasing a number of children with and without disabilities in institutional care even when none of the children are reunified with their families or placed in family-based care or adopted.

The reports of the RISP do not contain data on SOS Children's Villages' programs of care. In 1975, the SOS Kinderdorf financially supported the establishment of the first 'children's village' near Sremska Kamenica. According to the website of the organisation, in 2022 SOS Children Villages ran one 'children's village' where 60 children and 30 young people resided.[102] Established in 2004, the concept of the 'children's village' near Kraljevo was based

[95] Id. at, p. 21.
[96] Izveštaj o radu ustanova za smeštaj dece i mladih za 2015. godinu, (2016), Republički zavod za socijalnu Zaštitu. RISP, 2022.
[97] RISP, 2022, p. 23. Table 10.
[98] Id. at.
[99] Id. at.
[100]RISP, 2016, p. 34. Izveštaj o radu ustanova za smeštaj dece i mladih za 2018. godinu, (2019), RISP, p. 5-6.
[101] IT IS MY DREAM TO LEAVE THIS PLACE: CHILDREN WITH DISABILITIES IN SERBIAN INSTITUTIONS (New York, Human Rights Watch. 2016), p. 26.
[102] SOS Dečije selo Kraljevo, SOS Children's Villages Serbia, accessed: 16th March, 2023, available at https://sos-decijasela.rs/nasi-programi/sos-decije-selo-kraljevo/.

on a foster care model where 15 foster families cared for over 90 children and youth in over 10 dwellings.[103] The structure of the 'children's village' resembles congregated small-scale residential care. However, the NGO claims that the concept of care resembles care in foster families. The form of care provided by the SOS 'children's village' near Kraljevo, corresponds with a family-like type of care, which according to the interpretation of the CRC and the CRPD Committee, cannot be understood as family-based care. Therefore, any form of out-of-family care, whereas the term 'family' should be given an ordinary meaning,[104] presents an institutional form of care, according to the interpretation offered above and the interpretation of the CRPD Committee and the position of the Special Rapporteur for the Rights of Persons with Disabilities.[105]

Due to the inability to license their specific model of foster care, the SOS Children's Village near Kraljevo is under reform. According to an interviewee, lobbying efforts of SOS Serbia were not sufficient to convince decision-makers to amend the relevant acts in order to create the possibility for this type of care to be recognized in law and eventually licensed.[106] Although the reasons for that are not known, Serbia did not expand the forms of alternative care offered to children for the better or worse, despite the suggestions expressed in some UN resolutions.[107] It is unlikely that Serbian decision-makers had the CRPD Committee's interpretation in mind, especially as it was not that clear before the adoption of the CRPD GC 5 and later reports of the Special Rapporteur, which basically classify any type of out-of-family care including family-like care as in contradiction to the CRPD.[108]

The 'Children's village Dr Milorad Pavlović' near Sremska Kamenica is a state-run entity, unrelated to the SOS Children's Villages Serbia, that had 90 children and youth in care on the last day of 2021, of which 25 were disabled children.[109] Similarly to the SOS Children's village, it consists of 12 congregated dwellings located on the outskirts of town Sremska Kamenica, in the National park Fruška Gora.[110] The RISP includes data from this institution in its annual

[103] Id. at.
[104] See Part I, 1.3.1 Permissible alternative care options.
[105] Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas, Rights of Persons with Disabilities A/HRC/40/54, UN Human Rights Council, 2019, para. 19.
[106] M. L., Interview, 22nd May, 2023.
[107] See Part I, 4.3.1 General Comment No. 5 on living independently and being included in the community (2017).
[108] Ibid.
[109] The information was obtained from the Ministry for Social Affairs, by the MDRI-S on the basis of the Freedom of Information Act for the purpose of writing the Position of Persons with Disabilities: the starting report. Available on request: mdri.serbia@gmail.com
[110] History, Children's Village Dr Milorad Pavlović, accessed: 17th March, 2023, available at https://decijeselo.org.rs/istorijat/.

reports. There is no additional information available on the form of care provided; however, CWD residing there should be considered in residential care.

Importantly, the RISP considers this children's village as a form of residential care, which reflects the state's practice in relation to the understanding of what constitutes residential care. In that light, Serbian authorities' interpretations of residential/institutional care is closer to the understanding of the CRPD Committee and the corresponding interpretive community, which considers small group homes a form of institutional care and in conflict with the CRPD. As shown, in UN Guidelines, UNICEF ECARO's White paper, and certain NGOs' position papers, there is a tendency to refrain from labelling this type of care as institutional care, but rather as separate SSRC type of care. In contrast, Serbian authorities simply classify this type of care as institutional care (domski smeštaj – children's home), as other institutions that have hundreds of residents. It is important to note that some CWD who live in boarding schools for CWD are not covered by this data. Such data is not publicly available and not included in this thesis.

2.3. Family-based alternative care

Several authors provide informative overviews of the development of family-based care in Serbia in the last 20 to 30 years. Before the reform in the early 2000s, family-based care had been seriously affected by unfavourable socio-economic conditions of a country that participated in wars and was under international economic sanctions in this period.[111] During the 1990s, foster caregivers were losing support and financial compensation, hence the number of foster families decreased 35.8% from 1998 to 2003, when the recovery started. During the same period centres for family-based care were closed, and all competence was shifted to the Centres for Social Work (CSW) which did not have enough resources to adequately support and monitor foster care families.

The recovery started with a series of successful projects to expand foster care already in 2002, together with UNICEF and Save the Children. Projects were supported by the EU and governments of European countries including the Netherlands, Norway, and Sweden, which

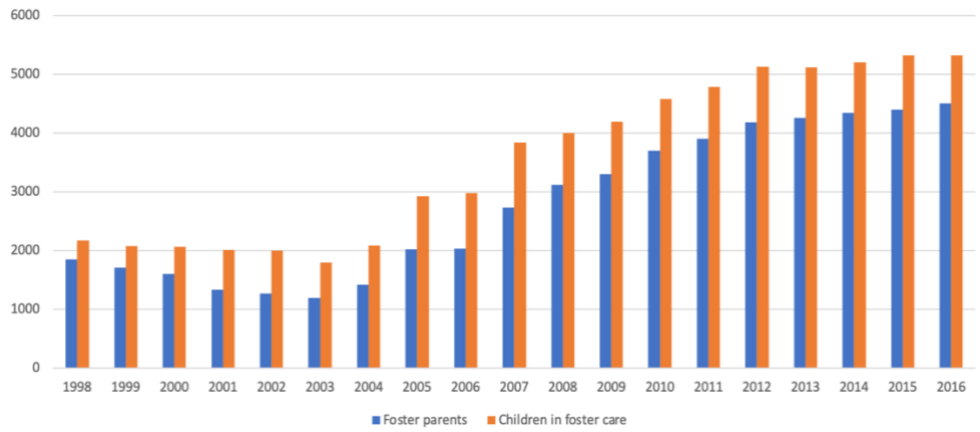
[111] See note 52.

brought a sharp increase in the number of foster parents and improvements in the quality.[112] Grujić also acknowledged that the role of foreign experts and exchange of knowledge and experience with them as well as their participation in the domestic reforms in Serbia was important for the reform of family-based care. Other critical measures for the reform, according to Grujić, were the establishment of regional Centres for family-based care and adoption, increased financial compensation and social and retirement insurance paid by the state to foster parents.[113]

The number of children in family-based care experienced expansion from 2003 to 2018, when the number of children in this form of care tripled, from 1795 to 5474. From 2018 to 2021 that number has steadily decreased to 5010.[114] On the other hand, the foster care for CWD, so-called 'specialized foster care' ('specijalizovano hraniteljstvo') has been far less used. The number of CWD in foster care was 347 as reported in the DIS (presumably related to 2021 when drafted), while the data for the 'intermittent foster care' were not known neither to the Ministry for Labour, Employment, Veteran and Social Affairs (MOLSA) at the time of drafting the DIS.[115] The number of CWD in foster care is dwarfed by the total number of children in this form of care, indicating the poor state of development of this type of care for CWD in Serbia. The share of CWD in foster care is only 6.93%, although data from 2015 reported that the share of CWD and children with health issues was 14.3%.[116] One of the reasons for the low number of CWD in foster care, argues Grujić, are prejudice and fear that potential foster parents have.[117] Thus, the training and awareness raising for foster parents needs to be even more intensive. Notwithstanding, one interviewee, former policymaker in the Government involved with the development of the foster care system, claimed that foster care for CWD was intentionally left aside during the first phase of reforms (after 2000) due to the lack of control mechanisms that would monitor foster families with CWD due to an allegedly higher risk of abuse and neglect, than in case of foster care for non-disabled children.[118] The total number of children in family-based care peaked in 2018 and has been steadily declining since.

[112] GRUJIĆ. 2017, p. 23.
[113] Id. at, p. 28.
[114] See Chart III.1 Children without parental care in family-based care and residential care between 2012 and 2022.
[115] "Official Gazette RS", Nr. 12/2022, p. 44.
[116] NOOIS. 2017, p. 56.
[117] GRUJIĆ. 2017, p. 43.
[118] H. N., Interview, 2022.

Chart III.3 Decline and expansion of foster care from 1998 to 2016. Source: Grujić, Dobrila. 2017. Teorija i praksa hraniteljstva u Srbiji, p. 20.



Types of alternative family-based care in Serbia are kinship and foster care. Kinship care is prioritized in the process of placement of any child separated from his/her parents. It is suspected that a substantial number of children are informally cared for by their relatives, meaning that those children are not counted as children in formal kinship care.[119] However, a RISP report provides evidence that around 20% of all children in alternative care are in kinship care, 68% in foster care and the rest in institutional care and shelters.[120]

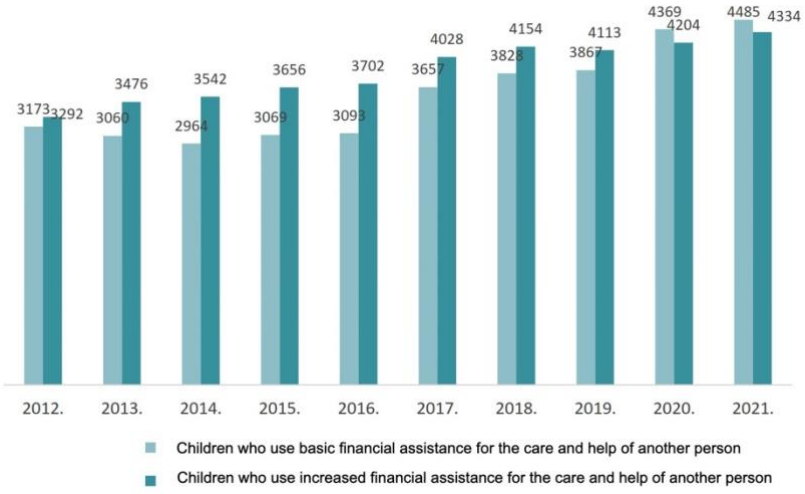
By examining quantitative data on children in institutional and family-based care in Serbia, it can be concluded that the former decreased nearly as much as the latter increased. In other words, in 2021 there were 2000 children less in institutional care, and around 3000 children more in family-based care than at the beginning of the century. Overall, the number of children in alternative care has increased compared to two decades ago. This data indicates that Serbia might have based its DI on the expansion of foster care, while the measures to prevent separation from families stayed underdeveloped, judging by the total number of children in alternative care.

[119] ŽEGARAC. 2014, p. 46.
[120] RISP, 2022, p. 17.

2.4. Adoption

Adoption is mostly considered not a form of alternative care,[121] but it is a way to secure life in a family environment for CWD. However, adoption rates, especially for CWD, remain low over the years. In 2021, only 88 children were adopted, including 24 inter-country (international) adoptions.[122] All children adopted by foreigners were CWD.[123] Also, none of the adopted CWD had been placed in institutions, which indicates that no CWD had got their right to live in a family environment reinstated through adoption.[124] Inter-country adoptions are allowed only where a child cannot be placed in a family-based care or adopted in-country, according to Article 21 (b) CRC. The fact that no CWD were adopted in Serbia, could have similar reasons to the low number of CWD in foster care, according to Grujić, that is the prejudice and fear of potential foster or adoptive parents. Experts warned about the association of high institutionalisation and high rates of international adoptions in the past. Romania banned international adoption prior to becoming a Member State of the EU, in order to consolidate its childcare system, argue Chou and Browne.[125]

Chart III.4 Children users of basic and increased allowance for the care and help of another person. Source: Ministry for Work, Employment, Veteran and Social Affairs in RISP. Children in the social protection system 2021. 2022.



[121] Nigel Cantwell & Anna Holzscheiter, A Commentary on the United Nations Convention on the Rights of the Child, Article 20: Children Deprived of Their Family Environment (André Alen, et al. eds., Brill | Nijhoff 2008), para. 123.
[122] RISP, 2022, p. 15.
[123] Id. at.
[124] RISP, 2022, p. 22-23.
[125] Shihning Chou & Kevin Browne, The Relationship between Institutional Care and the International Adoption of Children in Europe, 32 ADOPTION & FOSTERING (2008).

All the aforementioned data pertains solely to registered service providers. It is possible that some children receive services and support from non-registered service providers, which is not reflected in this data. However, authorities and civil society in Serbia have not identified any residential care for CWD in the past 20 years, apart from the SOS Children's Villages Serbia's children's village near Kraljevo.

2.5. Centres for Social Work

CSWs are important stakeholders, the core of the social protection system in Serbia, argues Žegarac.[126] These locally situated bodies conduct assessment of needs, planning, monitoring and coordination of provision of social services including alternative care, make decisions on the placement of children in care including institutional care, guardianship, reunification, adoption, material support, as well as planning and development of social protection on the local level.[127] They provide some CBS, and one CWS also provides residential care for specifically children with autism in Šabac. CSW initiates and participates in court proceedings on deprivation of parental rights.[128] The CSWs act as guardianship bodies, and the competent professionals within these organisations also serve as state guardians to children without parental care and adults deprived of legal capacity.[129]

RISP and syndicates of employees of CSWs highlighted gross understaffing, a trend of reduction in the number of employed, and increasingly precarious work conditions after 2014.[130] This occurred when strict controls on hiring in the public sector were introduced, two years after a right-wing party SNS came into power and began cutting public expenditure. In 2022, the syndicate argued that the shortage of staff is approximately 1700, while the systematization of workforce prescribes over 9200 staff.[131] Most of the employees are

[126] ŽEGARAC. 2014, p. 85.
[127] Law on Social Protection, "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Articles 68, 69, 119, 120. Rulebook on organization, normatives and standards of work of centres for social work, "Official Gazette RS", Nr. 59/2008, 37/2010, 39/2011 - another rulebook, 1/2012 - another rulebook, 51/2019, 12/2020 and 83/2022. Article 4.
[128] Family law, "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 266.
[129] Id. at. Articles 125, 131.
[130] Izveštaj o radu centara za socijalni rad za 2021. godinu, (2022), RISP.
[131] U sistemu socijalne zaštite Srbije nedostaje 1.700 radnika, Sindikat razmišlja o štrajku, Danas.rs, (2022), accessed: 15th May, 2023, available at https://www.danas.rs/vesti/drustvo/u-sistemu-socijalne-zastite-srbije-nedostaje-1-700-radnika-sindikat-razmislja-o-strajku/.

employed on a limited period, while the number of professionals was 18.8% lower in 2021 than in 2014, whereas the number of users increased, reports RISP.[132] Employees of CSWs who serve as state guardians sometimes have dozens and over one hundred individuals under their guardianship. The decrease in the number of employees over the last decade, amidst the increase in the total number of users of their services, was described by two interviewees as the collapse of the system. Considering the critical function of these bodies in the social protection system, the crisis of their functioning can significantly impede the successful provision of quality services and result in less CWD and their families realising their rights including the right to live in a family environment.

3. Legal and political implementation

3.1. Legal measures

The legal internalisation of transnational norms, according to Koh, occurs through the legislative, executive, and judicial branches. In the present section, all three means of implementation (or more broadly - internalisation) are explored by collecting and analysing statutory law, by-laws, decrees, and judicial decisions.

The Republic of Serbia underwent substantive and substantial law reforms after the 2000s, for the reasons explained above. This legal reform also encompassed laws related to the protection of the human rights of children and persons with disabilities, the protection of families, social protection, and education. All those laws are related and can impact the realisation of their right to family life and the provision of alternative care.

Laws are adopted by the Parliament (National Assembly), while bylaws are adopted by other state bodies, primarily the President and the Government (exceptionally by the Parliament). Types of bylaws are decrees and decisions (adopted by the Government),[133] orders, rulebooks, and guidelines (adopted by ministries and special organisations).[134] Bylaws are inferior to laws

[132] RISP, 2022.
[133] "Official Gazette RS", Nr. 98/2006. Article 123.
[134] Law on State Administration, "Official Gazette RS", Nr. 79/2005, 101/2007, 95/2010, 99/2014, 47/2018 i 30/2018 - another law. Article 15.

and must be in conformity with the law.[135] They do not establish new rights and duties, but only elaborate laws in more detail and regulate their application.

A law can be proposed by the Government, a member of the National Assembly, the Assembly of the Autonomous Province, at least 30.000 people who are entitled to vote, and the Protector of Citizens and the National Bank in the sphere of their competences.[136] Although members of the National Assembly adopt laws, they are not the most significant agents in the process of lawmaking in Serbia, considering that laws are almost always prepared by the executive branch. One political party dominates the executive and legislative branch for over 10 years (Serbian Progressive Party SNS is a dominant, ruling party since 2012), which ensures that laws proposed by the executive are rarely, if ever, rejected.[137] Therefore, legal implementation and political implementation overlap. However, the former is almost entirely contained within the latter, and the latter can also include means other than legal to internalize IHRL norms. In the case of legal implementation through the judiciary, the political aspect is less pronounced, depending on the level of independence of the judiciary from the executive, including the independence of the Constitutional Court, which in Serbia was argued to be in a poor state by some authors and institutions, including the Venice Commission.[138] After all, Serbian citizens voted in a referendum to amend the Constitution in 2022 in an attempt to address the lack of independence.[139] Also, considering that in Serbia's legal system judicial decisions are not sources of law, the executive branch overlaps further with the judicial by the fact that laws and other general legal acts created by the executive branch are sources of law (alongside the Constitution, ratified international agreements and general rules of international law).

[135] "Official Gazette RS", Nr. 98/2006. Article 195.
[136] Id. at. Article 107.
[137] Slaviša Orlović, Nadležnosti Parlamenta, in DILEME I IZAZOVI PARLAMENTARIZMA (Vukašin Pavlović & Slaviša Orlović eds., 2007). DANILO VUKOVIĆ, KAKO NASTAJU ZAKONI U SAVREMENOJ SRBIJI: ULOGA DRUŠTVENIH INTERESA I INSTITUCIJA U ZAKONODAVNOM PROCESU (Belgrade, SECONS, Institute for Sociological Research Faculty of Philosophy in Belgrade. 2014).
[138] Danilo Vuković & Marko Mrakovčić, Legitimacy, Independence and Impartiality: How do Serbian and Croatian Legal Professionals Assess Their Judiciaries?, 74 EUROPE-ASIA STUDIES (2022). Violeta Beširević, "Governing without judges": The politics of the Constitutional Court in Serbia, 12 INTERNATIONAL JOURNAL OF CONSTITUTIONAL LAW (2014).
[139] Serbia opinion on the draft constitutional amendments on the judiciary and the draft constitutional law for the implementation of the constitutional amendments, (European Commission for Democracy through Law & (Venice Commission)), Council of Europe, 2021.

3.1.1. The Constitution

The Constitution prescribes several norms directly related to the protection of all children and one specifically to CWD, norms on non-discrimination, personal liberty and security, freedom of movement, and the protection of physical and psychological integrity.

According to the Constitution, families, mothers, single parents, and children enjoy special protection, in accordance with the law (Article 66 (1)).[140] Parents have the right and duty to take care of their children (Article 65 (1)).[141] Special protection for children with disabilities and children without parental care is prescribed in Article 66 (3).[142] This provision resembles Article 23 (3) and Article 20 (1) CRC, which prescribe special protection for children without parental care and disabled children. The norm is general and the specification of the ways of its application is needed in accordance with Article 18 (2) of the Constitution. This norm was first introduced by the Constitution in 2006, and it was not part of the Charter of Human and Minority Rights and Civil Liberties of Serbia and Montenegro from 2003,[143] the Constitution of the Federal Republic of Yugoslavia from 1992,[144] or the Constitution of the Republic of Serbia from 1990.[145] Therefore, Article 66 (3) is most likely the consequence of the intention of the drafters to incorporate the protection of children without parental care and CWD from the CRC in the highest domestic legal act.

The Constitution also prescribes protection from discrimination on any basis and especially on the basis of several personal characteristics, including physical and psychological disabilities (Article 21 (3)). The Law on the Prevention of Discrimination against Persons with Disabilities was adopted in 2006, and was the first such law on the territory of Serbia.[146] Apart from the prohibition from different forms of discrimination and in different contexts, this law also obligates local self-governments (LSG) to promote the establishment of services 'to increase levels of independency of persons with disabilities in everyday life and realisation of their rights'.[147] Moreover, the law prescribes the duty of public bodies to ensure that the education

[140] "Official Gazette RS", Nr. 98/2006.
[141] Id. at.
[142] Id. at.
[143] Charter of Human and Minority Rights and Civil Liberties, "Official Gazette S&M" Nr. 6/2003.
[144] Constitution of the Federal Republic of Yugoslavia, "Official Gazette FRY", Nr. 1/92, amendments 29/00, and Constitutional law
[145] Constitution of the Republic of Serbia, "Official Gazette RS", Nr. 1/90-1, 1990.
[146] Law on the Prevention of Discrimination Against Persons with Disabilities, "Official Gazette RS" Nr. 33/2006 and 13/2016.
[147] Id. at. Article 32.

of CWD is an 'integral part' of the general system of education.[148] This law, however, was overshadowed by the more general Law on the Prohibition of Discrimination (LPD), adopted in 2009.[149] Aside from the general prohibition of discrimination on the basis of, *inter alia*, disability, rules on forms and cases of discrimination and a procedure for the protection from discrimination, the LPD established the Commissioner for Equality (CE).[150] The CE is another independent NHRI, alongside the Protector of Citizens, who received numerous complaints for the discrimination and violations of rights of persons with disabilities. Both human rights institutions have been important actors in protecting the human rights of citizens with disabilities in Serbia through different mechanisms, which is further explored in the section National Human Rights Institutions.

3.1.2. Family Law

An especially authoritative, the umbrella law on the protection of the family and children was adopted in 2005. This law incorporated many of the CRC norms and created some that should specifically address children in institutional care.

One novel norm of Family Law prescribes that parents who intentionally and unjustifiably avoid creating conditions to live together with their child who is in a residential care institution, are 'severely neglecting their parental duties'.[151] For this reason, those parents can be fully deprived of their parental rights, and their child put under guardianship. Although the law that preceded the Family Law contained a provision on the deprivation of parents of their parental rights due to severe neglect of parental duties, it did not specifically mention the duty of parents to work on creating conditions for reintegration with a child.[152] The norm of Article 81 (3)(4) can be understood as an intention of the lawmakers to improve the protection of family life of children in residential care by creating a duty of the parents to actually work toward the reintegration of their child. On the other hand, the norm can be seen as creating the possibility for an institutionalized child to be adopted or placed in family-based alternative care, where

[148] Id. at. Article 36.
[149] Law on the Prohibition of Discrimination, "Official Gazette RS", Nr. 22/2009 and 52/2021.
[150] Id. at. Article 1.
[151] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 81 (3)(4).
[152] Law on Marriage and Family Relations, , "Official Gazette RS", Nr. 22/93, 25/93, 35/94 и 29/2001. Article 139.

the child's parents are not interested in reunification. A child cannot be adopted without the consent of his/her parents while under their parental care.[153] When a child is without parental care, he/she can be adopted without consent from the biological parents.[154]

Children with disabilities can be put in foster care even when they are under parental care, unlike other children.[155] The possibility to allow foster care placements for CWD even when they are under parental care presents an attempt to respond to the fact that some parents cannot care for their CWD amidst the lack of adequate family- and community-oriented care and services and might decide to place a child in alternative care. Although it is a norm that should protect the right to live in a family environment for CWD it also reflects the issue of inadequate support to immediate families. The Family law also prescribes that a lawsuit for the protection of the rights of the child can be submitted for any of the rights in the Family law, that are not protected by another procedure.[156]

Article 60 of Family law largely incorporated the CRC articles 7 and 9 (1) on the right of the child to be cared for by his/her parents. It reads that 'the child has the right to live with its parents and to be cared for primarily by its parents'. The most important novelty, however, was that the separation from the parents can be made only after a decision by the court. In the law that preceded the Family Law, this decision could have been made by the guardianship authority too.[157] The Family law prescribes that 'the state is obligated to ensure protection in a family environment to a child without parental care, whenever it is possible'.[158] In the law that preceded Family law, it was prescribed that for the children who are without parental care 'special protection is provided through adoption, placement in another family or in another way'.[159] The prioritization of family care in law for children without parental care, therefore, was not a novel norm in 2007 when the Family Law substituted the older law.

Deprivation of parental rights can be only done by the decision of the court in cases prescribed in Articles 81 and 82 of the Family law.[160] The deprivation can be full or partial, but the court can never deprive the parent of a duty to pay child support. Therefore, even when a parent is

[153] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 95.
[154] Id. at. Article 96.
[155] Id. at. Article 113 (2).
[156] Id. at. Article 263 (2).
[157] "Official Gazette RS", Nr. 22/93, 25/93, 35/94 и 29/2001. Section III.
[158] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 6 (6).
[159] "Official Gazette RS", Nr. 22/93, 25/93, 35/94 и 29/2001. Article 9 (2).
[160] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Articles 81(5)(4) and 82(2).

fully deprived of parental rights, the parent still must pay child support. Parental rights can be restored by the court both in cases of full or partial deprivation.[161] When parents are deprived of parental rights, their child is placed under the guardianship of a guardian who is appointed by a CSW (the guardianship authority), who, *inter alia*, decides about the placement of a child in alternative care.[162]

A specific issue is an institution of 'temporary guardianship'. A temporary guardianship is imposed by the CSW, and not a court, and does not have a time limit.[163] Therefore, a child placed under 'temporary guardianship' can be separated from his/her parents and placed in an institution without a decision of the court. This practically presents an exception to the norm that only the court can decide on separation and placement in an institution of a child and reduces judicial protection of the right to live in a family environment.

Also, the law establishes that family foster care can be provided to a child without parental care and a child with a disability even when he/she is under parental care.[164] The law also defines when a child is considered to be without parental care: when he/she has no living parents, when parents are unknown or their residence is unknown, when parents are completely deprived of parental rights and/or legal capacity, when parents have not acquired legal capacity, when parents are deprived of the rights to care for their child, when parents are not taking care of their child or they do not care adequately.[165] Considering that a child of parents who are deprived of legal capacity is considered a child without parental care, the basis on which the child can be placed in alternative care, including residential care, is in stark contrast to CRPD Article 23 (4). This article prohibits separation on the basis of disability, whether of a child or parents. People with intellectual and psychosocial disabilities are most commonly deprived of legal capacity.[166]

Another significant issue is the guardianship of children without parental care. A guardianship authority decides about placing a child under guardianship, appoints a guardian to a child, and decides about his/her accommodation.[167] The guardianship authority, a CSW,[168] is obligated to

[161] Id. at. Article 83.
[162] Id. at. Article 125.
[163] Id. at. Article 132.
[164] Id. at. Article 113 (2, 3).
[165] Id. at. Article 113 (3).
[166] KOSANA BEKER & TIJANA MILOŠEVIĆ, POSLOVNA SPOSOBNOST - SUDSKA PRAKSA I ZAKONI U SRBIJI 2016. GODINE (Belgrade, MDRI-S. 2016), p. 32.
[167] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 125.
[168] Id. at. Article 12.

'try to primarily place a child in a kinship family'.[169] A rulebook that further regulates the work of CSWs prescribes that a CSW 'will undertake reasonable efforts' to keep the child in the family, or it 'will undertake all efforts to create conditions', to reintegrate the child back to his/her family (when a child is in an institution).[170] The same document prescribes that the principle of the least restrictive environment must always be observed when a CSW is creating a plan of services for the child, and that children under the age of 7 cannot be placed in an institution for more than 3 months, unless there are medical reasons for such a placement.[171] The principle of the least restrictive environment and the conditional institutional placement of children under the age of 7 significantly incorporate CRC standards, particularly concerning the last resort approach and the undesirability of residential care for all children.[172] On the other hand, the possibility to place a child longer than for 3 months in case of health-related reasons, can be a leeway to place children with different disabilities who are under the age of 7 for over 3 months due to their medical diagnosis.

A director of a residential institution can act as a legal guardian to children placed in that institution.[173] Given that the duty of a legal guardian is to care for the wellbeing and interest of the child, the possibility for the director of a residential care institution to serve as a guardian presents a conflict of interest in the context of potential rights violations within institutions.

In sum, the Family Law has increased the protection of the right to family life for children deprived of parental care and CWD by more stringently incorporating CRC standards on the prioritization of family-based care over institutions in Article 6 (6), and by including the duty of parents to facilitate reintegration when a child is in an institution. The possibility of separation based on the disability of the parents, conflicts with the CRPD, which had not been ratified by Serbia at the time the law was adopted.

[169] Id. at. Article 125 (4).
[170] "Official Gazette RS", Nr. 59/2008, 37/2010, 39/2011 - another rulebook, 1/2012 - another rulebook, 51/2019, 12/2020 and 83/2022. Article 70 (3).
[171] Id. at. Article 70 (5).
[172] See Part I, 1.1.1.4 Marginal role and undesirableness of institutions.
[173] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 130.

3.1.3. Law on Social Protection

The Law on Social Protection (LSP) was adopted in 2011, which terminated an older law on social protection.[174] This law serves as the umbrella legislation for the social protection system. LSP also reflected tendencies spurred by the ratification of the CRPD and the adoption of the UN Guidelines at the UNGA. One of the basic principles of this law is the provision of services in the natural and the least restrictive environment, ensuring that services are chosen in such a way as to enable the client to remain in the community.[175] Another principle is the 'best interest' principle for all users of social protection services, which lacks any elaboration on the meaning of the principle.[176]

One norm established the maximum capacity of institutions for the residential care of children to 50.[177] The institutions were given six months to conform with this and other novel standards.[178] Although this norm was far from the CRPD's commitment to family-based alternative care for CWD, it reflected the intention to reduce the number of children in institutions and at the same time to start conforming with the UN Guidelines to a higher degree concerning the forms of residential care provided to children. An older bylaw prescribed that the 'optimal capacity' of new residential institutions for children should be 80, while those facilities that were already existing at that time were exempted.[179] Notwithstanding, children are still placed in institutions that have well over 50 residents, as shown in the section on data on children in institutional care, showcasing that the norm has never been enforced.[180]

Also, in line with the UN Guidelines, one norm stipulates that, as a general rule, children under three years of age should not be placed in institutions, except in exceptional cases where they could be placed for up to two months.[181] However, the minister for social affairs can give permission for the placement even longer than two months. This exception has seemingly allowed that even 13 years after the adoption of the law some children under three are still

[174] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 229.
[175] Id. at. Article 27.
[176] Id. at. Article 26.
[177] Id. at. Article 54 (2).
[178] Id. at. Article 223 (1).
[179] Rulebook on closer conditions for the establishment and norms and standards for the functioning of social protection institutions for accommodation of childrren and youth without parental care and children and youth with behavioural disorders, "Official Gazette RS", 88/93, 121/03 i 8/2006, 63/06. Article 26.
[180] See note 80.
[181] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 53 (2)-3.

placed in residential care.[182] When a child is placed in an institution it is provided accommodation, 'satisfaction of basic needs', health care and education.[183]

The LSP stipulates that residential care is provided to a 'client who cannot, or for whom it is not in the best interest, to stay in the family or to receive services in the community or through family-based alternative care'. This norm relates to all people, including CWD. The norm does not follow the last resort principle of the CRC and the UN Guidelines. The wording indicates that residential forms of care could be resorted to for an unlimited number of reasons, including the lack of such services and alternatives. It also does not prescribe prior exhaustion of other options or at least the due consideration of other, less restrictive options that are more conducive to the well-being of a child (and adults). The requirement for residential placement is not restrictive enough in order to serve as a gatekeeping norm, or in other words to narrow down the possibility for residential placements. Indirectly, such a norm is not conducive to the further development of alternative care options and support and services that could enable CWD to live in a family environment.

LSP defines several CBS that are supposed to be the backbone of the realisation of the right to live in a family environment and the DI. Those services are divided into several groups in accordance with Article 40 LSP. Apart from residential care, the law prescribes services which should enable a person, including CWD, to not be institutionalized. 'Daily community services' (dnevne usluge u zajednici) are supposed to enable clients to remain in their family and community environments. They are provided by the LSG (not from the national level).[184] Services to support independent living are available for CWD aged 15 and older as alternatives to residential care, facilitating independent and community living.[185] Advisory-therapeutic and social-educational services are intensive support to families in crisis; counselling and support to parents, foster parents, and adoptive parents; support for families with CWD and other services.[186] Intersectoral services are provided when a client is in need of services provided by different sectors such as social care, education and/or health care.[187] LSGs are obligated to fund

[182] See note 71; Deca mlađa od 3 godine još uvek se smeštaju u ustanove u Srbiji, UNICEF Serbia, (2022), accessed, available at https://www.unicef.org/serbia/medija-centar/vesti/deca-mladja-od-3-godina-jos-uvek-se-smestaju-u-ustanove-u-srbiji.
[183] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 51.
[184] Id. at. Article 40 (2).
[185] Id. at. Article 45 (1).
[186] Id. at. Article 40 (4).
[187] Id. at.

those services, according to the LSP.[188] LSGs can receive earmarked transfers from the budget of the Republic to finance CBS.[189] Only the most undeveloped LSGs do not need to participate in funding. Other LSGs, eligible for earmarked transfers but not classified as undeveloped, must contribute by covering part of the costs, in accordance with the Decree on earmarked transfers in social protection.[190] Additionally, services that are of 'special importance' for the Republic of Serbia can be funded in this way regardless of the level of development of an LSG, which includes services for the 'preservation of family and prevention of separation of children'.[191]

All the above-mentioned are CBS, referred to in multiple CRPD provisions, most notably in Article 19 (b) CRPD, but also the CRC and the UN Guidelines.[192] Coming two years after the ratification of the CRPD, LSP reflected a powerful pull for the incorporation of CRPD norms. In general, it can be said that services in Article 40 (1-4) are compliant with the CRPD Article 19 and in general with the goal of ensuring the provision of services in the family and community and avoiding institutionalisation. The law on social protection that was substituted and terminated by the LSP, did not contain the term 'community-based service' and the only service of such type available for CWD were specialised day centres.[193]

However, apart from the placement in kinship and foster care, LSP lists several forms of residential care: institutional care, shelters and 'other forms of accommodation'.[194] The law also opened a possibility for the development of a novel form of care called 'social-health care institutions', which have not been developed in Serbia, despite it being defined in the law.[195]

The law allows (licensed) private entities to provide social care services, including residential care, but excluding family-based care.[196] However, no private residential care service providers, apart from SOS Children's Villages Serbia model of family-like care (which has been in the meantime transformed too), have provided such a form of care. This organisation

[188] Id. at. Article 209.
[189] Id. at. Article 207.
[190] Decree on earmarked transfers in social protection, "Official Gazette RS" Nr. 18/2016 and 38/2021. Article 5.
[191] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 207 (1)(3). and "Official Gazette RS" Nr. 18/2016 and 38/2021. Article 2 (3).
[192] Guidelines for the Alternative Care of Children, A/RES/64/142*, 2009, para. 34 (a, b).
[193] Law on Social Protection and Ensuring Social Security of Citizens, "Official Gazette RS", Nr. 36/91, 79/91, 33/93, 53/93, 67/93, 46/94, 48/94, 52/96, 29/2001, 84/2004, 101/2005 - another law, and 115/2005. Article 33.
[194] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 40 (5).
[195] Id. at. Article 60.
[196] Id. at. Articles 51 (1), 64, 115.

had not provided the family-like type of care to CWD. Family-based alternative care (kinship care and different forms of foster care) can be organised and monitored only by the state agencies, as mandated by law.[197] Direct providers of such care are always natural persons, and there is no private intermediary between the state agency for family-based care and the direct providers of such care.

Foster care is provided on a temporary basis.[198] There are five types of foster care: standard; foster care with intensive or additional support; urgent; intermittent and 'other forms of care in other families'.[199] The family-based alternative care is firstly provided by cousins (kinship care), when that is in the best interest of the child, and then other individuals who are assessed as appropriate and who have successfully attended training and acquired license.[200] As already explained in the section on the Family Law, foster care can be provided to CWD even when they are under parental care. Intermittent foster care is available only to CWD in biological, kinship, foster or adoptive families, and is supposed to allow parents of CWD to take rest from caring for their child, to preserve the proper functioning and capacities of the families.[201] Ultimately, intermittent foster care, as a form of respite care, can significantly help prevent the institutionalisation of CWD. A decree prescribed the formation of eight regional Centres for family-based care and adoption, across the territory of Serbia, to recruit, train and monitor foster families and provide support to those families.[202]

LSP also prescribes types of financial support. Financially deprived individuals and families are entitled to 'cash social assistance'.[203] However, the most important type of financial support for CWD and families is the 'allowance for the care and assistance of another person' (allowance).[204][205] The allowance is awarded to people (children and adults) who due to disability or health status need the assistance of another person to fulfil basic needs.[206] The allowance can be standard or increased. Persons who have permanent neurological or psychological impairments and those whose impairment is assessed at 100% are entitled to the

[197] Id. at. Article 64 (2),3
[198] Rulebook on foster care, "Official Gazette RS", Nr. 36/2008. Article 2 (1).
[199] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 49.
[200] Id. at. Article 50 (1)-2.
[201]. Article 3 (4).
[202] "Official Gazette RS", Nr. 16/2012 and 12/2013. Article 4.
[203] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 81.
[204] Id. at. Article 92.
[205] See Chart III.4 Children users of basic and increased allowance for the care and help of another person. Source: Ministry for Work, Employment, Veteran and Social Affairs in RISP. Children in the social protection system 2021. 2022.
[206] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court.

increased allowance.[207] A person is entitled to allowance regardless of their or their family's financial status, employment, number of family members etc.

An analysis of the incorporation of the CRC and the CRPD in legislation on social protection would not be complete without looking into rulebooks and decrees that further elaborate LSP and regulate the ways of enforcement. Firstly, the Decree on the network of institutions for social protection defined, apart from institutions for residential care, foresaw eight regional Centres for family-based care and adoption (CFCA).[208] Five CFCAs had already been established and the other three were planned.

The rulebook that further regulates standards and conditions for the provision of social care services is a particularly relevant addition to the LSP.[209] Adopted in 2013, it replaced an older rulebook.[210] Unlike the LSP, this rulebook specifies that the placement of a child (and youth aged 18-26 years) in residential care is always temporary, aimed at preparing the child for reintegration into their biological family, placement in foster care, or for independent living and community integration in the shortest possible time.[211] This represented a significant departure from a previous umbrella law on social protection, which had prescribed that residential care be provided to CWD on a permanent basis.[212] Also, the placement in shelters is limited to six months by the rulebook.[213]

Other than that, the rulebook only implies that placement in residential care for children is a last resort measure but does not say this directly. The requirement to provide residential care to a child is that a child's needs '… cannot be met in biological, kinship or foster care, or through the provision of CBS on the decision of the guardianship body, the court, referral of a centre for social work…'. Those provisions have furthered the incorporation, first and foremost of the CRC and the UN Guidelines in Serbia's legislation. The temporary character of residential care with the aim to reintegrate children as soon as possible is in line with UN Guidelines recommendation that the aim of residential care should be 'generally to provide temporary care'. The wording from the UN Guidelines indicates that such care could be also

[207] Id. at. Article 94 (1).
[208] See note 80.
[209] Rulebook on closer standards and conditions for the provision of social protection services "Official Gazette RS" Nr. 42/2013, 89/2018 and 73/2019. Article 22.
[210] Id. at. Article 107.
[211] Id. at. Articles 22 (1)-2, 43 (1)-2.
[212] "Official Gazette RS", Nr. 36/91, 79/91, 33/93, 53/93, 67/93, 46/94, 48/94, 52/96, 29/2001, 84/2004, 101/2005 - another law, and 115/2005. Article 84 (1)(4).
[213] "Official Gazette RS" Nr. 42/2013, 89/2018 and 73/2019. Article 25.

provided on a long-term basis, while the rulebook does not leave such a possibility, which reflects a more stringent protection of family life. The data on the length of placements, on the other hand, reveals the often long-term nature of residential care, highlighting a significant gap in enforcement.[214]

The rulebook also defines that SSRC is provided to CWD, with all levels of needed support (I-IV).[215] Each SSRC can accommodate up to 12 children, must be housed in a separate building, yet several SSRCs can be spatially, organizationally, and functionally linked.[216] Accommodation in shelters is limited to 6 months and in general it is not intended for CWD, but children in different risk situations.[217] Another service, respite care, which accommodates up to 50 clients in one building at once,[218] is particularly controversial within the disability community. This form of care should enable parents to take the time off from often exhausting juggling between work, different everyday tasks and caring for a disabled child, by placing a child in a form of short-term residential care, for a limited number of days and limited number of times throughout the year. It is only allowed for CWD over 5 years of age, for 45 days a year, and for a maximum of 20 days at once.[219] Although controversial in the community of disability scholars, this service can also prevent institutionalisation of CWD that is caused by the inability, stress and fatigue that parents might experience when they care for a child with a disability and was also recommended in the UN Guidelines.[220]

The rulebook also further regulates standards of CBS and support, such as day centres, 'personal companion' of a disabled child, supported independent living, and others. Supported living can be used by disabled children over 15 years of age (and adults), with an aim to facilitate their independence, life in the community, increase their quality of life, and serve as an alternative to residential care.[221] The norm on the provision of supported independent living arrangements to children 15 years old and older matches the position exhibited in UNICEF ECARO's White Paper, CRPD Committee's work and of both interpretive communities.[222]

[214] RISP, 2022, p. 22.
[215] "Official Gazette RS" Nr. 42/2013, 89/2018 and 73/2019. Article 24.
[216] Id. at. Articles 54 (1), 49.
[217] Id. at. Article 25.
[218] Id. at. Article 63.
[219] Id. at. Article 27.
[220] A/RES/64/142*, para. 38.
[221] "Official Gazette RS" Nr. 42/2013, 89/2018 and 73/2019. Article 89 (1).
[222] Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care (Group of organisations 2019). UN Disability and Child Rights Groups On Behalf of

A separate rulebook that regulates standards on foster care was adopted in 2008, replacing an older rulebook from 2005. As already stated, CWD can be provided with 'specialized foster care' even when they do have parental care, unlike other children.[223] The quality standards are not specifically addressed here, however some of those can have a direct impact on the number of children in foster care, such as the limitation to 2 disabled children per family or 3 non-disabled children (unless they have siblings).[224] Higher numbers of foster children in a family could contribute to increasing the total number of children in foster care. However, this risks depriving foster children of adequate attention and care, along with other children with similar characteristics, ultimately resulting in a family-like form of care, which could also be considered institutional care, as explained. Importantly the rulebook prescribes the popularization of foster care through media and other forms of awareness-raising campaigns, again in line with UN Guidelines.[225] One interviewee, a decision-maker at a state authority for social care, claimed that the UN Guidelines had an immense impact on law and policy from 2009 onwards, because this document was practically understood as legally-binding, despite its non-binding character.[226]

3.1.4. Other laws

In 2009, the Parliament adopted three particularly significant laws for the implementation of the CRC and CRPD, including the Law on the Ratification of the Convention on the Rights of Persons with Disabilities.[227] Apart from LPD, the Parliament also adopted the Law on Fundamentals of Systems of Education. The latter, which introduced the obligation to provide preschool (one-year-long) and primary education (8 years long) for all children, including CWD, also set forth principles and measures for inclusive education. The right to additional support in learning and schooling, and the right to education in a special group or school, was

Children without Parental Care: Key Recommendations (2019); Stela Grigoras, White paper. The role of small-scale residential care for children in the transition from institutional to community-based care and in the continuum of care in the Europe and Central Asia Region (UNICEF Europe and Central Asia Regional Office 2020), p. 31.
[223]. Article 3 (2).
[224] Id. at. Article 6 (4).
[225] Id. at. Article 20.
[226] Interview with T. N. 3rd April 2023.
[227] Law on the Confirmation of the Convention on the Rights of Persons with Disabilities, "Official Gazette RS - International Contracts", Nr. 42/2009.

guaranteed to children and adults with disabilities.[228] Measures for inclusive education of CWD, such as individual educational plans, accommodation of the educational programs, removal of physical and communicational barriers etc.[229] Furthermore, the right to education for CWD in residential social care institutions was granted.[230] This norm was supposed to address the notoriously low rate of enrolment of CWD in residential care in the schooling system, which persisted for years even after the adoption of the law.[231]

As part of these educational reforms, pedagogical assistants were introduced to help children requiring additional support in schools, including CWD.[232] Another important addition was the establishment of the 'personal companion' service, which is aimed at facilitating access to education, and assisting CWD in everyday activities, through direct personalized assistance of another person.[233] This law was perceived as a direct consequence of Serbia's ratification of the CRPD in 2009. It is one of the first measures of incorporation of the CRPD in the domestic system, and the further incorporation of the CRC.[234] Although it did not address the institutionalisation directly, the law on education introduced important measures that can facilitate the realisation of the right to family and life in a family environment, especially through the commitment and measures for inclusive education, services and support to CWD to attend inclusive education and special education, including 'the personal companion' service which provides broader assistance and can facilitate everyday conduct for CWD and their parents. This means that parents will have more time to rest and work, thus decreasing the likelihood of placing their child in an institution due to a lack of resources. Also, CWD who receive education in residential care, might be better prepared to transfer from institutional to family-based living or independent, supported living, however there are no studies in Serbia to support this assumption.

A new Law on Financial Assistance to Families with Children was adopted in 2017, replacing an older law of the same name. This new law introduced a provision that discriminated against families with CWD, by restricting their access to financial assistance depending on whether

[228] Law on the Fundamentals of the System of Education, "Official Gazette RS" Nr. 88/2017, 27/2018 - another law, 10/2019, 27/2018 - another law 6/2020 and 129/2021. Article 3 (3)
[229] Id. at. Article 97.
[230] Id. at. Article 7 (2) (4).
[231] JANJIĆ. BILJANA & KOSANA BEKER, EXCLUSION AND SEGREGATION OF CHILDREN WITH DISABILITIES IN RESIDENTIAL INSTITUTIONS IN THE EDUCATION SYSTEM (Belgrade, MDRI-S. 2016).
[232] "Official Gazette RS" Nr. 88/2017, 27/2018 - another law, 10/2019, 27/2018 - another law 6/2020 and 129/2021.
[233] Id. at. Article 136 (6).
[234] See note 12.

the child receives the 'allowance for care and help of another person' under the LSP. The authorities had argued (in the elaboration of the law) that budget expenditures should be decreased, and that alleged misuse of the right to special assistance by parents whose children were not disabled or severely ill, should be addressed as in Article 12 (7).[235] The Constitutional Court, however, found the provision unconstitutional and the discriminatory norm was deleted from the law. Thus, the law now ensures that parents of CWD and children with chronic illnesses are entitled to compensation for leave taken to care for their child, independent of receiving the 'allowance for care and help of another person' from the LSP.

In 2021, the Law on the Rights of Users of Temporary Accommodation in Social Protection was adopted,[236] after several years of drafting.[237] The adoption of the law was foreseen in the APC23 and was part of the EU's common negotiating position for Chapter 23.[238] The law regulates the rights of children and adults in institutional social care and their duties, the use of restrictive measures in residential institutions, prohibited treatments, and some aspects of functioning of those institutions. The reason to adopt the law was the previous inexistence of a legal basis for restrictive measures that were regularly imposed on users of those institutions. For this reason, following reports of extensive use of restrictive measures in social care institutions, the European Commission urged Serbian authorities to adopt such a law.[239]

Article 1 of the law establishes that it regulates the rights of users of '(…) temporary accommodation in institutions for social protection that are in the process of deinstitutionalisation…'. This sentence alone does not help to understand exactly which institutions are in the process of DI, and further elaboration is needed either through another lower legal act or a strategic planning document. The law also encompasses shelters and institutions for respite care.[240]

For the first time, this law provides a definition of DI within Serbia's legal framework:

[235] Initiative for the review of constitutionality and legality (Network of Organizations for the Children of Serbia MODS and National Organization for Rare Diseases Serbia), p. 8.
[236] Law on the Rights of Users of Temporary Accommodation in Social Protection, "Official Gazette RS" Nr. 126/2021.
[237] The author participated in one of the workgroups of the Ministry for social affairs to draft this law, as a representative of an NGO.
[238] See note 422.
[239] Serbia 2016 Report, COM(2016) 715 final, European Commission.p. 61 ; Serbia 2018 Report, COM(2018) 450 final, European Commission, p. 27.
[240] "Official Gazette RS" Nr. 126/2021. Article 4(1).

'Deinstitutionalisation is a process aimed at the prevention of placement in institutions of social protection and the preparation of users of temporary accommodation to return to the natural environment, which is achieved through the development of services in the community, their sustainable financing, respect for the right of users, their personal choice and participation in decision-making.'[241]

Such a definition is remarkably well-reflecting of the CRPD and the CRPD Committee's recommendations in General Comment 5 and their COs. The definition, most importantly, includes the development and sustainability of services needed to facilitate life in the community and family, and independent living, including the respect for the personal autonomy of persons with disabilities, in line with Article 19 CRPD, and the CRPD Committee's call to states to treat DI in a more comprehensive manner than through mere closure of institutions.[242] However, this definition does not explicitly state that an aim of DI is the closure or even the scaling down of institutions. It is aimed at the preparation of users of residential care, rather than being aimed at 'ending all forms of institutionalisation',[243] which falls short of the recommendations by the CRPD Committee. On the other hand, the law sets that the purpose of residential care is the reintegration of a person into his/her family, in the community.[244]

The law prescribes that accommodation to children is only provided as an exception, and it is based on principles of 'best interest and the full development of the child in a family environment'.[245] The accommodation of a child ends as soon as conditions for alternative, 'non-institutional' accommodation are met.[246] Additionally, an 'individual plan for the user' must outline how the service will conclude and facilitate the user's reintegration into the community.[247] The law prescribes that the placement of a child in residential care can last up to six months but may be extended if a 'detailed explanation' is provided. Following this, it can be extended for additional six-month periods, with no limit on the number of extensions.[248] This is another norm that reflects an implicit policy character, with an aim to discourage

[241] Id. at. Article 4(7).
[242] General comment no. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, Committee on the Rights of Persons with Disabilities, 2017. para 33.
[243] Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 11.
[244] "Official Gazette RS" Nr. 126/2021. Article 11 (1).
[245] Id. at. Article 10 (2, 3).
[246] Id. at. Article 10 (4).
[247] Id. at. Article 10 (7).
[248] Id. at. Article 13 (1, 2).

placements longer than 6 months, but not to prohibit them. It also reflects more recent developments of international standards and discussion on the international level that tend to limit placements of children to the shortest possible time, unlike the UN Guidelines which left the space for long-term placements too.[249] UNICEF ECARO recommended that any placement of a child should be as short as possible and never exceed 6-12 months, though only in high-quality SSRCs.[250] This recommendation received support from various child-rights NGOs.[251]

Another innovative feature is that the law explicitly permits civil society organisations (CSOs), in cooperation with the ministry, to conduct independent monitoring visits to residential institutions.[252] This provision surpasses even the CRPD and UN Guidelines, which mandate monitoring by 'independent authorities'[253] and a 'public authority'[254] but not CSOs.[255] This provision results from the significant influence of NGOs that have participated in such monitoring visits, and also contributed to the drafting of this law. The involvement and history of monitoring visits by NGOs, primarily MDRI-S and Human Rights Watch, demonstrate the relatively open and transparent operation of the residential care system for children in Serbia.

A new Law on the Protector of Citizens, adopted in 2021, prescribed that PC is an institution mandated with the monitoring of the implementation of the CRPD.[256] This way, the state fulfilled the recommendation of the CRPD Committee and furthered the incorporation of the CRPD in the domestic legislation.[257]

3.1.5. Enforcement gap

Although the analysis of statutory law indicates a significant level of legal incorporation of some CRC and CRPD norms, these are particularly relevant for realising the right of CWD to live in a family environment. However, data from state agencies and NGOs largely reveal a substantial enforcement gap. An enforcement gap is identified by comparing the norm, its

[249] See Part I, Chapter 3.2.1 The position of residential care.
[250] Grigoras. 2020, p. 34.
[251] "Official Gazette RS" Nr. 126/2021. Article 17 (1).
[252] Id. at. Article 38 (5).
[253] Convention on the Rights of Persons with Disabilities, UNTS, 2515, p. 3, A/RES/61/106, 2006. Article 16 (3).
[254] A/RES/64/142*, para. 128.
[255] Id. at, para. 55, 130.
[256] Law on the Protector of Citizens, "Official Gazette RS", Nr. 105/21. Article 2 (2).
[257] CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 67-68.

objective and purpose with the factual situation that the norm is supposed to address. The quantitative data published by RISP provide a good overview of the number of children in residential care and foster care disaggregated by age, the number of children using different CBS and financial support and their distribution and costs. Some reports by different NGOs, such as the NOOIS, MDRI-S and Centre for Social Policy provide similar data with negligible differences. MDRI-S and DRI have published three reports on the situation of CWD in residential care in Serbia, while HRW published one such report in 2017. The primary sources and information obtained through interviews with professionals in the social care system in Serbia and NGOs, together with different secondary sources such as state reports and NGO reports enable the triangulation of sources, which increases the reliability of this analysis and its results.[258]

First and foremost, since Serbian law does not prohibit institutionalisation, the mere fact that CWD are institutionalised does not, in itself, indicate an enforcement gap. However, the law limited the number of children per institution to 50 already in 2011, and gave institutions 6 months to conform to the standards from the day of its entry into force.[259] Despite this regulation, several institutions still house significantly more children than allowed, a situation that has been criticised by the CRC Committee.[260] The same law prescribed that children under the age of 3 are not placed in residential care, but a report by MDRI-S shows that 29 youngest children were institutionalized in 2021, of which 21 were disabled.[261] Considering that the law allows institutional placement even for the youngest children in exceptional cases, it cannot be claimed without any doubt that such a norm is unenforced on the basis of the number of the youngest children in institutions. However, the CRPD Committee interpreted the law as a prohibition against placing the youngest children in institutions, expressing concern that 'despite the legal prohibition on placing infants under the age of three in institutions, infants with disabilities continue to be placed in institutions directly from maternity wards'.[262] To establish a more reliable conclusion it would be useful to analyse the content of decisions to

[258] ROBERT K. YIN, CASE STUDY RESEARCH AND APPLICATIONS: DESIGN AND METHODS (SAGE Sixth edition. ed. 2018).
[259] See note 177.
[260] CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017, para. 39(b).
[261] LAZAREVIĆ, et al. 2022, p. 37.
[262] CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 13.

place the youngest children in residential care and to compare recent quantitative data with data from before the law was adopted. However, such data was unavailable to this study.[263]

Two norms prescribing that residential care should be temporary and for the shortest possible duration remain unenforced.[264] The data by RISP suggests that most of CWD stay in residential care for a very long time, and that a very small number of CWD is reunited with families or placed in another family-based care after their stay in an institution.[265] The Committee on the Prevention of Torture of the CoE and NGOs have also reported about this.[266] The same was confirmed in interviews by all interviewees, who were exceptionally well positioned to provide information on this issue. Several interviewees argued that the reason for this is that prevention of separation is poor, that the families are not supported enough to reunite with children, and the principle to separate children only as a last resort amidst the lack of interventions to prevent separation. According to interviewees and quantitative data from RISP, foster care for CWD is not as developed as for non-disabled children, leading to the long-term institutionalisation of CWD. The CRC Committee also noted the lack of measures aimed at preventing the institutionalisation of CWD.[267] Similarly, NGOs observed that in one shelter, 43% of children stayed longer than the legally prescribed six months, indicating a significant underenforcement of this norm.[268]

For nearly two decades, the number of foster care families and children in foster care in Serbia increased sharply, although there was a slight decrease from 2018 to 2021.[269] There is no doubt that such a form of care is well developed in Serbia, and that norms prescribing it are enforced in general. However, the so-called 'specialized foster care' for CWD is grossly underdeveloped, with only 6.93% of children in foster care being disabled.[270]

[263] The data was unavailable even after the submission of a request to access information of public interest to the competent authority, in accordance with the Law.
[264] See note 209, "Official Gazette RS" Nr. 126/2021. Article 1.
[265] See note 97.
[266] Europe, 2016, para. 178. It is My Dream to Leave This Place: Children with Disabilities in Serbian institutions. 2016, p. 26.
[267] CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017, para. 43(b).
[268] See note 213; ERIC ROSENTHAL, et al., SERBIA'S FORGOTTEN CHILDREN (Disability Rights International and Mental Disability Rights Initiative Serbia. 2021), p. 27.
[269] See Chart III.1 Children without parental care in family-based care and residential care between 2012 and 2022.
[270] See note 115.

Moreover, foster care is, by the rule, a temporary form of care, while in reality, it is long-term care.[271] This claim is supported by quantitative data from RISP and interviews. The reasons for long-term placements in foster care are similar to the reasons for long term placement in institutional care, according to interviewees – there is not enough support towards reunification, and children are separated from their biological families when the damage has already been significant, again due to the lack of support to families in risk. One specific type of foster care designated only for CWD – intermittent foster care, is not shown in the recent reports by RISP nor in the DIS, hence it is presumed that it is inexistent. This significant form of CBS could help to prevent institutionalisation and aligns with the CRPD Committee's position on CBS, unlike the respite care provided in institutional settings.[272]

Regional CFCAs are not established on the entire territory of Serbia and do not work at their full capacities, which according to interviewees who are foster care specialists, negatively impacts the quality of such care. By 2021, only seven such centres were established, despite a decree mandating eight across the country, indicating partial compliance.[273] Therefore, the relevant norm has not been fully enforced. Several interviewees thought that the strict control of employment and hiring freezes in the public sector, which was introduced in 2013 and ended in 2021,[274] slowed down the development and limited the coverage of the existent CFCAs, consequently impacting the quality of foster care. The same opinion was expressed by the Commissioner for Equality in her submission to the MOLSA in relation to the Draft Deinstitutionalisation Strategy and Grujić, who also warned of a possible collapse of the family-based care system in Serbia.[275] The decrease of the entire public sector as well as wages and pensions were one of the policies introduced and implemented with the help of the World Bank and the International Monetary Fund.[276]

[271] See note 198.
[272] CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 26.
[273] See note 190.
[274] Budget System Law, Official Gazette RS, Nr. 54/2009, 73/2010, 101/2010, 101/2011 , 93/2012, 62/2013 , 63/2013, 108/2013, 142/2014, 68/2015 - another law, 103/2015 , 99/2016 , 113/2017, 95/2018, 31/2019, 72/2019, 149/2020, 118/2021, 118/2021 - another law and 138/2022, CC decision - 33/2019, CC decision - 48/2019.
[275] Mišljenje na predlog Strategije deinstitucionalizacije, 021-01-323/2021-02 Commissioner for the Protection of Equality, 2021. GRUJIĆ. 2017, p. 23.
[276] Country partnership strategy for the Republic of Serbia for the period FY08-FY11, Report No. 41310- YF, World Bank, 2007, para. 3. Country Partnership Strategy for the Republic of Serbia for the Period FY12–FY15, Report No. 65379-YF, World Bank, 2011.

The provision and availability of CBS, as prescribed by the LSP, vary significantly across the country, with substantial disparities between urban and rural areas.[277] In general, children and adults in urban areas and large urban centres have a higher availability of those services than children and adults in small towns and rural areas, according to a report of the Government's Poverty Reduction Unit.[278] Also, some services are underdeveloped while others are going through a large expansion. For example, a service 'Family associate', which was praised for its success in preventing the separation of children in families at risk and supported by UNICEF, ceased to exist after several years of the provision in main cities in Serbia due to the lack of sustainable funding and the fact that the service was not standardized, hence other providers could not obtain a license for the provision of this service, according to interviewees and the DIS.[279] Conversely, the number of users of the service 'personal companion of the child' has increased almost five-fold in a five years period.[280] Several interviewees pointed out that the sharp increase in the number of CWD who use the named service has happened on the expense of other services, which seems to be supported by quantitative data too, considering that other CBS are not nearly as developed as the 'personal companion of the child'. The trouble with this, according to interviewees, is that the 'personal companion of the child' is not a comprehensive service and cannot help solving many other issues that should be addressed with other services. Considering the large differences in the availability of CBS, and that even the most prevalent service for CWD is available only in 59% of the municipalities in 2021 it can be argued that the right to benefit from those services is unavailable to many if not the majority of CWD, which was also condemned by the CRC Committee.[281] Therefore, norms that prescribe the provision of these services are only enforced to a certain extent and in some parts of the country.

Some of the reasons for the uneven distribution, the lack of pluralism of service providers and the overall underdevelopment of CBS can be found in the way those services are funded, according to interviewees and SIPRU.[282] According to the law, Local Self-Governments (LSGs) are responsible for financing these services, supported by funds from the Budget of the

[277] RISP, 2022. GORDANA MATKOVIĆ & MILICA STRANJAKOVIĆ, MAPIRANJE USLUGA SOCIJALNE ZAŠTITE I MATERIJALNE PODRŠKE U NADLEŽNOSTI JEDINICA LOKALNIH SAMOUPRAVA U REPUBLICI SRBIJI (Biljana Mladenović ed., Belgrade, Tim za socijalno uključivanje i smanjenje siromaštva Vlade Republike Srbije. 2020).
[278] MATKOVIĆ & STRANJAKOVIĆ. 2020.
[279] Id. at, p. 22. "Official Gazette RS", Nr. 12/2022, p. 15.
[280] See note 53.
[281] CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017, para. 43(c).
[282] MATKOVIĆ & STRANJAKOVIĆ. 2020, p. 30

Republic of Serbia.[283] Several interviewees thought that some LSGs may not be interested in increasing their expenditures by funding those services, considering that most of them need to at least participate with a portion of costs. A SIPRU study shows extremely low expenditures by LSGs for CBS, with an average amount of 454 dinars per citizen, per year in 2018.[284] According to the DIS, the significant transfers from the budget of the Republic to LSGs had not contributed to the further development of CBS, indicating a serious issue with the use of earmarked transfers including the absence of proper monitoring, which was also reported by the EC and anticipated by the World Bank.[285] Another part of the problem in 2021 according to RISP (and the interviewees too) is the lack of private service providers.[286] The CRPD Committee criticised an 'overly complicated licensing process' for services providers.[287]

The new law designated the PC as the monitoring body for the CRPD's implementation in Serbia. However, this function had not been realized even two years after the law's adoption.[288] The law regulating the rights of users of accommodation in residential care has not been fully implemented, according to the PC, either.[289]

3.2. Judicial measures

This section contains an analysis of judicial decisions concerning the right to family life of CWD. The goal of the analysis is to find out whether and how courts and strategic litigation impacted the realisation of the right to live in a family environment for CWD and the implementation of the relevant international norms. Especially relevant are cases concerning: the provision of residential care and other forms of alternative care; community-based and family services and support; and financial support to CWD and their families.

A systematic review of courts' databases is conducted by reviewing databases containing decisions of the Constitutional Court, the Supreme Court, and appellate courts. The primary reason for focusing on the decisions of the highest courts, particularly the Supreme Court, is their ability to influence law and practice through highly authoritative decisions, even though

[283] See note 189.
[284] MATKOVIĆ & STRANJAKOVIĆ. 2020, p. 30.
[285] "Official Gazette RS", Nr. 12/2022; COM(2018) 450 final, European Commission, p. 41.
[286] RISP, 2022.
[287] CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 39.
[288] See note 256.
[289] Mišljenje Zaštitnika građana, 353-4/23, Protector of Citizens, 2023.

court decisions are not a source of law in Serbia.[290] Additionally, Serbian courts harmonize their practices by publishing decisions from the Supreme Court and appellate courts and through exchanging these decisions in joint sessions.[291] In this way, through efforts to harmonise judicial practice, decisions from these courts may have an impact broader than just for a specific case by indicating what the future practice of the courts in similar cases might be.

The decisions of the Constitutional Court, an independent body not part of the judicial system, regarding the review of constitutionality and legality of norms, can be sources of law. This makes the practice of this court especially relevant. When the Constitutional Court finds a norm unconstitutional the norm terminates, after the publication of the decision in the official gazette.[292] Appellate courts are the second-instance courts that deal with appeals on decisions of higher and basic courts.[293] Higher courts are first instance courts, among other issues, for the protection from discrimination and protection of private life, and second instance for some decisions of basic courts in civil law cases.[294] Basic courts' decisions are not included in the analysis because they are first instance courts and the lowest in the hierarchy of courts. If the practice of courts higher than basic courts (i.e. the courts that review decisions of basic courts and whose decisions are more authoritative than basic courts' decisions) does not indicate that the judicial system is a significant implementation agent, an analysis of decisions of basic courts would highly unlikely overturn such a conclusion.

Identified decisions are assessed for their potential to have a wider impact on the basis of the type of court (it is expected that a decision of the Supreme Court has more impact than that of an appellate court), the type of the decision (the legal outcome), the type of action or act (e.g. a general legal act or action of an individual) that was addressed by the decision, of the characteristics of plaintiffs (e.g. NGOs, advocates, human rights lawyers, individuals), and on the basis of real-life consequences, where known. Nolan, Skelton and Ozah add other

[290] DRAGOMIR MILOJEVIĆ, et al., HARMONIZATION OF COURTS' PRACTICE: CHALLENGES AND POSSIBLE SOLUTIONS (OSCE Mission to Serbia. 2015), p. 15.
[291] In general: id. at.
[292] "Official Gazette RS", Nr. 98/2006, 115/2021. Article 168 (3).
[293] Law on the Organisation of Courts, "Official Gazette RS" Nr. 116/2008, 104/2009, 101/2010, 31/2011 - another law, 78/2011 - another law, 101/2011, 101/2013, 106/2015, 40/2015 - another law, 13/2016, 108/2016, 113/2017, 65/2018 - odluka US, 87/2018 and 88/2018 - CC decision. Article 24.
[294] Id. at. Article 23 (1)(7), (2)(3).

identifiers of 'child rights strategic litigation' too: the process that led up to the case, how child rights shaped the application and the remedy granted.[295]

Databases of the Constitutional Court, Supreme Court and appellate courts are searched for the following keywords: disability, developmental issues (a term commonly used in legislation 'smetnje u razvoju'), Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, residential care, children's home, social care institution, an institution for accommodation, the right to family, the right to live in a family environment, parental rights.[296] All terms are searched in Serbian Cyrillic. Two used databases are online bases, one provided by the Republic of Serbia and the other by a private provider.[297] Higher courts' decisions are not accessible through a publicly available database, but their practice is compiled in bulletins published by these courts.

Access to relevant decisions is restricted due to confidentiality rules. These rules apply to all cases involving family relations and the placement of a person under guardianship, as stipulated by the Family Law.[298] All data in courts' records are classified information in those cases.[299] Also, in cases involving children, the court can exclude the public in all civil proceedings, in accordance with the Civil Procedure Law.[300] Therefore, a significant portion of relevant cases may not be included in this review.

Another limitation is the potential inaccuracy of the databases. The potential absence of data or malfunctioning databases might lead to incomplete search results, thereby affecting the quality of this analysis.

[295] AOIFE NOLAN, et al., ADVANCING CHILD RIGHTS-CONSISTENT STRATEGIC LITIGATION PRACTICE (ACRISL. 2022), p. 20
[296] In Serbian Cyrillic: инвалидитет, сметње у развоју, дете ометено у развоју, Конвенција о правима детета, Конвенција о правима особа са инвалидитетом, дом за децу, домски смештај, институција за смештај, институција социјалне заштите, право на породицу, право на живот у породичном окружењу, родитељско право.
[297] Judicial practice, 2023, Date, 2023); Propisi.net, 2023, Date, 2023).
[298] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Articles 206 (1), 331 (1).
[299] Id. at. Articles 206 (2), 331 (2).
[300] Civil Procedure Law, "Official Gazette RS" Nr. 72/2011, 49/2013 - CC decision, 74/2013 - CC decision, 55/2014, 87/2018 and 18/2020 and 10/2023 - another law.

3.2.1. Constitutional Court

The Constitutional Court, an independent state institution, is not part of the judicial system of the Republic of Serbia.[301] It is mandated with, *inter alia*, reviewing the compliance of law and other general legal acts with the Constitution and with ratified international agreements.[302] The process for the assessment of compliance can be initiated by state bodies, bodies of the autonomous province and an LSG, or at least 25 parliament members.[303] Also, any legal or a natural person has the right to submit an initiative for the review of constitutionality.[304] An act deemed unconstitutional by the Constitutional Court is nullified on the day the decision is published in the official gazette.[305] The review of constitutionality serves as a valuable tool, especially for NGOs, to contest the compliance of laws and other legal acts with the Constitution, the CRC, and the CRPD. A party can also submit a constitutional complaint to the Constitutional Court for any legal act or action of state bodies or other organisations that are competent to conduct the public mandate that violates or restricts human and minority rights protected by the Constitution.[306] The principle of subsidiarity must be respected.[307]

The search of the database of the judgments of the Constitutional Court retrieved only one relevant result, which was the review of the constitutionality of a legal norm. The constitutionality review of the norm in Article 12 (7) Law on Financial Assistance to Families with Children is relevant to the realisation of the right to family life for CWD, because the existence of support, including financial support, can preclude the placement of a disabled child in an institution. Article 12 of the law regulates compensation for loss of income due to absence from work during paternity leave for child care, and leave for special care of the child.[308] The leave for special care of the child can be taken by a parent when their child has a disability or a severe chronic illness until the child reaches 5 years of age, in accordance with the Labour Law.[309] The ministry competent for the financial support to families is obligated to pay the

[301] "Official Gazette RS", Nr. 98/2006. Article 166 (1).
[302] Id. at. Article 167 (1).
[303] Id. at. Article 168 (1).
[304] Id. at. Article 168 (2).
[305] "Official Gazette RS", Nr. 98/2006, 115/2021. Article 168 (3).
[306] "Official Gazette RS", Nr. 98/2006. Article 170.
[307] Id. at.
[308] Law on Financial Assistance to Families with Children, "Official Gazette RS", Nr. 113/2017 and 50/2018.
[309] Labour Law, "Official Gazette RS", Nr. 24/2005, 61/2005, 54/2009, 32/2013, 75/2014, 13/2017 - CC decision, 113/2017 and 95/2018 - authentic interpretation. Article 96 Rulebook on closer requirements, procedure and way of realizing the right on parental leave from work or to part time work due to special care for the child, "Official Gazette RS", Nr. 56/2018. Articles 3-10.

compensation of income to parents from the means of the budget of the Republic of Serbia, including the taxes and contributions for social security.[310]

Complainants, two NGOs working for the rights of children (Network of Organisations for the Children of Serbia MODS and National Organisation for Rare Diseases) submitted an initiative for the assessment of constitutional and legal compliance of Article 12(7) of the law, which prescribed that a parent whose child with a disability or a chronic illness receives an allowance for the help and aid of another person (financial assistance in accordance with LSP) cannot be entitled to compensation for the absence from work due to special care of the child.[311] The NGOs argued that the norm was non-compliant with the ECHR, the Constitution of the Republic of Serbia, the CRC, the ICESCR, and the RESC. The complainants argued that the norm of the law effectively resulted in the restriction of the human rights of CWD, that it was discriminatory, and that it, *inter alia*, violated norms of Article 19 and Article 23 of the CRC. In relation to Article 23 CRC, the complainants argued that the norm of the law was contrary to the obligation of states parties to recognize the right to a dignified life and ensure special care for CWD. Importantly, the complainants referred to the official elaboration of the draft law, which openly asserted that the law should reduce budget expenditures, especially due to alleged misuse of the right to special assistance by parents whose children had no disability or were healthy.[312]

Another complainant had argued that the norm of the law violated, *inter alia*, Article 28 of the CRPD on the adequate standard of living and the right to social protection without discrimination.[313]

The Constitutional Court consolidated multiple initiatives aimed at reviewing Article 12 (7) of the Law on Financial Support for Families with Children but did not disclose the identities of the initiators.[314] The Court ruled that Article 12 (7) was unconstitutional, citing a violation of the legal system's principle of unity. Firstly, judges concluded that the disputed norm of the Law on Financial Assistance to Families with Children had regulated the right from the sphere of labour law and the right to social protection. Secondly, the Constitutional Court determined

[310] "Official Gazette RS", Nr. 113/2017, 50/2018, 46/2021 - CC decision, 51/2021 - CC decision, 53/2021 - CC decision, 66/2021 and 130/2021. Article 14 (7).
[311] "Official Gazette RS", Nr. 113/2017, 50/2018, 46/2021 - CC decision, 51/2021 - CC decision, 53/2021 - CC decision, 66/2021 and 130/2021. Article 12 (7).
[312] Initiative for the review of constitutionality and legality, p. 8.
[313] Constitutional Court, ИУз-266/2017.
[314] Id. at.

that the disputed norm in part contradicted the Labour Law, which had already prescribed the right to compensation for the absence from work for the purpose of special care of the child.[315] Then, the Court demonstrated that considering the object of the disputed law is to improve the financial status of families with children, and not to regulate rights in relation to work and employment, the law could not be understood as a *lex specialis* to the Labour Law. Further, the Court held that the compensation cannot be conditioned by requirements other than the parents' employment status as prescribed in the Labour Law, meaning that the right of the child to the allowance for help and care of another person is not relevant in such a case.

The Court also found that the right to social and retirement insurance would be violated if compensation was not paid to a parent. The ministry responsible for financial support to families is obligated to pay these contributions alongside salary compensation. Therefore, if there is no compensation for the salary, parents would not receive social and retirement insurance contributions either.

The Constitutional Court did not consider other claims by the complainants as they would not change the outcome of the decision.[316] Therefore, the Court did not base its argumentation on the CRC or CRPD but instead focused on the incompatibility of the Law on Financial Assistance to Families with Children with the Labour Law, ruling that the critical norm was non-compliant with the law and the Constitution. The right to salary compensation during the leave from work for the purpose of caring for a child with a disability or severe chronic illness was present in the Law on Labour Relations from 1996, although only mothers were entitled to it.[317]

3.2.2. Supreme Court

The Supreme Court is the highest court in the Republic of Serbia. Following constitutional amendments in 2021, the court's name was changed from the Supreme Court of Cassation to the Supreme Court. Under the Family Law, a party can request the Supreme Court to revise a

[315] "Official Gazette RS", Nr. 24/2005, 61/2005, 54/2009, 32/2013, 75/2014, 13/2017 - CC decision, 113/2017 and 95/2018 - authentic interpretation. Article 96 (3).
[316] Constitutional Court, IУз-266/2017.
[317] Law on Labour Relations, "Official Gazette RS", Nr. 55/96 and 28/2001. Article 81 (2).

final decision made by a lower court.[318] The Supreme Court is, *inter alia*, mandated with the standardization of courts' practice,[319] for which it has several means available.[320] Nevertheless, serious obstacles in the harmonization of judicial practice persist, posing a serious threat to the rule of law in Serbia.[321]

The search of the database of the Supreme Court retrieved two relevant decisions. In a 2019 decision, the Supreme Court utilized the CRC to support its argumentation; however, this case did not directly relate to the right to live in a family environment. The Supreme Court referred to the Family Law and the norms of the CRC contained in Article 27 (1)-2 on the right to an adequate standard of living and the parents' duty to secure such a standard of living.[322]

Another decision from 2016 involved a father who requested the Supreme Court to revise an appellate court's decision. This decision had upheld a basic court's ruling that deprived him of parental rights over his son, who has an intellectual disability (the term 'moderate mental retardation' is used in the decision).[323] The court confirmed the decision of the lower courts that the parental rights should not be reinstated to the father due to the lack of his parenting skills, and due to claims of the guardianship authority that the son (then already adult) of the complainant adjusted well to the life in a residential institution for the care of children, youth and adults with disabilities.[324] The court focused not on the reasons for the child's institutional placement, but rather the justification for the deprivation of the father's parental rights. However, the judgment uncovers two relevant positions taken by the basic court and the guardianship authority: that the placement of the child in an institution was taken on the basis of the failure of the father to ensure that the son was getting the medical treatment (a prescribed pharmaceutical was not found in the blood of the child) and the lack of competencies of the father to care for his disabled child. The reasons for separating the child from his parent appear

[318] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 208.
[319] "Official Gazette RS" Nr. 116/2008, 104/2009, 101/2010, 31/2011 - another law, 78/2011 - another law, 101/2011, 101/2013, 106/2015, 40/2015 - another law, 13/2016, 108/2016, 113/2017, 65/2018 - odluka US, 87/2018 and 88/2018 - CC decision. Article 31.
[320] MILOJEVIĆ, et al. 2015, p. 21-22.
[321] Milica Kolaković-Bojović & Elena Tilovska Kechegi, The Uniform Application of Law - EU Standards and Challenges in Serbia, in YEARBOOK HUMAN RIGHTS PROTECTION: FROM ULAWFULNESS TO LEGALITY (Zoran Pavlović ed. 2018).
[322] Supreme Court of Cassation, Rev. 2015/2019 6th June 2019.
[323] Supreme Court of Cassation, Rev. 453/2016, 20th April 2016.
[324] Id. at.

contentious; however, more detailed information is necessary for a reliable analysis. Judgements of lower courts in the same case cannot be found in databases.[325]

3.2.3. Appellate courts

The search of the database of appellate courts retrieved two relevant decisions. In a case decided by the Appellate Court in Novi Sad, a father contested a basic court's decision that awarded parental rights to the mother. In this, case the court stated that:

'According to the Convention on the Rights of the Child, a child should live in a family environment, (a child) has the right to be cared for primarily by his/her parents, and to maintain relationships with his/her close cousins.'[326]

This case did not involve residential care for the child; therefore, the CRC reference did not directly pertain to ensuring family care for the child. However, it did reflect an understanding of the court on the importance of life in a family environment for all children.

The Appellate Court in Belgrade in 2021 found that where parents do not maintain contact with a child who is in residential social care, they severely violate their parental duties and can be fully deprived of their parental rights.[327] The case concerned a child who was left in residential care after birth, due to a congenital impairment. According to the child's neurosurgeon, the medical treatment was complete, eliminating the need for further hospitalisation.[328] The parents had previously informed the CSW that they were unable to care for the child with an impairment and had decided to only keep the child's twin, who was born without impairments. They agreed with the decision to place the impaired child in residential care.[329]

In 2017, the CSW determined that staying in residential care was not in the child's best interest and that reintegration into the family would better support the child's development and wellbeing.[330] The same CSW concluded that the parents were not interested in reintegrating

[325] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 206.
[326] Appellate Court in Belgrade, Гж2 75/2021.
[327] Id. at.
[328] Id. at.
[329] Id. at.
[330] Id. at.

their child, leading to a proposal to initiate proceedings for the deprivation of parental rights.[331] The basic court determined that the parents' occasional visits to their child were insufficient and that they had still severely neglected their parental duties.[332] According to the CSW, the child had never spent a weekend at his/her parents' home, nor was he/she ever taken out of the institution by the parents.[333] Finally, the Appellate Court in Belgrade confirmed the decision of the basic court and deprived the parents of their parental rights except of the duty to support the child financially.[334]

Neither the basic court nor the Appellate Court in Belgrade specifically mentioned either the CRC or the CRPD. The CSW did, however, argue that family care would be the best for the child with a severe disability in the specific case, which was accepted by the courts as a fact. Considering that the present process was taken in relation to the deprivation of parental rights and that the Family Law is precise about the cases in which those rights can be taken from parents, the Court did not have to base its decision on international law. The court's acceptance of the argument aligns with the principles of the CRPD and the CRC, emphasizing the importance of family care and the child's best interests. The judgment goes beyond the text of the Family Law and asserts that the best environment for the child is the family.

Another case of the Appellate court in Belgrade from 2021 considered a child with an intellectual disability (the term used in the decision is 'severe mental retardation'), who was placed in a residential institution after birth due to the type of disability. The child was 'automatically' placed in an institution after birth based on the assessment of his/her intellectual capacities, which was done in accordance with the Decision on the criteria for the classification of children with developmental disabilities. This legal act was voided in 2010.

Similar to the previously described case, a CSW was obligated to initiate procedures to deprive parental rights if parents, whose children were in residential care, showed no intent to work toward reintegration of their child into the family.[335] This was in accordance with the Family Law, covering all aspects of parental rights except for the parents' duty to pay child support to the residential institution where their child lives. Such a decision was enforced by a basic court in 2016. In 2021, a basic court reinstated the parental rights to the parents. In the case before

[331] Id. at.
[332] Id. at.
[333] Id. at.
[334] Id. at.
[335] "Official Gazette RS", Nr. 18/2005, 72/2011 - another law and 6/2015. Article 81 (3)(4).

the Appellate Court, one of the two CSWs involved argued that parental rights should only be reinstated if the parents had first reintegrated the child into the family. However, the other CSW argued and presented evidence of great care of the parents for their child while in residential care and an overall intention to reintegrate the child with the family. Furthermore, this CSW contended that reintegration actions could only proceed following a court's decision to restore parental rights, a position the Appellate Court upheld. The court denied the complaint and confirmed the decision of the basic court to reinstate the parental right to the parents who showed the motivation and intention to reintegrate the child back in their family.

The two recent judgments of the Appellate Court in Belgrade have several important features. The deprivation of parental rights of parents who do not work towards the reintegration of their institutionalized child back in the family is a form of sanction, which the court explicitly stated.[336] While the deprivation of parental rights is not total, parents are still required to pay child support to the institution where their child resides. Parents must show motivation and intention to reintegrate the child, which is assessed primarily by the CSW and competent bodies of residential institutions, and the court. In the case Гж2 473/21, the complainant – one of the CSWs involved in the case, insisted that parents should submit a request for the reunification of the child as a condition before their parental rights are given back to them. Actions and arguments of both CSWs demonstrated that parents had to display a great deal of dedication to reintegrate their child back into their family, in order to prove that reunification is plausible in the future on the basis of their behaviour and actions.

Consequently, parents are in a way conditioned to seriously approach the reunification of their child in order to have their parental rights back, otherwise, they will be deprived of those and obliged to pay child support to the institution. In the first case (Гж2 75/21), where the parents were eventually deprived of parental rights except from paying child support, the CSW argued that the family environment is the best for the disabled child in that case, which the court considered as a fact. Although based only on the named two cases, and the positions of three CSWs, the arguments of those bodies and the courts indicate that there is a tendency to incite parents to reintegrate their children, otherwise they will be 'sanctioned' with the deprivation of parental rights and an obligation to pay child support.

[336] Appellate Court in Belgrade Гж2 473/21, 9th September 2021.

On the other hand, such an approach by the court could severely reduce the chances for reunification amidst the lack of support for the biological parents. Different support and services may be needed to facilitate the reunification, and placing a burden only on the parents may result in a low number of reunifications. Indeed, the data provided by the RISP year after year shows that a very small number of CWD are reunited with their families after being placed in alternative care.[337]

3.2.4. Higher courts

In a review of available court practice reports of higher courts in Belgrade and Novi Sad, no relevant decisions were identified. Reports from other higher courts were not available, nor were their decisions accessible in the databases.

3.3. National Human Rights Institutions and structures to facilitate the implementation of human rights treaties

The present section investigates the role of two NHRIs, the Protector of Citizens (PC) and the Commissioner for Equality (CE), in the implementation of relevant CRC and CRPD norms. Their role and activities are explored through several mechanisms of their action: complaints mechanisms, human rights monitoring, legal initiatives, and awareness raising. Primary sources for this analysis include laws on the establishment and functioning of NHRIs, decisions from these institutions, and interviews. Other sources include reports from NHRIs, academic papers, and NGO reports on the activities of these institutions.

The first Law on the Protector of Citizens was adopted in 2005 and the institution started its operations in 2007. Norms on PC are also in the Constitution prescribing its independence, competence and limitations PC is mandated with the control of the work of public administration except the highest authorities, the Constitutional Court, courts and the prosecutor, concerning the violation of the rights of citizens.[338] PC can propose laws and legal

[337] See note 97.
[338] "Official Gazette RS", Nr. 98/2006, 115/2021. Article 138.

amendments significant for the realisation of the rights of citizens, initiate reviews of constitutionality and legality before the Constitutional Court, and conduct monitoring in places where people may be deprived of their liberty, including residential institutions for the care of children.[339] The latter was established in accordance with the ratified Optional Protocol to the CAT on independent systems for regular visits to places of liberty deprivation.[340] PC can also on its own initiative or upon receiving a complaint from a citizen start an inquiry procedure.[341] The new Law on the Protection of Citizens prescribes that this institution is mandated with the monitoring of the implementation of the CRPD.[342] Introducing this novel norm, the state fulfilled the recommendation of the CRPD Committee.

CE was legally introduced in 2009, with the Law on the Prohibition of Discrimination,[343] and it started working in 2010.[344] This body receives complaints of discrimination and initiates procedures, issues opinions, recommendations and measures.[345] CE can initiate the review of constitutionality and legality before the Constitutional Court,[346] file a lawsuit before a competent court in the interest of the discriminated individual, conduct awareness raising activities, monitor the implementation of laws, cooperate with NGOs etc.[347]

According to NGOs, the rate of measures of the two NHRIs' that are implemented is 'relatively high'.[348] However, according to the same report, these measures had a limited impact, restricted to the specific cases they addressed, and thus did not achieve systemic changes through these mechanisms.[349] This section therefore poses the question: 'How have national human rights institutions and state structures that facilitate the implementation of the CRC and the CRPD addressed the implementation of the right to live in a family environment for CWD?'.

[339] "Official Gazette RS", Nr. 105/21. Articles 20, 22, 25
[340] Id. at. Article 2 (1).
[341] Id. at. Articles 28-38.
[342] Id. at. Article 2 (2).
[343] "Official Gazette RS", Nr. 22/2009 and 52/2021. Section IV.
[344] MILIJANA TRIFKOVIĆ, et al., ULOGA I POLOŽAJ ZAŠTITNIKA GRAĐANA I POVERENIKA ZA ZAŠTITU RAVNOPRAVNOSTI. RADNI IZVEŠTAJ (Belgrade, CRTA, A11, 2019).
[345] "Official Gazette RS", Nr. 22/2009 and 52/2021. Article 33 (1), 2.
[346] "Official Gazette RS", Nr. 98/2006, 115/2021. Article 168 (1).
[347] "Official Gazette RS", Nr. 22/2009 and 52/2021. Article 33 (3), 6, 7, 9, 10.
[348] TRIFKOVIĆ, et al. 2019, p. 12.
[349] Id. at.

3.3.1. Protector of Citizens (Ombud)

The present section contains an analysis of opinions, positions, recommendations, and legal initiatives of the PC. Altogether, 286 Opinions and 88 initiatives of the PC, available on the website of the institution, were reviewed to identify documents directly or indirectly related to the realisation of the right to live in a family environment for CWD. Those Opinions were issued between September 2008 and April 2023. Opinions that are assessed as relevant are then analysed to uncover what the PC recommended to authorities and if possible if its recommendations were accepted. Relevant documents were those which addressed laws, policies and practices related to children in general or specifically CWD, persons with disabilities, social protection, and family protection. The success of the PC's intervention is assessed by looking for the incorporation of the PC's recommendations in the targeted documents and acts or through secondary sources that contain information on the success of the PC's recommendations. Considering that other actors and factors may contribute to the change that was also recommended by the PC, such a success could not be solely attributed to this institution, but its contribution and influence are presumed considering the constitutional status and the authority of this NHRI. The actions of the PC in relation to individual complaints are not analysed due to their limited impact beyond the specific case. This inability to influence broader changes when acting on individual complaints was captured in a study on the role of NHRIs in Serbia.[350]

Several significant Opinions were issued by the PC in relation to drafts and amendments of new or existing laws, ratification of instruments, and several on different strategic documents. Some of those Opinions were issued after citizens complained about certain acts, while some were self-initiated by the PC, in accordance with the law.[351]

The contents of thirteen opinions and initiatives that were found relevant were analysed in depth. The PC addressed several laws and strategic and policy documents concerning the rights of children with disabilities. The PC referred to the CRC and the CRPD multiple times when criticizing certain aspects of those documents, arguing that these are not compliant with the conventions, and to support its recommendations.

[350] Id. at.
[351] Mišljenje Zaštitnika građana, 353-30/21, Protector of Citizens. Article 27.

In 2014, the PC submitted an initiative to the Government for the ratification of the Optional Protocol to the CRC on individual communications; however, this instrument had not been ratified as of 2023.[352] Several Opinions in relation to the Law on Financial Assistance to Families with Children, issued throughout the years, criticized, inter alia, Article 12 (7)both during the law's drafting phase and later, after citizens complained of rights infringements.[353] The ministry competent for the family protection did not change the law, however, the norm was later found unconstitutional. In recent Opinions concerning this law the PC recommended several improvements in relation to support for CWD and parents with disabilities, however, the law had not been changed before the cut-off date for this study, thus it was not possible to assess the influence of the PC's intervention on the act.[354] The PC made several critical recommendations regarding the Draft Law on the rights of users of temporary accommodation, some of which were adopted; however, none are directly relevant to this study.[355]

The PC demonstrated significant interest in the Draft Strategy for the improvement of the position of persons with disabilities in the Republic of Serbia 2020-2024 (SIPWD), by issuing several Opinions to the MOLSA between 2016 and 2020. In those Opinions the PC recommended the establishment of a monitoring mechanism for the implementation of the CRPD,[356] increasing the number of OPDs providers of CBS and a general increase in the number of CBS.[357] In an Opinion from 2023, the PC criticized the lack of implementation of the previous action plan to the SIPWD.[358] Some of the recommendations seem to be adopted, considering that the Strategy foresaw the increase in the number of those services as well as the establishment of a monitoring mechanism under the auspices of the PC.[359] On the other hand, the registry for the CWD which was proposed by the PC was not foreseen by the Strategy.

The PC also criticized the Draft Deinstitutionalisation Strategy 2022-2026 (DIS) for its lack of comprehensiveness regarding target groups and for failing to consider inter-sectoral cooperation.[360] The PC suggested a new social protection strategy because the last expired in

[352] Inicijativa Zaštitnika građana, 9-2-14/14, Protector of Citizens, 2014.
[353] Mišljenje Zaštitnika građana, 323-105/20, Protector of Citizens, 2019. Mišljenje Zaštitnika građana, 183-25/2017, 2017; Protector of Citizens, 2023.
[354] Protector of Citizens, 2023.
[355] Mišljenje Zaštitnika građana, 4110-19/2019, 2019.
[356] Mišljenje Zaštitnika građana, 183-5/2017, Protector of Citizens, 2017; Mišljenje Zaštitnika građana, 273-819/16, Protector of Citizens, 2016.
[357] Mišljenje Zaštitnika građana, 353-2/20, Protector of Citizens, 2020.
[358] Mišljenje Zaštitnika građana, 353-6/23, (Protector of Citizens), 2023.
[359] Strategy for the Improvement of the Position of Persons with Disabilities in the Republic of Serbia 2020-2024, "Official Gazette RS", Nr. 44/20, p. 62.
[360] Protector of Citizens,

2009 and the harmonization of those two documents. However, the final document did not reflect the PC's recommendations.

The PC carries out the mandate of the NPM, established under the OPCAT, in the form commonly referred to as 'Ombuds+' from 2011. This form of NPM includes the participation of CSOs in NPM activities, including interviews with residents and employees of visited institutions and in drafting reports and recommendations. The law prescribes that the NPM has unobstructed access to places where people are deprived of liberty, including residential institutions in social care.[361] The PC regularly criticized the treatment and material conditions in social care institutions, as well as the slow DI process.[362] According to the PC, their reports had contributed to the improvement of material conditions, while the issues with lack of CBS and the incompliance of legal acts with international human rights instruments remains.[363]

3.3.2. Commissioner for the Protection of Equality

This section reviews 234 documents issued between 2011 and 2023, which include legal initiatives, opinions, and recommendations on legal acts and policy documents by the CE, all published on the institution's website.[364] In total, 10 documents were analysed in-depth. The analysis is approached in the same way as the analysis of the work of the PC in the previous section. Where it is found that a certain change or action that was requested or suggested by the CE is realized, it is not automatically attributed solely to the CE, considering there may be other actors and factors that contributed. However, considering that this is one of the highest state authorities in the country it is reasonable to assume that its contribution is not negligible.

The CE focused on correcting various norms of the Law on the Assistance to Families with Children, including Article 12(7) on paid leave for parents of children with disabilities and severe illness. It can be said that the CE had a significant role in supporting CSOs that submitted a proposal for the constitutionality review. The Constitutional Court is not obligated to start

[361] "Official Gazette RS", Nr. 105/21. Article 25.
[362] DESET GODINA RADA NACIONALNOG MEHANIZMA ZA PREVENCIJU TORTURE U REPUBLICI SRBIJI (Protector of Citizens. 2021), p. 61-63.
[363] Id. at.
[364] Zakonodavne inicijative i mišljenja o propisima, Commissioner for the Protection of Equality, accessed: 21 April, 2023, available at https://ravnopravnost.gov.rs/misljenja-i-preporuke/zakonodavne-inicijative-i-misljenje-o-propisima.

the constitutionality review based on an initiative submitted by CSOs which is also the right of any other citizen, but it is obligated to do so when a state authority initiates the procedure.[365] The CE communicated with the Constitutional Court to support an initiative already submitted by CSOs, informing the court that it would initiate the procedure itself if the court did not act on the CSOs' initiative.[366] The significant decision of the Constitutional Court was already analysed in the section on the decisions of the Constitutional Court. The CE, as well as the PC, submitted an Opinion to the ministry competent for the protection of families recommending that the law is amended in relation to the abovementioned norm.[367]

The CE actively participated in drafting the SIPWD and the DIS. The CE issued important recommendations to improve the Draft DIS including the relaxation of licensing procedures for providers of CBS, an increase in the number of personnel of CSWs, capacity-building of LSGs for the provision of CBS, the harmonization of the DIS with a previous strategic document adopted in relation to the pre-accession negotiations of Serbia and the EU.[368] Finally, the DIS plans for capacity building of LSGs to develop and provide CBS, along with reporting and needs assessments, as critical aspects of the reform.[369] However, other relevant suggestions by the CE were not included in the DIS, implying a limited impact of the CE on this document.

3.3.3. Structures to facilitate the implementation of human rights treaties

The Republic of Serbia, the Autonomous Province of Vojvodina and LSGs have established structures designed to coordinate and promote the implementation of policies, laws, and international norms related to child and disability rights. Koh argues that such internal structures are relevant factors in compliance with IL norms, hence should be considered when examining a process of internalisation.[370]

Formed in 2002, the Government's Council for the Rights of the Child aims to monitor children's rights in Serbia, ensure coherence among government sectors in child-related actions, evaluate these actions' impact on children's rights, and promote the implementation of the CRC. The functioning of the Council has seemingly been limited in impact and intensity.

[365] "Official Gazette RS", Nr. 98/2006, 115/2021. Article 168.
[366] Inicijativa za izmenu člana 12 stav 7 Zakona o finansijskoj podršci porodici sa decom, 00004/2019-02, Commissioner for the Protection of Equality, 2019.
[367] Id. at.
[368] Commissioner for the Protection of Equality, 2021.
[369] "Official Gazette RS", Nr. 12/2022, p. 41.
[370] See Introductory Chapter, 3. Research Framework.

In 2017 the CRC Committee expressed its concerns with the questionable impact of the Council, its rare meetings and inexistent oversight of the relevant actions of the National Assembly.[371] The Council lacks transparency and involvement of the CSOs too. In that light, the capacity of the Council to significantly impact the realisation of children's rights is doubtful.

In 2021, the Law on the Protector of Citizens was amended to prescribe that an independent monitoring body for the implementation of the CRPD is part of the PC.[372] Such a body has not been established before April 2024. The PC proposed that the yet-to-be-adopted action plan for DIS include provisions for the necessary funds and additional personnel to enable the PC to effectively function as an independent monitoring body for the CRPD. Considering that, it can be concluded that Serbia is 14 years late in fulfilling the obligation of Article 33 (2) CRPD, since it ratified the CRPD in 2009. On the other hand, the PC and CE, although not specifically designed to facilitate the implementation of the CRC and the CRPD, do conduct activities related to the promotion of those treaties, including regularly issuing recommendations to authorities based on the treaties, as it was elaborated in the section National Human Rights Institutions.

Reinstated in 2021 for four years, the Government's Council for Persons with Disabilities coordinates the drafting of laws and policies for disability rights, oversees the implementation of international legal norms, and enhances cooperation with CSOs and international organisations.[373] The Council is multisectoral, and apart from representatives of persons with disabilities has representatives of different governmental authorities and academia.[374] There are no representatives of specifically CWD or representatives of human rights NGOs. This is not the first such a council with the Government of the Republic of Serbia and one was established in 2005, but its impact was questionable due to insufficient resources and the insufficient intensity of its operation.[375] Similar councils have been formed on the local level, in several cities including Belgrade, Bor, Kragujevac, Novi Sad and Zrenjanin to monitor and guide the development of local policies.

[371] CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017.
[372] "Official Gazette RS", Nr. 105/21. Article 2 (2).
[373] Decision on the formation of the Council for Persons with Disabilities, "Official Gazette RS", nr. 51/2021, Government of the Republic of Serbia, 2021.
[374] Id. at.
[375] "Official Gazette RS", Nr. 44/20, p. 4-5.

The Council for the Monitoring of the Implementation of UN Human Rights Recommendations was established in 2014 within the Office for Human and Minority Rights, following a UPR mechanism recommendation to Serbia to establish such a body. After the dissolution of the Office, the Council continued its operations under the Ministry for Human and Minority Rights and Social Dialogue.[376] It monitors the implementation of UPR and UN treaty bodies' recommendations. The Council's activities are notably transparent, with CSOs actively participating in meetings, as evidenced by the minutes published online.[377] Additionally, the Council contributes to the drafting of state reports to UN treaty bodies, including the CRC Committee in 2022.[378] A group of CSOs also formed the Platform for Organisations for Cooperation with UN Human Rights Mechanisms, an independent entity comprising human rights NGOs and DPOs aimed at enhancing monitoring capabilities and increasing advocacy influence before the state and UN bodies.

3.4. Strategic policy documents

This section explores how policymakers addressed the implementation of relevant CRC and CRPD norms and the realisation of the right for CWD to live in a family environment through strategic public policy documents. The 2018 law defines a public policy document as an act used by various actors to determine and elaborate on already established public policies. It lists several types of such documents, including strategies, programs, policy concepts, and action plans.[379] The present section considers other policy documents such as agreements of the Republic of Serbia with the World Bank.

As crucial as the content of these documents is their level of implementation, which often more accurately reflects the true intentions and capacities of the responsible authorities. An implementation gap is identified by comparing the goals of the policy documents over a specified timeframe with data from primary and secondary sources, to determine if these goals were achieved (e.g. a goal to increase the number of CWD in foster care by 2021 is assessed

[376] Decision on the amendments of the Decision to form a Council for the monitoting of the recommendation of UN human rights recommendations, Ministry for Human and Minority Rights and Social Dialogue.
[377] Savet za praćenje UN preporuka, Ministry for human and minority rights and social dialogue, accessed: 3rd May, 2023, available at https://www.minljmpdd.gov.rs/savet-za-pracenje-un-preporuka.php.
[378] Minutes - XVI thematic meeting of the Council, (Council for the monitoring of implementation of UN human rights recommendations), 2022.
[379] Law on the Planning System of the Republic of Serbia, "Official Gazette RS", Nr. 30/2018. Article 10.

by comparing data from the base year and from 2021). Sources for the analysis are primarily public policy documents and legal acts, reports of state authorities, NGOs, and academic sources. Sources for the assessment of the implementation of EU-related strategic documents are also reports of the European Commission. Thus, this section addresses whether and how Serbian Government public policies, enshrined in the public policy documents, have impacted the realisation of the right for CWD to live in a family environment.

The relevant documents identified for this study include:

- DIS 2021 – 2026;
- SIPWD 2020-2024 and an accompanying action plan;
- Protection and Prevention of Children from Violence Strategy 2020 – 2023;
- Protection of Mental Health Programme 2019 - 2026.
- Revised Action plan for Chapter 23 (APC23) from 2020;
- Employment and Social Reform Programme (ESRP) from (2016);
- Social Protection Development Strategy 2005 - 2009;
- Antidiscrimination Strategy and an accompanying Action Plan;
- Country Partnership Frameworks between Serbia and the World Bank.

Also, public policy documents that were implemented in the past, and are highly relevant for the present issue are revisited to capture the policy development in the last 20 years. These are the National Plan of Action for Children and the Development of the Social Protection Strategy 2005-2009, the SIPWD 2007-2015.

3.4.1. Deinstitutionalisation Strategy

The latest and arguably most relevant DIS outlines several measures and activities to support life in a family environment for CWD. Previously, Serbia lacked a strategic document on DI; its development followed recommendations from various bodies, including the CRC

Committee, [380] the CRPD Committee, [381] the European Commission, and decades of advocacy by NGOs.

The PC and the CE criticized the DIS for being too narrow and limited in its scope of target groups and involved state sectors, noting that a more comprehensive Social Protection Development Strategy should have been adopted first. Indeed, the DIS practically relates only to children and adults with disabilities, which is of critical interest to this study. Another significant problem in relation to the drafting of the DIS is that DPOs had not been consulted, contrary to the general obligation of the CRPD, or human rights NGOs.[382] Professionals from residential institutions and non-profit service providers were consulted through focus groups.[383] This composition of participants could shift the focus from meeting the human rights of children and adults with disabilities to fulfilling the needs of residential care providers and other services.

The DIS foresees developing a Draft LSP that extends the prohibition of institutional placement of children from 3 years old to 7, with exceptions as currently allowed by law, and limits the maximum duration of institutional stays for children.[384] Further, an issue with the lack of standardization for specialised and intermittent foster care should be remedied by amending the relevant rulebook, which should enable more efficient development of foster care for CWD, 15% increase of the number of CWD in foster care and 200% increase of the number of children in emergency and intermittent foster care (the base value is not known).[385] Also, the supported living service for youth and CWD over 15 years of age should be increased by 300% by 2026.[386] The DIS describes a 300% increase in service users from 50 to 150; however, a 300% increase from 50 would actually result in 200. Furthermore, the number of users of personal companions for children should be increased by 30%. For this reason, it is not clear if the number of users of the service should be 150 or 200 by 2026. The issue, however, could be corrected with an action plan that has not been adopted by April 2024.

Interestingly, and in line with the prior DI-related planning, this strategy does not foresee the closure of residential institutions for children and youth but their transformation to centres for

[380] CRC/C/SRB/CO/2-3, Committee on the Rights of the Child, 2017, para. 44.
[381] CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 40.
[382] A/RES/61/106. Article 4 (3).
[383] "Official Gazette RS", Nr. 12/2022, p. 61.
[384] Id. at, p. 39.
[385] Id. at, p. 44.
[386] Id. at, p. 45.

children, youth and families and the provisions of family-oriented outreach services.[387] This public policy of Serbian authorities, that stretches at least 15 years in the past, can be understood as a way to alleviate the concerns of employees of residential institutions, which had been opponents to DI-related initiatives, according to interviewees. Sometimes it is argued that the infrastructure of those institutions should not be wasted, hence the transformation is desirable. Those institutions that will be designated for transformation by the MOLSA will not be able to take new residents.[388] An umbrella plan of transformation is yet to be developed by MOLSA.

Additionally, the DIS assigns roles to the NPM and the PC for monitoring the quality of residential social care and for establishing a body to oversee the implementation of the CRPD.[389] Improved planning of the development of CBS by a new ministerial body for DI and improved monitoring of the use of earmarked transfers for CBS on a local level is needed, as well as increased competencies of professionals to implement and advocate for DI and general awareness raising.[390] Also, the DIS asserts that all LSGs will have strategic documents on the development of CBS which must be in compliance with an umbrella plan of the MOLSA on the transformation of residential institutions.[391]

Apart from the issues expressed by the PC and the CE, the DIS is also narrow concerning the breadth of the reform needed for a successful DI process. Namely, Article 19 CRPD and the GC5 of the CRPD Committee, emphasize the importance of the availability and accessibility of general (not disability-specific) services to children and adults with disabilities, as an indispensable aspect of inclusion in the community and family living.[392] The DIS lacks this aspect, which according to an interviewee is a major limitation of the document.

The DIS, in accordance with the law,[393] determines the adoption of an action plan 90 days after the adoption of the strategy at the latest. An action plan, however, was not adopted even 15 months later, which is a major obstacle for the implementation of the strategy, considering that an action plan is a mandatory part of a strategy that should in detail guide its implementation.[394]

[387] Id. at, p. 50.
[388] CRPD/C/GC/5, para. 39.
[389] "Official Gazette RS", Nr. 12/2022, p. 39.
[390] Id. at.
[391] Id. at.
[392] CRPD/C/GC/5.
[393] "Official Gazette RS", Nr. 30/2018. Article 18 (3).
[394] Id. at. Article 18 (1).

On that note, it can be safely concluded that the implementation gap has already been formed in regard to all goals and measures planned with the DIS.

3.4.2. Other policy documents

The Government adopted the SIPWD 2020-2024 in 2020. The previous SIPWD, which spanned from 2007 to 2015, expired without the adoption of action plans, leaving the strategy unimplemented. The present SIPWD is followed by an action plan that was adopted more than one year after the Strategy, in contrast with the law. Goals in the SIPWD include increased social inclusion and the realisation of the right to family life.[395] The strategy anticipates the adoption of a DI program, alongside the development of CBS and enhanced support for families.[396] The 2021-2022 action plan includes activities such as promoting DI, transforming institutions, developing CBS, and fostering a diverse range of CBS providers. For the financing of the planned activities, the action plan relies largely on the funds from the EU. The DI-conducive measures and statements were also part of the previous SIPWD, adopted in 2005. For example, the old SIPWD expressed that the family is the best environment for a person with a disability and that family-based care should be promoted for persons with disabilities.[397]

A special case is the Protection and Prevention of Children from Violence Strategy 2020 – 2023, which foresaw a legal amendment that should enable the development of SSRC in place of large residential institutions. This is the only strategic document that prescribed SSRC, but the activity has not been implemented, despite the action plan which set it for 2021.

The Social Protection Development Strategy 2005-2009 contained measures aimed at the development of CBS and the recognition of the family environment as the best for persons with disabilities. It did not explicitly mention DI or the CRPD, but it did refer to the CRC.

[395] "Official Gazette RS", Nr. 44/20. ch. 5.2.
[396] Id. at.
[397] Strategy for the Improvement of the Position of Persons with Disabilities in the Republic of Serbia 2007-2015, "Official Gazette RS", Nr. 01/2007.

The Mental Health Protection Program 2019-2026 is built on the principle of the provision of mental health services in the community, which can help to prevent the institutionalisation of children with mental health issues.

The ESRP is a document specifically created in relation to the accession negotiations of Serbia with the EU. Goal number 3 is to increase the support to families at risk, to continue the DI process, and the development of services in the community. In that light, several activities are planned including better control and allocation of earmarked transfers to LSGs, capacity-building of LSG for the development of CBS, improve non-material support to families in risk and prevention of separation, creation of a plan for the transformation of residential institutions and kinship and foster care for CWD.[398] These activities were subsequently incorporated into the DIS 2021-2026, demonstrating the significant influence of EU-related documents on internal policy frameworks. This document was based on the EU Enlargement Strategy 2013-2014, which stated that enlargement countries should work on the DI of children, that they mostly have legal frameworks set up properly but that the implementation is lagging.[399]

Another document of such type is the Action Plan for Chapter 23 from 2016, which listed the increase of capacities of service providers to provide DI-conducive services and the adoption of a law that should protect the residents of residential institutions in social care. The latter was implemented with the adoption of the law in 2021.[400] The Revised APC23 from 2020 foresaw the improvement of resources in large and small institutions for children while they are in the process of transformation and the adoption of DIS which will further elaborate the process of transformation and the increase of family-based solutions.[401] Some of the indicators are increased numbers of CWD in foster and kinship care, and families benefiting from 'shared parenting'. The increase of CWD in foster care has not been detected in the period after the adoption of the APC23. Shared parenting was not used in 2019, and the Revised APC23 set the goal of 300 families by 2022. No sources are available that detail the concept of shared parenting in Serbia or its implementation path, and the RISP lacks data on shared parenting for CWD, suggesting that this care model remains underdeveloped. The lack of implementation of measures concerning family-based care is evident.

[398] Employment and Social Reform Programme in the Process of Accession to the EU, (Government of the Republic of Serbia), 2016.
[399] Enlargement Strategy and Main Challenges 2014-15, COM(2014) 700 final, European Commission, p. 16.
[400] See note 236.
[401] Revised Action Plan for Chapter 23, Government of the Republic of Serbia, 2020, p. 258.

Other indicators include strict control over institutional placements of CWD and a year-over-year decrease in admissions. Also, the document expressly mentions the UN Guidelines, the CRPD and the GC 5 of the CRPD Committee, which should guide the creation of alternatives to institutions. This strategic document is the first to mention GC5 of the CRPD Committee, which essentially excludes the possibility of any form of institutional care, including SSRC. Further development of such a form of care was not planned. However, the measure to increase resources in both small and large institutions contradicts GC5, the views of the Special Rapporteurs for health and on the rights of persons with disabilities, and the CRPD Committee's recommendations to Serbia.[402] Conversely, the EC holds the position that investments of EU funds in residential care in Member States are allowed as long as the country has DI-related strategies in place which was met with a lot of criticism by some NGOs and DPOs.[403] Strictly speaking 'improvement of resources in small and large residential institutions' could mean the improvement of staff/resident ratio for example, however, the actual renovation and expansion of some institutions for CWD has already taken place and others are planned in the near future. Significant funds were invested in the 'Kolevka' institution, approximately EUR 6.4 million, and in the 'Veternik' institution, around EUR 3.4 million (ongoing renovation), according to data from the Ministry for Public Investments.[404] The renovation goes far beyond the removal of threats to the health of residents, which would be compatible with the DI goals unlike extensive renovations, and includes building state-of-the-art facilities, such as the one in 'Kolevka',[405] which threatens to undermine DI processes.[406]

Beyond investments in institutional care, other measures such as the adoption of the aforementioned law and the DIS in 2021 have been completed. The adoption of both the named law and the DIS, reflecting the ESRP and both the original and Revised APC23, suggests that the implementation of EU-related documents may be more careful compared to those not directly tied to EU accession negotiations. Still, this is only the adoption of legal and strategic

[402] CRPD/C/GC/5. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21, (UN Human Rights Council), 2017, para. 95(b). CRPD/C/SRB/CO/1, Committee on the Rights of Persons with Disabilities, 2016, para. 40.
[403] See Part II, Austria, Chapter 3.5.2. ESI Funds and institutional care in Austria and the EU.
[404] Renovation of public facilities, Ministry for public investments, accessed: 27th April, 2023, available at http://www.obnova.gov.rs/cirilica/news/category/obnova-objekata-javne-namene.
[405] Improved capacities of the home for children with deranged development "Kolevka" in Subotica, Ministry for work, employment, veteran and social affairs, (2022), accessed: 27th April, 2023, available at https://www.minrzs.gov.rs/sr/aktuelnosti/vesti/unapredjeni-kapaciteti-doma-za-decu-ometenu-u-razvoju-kolevka-u-subotici.
[406] CRPD/C/GC/5, para. 49.

acts, while the actual real-life measures that should contribute to the family life of CWD have either not been implemented or the information on their implementation is inexistent.

The connection of the implementation of the CRC and CRPD with the EU accession process for Serbia is an example of an 'issue linkage'. The progress of Serbia in aligning with EU acquis includes improvement of the position of CWD, which is concretized through documents such as APC23 and ESRP, while the reforms in social care are often supported by EU funds through different funding instruments.[407]

The National Action Plan for Children from 2004 to 2015 was the first strategic document to directly address the rights of CWD following the fall of the authoritarian regime and Serbia's transition to democracy. The document was explicitly based on the CRC and the UN Millennium Development Goals, and the need to fulfil requirements in relation to the EU integration.[408] The document set a goal to deinstitutionalize care for children. It was noted that too many children are in institutional care, including infants, as well as the decline of foster care. Following that, goals to increase awareness, align legal and policy frameworks with international standards, improve data collection and increase the availability of some CBS were set. The development of foster care, prevention of separation, the transformation of institutions and the shift from long-term to temporary care in institutions were foreseen.

In collaboration with the World Bank, the Serbian Government planned and implemented cost reductions in the public sector by freezing hiring and reducing wages. This also hit the system of social protection, which is suffering from, *inter alia*, a lack of capacity of CFCAs and CSWs.[409] Additionally, the World Bank supported Serbia's efforts to decentralize social protection services, acknowledging potential negative effects on local availability, similar to trends observed in other Eastern European countries.[410] The World Bank indicated that preventive measures were necessary; [411] however, data on the local availability of CBS suggests that these issues were not adequately addressed.

[407] See 'European Union'.
[408] National Action Plan for Children, (Government of the Republic of Serbia), 2004.
[409] See 'Centres for Social Work'.
[410] Report No. 41310- YF, World Bank, 2007, para. 85.
[411] Id. at.

3.5. European Union

Interviews and data on the CRC implementation suggest that the democratic transition of the early 2000s significantly contributed to reforms in social protection generally, and family-based care specifically. The new government demonstrated a greater willingness to adopt IHRL norms and engage in cooperation with the EU and other Western countries, leading to numerous projects and enhanced support for social protection reforms. For example, the new Serbian Constitution from 2006 contains one of the longest bills of rights in Europe.[412]

Beth Simmons' study 'Mobilizing for Human Rights' found that 'newly transitioned democracies' are more likely to ratify international treaties such as the CRC, CEDAW, and CAT compared to non-democratic and even stable democracies.[413] And indeed, Serbia ratified the CRC in 2001 and established a child-rights agenda driven by a democratic transition, which increased motivation to address neglected human rights issues, including the rights of CWD. This is also evidenced by the establishment of the Government's Council for the Rights of the Child in 2002[414] and the adoption of the National Action Plan for Children in 2004 (NAPC). The latter was explicitly based on the CRC and the UN Millennium Development Goals, and the need to fulfil requirements in relation to the EU integration.[415] Serbia's EU integration path necessitated meeting the EU's 'Copenhagen criteria' from 1993, which prioritizes human rights standards as fundamental for progress and eligibility for benefits such as financial assistance.[416] In other words, the motivation to symbolically and structurally break away from the old regime's infamous human rights record was supported by foreign financial assistance, primarily from the EU.

The EU has been the most significant international partner of Serbia for many years and the biggest international development aid provider.[417] The cooperation intensified with the EU-candidate status of Serbia, which was obtained in 2012. Considering that the EU ratified the CRPD their actions, including funding, need to comply with the CRPD and facilitate the

[412] See note 16.
[413] BETH A. SIMMONS, MOBILIZING FOR HUMAN RIGHTS: INTERNATIONAL LAW IN DOMESTIC POLITICS (2009), p. 86.
[414] See 'Structures to facilitate the implementation of human rights treaties'.
[415] See note 408.
[416] Frank Schimmelfennig, EU Political Accession Conditionality after the 2004 Enlargement: Consistency and Effectiveness, 15 JOURNAL OF EUROPEAN PUBLIC POLICY (2008).
[417] EU Funds, Ministry for European Integrations, accessed: 28th April, 2023, available at https://www.mei.gov.rs/eng/funds/eu-funds/.

implementation of the convention.[418] Furthermore, the CRPD Committee recommended that the EU allocate funds to develop and provide CBS for CWD, support DI, and prevent institutionalisation, including within the context of international cooperation.[419] Serbia is a recipient of substantial financial means from the EU, primarily through the Instrument for Pre-accession Assistance (IPA), which is aimed at supporting candidate countries to comply with the EU acquis. Objectives of financial programming of Serbia and the EU throughout the years included the increased social inclusion of CWD and improved access to CBS.[420] Support is set to continue under the IPA III programming framework for 2021-2027, which specifically targets financial assistance to support DI and strengthen CBS.[421]

Beyond significant financial support, Serbia's EU integration impact includes an arguably inconsistent political commitment to align with, adopt, and implement the EU acquis, particularly concerning the rights of children and persons with disabilities. In fact, the political and financial aspects of Serbia – EU relations appear indivisible. Support for family-based care, development of CBS, DI, and the implementation of the CRPD form part of the EU's negotiating position for Serbia under Chapter 23 on Judiciary and Fundamental Rights.[422] The 2014 screening report for Chapter 19 on Employment and Social Policy acknowledged the need for measures to prevent institutionalisation, child-family separation, and to enhance CBS availability.[423] The European Commission has regularly reported on the state of rights CWD in Serbia, criticized the institutionalisation and recommended different DI-related measures.[424]

Consequently, Serbia's progress towards EU membership depends, among other things, on fulfilling requirements to ensure CWD have the right to live in a family environment, a goal financially supported by the EU. This relationship creates an 'issue linkage' between Serbia's EU integration process and the right of CWD to live in a family environment. According to Koh, issue linkages can significantly drive transnational norm internalisation; however, the nature of Serbia-EU relations will largely determine the impact of these linkages. Political

[418] See Part II, Austria, ch. Status of the CRPD in the EU law.
[419] Concluding observations on the initial report of the European Union*, CRPD/C/EU/CO/1, Committee on the Rights of Persons with Disabilities, 2015, para. 23, 75.
[420] Annex to the Indicative Strategy Paper for Serbia for the period 2014-2020, C(2018) 5064 final, (European Commission), 2018; Instrument for pre-accession assistance (IPA II) Indicative Strategy Paper for Serbia for the period 2014-2020, (European Commission), 2014.
[421] Instrument for Pre-Accession Assistance (IPA III) Programming Framework for the period 2021-2027, C(2021) 8914 final, (European Commission), p. 49.
[422] European Union Common Position Chapter 23, 10074/16, (Council of the European Union), 2016, p. 16, 29.
[423] Screening report Serbia Chapter 19 – Social policy and employment, (European Commission), 2014, p. 13.
[424] For example: Serbia 2015 Report, SWD(2015) 211 final, (European Commission), 2015, p. 57. COM(2018) 450 final, European Commission, Serbia 2022 Report, SWD(2022) 338 final, (European Commission), 2022.

science scholars' analyses of the EU-Serbia relationship and the development of democracy and rule of law are crucial for understanding the complexity and the evident lack of consistency and predictability in this relationship.[425]

3.6. International and domestic organisations

'Transnational norm entrepreneurs' have played a significant role in promoting the rights of children and persons with disabilities in Serbia. To begin with, UNICEF has been an important supporter of the development of foster care and CBS since the beginning of the 2000s.[426] UNICEF also expanded foster care and early intervention, and supported a commendable outreach service for CWD, which, unfortunately, lacked standardization and sustainable funding.[427] Together with MOLSA, it implemented a project aimed at transforming residential care for children and developing CBS. In 2023 UNICEF is working on mapping resources in residential institutions in transformation and will work on establishing family-support centres, the provision of services to CWD and prevention of institutionalisation, together with the Government.[428] The long-term presence of UNICEF in Serbia and its involvement in nearly all major projects related to family support, DI, prevention of institutionalisation, and foster care, as well as its role in implementing strategic Serbian and EU documents, underscore its significant impact on the implementation of relevant CRC and CRPD norms in Serbia.

Other potentially significant actors are human rights watchdogs, NGOs that monitored and reported on the state of rights of CWD in institutional care and in general. Disability Rights International and Mental Disability Rights Initiative Serbia published three monitoring reports from institutions for children and adults with disabilities in Serbia in 2007, 2013 and 2021. Human Rights Watch published such a report in 2016.[429] All of the reports, supplemented with

[425] E.g. Marko Kmezić, Rule of law and democracy in the Western Balkans: addressing the gap between policies and practice, 20 SOUTHEAST EUROPEAN AND BLACK SEA STUDIES (2020).
[426] Conference, Izazovi hraniteljstva na početku 21. veka, Dobrila Grujić ed., Centar za porodični smeštaj i usvojenje Beograd 2014, p. 11.
[427] SITUACIONA ANALIZA USLUGA ZA BEBE I MALU DECU SA SMETNJAMA U RAZVOJU U REPUBLICI SRBIJI (Belgrade, UNICEF. 2018).
[428] Negotiating position of the Republic of Serbia for Inter-governmental Conference on accession of the Republic of Serbia to the European Union For Chapter 23 Judiciary and Fundamental Rights, (Government of the Republic of Serbia), 2016, p. 38, 56, 57.
[429] LAURIE AHERN & ERIC ROSENTHAL, TORMENT NOT TREATMENT: SERBIA'S SEGREGATION AND ABUSE OF CHILDREN AND ADULTS WITH DISABILITIES (Washington D.C., Mental Disability Rights International. 2007). The Hidden and Forgotten: Segregation and neglect of children and adults with disabilities in Serbia, (Belgrade,

pictures and testimonies of residents, uncovered utterly disturbing material conditions, overcrowding, ill-treatment and neglect of CWD in some cases.

Each report received substantial media coverage, following which authorities often attempted to discredit the organisations and deny the allegations. An interviewee who was part of the competent authorities reported that those reports induced feelings of shame, but they doubted that the reports had a significant impact.[430] However, one report prompted an immediate positive response when the then Minister for Social Affairs, Rasim Ljajić, prohibited further admissions and announced the relocation of CWD from the Kulina institution after the report exposed horrifying conditions, abuse, and neglect. The move of the ministry was commended by the CRC Committee.[431] The United States Government referred to NGOs' findings of serious human rights violations of CWD in institutions in 2016 and 2021.[432] The reactions of national media, politicians, a foreign government, and the perception of interviewees indicate that those human rights reports have significantly increased the visibility of CWD in residential institutions. Additionally, the impact is enhanced by NGOs' follow-up actions, which have utilized the reports' findings in their advocacy efforts towards the EU, the UN, the CoE, and in public advocacy.

Numerous NGOs have engaged in promoting the right for CWD to live in a family environment through advocacy, research, and service provision. SOS Children's Villages Serbia has operated a form of family-like care for non-disabled children. This organisation also supported families at risk of separation including families with CWD. The Network of Organisations for the Children of Serbia has actively advocated for DI and submitted an initiative to amend the law that threatened to reduce support for working parents of CWD.[433] Save the Children provided significant support for the development of foster care in Serbia, according to Grujić.[434] The National Organisation of Persons with Disabilities of Serbia (NOOIS) published a situational analysis on the position of CWD and emphasized the issue with the realisation of

MDRI-S. 2013). It is My Dream to Leave This Place: Children with Disabilities in Serbian institutions. 2016. ROSENTHAL, et al. 2021.

[430] T. N., Interview, 3rd April, 2023.

[431] AHERN & ROSENTHAL. 2007; Domu u Kulini zabranjen prijem dece, Aleksinačke vesti, (2007), accessed: 28th April, 2023, available at https://www.aleksinac.net/?view=lat&action=news&id=domu-u-kulini-zabranjen-prijem-dece&category=vesti. CRC/C/SRB/CO/1, 2008, para. 48.

[432] 2021 Country Reports on Human Rights Practices: Serbia, (Human Rights and Labor Beureau of Democracy), U.S. Department of State, 2022.

[433] See note 235.

[434] GRUJIĆ. 2017, p. 8.

the right to live in a family environment.[435] However, this particularly important organisation (it is a national umbrella organisation of all DPOs), has mostly avoided confrontation with the Government and has not attempted to hold it accountable in relation to the rights of CWD. It is a relatively young organisation, constituted in 2009, but its members are some of the oldest DPOs in the country constituted as early as right after the Second World War.[436] The NOOIS normally participates in law- and policy-making process and is focused on cooperation with authorities. It is, as well as its members, funded regularly from the state budget, which was shown to impede its independence, according to research on disabled people's movement in Serbia.[437] Also, most of the DPOs that are gathered around NOOIS were constituted during the socialist era. Mladenov argues that DPOs constituted in Central and Eastern Europe before the end of socialism were extensions of the state, rather than independent civil society organisations.[438]

According to research, DPOs and human rights NGOs are regularly in some way included in the processes of drafting laws and policy documents, but their participation is evaluated as tokenistic.[439] The possible reason for this is the need of decision-makers to fulfil some good governance standards such as the inclusion of CSOs, but without a real intent to accept their inputs.[440]

Typically, faith-based organisations in Serbia do not provide residential care for CWD. The Serbian Orthodox Church operates a residential institution at the Sveta Petka Izvorska Monastery, which previously accommodated children with disabilities but housed only adult women with disabilities in 2023, as per the monastery's website.[441]

[435] SITUACIONA ANALIZA: POLOŽAJ DECE SA SMETNJAMA U RAZVOJU I INVALIDITETOM U REPUBLICI SRBIJI (Belgrade, NOOIS. 2017).
[436] Organizacije članice, National Organization of Persons with Disabilities of Serbia, (2022), accessed: 28th December, 2022, available at https://noois.rs/organizacije-clanice/.
[437] Keravica, Stefanović, Petri. Disabled peoples' movement in an eroding democracy – Serbia. 2023. (Unpublished study). For the research report, please contact the author via email at lazar.m.stefanovic@gmail.com.
[438] TEODOR MLADENOV, DISABILITY AND POSTSOCIALISM (Routledge. 2017).
[439] See note 12.
[440] Ibid.
[441] Manastir Sveta Petka Izvorska, Sveta Petka Izvorska, accessed: 3rd May, 2023, available at https://www.svetapetkaizvor.com/.

4. Key findings

4.1. The situation in alternative care

The number of all children, CWD included, in institutional care has significantly decreased in Serbia during the 21st century. After a century dominated by institutional care, a pivotal shift occurred in 2003, with family-based alternative care becoming the predominant form of care (Figure 1). Currently, the number of children without disabilities in family-based care is around 20 times higher than the number in institutions, while the number of CWD in institutional care is roughly equal to the number of CWD in family-based alternative care (397 and 347 respectively).

Data on the number of CWD in family-based alternative care at the beginning of the 21st century are unavailable, primarily because they are not distinguished from the figures for young adults (18-26 years old). The proportion of CWD in institutions was approximately 70% in 2021 and has been stable for some time. The available data indicates a significant overall decrease in the number of institutionalized children but a less pronounced reduction among institutionalized CWD. This suggests that the right of CWD to live in a family environment has been more severely neglected compared to non-disabled children.

The reduction in the number of children in institutions, coupled with the increase in family-based care—primarily for non-disabled children—and the lack of effective separation prevention mechanisms and CBS, suggest that this reduction was primarily driven by the expansion of family-based care. This finding is consistent with the opinions of several interviewees.[442]

However, it is not entirely clear whether the same conclusion can be inferred for CWD, considering that the number of CWD in institutions is still, although only slightly, higher than the number in family-based care. Furthermore, it should be emphasized that all children and especially CWD rarely go from institutions back to their biological families, to family-based care or adoption. CWD mostly age out simply by turning 18 but stay in the same institution, or by death. This is evidenced in the reports of the RISP on the reasons of leaving institutions and

[442] C. E., Interview, 10th April, 2023.

NGOs and was confirmed by interviewees.[443] Given that ageing out and death are the predominant reasons for leaving institutions and considering the still underdeveloped family-based care system for CWD, it is suspected that the decline in institutional admissions for CWD is not solely due to family-based alternatives. Therefore, the reduction has been likely achieved also through some of the measures such as the conditional moratorium on the placements of children under three years of age institutions. The moratorium has not stopped but has slightly reduced the number of admitted infants,[444] which was also, although reportedly not to a large extent, followed by the provision of urgent foster care to CWD under 3.[445] Additionally, the provision of certain CBS (such as family associate, personal companion for the child, and home assistance) and material support—though often deemed insufficient and unevenly distributed—might also have contributed to the reduction in institutional admissions for CWD. Last but not least, NGO reports on the situation of CWD in institutional care may have discouraged some parents from placing their children in such facilities.

A major issue is the long-term placement of CWD in both institutional care and foster care. Consequently, CWD who are once placed in an institution rarely, if ever, have their right to live in a family environment reinstated. This is also the case for many non-disabled children.

The expansion of alternative family-based care ceased in 2018, and the number of children in this type of care has been declining. Contributing factors include the ageing population of foster caregivers, a low influx of younger foster caregivers, and reduced capacities at CFCAs and CSWs—both critical in the recruitment, training, support, and monitoring of family-based care. The reduction in personnel results from strict employment controls and hiring freezes in the public sector, enforced from 2013 to 2021. This was the second time, after the 1990s economic crisis in Serbia that family-based care shrank from the lack of resources or public cost-cutting, while residential care did not. This indicates that family-based care and even more CBS lack sustainability in Serbia.

The underdevelopment and uneven distribution of CBS are well-document by virtually all stakeholders. CBS have not been comprehensively developed, with authorities focusing primarily on expanding specific services like the ‘personal companion’ for CWD, while other

[443] RISP, 2022, p. 27.
[444] Deca u sistemu socijalne zaštite 2020., (2021), RISP, p. 23.
[445] The author submitted a request for access to the information of public interest to the Ministry for Family and Demographics, requesting the information on the number of CWD in urgent foster care. A reply has not been received before the conclusion of this thesis.

services remain accessible to only a limited number of individuals. The reason for this, according to interviewees, may be limited funds designated for this type of services. Some other CBS ceased to exist due to unsustainable, project-based funding and issues with standardization. The licensing of community-based service providers is an obstacle to the proliferation of providers especially amongst DPOs and NGOs, according to the CRPD Committee and other stakeholders. Another funding-related issue is the capacity of Local Self-Governments (LSGs) to absorb and utilize earmarked funds from the national budget. Additionally, since institutional care is funded nationally and CBS are primarily funded locally, some interviewees suspect that LSGs lack interest in providing CBS when institutional care incurs no cost to them.

In-country adoption of CWD is virtually non-existent, likely due to similar reasons why specialized foster care is less developed than foster care for non-disabled children—stigma, prejudice, and a lack of CBS and services for CWD and their families.

4.2. Internalisation journey

4.2.1. Commendable Incorporation and poor enforcement

An analysis of several critical laws reveals that each new piece of Serbian legislation has progressively incorporated the CRC, CRPD, and UNGA resolutions on the rights of the child, including UN Guidelines, more extensively than its predecessors. However, an exception is the Law on Financial Assistance to Families with Children, which included a problematic cost-cutting norm that was nullified following a Constitutional Court decision.[446] Some laws have introduced rules that surpass the recommendations of the UN Guidelines. For instance, these laws stipulate that any placement of a child in institutional care should be temporary, aligning with recent UNGA resolutions on the rights of the child.

In another case, a law completely aligned with UN Guidelines by prescribing that children under three are not placed in institutions as a rule. One interviewee, a decision-maker in the

[446] See ‘Constitutional Court’.

state authority for social protection, regarded the UN Guidelines as authoritative as a binding document, a perspective that is reflected in Serbian law, as shown. The authoritativeness of the UN Guidelines in the country, however, was certainly not coincidental and was most likely supported by the intensive work of UNICEF, and other NGOs such as SOS Children's Villages Serbia to promote and implement it in law and practice, according to an interviewee.[447] Conversely, the CRPD and the CRPD Committee's interpretations regarding the provision of alternative care only in families for CWD, are not domesticated. Overall, this analysis suggests that Serbian statutory law is particularly receptive to the norms of the CRC and, to a lesser extent, the CRPD.

In other words, Serbian laws have become mostly aligned with the CRC and the UN Guidelines in the past 20 years. Also, the right to special assistance and protection of children deprived of their family environment, (Article 20 (1) CRC), the obligation to provide alternative care (Article 20 (2) CRC), special protection of CWD and extended assistance to parents free of charge (Article 23 (2, 3) CRC), are incorporated in the Constitution and the law.[448] The prioritization of family environment over institutional care has a history of over 100 years in Serbian law, hence it even precedes IHRL standards. The norm of the law that institutions for children can have the maximum 50 residents, however, is not aligned with UN Guidelines which recommended small, high-quality residential care.[449]

Contrasting with the commendable incorporation of the CRC, Serbian law has not integrated CRPD Article 23 (5). Institutional care is explicitly regarded as a form of care and despite the DI efforts, there are no signs of intention to legally ban institutional care for CWD. In relation to SSRC Serbian authorities are aligned with the interpretation of the CRPD Committee that SSRC is a form of institutional care. This is evidenced through the explicit categorization of SSRC as a form of institutional care in LSP.[450] Also, SSRC, in general, is not widely used, and five SSRCs that are operational were constructed to transfer CWD from an institution where DRI uncovered horrific material conditions, abuse and neglect of children. The limited proliferation of SSRCs indicates that Serbian authorities view it as institutional care, which is not conducive to realising the DI of CWD.

[447] N., Interview Stefanović, 3rd April, 2023.
[448] See The Constitution', 'Family Law'.
[449] See 'Law on Social Protection'.
[450] "Official Gazette RS", Nr. 24/2011, 117/2-22 - decision of the Constitutional court. Article 47.

Statutory law also incorporates Article 19 CRPD to an extent by prescribing the existence of CBS but falls short of fully implementing the obligation to actually provide CBS. This article is also not incorporated with regard to the obligation to ensure that persons with disabilities, including CWD, are not obliged to live in any particular living arrangement (Article 19(a) CRPD), considering that CWD can be placed in institutional care, hence they can be obliged to live in an institutional environment.

Foster care for CWD is underdeveloped, and despite being a temporary form of care by law, in reality, it is long-term care. The lack of support for family reunification and the availability of specific types of community-based care, such as intermittent foster care, appears to be contributing to the reliance on institutional care for CWD, which goes against the CRPD Committee's position on CBS. The provision and availability of CBS for CWD are inconsistent across Serbia, marked by inadequate family support and limited access to community-based care options, potentially exacerbating the institutionalisation of CWD.

The enforcement gap for domesticated norms is severe, with some critical regulations remaining unenforced for many years after enactment.[451] The enforcement gap is evident in various areas, including the institutionalisation of CWD. Although Serbian law restricts the number of children per institution and prohibits placing children under the age of three in residential care, reports indicate that some institutions still exceed these limits, including housing infants and toddlers with disabilities. Furthermore, the enforcement of residential care as a temporary and short-term solution is inadequate, resulting in many children remaining in institutions for extended periods with few efforts directed towards family reunification or alternative family-based care, such as foster care.

The poor enforcement suggests that while the executive and legislative branches are to an extent willing to align legal and policy frameworks with the rules of international law in relation to CWD and children in general, there is either no political will or not enough capacity to actually enforce and implement those norms and measures. The readiness to incorporate international standards may also stem from low accountability for their implementation. This finding is consistent with opinions and findings of the EU Court of Auditors, academics, and NGOs that rules are incorporated from international or regional law without a real intention to

[451] See ‘Enforcement gap’.

enforce and implement them.[452] This is particularly true in the context of EU integration, where numerous laws and policy documents are adopted to align the domestic framework with EU standards.

Hathaway argues that sometimes states that are not full democracies ratify treaties because the ratification is costless and may earn them some political points, while the costly enforcement is neglected because there are no internal mechanisms that will hold the state accountable for the enforcement of treaties.[453] An insufficient level of the rule of law is thus a significant impediment. In the case of Serbia, it did not only ratify treaties, but authorities regularly adopt laws and policies that stay unimplemented, possibly due to the same reasons – the state institutions such as courts and NHRIs, and private entities such as NGOs are not powerful enough to hold the Government and competent authorities accountable.

Judging by the level of incorporation of primarily the CRC, and also the CRPD, in law and policy, which is not negligible, on the one hand, and on the other the enforcement and implementation issues, it can be said that there is some level of shallow or incomplete internalisation of relevant norms.[454]

In conclusion, although Serbia has incorporated certain CRC and CRPD norms into statutory law, there remains a significant enforcement gap in realising the rights of CWD, particularly concerning institutionalisation, family-based care, and CBS. This enforcement gap is evidenced by the continued reliance on institutional care, long-term placements in foster care, and inconsistent provision of CBS. Efforts are needed to address these enforcement gaps and ensure that the rights of CWD are fully realized in Serbia in accordance with international human rights standards.

[452] SPECIAL REPORT: EU SUPPORT FOR THE RULE OF LAW IN THE WESTERN BALKANS: DESPITE EFFORTS, FUNDAMENTAL PROBLEMS PERSIST (European Court of Auditors. 2022).
[453] Oona A. Hathaway, Why Do Countries Commit to Human Rights Treaties?, 51 JOURNAL OF CONFLICT RESOLUTION (2007).
[454] See more on incomplete internalisation: Ryan Goodman & Derek Jinks, Incomplete internalization and compliance with human rights law, 19 EUROPEAN JOURNAL OF INTERNATIONAL LAW (2008).

4.2.2. The paradox of low institutionalisation of children with disabilities despite ineffective CRPD enforcement

The argument that Serbia has only shallowly implemented legal and political frameworks for the right to live in a family environment for CWD may seem contradictory, given the notably low rate of institutionalisation of CWD in the country. This apparent paradox stems from the assumption that a low rate of institutionalisation should correlate with effective implementation of IHRL obligations concerning the right to live in a family environment. The discrepancy in Serbia suggests that a human right may not be widely violated - evidenced by the comparably low number of institutionalised CWD - even though IHRL norms aimed at realising this right are not effectively implemented. In this scenario, it could be argued that pre-existing non-legal and non-political conditions have, consciously or not, led to the comparatively limited violation of the right to live in a family environment.

This observation is significant for several reasons Firstly, it emphasizes that states are still obligated to meet treaty obligations related to the realisation of this right, including the protection and support of CWD and their families and the provision of family-based alternative care solutions, despite the lack of widespread violations. Failure to meet these obligations can result in poor social inclusion for the beneficiaries and their inability to enjoy other human rights, due to the inter-connectedness of human rights. Secondly, within such a framework, CWD remain at a constant risk of institutionalisation, and should the socio-cultural conditions change, they might find themselves institutionalised. Lastly, from a methodological standpoint, although quantitative data is valuable for assessing the implementation of IHRL norms, interpreting it requires corroboration with additional sources. Notwithstanding, following the TLP scholarship's differentiation of legal, political, and social internalisation of IHRL norms, where the latter can arise independently from the two former types, it could be argued that there is a significant social internalisation of the right to live in a family environment for CWD.[455] The reasons driving social internalisation, namely socio-cultural factors, must be researched using appropriate methodologies, which are beyond the scope of this dissertation.

[455] See Introductory chapter, Chapter 3. Research Framework.

4.2.3. The lack of strategic litigation

Courts have not played a significant role in implementing the CRC and CRPD. Potential reasons include the judiciary's questionable independence from the executive, low public confidence due to this perceived lack of independence, and notoriously lengthy court processes that may deter citizens from pursuing justice. Furthermore, NGOs rarely engage in strategic litigation to achieve their goals, preferring to influence the executive during the drafting of legal acts and policy documents instead.

The analysis of decisions from the Constitutional Court, and the Supreme and appellate courts, reveals a very small number of publicly available cases directly addressing the right of CWD to live in a family environment. This can be due to the lack of such cases, or the above-mentioned legal restrictions of access to cases involving children, guardianship and family relations, or the combination of those two reasons.

One significant decision by the Constitutional Court, which deemed a norm in the Law on Financial Assistance to Families with Children unconstitutional, is crucial for preventing abandonment of CWD by their parents due to financial difficulties.[456] The nullified norm had threatened to further deteriorate the position of these families, potentially forcing some to place their disabled children in institutions to maintain employment and income. This is a notable yet rare example of successful strategic litigation addressing legislation indirectly related to the right of CWD to live in a family environment in Serbia.

In that context, some significance in the realisation of that right in Serbia should be attributed to the Constitutional Court, NGOs, and the practice of strategic litigation, even though the decision was not based on that specific right or the CRC and CRPD. The fact that this is the only such case indicates an extremely limited use of the Constitutional Court to facilitate the implementation of relevant CRC and CRPD norms in Serbia. This case fulfils the requirement of strategic litigation since the litigation originated from NGOs, with arguments centred on child rights and human rights norms in the CRC and domestic legislation.[457] The court's decision altered a general legal act, potentially benefiting all families with CWD where parents work across Serbia.

[456] See ‘Constitutional Court’.
[457] See note 295.

The Supreme Court cited the CRC to support its arguments concerning parental duties to provide children with the highest attainable living standards, health protection, education, and opportunities for rest, leisure, play, and recreation.[458] However, the analysis of the Supreme Court decision does not provide sufficient information to conclude that such decisions have aided the realisation of the right to live in a family environment or the internationalisation of relevant CRC and CRPD provisions, nor can they be considered examples of strategic litigation.

The review of court practice identified a few significant cases on deprivation and restoration of parental rights before appellate courts over children in institutions.[459] It was discovered that one appellate court had recently, on two separate occasions, based its decisions on the parents' duty to work towards reintegration of their disabled child into the family when the child is placed in an institution. The norm underlying these judgments aimed to 'sanction' parents who fail to work towards this goal by depriving them of parental rights and imposing the duty to pay child support to the institution (as stipulated by the Family Law), while also facilitating the legal adoption of the child to restore family life in an adoptive setting. Both judgments were adopted in 2021, and by the same appellate court. This is an underwhelming quantity, for which it cannot be argued to significantly impact the realisation of the right to live in a family environment for CWD. Nonetheless, it is highly questionable whether such an approach by the courts is indeed favourable for the reunification of children with their parents, or it discourages the reunification. Given that not a single child with a disability was reunified with their parents in 2021, this approach does not appear to be effective. Additionally, this approach aims to create conditions for adopting children in residential care, which proved futile as no children with disabilities residing in CYWD institutions were adopted in 2021.[460] Considering that the two decisions are relatively recent, it is possible that such decisions had not been made in the past, and that if similar decisions, in an effort to harmonize the practice of courts, based on Article 81 (3)(4) Family Law are made in the future, they could result in either more reunifications or more adoptions of CWD who reside in institutions.

To sum up, based on the available decisions of the courts, it can be concluded that they have not been significant agents of the implementation of relevant CRC and CRPD provisions. The significant potential, however, can be found in the strategic litigation before the Constitutional

[458] See 'Supreme Court'
[459] See 'Appellate courts'.
[460] See note 99.

Court, either through the submission of initiatives for the review of constitutionality and legality or through the constitutional complaint. The review of constitutionality and legality is free and relatively simple to initiate, although it does involve a certain level of expertise by those who submit the initiative. On the other hand, potential costs, length of courts' procedures and low confidence in the judicial system can repel many individuals from starting such a journey.[461] After all, considering that the Serbian legal system does not recognize courts' practice as a source of law, the impact of such decisions on individuals other than parties in the process is significantly more limited than in common law systems. Following that, one could argue that strategic litigation could be attainable only through the Constitutional Court, or the Supreme Court. A study about strategies of disabled people's movement in Serbia uncovers that strategic litigation is rarely used for their goals, for the reasons mentioned.[462]

The finding of this analysis is consistent with Simmons' finding that litigation is a significant agent of implementation of IHRL only where courts are independent and of a 'good quality'.[463] Also, obligations to provide support to families or family-based alternative care is of a positive nature, which seems to be harder to litigate than liberties in general. Moreover, the limited activity of the Austrian judiciary regarding the right to live in a family environment suggests that the independence and quality of courts are not the sole conditions necessary for courts to play an impactful role in implementing this right. Other factors include the legal system's adherence to the *stare decisis* doctrine, the possibility of directly applying human rights treaties in court, the extent of the CRC and CRPD incorporation, and the awareness among NGOs and potential litigators of the right for CWD to family life.

4.2.4. Large potential of NHRIs and futility of advisory bodies

The main NHRI in the country, the PC, along with the equality body, the CE, play significant roles in addressing the rights of CWD by actively participating in the drafting of laws and policies. Their contributions are characterised by frequent engagements with state authorities, offering recommendations, and supporting CSOs.[464] However, it is important to note that the

[461] On the low confidence in judicial system in Serbia: Vuković & Mrakovčić, EUROPE-ASIA STUDIES, (2022). Slobodan Vuković, Problemi poverenja u pravosuđe, 41 SOCIOLOŠKI PREGLED (2007).
[462] See note 12.
[463] SIMMONS. 2009, p. 14.
[464] See 'Protector of Citizens (Ombud)'; 'Commissioner for the Protection of Equality'.

impact of these bodies may be limited and can vary greatly. While there are instances where their impact has been significant, there are also cases where their influence may be restricted or inexistent. The competence to initiate a constitutional review of legal acts and actions is a powerful tool available to the NHRIs, yet it is rarely used. Both bodies have consistently referred to the CRC and CRPD in their communications with state authorities, recommending measures compliant with these conventions in relation to DI, including the expansion of CBS and strengthening families. Additionally, the new competence of the PC to monitor CRPD implementation, as outlined in Article 33 of the Convention, could significantly advance the implementation of the instrument in Serbia.

Nonetheless, there might be some synergistic effect of the PC, the CE and CSOs, as demonstrated in the case presented before the Constitutional Court. This collaborative effort resulted in successful litigation, resulting in the norm that threatened to decrease the financial support to families with CWD being declared unconstitutional. Although there is no evidence that the PC and CE intentionally collaborated on the issue, they have acted in the same direction and towards the same ministry, using similar arguments, as well as the CSOs. To sum up, the NHRIs are significant actors in the promotion of implementation of the CRC and the CRPD, and the most effective when there is collective action and coordination among the bodies and CSOs.

The Government Council for the Right of the Child and the Council for Persons with Disabilities have had a limited impact on implementing the CRC and CRPD.[465] This is primarily due to their advisory roles, lack of independence, transparency, infrequent meetings, and disruptions in operations whenever a new government is formed. A council for the implementation of UN human rights recommendations is more transparent in work, has regular meetings, and involves CSOs, but lacks structural independence. An independent body to monitor the implementation of the CRPD is yet to be established with the PC. Therefore, it cannot be concluded that these structures had any significant impact on the realisation of the right to live in a family environment for CWD.

[465]See ‘Structures to facilitate the implementation of human rights treaties’.

4.2.5. Public policy planning and realisation gap

There is a considerable number of public policy documents related to the rights of CWD including the right to live in a family environment, alternative family-based and residential care, that have been adopted in the past 15 years in Serbia. Some implementation gaps were identified above, and others were reported by various actors in the process, including the CRPD Committee, the CRC Committee, the EU, NGOs, and even by the MOLSA. Some of the strategic documents, including the DIS, were not accompanied by implementation plans (action plans), which hindered their effectiveness from the outset.[466]

Newer strategic documents, like the SIPWD 2020-2024, are accompanied by action plans, albeit with significant delays, despite the legal requirement to adopt these plans no later than 90 days after a strategy is adopted. Therefore, most planned measures and activities of strategic documents are not implemented at all or not in a given timeframe. Generally, all relevant documents highlight the importance of family-based care for CWD, prioritising the development of alternative care and family-oriented services over institutional care. Therefore, broadly speaking, most strategic documents were compliant with the CRC, while compliance with the CRPD was occasional. The only document that foresaw the creation of conditions for the transformation of large institutions to SSRC was the strategy addressing violence against children, while other documents completely avoided the development of SSRC. This implies that, for the most part, Serbia's authorities have complied with the CRPD and the CRPD Committee's recommendations concerning the avoidance of SSRC.

Public policy documents also reveal a specific feature of DI in Serbia: the plan to transform large residential institutions into providers of other services. This is likely an attempt to avoid potential conflict with many employees of large residential institutions, who have opposed reforms since the early 2000s. Some residential institutions for CWD are situated in underdeveloped areas of the country, in small towns or rural areas, where the local population is economically dependent on those institutions. One interviewee commented that: 'A (residential) institution is a factory for a small town'. It is not clear how large residential institutions, situated in rural areas, will become service providers of CBS that are supposed to be provided in the place of living of a child with a disability and his/her family, considering the distance from more populated areas. The aforementioned anti-violence strategy even

[466] See 'Deinstitutionalisation Strategy', 'Other policy documents'.

envisaged transforming large institutions into SSRCs, a concept that is particularly problematic and starkly contradicts both the CRC and the CRPD.[467]

The analysis showed that EU accession-related strategic documents are seemingly more likely to be at least partly implemented than other strategic documents.[468] However, the express implementation of the APC23 was related only to the legal amendments, which was also recommended by other actors, hence it cannot be attributed only to this document, and the renovation of institutional care facilities which is overall not conducive to the realisation of the right to live in a family environment for CWD. Furthermore, while these documents reference the CRPD and the CRPD Committee's positions, they include actions that are not compliant with those guidelines. There could be several reasons for a more dedicated approach to EU-related planning including the connection of the progress of Serbia towards EU membership, which is an overall strategic goal of all Governments of the Republic of Serbia in the last two decades. In that way, an 'issue linkage' is created between the realisation of the rights of CWD and the implementation of the CRC and the CRPD on one hand, and on the other the progress towards membership in the EU and access to EU funds, on the other. Notwithstanding, the impact of such a linkage depends on the relationship between Serbia and the EU and other issues in the context of the negotiations.

Conversely, the extensive and expensive renovations of existent small and large residential care were planned in the EU accession related APC23, despite the concurrent reference to the CRPD and GC5 of the CRPD Committee in the same document. The renovations were undertaken expressly and are one of the rare measures timely implemented, which can raise the question of the commitment of Serbian authorities to the development of CBS, that are a backbone of the DI process, and focus more on investments in residential care.

In conclusion, current public policy documents set measures for DI of CWD, prioritization of family-based care, and transformation of residential institutions. However, these plans have shortages, as they are not comprehensive enough and action plans for their implementation are regularly long overdue. Importantly, all strategic documents in the past and currently have

[467] Such an approach has been fully adopted in implemented in Austria: See Part II, Austria, Chapter 2.2. Reform of the long-term care system and residential care.
[468] See 'Other policy documents'.

emphasised that the provision of CBS and support to families is a precondition for a successful DI.

4.2.6. European union, democratic transition, and NGOs

An issue linkage has been identified between Serbia's EU accession negotiations and the rights of CWD. The progress of Serbia towards EU membership and access to significant EU financial assistance is conditioned, among other things, on the progress in implementing the CRC and the CRPD, including the DI of CWD.[469] The quality of this linkage is sensitive to the overall relationship between Serbia and the EU. Still, the relevant issue might not be the highest on the agenda in the negotiations process, and other topics might be more pressing for the EU and Serbia such as the reform of the judiciary, Serbia-Kosovo relations, or media freedom.

Nonetheless, from the onset of democratic transition in 2000-2001, the EU supported reforms relevant to the rights of CWD to life in a family environment by providing funding for the expansion of foster care and the expansion and provision of CBS. Serbia-EU strategic documents, such as the Action Plan for Chapter 23, have included DI-related measures specifically aimed at CWD, which have contributed to the adoption of relevant laws and policies; however, the practical implementation remains questionable.

Another collateral consequence, as Hathaway argues, involves the actions of NGOs that are prepared to expose human rights violations, potentially damaging a country's image in international forums. This can have material consequences, especially for transitional countries like Serbia.[470] This is exactly what happened on several occasions when NGOs published in total four human rights monitoring reports from institutions for CWD, between 2007 and 2021.[471] Although the impact of these reports is difficult to assess, an immediate consequence was identified when further admissions of CWD were halted, and those stationed in the Kulina institution were transferred to SSRCs. As it was argued, the reports have most likely increased the visibility of the issue and incited authorities not to turn a blind eye to CWD in institutions. Secondly, raising public awareness about appalling conditions in some institutions could have

[469] See 'European Union'.
[470] A. Hathaway Oona, Why Do Countries Commit to Human Rights Treaties?, 51 THE JOURNAL OF CONFLICT RESOLUTION (2007).
[471] See 'International and domestic organisations'.

discouraged some parents from placing their disabled children in institutional care. Moreover, it should not be overlooked that these reports would not have been possible without the authorization of competent authorities allowing NGOs access to closed residential institutions. Therefore, some level of transparency was a precondition for the successful work of the human rights NGOs.

Nevertheless, only a few human rights NGOs have addressed the issue as human rights watchdogs, while the majority of the disability-oriented civil society, primarily DPOs, has largely remained silent on the serious violations of the rights of CWD. Instead, these organisations, such as the National Organisation of Persons with Disabilities of Serbia, have focused on cooperating with authorities without making meaningful attempts to hold them accountable, as indicated by research on the disabled people's movement in Serbia.[472]

Apparently, international organisations, particularly UNICEF, have played a significant role in transitioning from institutional to family-based care. UNICEF has supported the expansion of family-based alternative care since the early 2000s and continues to provide various forms of support, including social protection expertise and research.

Table III.13List of facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in Serbia.

Serbia		
	Facilitators	Impediments
1.	The long tradition of alternative family-based care;	The legacy of institutional care for people with disabilities;
2.	Democratic transition;	Stigma and prejudice against people with disabilities in the society and amongst decision-makers;
3.	Cooperation with the EU and alignment with the EU acquis;	Wars and economic sanctions during the 1990s;
4.	Expansion of family-based care after 2003;	Cost-cutting in the public sector including social protection after 2013;
5.	Legal reforms and incorporation of some CRC and CRPD norms and standards	The resistance to change from within the system of social protection, primarily from institutional care;

[472] See note 12.

	from UN Guidelines and later UNGA resolutions on the rights of the child;	
6.	The support of international organisations, primarily UNICEF;	Poor separation prevention and reunification interventions;
7.	The work of NGOs human rights watchdogs;	The resilience of institutional care on cost-cutting and adverse times and sensibility of family-based care and CBS;
8.	Involvement of the NHRIs in law- and policymaking;	Renovation and expansion of residential institutions for CWD;
9.	The Constitutional Court's review of constitutionality and legality;	Insufficient and unsustainable funding of CBS, and the lack of capacities of local municipalities to utilize earmarked funds;
10.	Complementary actions of NHRIs and NGOs;	Uneven distribution of CBS;
11.	The transparency of authorities in relation to the situation in institutional care.	The lack of plurality of CBS providers and demanding licensing conditions;
12.		The lack of independence or the inexistence of bodies that facilitate the implementation of the CRC and the CRPD;
13.		The underenforcement of laws and policies amidst the lack of political will;
14.		The lack of accountability of incumbents;
15.		Insufficient independence of the judiciary and thereof the lack of strategic litigation;
16.		The lack of independence of the largest DPOs;
17.		The lack of meaningful engagement of CSOs in law- and policymaking.

PART IV South Africa

1. Context

The Republic of South Africa is a country in the Sub-Saharan region, with an estimated population of 60,6 million citizens in 2022. The share of children under 15 in the South African population is 28.1%, amounting to over 17 million individuals.[1] Children under 18 make up around 34% of the population, which is approximately 20 million children.[2] The largest number of children lives in Gauteng, followed by KwaZulu-Natal.[3]

The number of CWD in South Africa varied from 474.000 to 2.1 million in different reports, according to a government situational analysis from 2012.[4] The prevalence of HIV/AIDS amongst South Africa's population is estimated to 13.9%.[5] The high prevalence of HIV/AIDS is one the causes behind the large population of children without living parents. However, the Children's Institute's website explains it is well-established that children in South Africa often do not live with their parents in the same household, which does not mean they are necessarily abandoned by their parents.[6] Children are often cared for by their relatives, such as grandparents, aunts and uncles and other members of the community. The Institute reports that the largest shares of children who do not live with either of their parents are in the Eastern Cape and the Free State (32.8% and 24.3%) and the lowest in Gauteng and the Western Cape (10.6% and 14.3%).[7] Two sources show that the share of children who live with both parents in South Africa is one of the lowest in the world - 32% and 34%.[8] This characteristic of South African childhoods, according to the research, is caused by many factors including the labour migration and Apartheid population policies, poverty, education and housing possibilities, childcare

[1] South Africa Yearbook 2021/2022, (2022), Government Communications.
[2] *Children in South Africa*, Children's Institute, UCT, (2022), accessed 23rd June 2022, *available at* http://www.childrencount.uct.ac.za/indicator.php?domain=1&indicator=1.
[3] Id. at.
[4] CHILDREN WITH DISABILITIES IN SOUTH AFRICA: A SITUATION ANALYSIS 2001-2011 (Department of Social Development / Department of Women, Children and People with Disabilities / UNICEF. 2012).
[5] Government Communications, 2022, p. 3.
[6] Children's Institute, UCT, 2022.
[7] Id. at.
[8] World Family Map. Mapping Family Change and Child Well-being Outcomes, (2017), Social Trends Institution. Children's Institute, UCT, 2022.

practices established through custom, low marriage and cohabitation rates.[9] Therefore, nuclear families are less prevalent in the South African society than some other forms of families.[10]

The country has 9 provinces, of which the largest by population is Gauteng with 16.1 million, followed by KwaZulu-Natal with 11.5 million residents in 2022.[11] Gauteng is also the smallest province by area and the home of one of three capital cities Pretoria, and the biggest city Johannesburg. The other two capital cities, Bloemfontein and Cape Town are situated in the Free State and the Western Cape, respectively. The seat of the Government of South Africa is in Pretoria, the Parliament is in Cape Town and the Constitutional Court is in Johannesburg. Gauteng is the home for 21% of South Africa's children under 15, which is approximately 3.5 million.[12] It is a financial and business centre of the country, and the province with the highest *per capita* income in South Africa.[13] The capital of the Gauteng Province is Johannesburg.

South Africa is an upper middle-income country[14] with a high human development index (ranked 114th in the world).[15] South African society is commonly considered one of the least equal societies in the world, and with a notoriously high unemployment rate.[16] The diverse population of South Africa follows many different religions and religious denominations, including Traditional African religions, Christianity, Islam, Hinduism and Buddhism.[17] South Africa borders with Lesotho, Eswatini, Mozambique, Botswana and Namibia.

The Republic of South Africa is described as a multiparty, parliamentary, constitutional democracy,[18] with the first democratic elections held in 1994. South Africa has been part of the AU (and OAU) from 1994 and a state party to the two most significant human rights instruments of the AU – the African Charter on Human and Peoples' Rights and the African Charter on the Rights and Welfare of the Child (1994 and 2000 respectively). It is also a part

[9] Institution, 2017, p. 26. Children's Institute, UCT, 2022.
[10] Revised White Paper on Families in South Africa, "Government Gazette RSA" Nr. 44724, Department of Social Development, 2021, p. 150 – 151.
[11] Government Communications, 2022.
[12] Children's Institute, UCT, 2022.
[13] Government Communications, 2022. p. 4.
[14] *World Bank Open Data*, The World Bank Group, (2023), accessed, *available at* https://data.worldbank.org/.
[15] United Nations Development Programme, *Human Development Report 2020: The Next Frontier Human Development and the Anthropocene*, (2020).
[16] The World Bank Group, 2023.
[17] Government Communications, 2022.
[18] 2022 Country Reports on Human Rights Practices: South Africa, (Human Rights and Labor Beureau of Democracy), U.S. Department of State, 2022.

of an informal group of five economies, commonly referred to as BRICS, which includes Brazil, Russia, China, and India.

Ann Skelton writes that the elections in 1994 already signified a positive outlook for the rights of children in South Africa.[19] Nelson Mandela's proposal to decrease the voting age to 14 and the ratification of the CRC already in 1995, were very good indicators of the new government's motivation to improve the state of children's rights, argues Skelton.[20] The day of the ratification of the CRC by South Africa (16th June) is also the continental Day of the African Children, and the day when the Soweto uprising from 1976 is annually commemorated, thus the symbolism is strong. The Constitution adopted in 1996 included solid protection of children's rights, which was further evidence for the strong child-rights orientation of the new Republic.[21] In the next 15 years, explains Skelton, a number of child-rights-oriented laws were adopted. Undeniably, the political transition of 1994 was a significant driver of change also for children's rights in South Africa.

Nelson Mandela's African National Congress (ANC) party has been the dominant political force since 1994. In 2023, the President of South Africa is ANC's Cyril Ramaphosa, and the party holds 57.50% of seats in the National Assembly. The ANC's manifesto for elections in 2019 stated that the Government will increase access to social grants including for orphans, children, and persons with disabilities, and make disability a cross-cutting issue in all government programmes.[22]

The book "Incorporating the UN Convention on the Rights of the Child into National Law" explores the incorporation of this instrument in 12 jurisdictions. It contains a chapter on South Africa, written by Ann Skelton. The author in her section explores the level of incorporation, gaps, as well as drivers and obstacles in the process. Civil society, courts, and strategic litigation are found to be important factors in the incorporation of the CRC, while Parliament and independent human rights institutions are much less significant drivers.[23]

[19] Ann Skelton, *Incorporating the CRC in South Africa*, *in* INCORPORATING THE UN CONVENTION ON THE RIGHTS OF THE CHILD INTO NATIONAL LAW (Ursula Kilkelly, et al. eds., 2021), p. 146.
[20] Id. at, p. 147
[21] Constitution of the Republic of South Africa, "Official Gazzette RSA" No. 108 of 1996, amend. 2013, 1996. Article 28.
[22] The ANC's 2019 election manifesto (African National Congress ed., 2019).
[23] Skelton. 2021.

This thesis explores the implementation of relevant CRC and CRPD norms on the right of children with disabilities to live in a family environment and alternative care. Therefore, it examines not only the legal incorporation of the CRC and CRPD but also their application and the factors that have influenced the process. Still, there is a significant overlap between this study and Skelton's concerning the exploration of the legal incorporation of the CRC, the role of courts and strategic litigation. Ann Skelton's study, however, lacks a disability-rights perspective and does not touch upon the rights of CWD. Drivers and obstacles and the overall success in the implementation of children's rights found by Skelton do not necessarily relate to CWD, especially considering that those children are more often than not left behind during reforms.

There are other relevant studies on the incorporation or implementation of the CRC in South Africa, including Kilkelly's and Liefaard's study "Legal implementation of the UNCRC: lessons to be learned from the constitutional experience of South Africa".[24] That study looked into the potential for the maximisation of constitutional protection of children's rights, especially through the South African Constitutional Court.

The Centre for Human Rights of the University of Pretoria published in 2015 a study titled "South Africa Disability Legislation and Policy Gap Analysis".[25] The study, unfortunately, does not address the issue of institutionalisation and alternative care for CWD. It does, however, provide a valuable starting point for the identification of relevant pieces of legislation, policy documents and case law.

UNICEF has conducted several relevant studies in South Africa and the region in the last 20 years. In 2021, a publication from the UNICEF ESARO called for care reform and a decrease in reliance on residential care for children in line with UN Guidelines.[26] A separate paper on the situation of CWD and care reform in the region was published in the same year. There, UNICEF ESARO called for a more careful approach to small residential care, and noted the opposition of the CRPD Committee and the Special Rapporteur on the rights of persons with disabilities to such care.[27] Most recently the same office published a report on inclusive

[24] Ursula Kilkelly & Ton Liefaard, *Legal implementation of the UNCRC: lessons to be learned from the constitutional experience of South Africa*, 52 52 DE JURE LAW JOURNAL (2019).
[25] SOUTH AFRICA DISABILITY LEGISLATION AND POLICY GAP ANALYSIS (Charles Ngwenya, et al. eds., Centre for Human Rights, University of Pretoria.).
[26] Caring Systems: Maximising synergies between care reform and child protection system strengthening in Easterrn and Southern Africa, (2021), UNICEF ESARO.
[27] Children with Disabilities and Care Reform in Eastern and Southern Africa, (2021), UNICEF ESARO, p. 12.

education in Southern and Eastern Africa.[28] In 2015, UNICEF studied the situation of children with disabilities under four years of age and their access to early childhood development services in South Africa. It noted, *inter alia*, the issue with the proliferation and poor implementation of public policies and the lack of focus on CWD.[29] In the past, UNICEF South Africa published a situational analysis on CWD in the country for the period 2001-2011.[30]

1.1. Legal system, the Constitution, and international treaties

The legal system of South Africa is commonly called South African Law and is a mix of Roman and Dutch law. The influence of those two legal systems is a consequence of the colonisation of the southern tip of Africa, by Dutch colonists in the 17th century, who were followed by British colonists. Customary law is recognised in the Constitution of the Republic of South Africa (the Constitution).[31] Skelton explains that it is still practised in parts of the country, despite the introduction of European legal systems.[32]

The Roman-Dutch mix was heavily influenced by the English common law system, hence there is a law of precedent in South African Law, further elaborates Skelton.[33] *Stare decisis* principle means that law is developed through case law, and that lower courts are bound by decisions of higher courts. This is an especially important characteristic to consider when examining the implementation of IHRL norms in South Africa. It is expected that the law of precedent attracts a larger volume of strategic cases compared to systems where court decisions cannot be sources of law, such as in Austria and Serbia. Furthermore, this should facilitate a significant impact of strategic litigation, provided that the judiciary is independent from other branches, particularly the executive. Additionally, CSOs might focus more on strategic litigation than on advocacy in a narrow sense.

[28] Mapping and Recommendations on Disability-Inclusive Education in Eastern and Southern Africa, (2023), UNICEF ESARO.
[29] Study on Children with Disabilities From Birth to Four Years Old, (2015), Department of Basic Education & UNICEF South Africa.
[30] Children with Disabilities in South Africa: A Situation Analysis 2001-2011. 2012.
[31] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. Section 39.
[32] Skelton. 2021.
[33] Id. at, p. 149.

1.1.1. Status and effect of international treaties

The Constitution prescribes that an international agreement becomes law once it is enacted by national legislation, which has not yet been done in the case of the CRPD.[34] Therefore, the ratification itself is not enough, but an adoption of a law is needed for courts to base decisions on an international treaty. Nevertheless, an international treaty is binding upon South Africa after ratification.[35] Section 231(4) more closely aligns with a dualist than a monist system, considering the explicit need for legal incorporation before a treaty is enforceable, except for self-executing provisions of a ratified treaty, where those provisions are not inconsistent with the Constitution or an Act of the Parliament.[36] Scholtz and Ferreira exhibited the same understanding.[37]

Notwithstanding, Sloth-Nielsen and Kruuse argued that the South African courts go beyond the monism/dualism division in the case of child rights and are even invoking soft law instruments on child rights.[38] Additionally to Section 231 (4), Sections 39 and 233 of the Constitution stipulate that the courts must consider international law when interpreting the Bill of Rights, and interpret any legislation in consistency with international law.

The South African Law Reform Commission (SALRC) refers to several legal experts who support an understanding that international agreements are not applicable before the court before a national legislation is enacted.[39] Still, according to Strydom and Hopkins, the state is prohibited from doing anything conflicting with the international agreement in the period between the ratification and the enactment of appropriate legislation.[40]

Discussions on monism / dualism exist in South Africa as in many other countries. This does not surprise considering the issue is rarely a "clear cut" question, and that reality might be different and more complex than an understanding obtained through a literal interpretation of

[34] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. Section 231 (4).
[35] Id. at. Article 231 (3).
[36] Id. at. Section 231 (4).
[37] Werner Scholtz & Gerrit Ferreira, 41 41 THE COMPARATIVE AND INTERNATIONAL LAW JOURNAL OF SOUTHERN AFRICA (2008), p. 332.
[38] Julia Sloth-Nielsen & Helen Kruuse, *A maturing manifesto: The constitutionalisation of children's rights in South African jurisprudence 2007-2012*, 21 21 THE INTERNATIONAL JOURNAL OF CHILDREN'S RIGHTS (2013), p. 22.
[39] Domestication of the Convention on the Rights of Persons with Disabilities, Issue paper No. 39, SALRC, 2020. Chapter 8.
[40] Hennie Strydom & Kevin Hopkins, *International Law*, *in* CONSTITUTIONAL LAW OF SOUTH AFRICA SECOND EDITION (Stuart Woolman, et al. eds., 2015). *as cited in* Issue paper No. 39, SALRC, 2020, p. 149, para. 8.4.

a supreme law. Regardless, the CRPD has not been enacted domestically through legislation, and the SALRC's work on the incorporation of the CRPD is aimed at changing that.

1.1.2. The Bill of Rights

The Bill of Rights, *inter alia*, prohibits discrimination and is based on equality of outcome.[41] It expressly recognises that some individuals and groups may be in a particularly marginalized position, and some legislative and other measures may be taken to ensure their equality.[42] "Unfair" discrimination on the grounds of disability is explicitly recognised, while the Bill of Rights also recognises that differential treatment may be justified in some cases. The norm against unfair discrimination, however, allows exceptions on the grounds of disability, unlike those based solely on race, ethnicity, social origin, colour, sex, religion, and language. The "fair discrimination" aligns with the concept of affirmative or preferential measures as detailed in the Anti-Discrimination Act.[43]

Section 28 specifically addresses the rights of children. It was seen as one of the most advanced constitutional provisions concerning children's rights at the time of adoption.[44] The right to "family care or parental care, or to appropriate alternative care when removed from the family environment" is guaranteed.[45] Children also have the right to social services, and that their best interests are paramount in every matter concerning the child.[46] The right to social services, and social assistance where needed is also defined in §27, and subject to progressive realisation.[47]

1.1.3. Judicial system

Section 166 of the Constitution delineates the types of courts within the country. The courts are the Constitutional Court, the Supreme Court of Appeal, the High Court of South Africa

[41] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. § 9.
[42] Id. at. § 9 (2).
[43] Promotion of Equality And Prevention of Unfair Discrimination Act 4 of 2000, "RSA Government Gazette", Act No. 4, 2000. § 14 (1).
[44] Kilkelly & Liefaard, DE JURE LAW JOURNAL, (2019).
[45] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. § 28 (1) (b)
[46] Id. at. §28 (1)(c), (2).
[47] Id. at. §27 (1)(c), (2).

(and any high court of appeal that may be established by an Act of Parliament to hear appeals from any court of a status similar to the High Court of South Africa), the Magistrates' courts (and any other court established or recognised in terms of an Act of Parliament, including any court of a status similar to either the High Court of South Africa or the Magistrate's Courts).

The CC is the highest court in South Africa and it may, *inter alia,* decide on the constitutionality of any parliamentary or provincial bill. The President, Provincial Premiers, and members of the Provincial legislature may refer legislation to the CC for the review of constitutionality.[48] Apart from the CC, all courts, except those lower than the High Court of South Africa, may rule on the constitutionality of any legislation or an act of the president.[49] Any ruling of these courts on the constitutionality must be confirmed by the CC.

The Supreme Court of Appeal is never a first-instance court, and it issues judgments that are binding on all courts in South Africa. The High Court of South Africa has a division in each province, and its judgments are binding on other courts in that province and persuasive for courts in other provinces. It can be a first-instance and a second-instance court. Skelton explains that it is part of common law that the High Court has inherent jurisdiction over cases concerning minors.[50]

Children's courts are a special type of courts, which are on the level of Magistrate's courts. They decide on various issues including the provision of early intervention and developmental services, well-being and protection of the child, placement in temporary safe care, alternative care, or residential care, adoption.[51] The Magistrates' courts judgments are not binding on other courts. Skelton argues they do not have much impact beyond the case concerned, however, those cases may climb up the court hierarchy through appeals. To support this, Skelton lists several cases which started before Magistrates' courts, but ended up being adjudicated by the CC and changing the law in South Africa.[52]

[48] Id. at. § 127 (2)(c), §79(4)(b), (5), §84 (2)(c).
[49] Id. at. §170.
[50] Skelton. 2021, p. 152.
[51] Children's Act, No. 38, 2005. § 45, 46.
[52] Skelton. 2021, p. 151.

1.1.4. The Parliament

The Parliament consists of the National Assembly and the National Council of Provinces. The National Assembly must have between 350 and 400 members, who are elected for a term of five years.[53] The Parliament has the national legislative power, the provinces adopt legislation on the provincial level, and the Municipal Councils on the local level.[54]

An important aspect of the work of the Parliament are "portfolio committees", including on women youth and persons with disabilities, then social development, and health. Skelton claims that these committees are important target groups of advocacy efforts.[55] They facilitate the participation of NGOs and other interested groups in the process of drafting law and other acts, which appears especially impactful, according to Skelton.[56]

1.1.5. International and regional human rights recommendations

The present section contains an overview of all relevant observations, recommendations and decisions from the UN human rights mechanism and the regional human rights mechanism on the implementation of the relevant norms. This overview serves as a starting point for the exploration of the implementation of relevant norms in South Africa.

South Africa is a state party to ACHPR (1994), ACERWC (2000), CRC (1995), CRPD (2007), OPCRPD (2007), ICCPR (1998), ICESCR (2015), CAT (1998), OPCAT (2019), CEDAW (2005).[57] South Africa is not a party to the Optional Protocol to the CRC on individual communications.

In 2016, the CRC Committee noted a lack of data on CWD and a general absence of laws and policies aimed at realizing their human rights[58] - a concern also raised in 2000.[59] The same body criticized the increased institutionalization of children due to abuse, neglect,

[53] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. §46 (1), §49 (1).
[54] Id. at. §42, 43.
[55] Skelton. 2021, p. 150.
[56] Id. at.
[57] Years of ratification are in the brackets.
[58] Concluding observations on the second periodic report of South Africa, CRC/C/ZAF/CO/2*, Committee on the Rights of the Child, 2016, para. 43.
[59] Concluding observations: South Africa, CRC/C/15/Add.122, Committee on the Rights of the Child, 2000, para. 32.

abandonment and HIV infections.[60] On the other hand, the CRC Committee commended the adoption of legislation which in case of separation of a child from his/her family prioritizes "family-like" care.[61] Further, the treaty body recommended improvements in the foster care system that experienced difficulties such as "substantial backlog and lapses of foster care orders".[62] It is not entirely clear why the CRC Committee commended the prioritization of "family-like" care instead of family-based care (such as kinship or foster care), considering that the CRC and later standards, including the UN Guidelines clearly prioritize the latter.

In 2018, the CRPD Committee expressed concerns about the institutionalisation of CWD in both formal and informal settings.[63] Accordingly, the treaty body recommended that authorities support CWD in "family and community settings", promote awareness about "family and community-based provisions instead of institutionalisation" and adopt strategic DI documents.[64] Interestingly, the phrase "community settings" was not mentioned in the Concluding Observations of the CRPD Committee examined in the general part of the thesis. It is unclear what the CRPD Committee specifically meant by "community settings"; however, considering that this recommendation came one year after General Comment No. 5, it is certain that the phrase does not correspond to any residential setting for CWD.[65] Most likely, the treaty body referred to the tradition of extended family care and community-care for children including for children without parental care, which is deeply rooted in African societies.[66]

The CRPD Committee was also concerned with the impact of the "Life Esidimeni" tragedy on a DI process in Gauteng,[67] which is explored separately in this study, including through interviews with key informants.

The search of the UPR database, yielded only two relevant results. South Africa received a recommendation from Chile to improve access to services for CWD living in rural areas, while Azerbaijan endorsed the adoption of measures for the protection and integration of CWD.[68]

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[60] CRC/C/ZAF/CO/2*, Committee on the Rights of the Child, 2016, para. 41 (b).
[61] Id. at, para. 41.
[62] Id. at.
[63] Concluding observations on the initial report of South Africa, CRPD/C/ZAF/CO/1, Committee on the Rights of Persons with Disabilities, 2018, para. 12 (c).
[64] Id. at, para. 13 (d), 35 (a).
[65] See Part I, 4.3.1 General Comment No. 5 on living independently and being included in the community (2017).
[66] Usang M Assim, Understanding Kinship Care for Children in Africa: A Family Environment or an Alternative Care Option? (2013), University of the Western Cape).
[67] CRPD/C/ZAF/CO/1, 2018, para. 34.
[68] *UPR Info Database*, UPR Info, accessed: 2nd May 2023, *available at* https://upr-info-database.uwazi.io/en/.

The African Committee of Experts on the Rights and Welfare of the Child recommended to South Africa's authorities to provide care and dependency grants for CWD in 2014.[69] In the same document, the treaty body criticized the lack of data on children in alternative care and commended the expansion of foster care.[70]

In 2019 the African Committee repeated the need to provide disability grants to all CWD, which was challenging due to inconsistencies in the legal framework, as well as the issue of data collection.[71] The treaty body criticized a problem with the foster care system which did not serve all foster carers appropriately resulting in the reduction of this form of care.[72] Further, the African Committee expressed concern that the majority of CWD do not have access to support and services, although the drafting of the White Paper on the Rights of Persons with Disabilities (WPRPD) was commended.[73]

To summarise, the foster care system has expanded but also faced a severe crisis, prompting the Centre for Child Law to file a lawsuit against the competent authorities. The issue of long-term institutionalisation of CWD was addressed solely by the CRPD Committee. Although some improvements in law and policy were acknowledged, their enforcement was questioned by treaty bodies.

The treaty bodies have regularly criticized the lack of data on CWD and data on children in alternative care. This is a significant impediment to the improvement of the position of CWD in South Africa, and also to the implementation of relevant norms. Collecting and analysing quantitative data on CWD is beyond the scope of this study. The lack of quantitative data is also a challenge for assessing the state of rights of CWD in relation to alternative care and life in a family environment, and to assess the enforcement of certain laws, policies, and actions. However, considering that the study is looking specifically into several aspects of implementation or relevant international norms, it is still possible to identify the presence and

[69] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Republic of South Africa Report on the Status of Implementation of the African Charter on the Rights and Welfare of the Child (African Committee of Experts on the Rights and Welfare of the Child), 2014, para. 28.
[70] Id. at, para. 28, 31.
[71] Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child to the Republic of South Africa on its First Periodic Report on the Implementation of the African Charter on the Rights and Welfare of the Child (African Committee of Experts on the Rights and Welfare of the Child), 2019, para. 22.
[72] Id. at, para. 21.
[73] Id. at, para. 28.

the lack of specific factors and some of their characteristics. Considering the lack of data, as well as the lack of legal and policy frameworks, as reported by the treaty bodies, this will likely lead to a conclusion that the implementation of relevant norms is less than satisfying.

2. Situation of children with disabilities

Over the last 30 years, care for children and families has changed significantly, primarily in response to the imperative to address the catastrophic human rights record of the pre-1994 era. Apartheid policies were characterised as dualistic, considering they exhibited different rules and standards based on race. Those racist policies meant that Black, Coloured, and Indian families and individuals were either completely excluded from social benefits or were entitled to a fraction of what White families were eligible for.[74] The dualist policies also encompassed disability benefits and institutional care for children, which results in uneven distribution even today. Additionally, facilities such as special boarding schools were developed in Gauteng and the Western Cape—provinces historically populated predominantly by White families. Consequently, many learners with disabilities today must relocate to Gauteng or the Western Cape, often far from their homes.[75]

In the late 1990s and early 2000s, social benefits, primarily various types of child support and disability grants were significantly expanded. Some authors argue that a post-1994 human rights and development agenda of the democratic government was impacted also by a neoliberal agenda, which meant the decrease of public spending and reliance on NGOs and the private sector for the provision of social and health services.[76] Bond argued that agreements with international financial institutions and other economic policies adopted post-1994, scuppered the later human rights and wealth redistribution efforts.[77] Indeed, a macroeconomic policy of South Africa by the end of 1990s focused on reducing costs for social welfare, and seeing the decrease in reliance on institutionally-based services as a form of cost reduction, rather than a human rights-driven goal, which would include the development of adequate and free of charge community-based services.[78]

[74] "Government Gazette RSA" Nr. 44724, p. 148-149.
[75] Education White Paper 6 - Special Needs Education, (Department of Education), 2001, p. 14.
[76] Abigail Ornellas & Lambert K Engelbrecht, *The Life Esidimeni crisis: Why a neoliberal agenda leaves no room for the mentally ill*, 54 54 SOCIAL WORK (2018), p. 302.
[77] PATRICK BOND, ELITE TRANSITION : FROM APARTHEID TO NEOLIBERALISM IN SOUTH AFRICA (Pluto Press Revised & expanded edition. ed. 2014). Chapter 5.
[78] Growth, Employment and Redistribution. A Macroeconomic Strategy (GEAR), Department of Finance, 1996, p. 15.

The numbers of children in institutional care pre-1994 are not available, while the numbers of CWD in institutional care today are not adequately disaggregated and do not encompass all types of institutional care. The South African Statistics Office published that 5.2% of children in the country over the age of five have some kind of disability. Another study estimates the number of "severely" disabled children to be 474.000, but also acknowledged that data on CWD under five years of age are inexistent.[79] The DSD assessed that CWD make up 28% of the child population in CYCCs,[80] while the UN Global Study found that 20.2% of children in residential care had some kind of a disability.[81] A UNICEF and DBE's research from 2012 also acknowledged the absence of data on CWD in CYCC, and the overall poor data collection on disability and services.[82]

2.1. Contemporary care for children with disabilities

This section of the country study investigates the complexities surrounding the care provisions CWD in South Africa, focusing on support and services for CWD within their families, and family-based and institutional care systems. The analysis reveals substantial deficiencies in data availability concerning CWD in family-based care and underscores systemic shortcomings in recognising and supporting kinship care. However, it also acknowledges the efforts to increase social grant coverage for kinship carers, which indicate a move towards more inclusive care policies. This section explores the Life Esidimeni tragedy from the perspective of responsible DI actions and its wider effect on the prospects of DI in Gauteng and the rest of the country.

2.1.1. Family-based care

The long tradition of care for children outside of a nucleus family means that a large number of children are factually in informal kinship care, for which there is no data on the prevalence,

[79] National Integrated Early Childhood Development Policy 2015, DSD, 2015, p. 44.
[80] Julia Sloth-Nielsen, *Child Protection in South Africa*, *in* THE OXFORD HANDBOOK OF CHILD PROTECTION SYSTEMS (Jilll Duerr Berrick, et al. eds., 2023), p. 554.
[81] MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 190.
[82] Children with Disabilities in South Africa: A Situation Analysis 2001-2011. 2012, p. 68, 69.

claims Sloth-Nielsen.[83] In fact, kinship care is not formally recognised as such, but a member of the family, who is not a guardian of the child, can be recognised as a foster parent. Therefore, the only recognised family-based alternative care option for CWD in South Africa is foster care. One foster household (a single foster parent, or a couple) can care for up to six foster children. This number can be higher where there is a need to place siblings together, or where a court decides that it is in the best interests of all the children.[84]

Foster care can also be organized in clusters, in accordance with the Children's Act. Foster care in a cluster is provided by an organisation which gathers multiple foster parents to care for up to six children per foster parent or a foster couple. Those can be private organisations such as NGOs, companies, and churches. This form of foster care raised concerns in the past about its characteristics which resemble group care, rather than family-based care.[85] This was addressed in several legal amendments, which is explored in the subsection Children's Act.

The data from May 2023 shows that 289.140 children received the foster child grant that month.[86] There is no available data on the number of children in foster care, and no data on CWD in foster care. The amount of a foster child grant is approximately R1120, which translates to approximately 55 EUR per month.[87] A child can be eligible for a foster care grant until the age of 18, or 21 if he/she attends school.[88]

The number of children for whom the foster care grant was paid dramatically increased between 2003 and 2011 (over 500.000), only to plummet by 2023.[89] Hall explains that the increase was the consequence of circumstances on the ground and policy change by the DSD. Namely, the DSD initially found eligible to receive foster grants only the children who were victims of abuse and neglect, and for that reason placed in foster care.[90] Later, the DSD shifted their policy, and also orphaned children, whose number was on the rise due to HIV-related

[83] Sloth-Nielsen. 2023, p. 552.
[84] Children's Act 2005, as amended 2007, § 185.
[85] Carmel R Matthias & F Noel Zaal, *Supporting familial and community care for children: legislative reform and implementation challenges in South Africa*, 18 18 INTERNATIONAL JOURNAL OF SOCIAL WELFARE (2009).
[86] Children's Institute, UCT, 2022.
[87] As of June 2023: *Foster child grant*, Government of South Africa, accessed: 4th July, 2023, *available at* https://www.gov.za/services/child-care-social-benefits/foster-child-grant.
[88] Regulations in Terms of the Social Assistance Act 13 of 2004, "Government Gazette RSA" Nr. 27316, 2005. § 32 (5).
[89] Children's Institute, UCT, 2022.
[90] Id. at.

deaths, became eligible for this type of grant.[91] Further explains Hall, foster care grant is also seen as a poverty alleviation measure, therefore family members, who were not guardians of children but cared for them, were encouraged to apply too.[92] Apart from foster care grants, foster parents may receive the care dependency grant for a disabled child.

The number of CWD in foster care is not publicly available. It is, however, suspected that this number may be disproportionally low, as reported by an interviewee. The interviewee argued that foster care for CWD is not common, and that if it takes place, foster carers are family members of the child.[93] When this observation of a well-positioned DPO representative is compounded with the fact that foster care programmes specifically designed for CWD are lacking, and reportedly the presence of strong stigma and prejudice, it is reasonable to suspect that CWD are rarely benefiting from foster care. Where foster care options are insufficient, children may end up in institutions as the first option.

Several authors and advocates view burdensome and inefficient procedures, coupled with the lack of recognition of kinship care as a form of alternative care, as crisis-generating factors in the foster care system of South Africa.[94] The crisis was evidenced in large backlogs in foster carers' grants payments, for which the CCL initiated a lawsuit against the national and provincial departments for social development. The dramatic decrease in foster child care grants, as shown above, is the direct consequence of the crisis. Sloth-Nielsen explains that the Children's Act's new obligation (as of 2010) to renew court orders with regard to children in alternative care was part of the problem.[95] Namely, the court orders were not renewed timely due to capacity constraints, and hundreds of thousands of pay-outs simply ceased.[96]

The court ordered the DSD to report every six months on the steps taken to comprehensively resolve the problem, by 2022. Some of the solutions have been introduced with amendments to the Social Assistance Act and pending amendments to the Children's Act. The Social Assistance Act enabled the Minister to prescribe a so-called top-up grant as an addition to the child support grant to orphaned children in care of the wider family member or another primary

[91] Id. at. Ann Skelton, *Kinship Care and Cash Grants: In Search and Sustainable Solutions for Children Living with Members of Their Extended Families in South Africa*, INT'L SURV. FAM. L. (2012), p. 336.
[92] Children's Institute, UCT, 2022.
[93] L. B., Interview, 28th June, 2022.
[94] Skelton, INT'L SURV. FAM. L., (2012), p. 334. Katharine Hall, et al., *Social assistance for orphaned children living with family*, SOUTH AFRICAN CHILD GAUGE (2016).
[95] Sloth-Nielsen. 2023, p. 553.
[96] Id. at.

caregiver. This amendment is compatible with the longstanding proposals of experts and civil society.[97] For that purpose the DSD allocated R1.6 billion for the 2022/2023 financial year.[98] This, according to authors, should reduce the burden on the administration and increase the coverage of children in kinship care who receive social grants.[99] Kinship carers, should thus be subject to less strict conditions than a foster carer, and receive an increased child support grant.

The lack of data on CWD in family-based care is a significant obstacle to a more nuanced analysis of the situation. The information on the situation in the social security system, however, indicates a rather bleak picture for CWD in need of family-based care outside of the immediate family. This is based on the crisis of the foster care system, reflected in the dramatic decrease in foster child grants, which was far lower than the number of children in need of those grants. Moreover, experiences from other countries have shown that CWD often do not benefit from family-based alternatives, even when these solutions are well-established. If this is the case in South Africa, the reality for CWD in terms of life within a family environment is likely to be utterly unfavourable.

2.1.2. Institutional (residential) care

CWD are placed in different types of residential care, including CYCC and Care and Rehabilitation Centres (Care Centres). The lack of definition of disability and standardized assessment reduces the reliability of data on the number of CWD in any form of care. The issue with the recognition of the disability of children in residential care was also observed by the author of this study during a visit to a CYCC in the Northern Cape. The institution did not have data on the disabilities of children, but the teaching staff assumed that some of the children had "learning disabilities".[100]

The number of CWD in institutional care is not clear and different sources provide significantly differing numbers. South Africa's Initial report to the CRPD Committee acknowledged the

[97] Skelton, INT'L SURV. FAM. L., (2012).
[98] Government Communications, 2022, p. 204.
[99] Skelton, INT'L SURV. FAM. L., (2012). Sloth-Nielsen. 2023.
[100] The visit to a CYCC was conducted by the SAHRC. The author participated as a staff of the Centre for Child Law, which partnered with the SAHRC.

serious lack and issues with disability data in general, and not only CWD.[101] The UN Global Study situates South Africa amongst the countries with the lowest rate of institutionalisation of children (less than 100 per 100.000 children).[102] The same study shows that 20% of children in South African institutions are disabled.[103] A study from 2012 showed that 21.630 children lived in different institutions, including hospitals and boarding schools according to 2001 population census results.[104] That number seems to be a gross underestimation, considering that the provincial DSD in Gauteng published that 175 institutions for CWD operated only in this province, accommodating 12.000 CWD. The state also noted in its initial report to the CRPD Committee that data on disability cannot be compared effectively due to changes in methodology.[105]

According to a reply from the DSD to a Parliamentary question, there are 397 registered CYCCs in the country, of which 362 are run by non-profit organisations (NPO), and 35 are public.[106] By far the largest number of CYCCs are situated in Gauteng (114), followed by Free State (55), while Limpopo has only 9 registered CYCCs on its territory.[107] There is no information which of those provide care to CWD. There are several CYCCs in Gauteng with a capacity of over 100 beds, with the largest one providing 250 beds (Jakaranda Children's Home), followed by the SOS Children's Villages South Africa (160), while the smallest CYCCs accommodate 8 - 12 children.[108] The total bed capacity in all CYCCs is 18.022, of which 5.058 in Gauteng. The DSD provides an overview of monies allocated to provinces for the CYCCs, but not for Gauteng. In the Mpumalanga 2021/2022 financial year, for example, R55,949,000 was allocated for CYCCs with a capacity of 1,206 beds, averaging roughly R46,400 per bed per year and R3,900 per month.[109] The data by the DSD relates only to the provision of care in CYCCs, which is not the only form of institutional care for CWD.

Research by Hope and Homes for Children (HHC) supplements the data from the DSD. Namely, according to the HHC research, 9.2% of children in CYCC are orphans, and 74%

[101] Initial Report of South Africa, CRPD/C/ZAF/1, (Committee on the Rights of Persons with Disabilities), United Nations, 2009, p. 6.
[102] NOWAK. 2019, p. 503.
[103] Id. at, p. 190.
[104] CHILDREN WITH DISABILITIES IN SOUTH AFRICA - SITUATIONAL ANALYSIS (DWCPD / DSD / UNICEF. 2012), p. 33.
[105] CRPD/C/ZAF/1, United Nations, 2009.
[106] Internal Question Paper, Number 16 - 2022, (Department for Social Development), 2022, p. 5.
[107] Id. at.
[108] Id. at.
[109] This converts to roughly 2.267 EUR per year and 189EUR per month per bed.

remain there between 2 and 10 years.[110] This led them to the conclusion that the temporary care in CYCC is in reality long-term institutional care.

Two main types of institutions for CWD are falling under two governmental departments. CYCCs are defined in the Children's Act and are part of the system of social protection, while Care Centres are defined in the Mental Health Care Act and are a part of the health care system. Psychiatric hospitals may accommodate CWD on a permanent basis too. There are also group homes, a type of group residential care within the community, in accordance with regulations following the National Health Act.[111] Except in psychiatric hospitals and Care Centres, major providers of residential care for people with mental illness and intellectual disabilities are NGOs.[112] Care Centres are types of socio-medical facilities for the long-term care of people with severe or profound disabilities and mental illnesses. They provide basic social protection and medical treatment. In these institutions also involuntary mental health patients may be accommodated.[113] A report by DSD argues that most children with "severe" disabilities are actually placed in institutions under DH and not institutions under DSD.[114]

Under the Department of Education (DE) some "special" schools provide residential care for CWD. The provision of residential care to CWD for education is another form of institutionalisation and deprivation of the family environment. The Global Study recognised that CWD placed in "special" boarding schools are at an "extremely high risk of long-term institutionalisation".[115] Those establishments are not supposed to provide accommodation 365 days a year, according to the DSD.[116] SADA (South African Disability Alliance) claims that over 35.000 CWD are accommodated in special schools with hostels and far away from their

[110] *Hope and Homes for Children: Families, Not Institutions Reforming Child Protection systems from Reactive to Proactive. The Importance of Measurement in Care Reform in South Africa*, Better Care Network, (2023), accessed: 24th April, 2024, *available at* https://bettercarenetwork.org/sites/default/files/2021-10/South%20Africa%20Presentation%20for%20Measurement%20Taskforce%20One%20Child%20One%20Family%20HHCSA%20Aug%2021%20final.pdf.
[111] Policy Guidelines for the Licensing of Residential and / or Day Care Facilities for Persons with Mental Illness and / or Severe or Profound Intellectual Disability, "Government Gazette RSA", Nr. 41498, Department of Health, 2018, para. 2.3.
[112] Id. at, p. 138
[113] Mental Health Care Act, 2002, "Government Gazette RSA", Nr. 24024, 2002. §6 (7).
[114] Comprehensive Report on the Review of the White Paper for Social Welfare 1997, DSD, 2016, p. 127.
[115] NOWAK. 2019, p. 195.
[116] DSD, 2016, p. 127.

homes.[117] Furthermore, the DPO argued that hostels attached to special schools do not differ from large institutions for long-term care, and that CWD are *de facto* institutionalised there.[118]

Also, providers may provide other types of residential care for CWD that are not strictly defined in the law. Moreover, the issue of unregistered providers of residential care may exist, as it is the practice in some other countries, however, no assessments are available on their prevalence. Three interviewees reported that group homes for CWD "pop up" and "flourish" in the Western Cape, and that there might be institutions that are not counted in that province.[119] Furthermore, the interviewees indicated that DI is understood as a transition from large institutional care to smaller institutional facilities that provide residential care, which provided a basis for the flourishment of smaller, NGO-run residential facilities. A report of the DSD also acknowledged the issue of unregistered residential care apparently "mushrooming".[120]

Interviewees emphasised that the lack of provision of basic services such as running water and electricity in some areas, may contribute to the decision of parents or family members to place their child in institutional care, especially if the child requires some level of medical care on a daily basis. Moreover, in the last several years South Africa is experiencing a severe crisis of the national electric supply system, which may further endanger those in institutional care, but also drive some carers to institutionalise their disabled child in the hope that an institution may provide a more stable supply of basic services. Although the insufficiency of disability-specific, home- and community-based services may be a shared feature of all three countries studied here, the issue of access to electricity and running water is predominantly a characteristic of South Africa. Further research is needed to explore any potential link between institutionalisation and the unreliable provision of basic services in South Africa.

Therefore, although the DSD provided some valuable data on children in CYCCs, it does not state how many CWD are in institutional care, where and for how long. Considering that Care Centres according to the law are designated for the permanent care of people with intellectual and severe or profound disabilities, it is suspected that the largest share of children with such disabilities in institutional care is actually in Care Centres, under the DH.

[117] SADA UN CRPD Shadow Report, (2023), SADA, p. 14.
[118] Response to the South African Government's Reply to the List of Issues Of The UN Committee on the Rights of Persons with Disabilities, (2018), SADA.
[119] E. H., et al., Interview, 29th June, 2022.
[120] DSD, 2016, p. 122.

The placement in mental health care institutions, such as psychiatric hospitals and Care Centres is not regulated the same way as the placement in CYCC. The law regulating the care in those facilities lacks safeguarding mechanisms such as the regular review of alternative care placement and placement in institutional care as a last resort, which is elaborated in the subsection on the legal implementation.[121]

The terminology used in the Mental Health Care Act and corresponding regulations, as well as in the Initial report of South Africa to the CRPD Committee, indicate inconsistent use of the notions of institutional care and residential care. Namely, regulations to the Social Assistance Act seemingly use the word "institution" as an umbrella term for any kind of out-of-family care which also provides accommodation/residence to a child. When a child is in such care, they lose the right to the child support grant.[122] Conversely, the State Report to the CRPD Committee clearly distinguishes between institutional and residential care.[123] Then, Children's Act and its regulations used the term residential care and residential care programme to denote out-of-family residential care and programmes provided there, which also includes CYCC.[124] Guidelines for the licensing of residential care for mental health care users defines "residential care facility" as any facility providing residential care, including group homes, care homes, halfway houses, assisted living.[125] None of the residential facilities, regardless of their size, is labelled or described as "family-like".

2.1.3. Community-based services and material assistance

There are three types of grants that may be available to CWD, in accordance with the Social Assistance Act: the child support grant (CSG), the foster child grant (FCG), and the care dependency grant (CDG).[126]

CSG is the most widespread social grant, received by approximately 13 million children in South Africa in 2021.[127] Primary caregivers are eligible for CSG until the child attains the age

[121] See Uneven legal incorporation.
[122] "Government Gazette RSA" Nr. 27316. §4 (2)(d).
[123] CRPD/C/ZAF/1, United Nations, 2009, para. 21.
[124] Children's Act 2005, amendments 2007. § 156 (e)(v).
[125] "Government Gazette RSA", Nr. 41498.
[126] Social Assistance Act No. 13, 2004, "Official Gazette RSA" Nr. 26446, 2004. § 3.
[127] Children's Institute, UCT, 2022.

of 18 unless he/she is cared for in an institution. Also, a child who heads a child-headed household is eligible for this grant. The amount of CSG per child per month is R500, with a top-up of R250 for relatives caring for double orphans (where both parents are deceased).[128] Caregivers are means-tested for the CSG.

The FCG and the problem with its administration are explored in the chapters *Family-based care* and *the Constitutional Court.*

CDG is another significant social grant to all CWD and their families. Immediate parents and foster parents of CWD are both eligible for this type of social grant.[129] The worth of CDG is R 2080, or roughly EUR 102 per month.[130] Hence, foster parents who care for CWD may receive two social grants concurrently. Foster parents are not means-tested for FCG and CDG. Immediate parents are means tested for CDG. Also, a child is eligible for a CDG until he/she attains the age of 18, when he/she becomes eligible for a disability grant.[131]

While the number of paid FCG decreased during the last decade, the number of CDG has seen a steady increase. In May 2023, 158.723 care dependency grants were paid, and in 2015 127.139.[132] In 1998, only 8.000 such grants were paid, while in 2007 99.000, according to South African Social Security Agency, as reported by Hall.[133]

The take-up (coverage) of CDG is not clear, which is the result of the poor collection of data on CWD. Still, the take-up of CDG is believed to be well below the number of children who are eligible for it. The reason for this, according to the UN Global Study, may be that the eligibility criteria and assessment correspond with the medical model of disability, rather than a social model.[134] In other words, the eligibility may be solely based on a medical assessment and diagnosis, and set strictly to exclude a good portion of CWD. Apart from the unknown

[128] The amount of CSG translates to roughly 25.5 EUR and the top-up to 12.7 EUR.
[129] "Official Gazette RSA" Nr. 26446. § 7(a).
[130] As of June 2023: *Care Dependency Grant*, Government of South Africa, (2023), accessed: 4th July, 2023, *available at* https://www.gov.za/services/services-residents/parenting/child-care/care-dependency-grant.
[131] "Government Gazette RSA" Nr. 27316. §32 (6).
[132] Fact Sheet: A statistical summary of social grants in South Africa, (SASSA), 2023. White Paper on the Rights of Persons with Disabilities: Approved by Cabinet on 9 December 2015, "Government Gazette RSA" Nr. 39792, Department for Social Development, 2016, p. 23.
[133] Children's Institute, UCT, 2022.
[134] NOWAK. 2019, p. 553.

take-up, there is an issue with the height of those grants. Bond argues that the distribution of grants is privatised and, as such, is associated with severe issues, as seen in the case of FCG.[135]

There are a number of programmes and services that have been planned and fewer that have been delivered in the last 20 years. Most of these programmes are related to family strengthening and prevention, as well as the protection of children from abuse, neglect, and violence. Hall *et al.* outline the structure of a policy framework aimed at children and families in South Africa Child Gauge 2018. The authors list a number of services grouped in the following way: universal infrastructure and service (for everyone), targeted services and benefits (e.g. social grants and services for CWD) and specialised, emergency services (e.g. alternative care and child protection).[136]

Primary providers of in-home and community-based services, including those for CWD, are DSD and DH, while most social services are delivered by non-profit organisations (NPOs).[137] The uptake and availability of those services are not reliably measured. Still, people with disabilities almost unequivocally criticize the limited availability, as reported by the DSD.[138] The same was reported by several interviewees.[139] Furthermore, the accessibility and availability of general services to CWD is highly questionable, including the early child development (ECD) services and partial care.[140] Only 4-5% of disabled children under the age of 7 attend ECD programmes.[141] The DSD saw main reasons for this were an inadequate allocation of funds towards ECD programmes for CWD, and that the programmes were not tailored for CWD.[142] The responsibility for ECD programmes shifted from the DSD to the Department of Basic Education (DBE) in 2022.

The Inter-ministerial Committee on Early Child Development has found that up to 95% of CWD lack access to parenting support, early childhood disability screenings, community-based rehabilitation services, and early learning and development programmes.[143] The body further

[135] BOND. 2014.
[136] Katharine Hall, et al., *Supporting Families in South Africa: A policy map*, *in* SOUTH AFRICAN CHILD GAUGE 2018 (Katharine Hall, et al. eds., 2018), p. 117.
[137] Id. at.
[138] DSD, 2016, p. 120.
[139] B., Interview Stefanovic, 28th June, 2022. H., et al., Interview Stefanovic, 29th June, 2022.
[140] DSD, 2016, p. 122.
[141] DSD, 2015, p. 44.
[142] Id. at, p. 44.
[143] Id. at.

argues that reasons for this are the lack of additional funding for those programmes and unsatisfying inter-sectoral coordination.

2.1.4. Adoption

Adoption provides a permanent solution to restore the right to family or parental care for CWD. However, UNICEF research indicates that domestic adoption of CWD is relatively uncommon in Southern and Eastern Africa. The insufficient investment in family-based care, the lack of knowledge and prejudice among the general public, social services professionals and decision-makers are named as the main reasons for this situation in the region.[144] The inter-country adoption of CWD is more common, according to the same researChapter[145] Earlier research on trends and patterns of adoption in South Africa reports a low number of adoption, especially when compared to the reported number of children in institutional care, according to authors.[146] This research did not capture a disability perspective of adoptions.

2.2. Lessons learnt from the Life Esidimeni tragedy

The Life Esidimeni tragedy is a case of the transfer of nearly 2000 people with disabilities from a large, psychiatric institution to other forms of residential care and families, which resulted in over 140 deaths in 2016. Arguably, this tragedy has had far-reaching consequences on the future of DI and family- and community-based care in Gauteng and the rest of the country. This was noted by the CRPD Committee, and by some of the interviewees, who indicated that many stakeholders and the general public may be more reluctant to support future transitions from institutional to community- and family-based living for children and adults with disabilities after this tragedy.[147]

Life Esidimeni is a psychiatric residential institution which provides long-term care for adults and children with disabilities, situated in Gauteng. It is a private company, which operates

[144] ESARO, 2021, p. 7.
[145] Id. at, p. 13.
[146] Zitha Mokomane, et al., *Adoption in South Africa: trends and patterns in social work practice*, 17 17 CHILD & FAMILY SOCIAL WORK (2012).
[147] CRPD/C/ZAF/CO/1, 2018, para. 34.

under a public-private partnership agreement with the provincial DH. The institution has 10 facilities across five provinces, with a total of 3000 beds, according to the information on their website.[148] In 2015 GDH terminated the contract with Life Esidimeni and started a process of the relocation of over 1000 residents with intellectual and psychosocial disabilities to other, smaller NGO-run residential facilities.

This process was part of the GDH project titled Gauteng Marathon Mental Health Project. The project aimed at transferring people with disabilities from the large institution, into smaller, NGO-run, residential facilities, closer to the community, then to specialized hospitals and to families. Approximately 1800 Life Esidimeni residents were relocated, of which 1200 were in smaller institutional care provided by NGOs, 275 in specialized hospitals, and 300 with their families.[149] The transfer resulted in 144 confirmed deaths and 44 people whose whereabouts are not known.[150] The remaining users were, after the tragedy, transferred to different hospitals, including back to Life Esidimeni.[151]

Several CSOs reached out to the GDH in 2015 to warn the authorities of the serious dangers of the contract termination with Life Esidimeni, and asked for the process to be slowed down. Section 27, a Johannesburg-based NGO, represented families of Life Esidimeni residents in litigation that settled with an agreement that the GDH provide a safe transition plan. The GDH however did not comply with the agreement and such a plan was never created and implemented.[152] The actions of CSOs resulted in a slight delay in the transfer, and the GDH finally started transfers in 2016. The transfers were characterized as "chaotic" and haphazard, with residents being loaded onto trucks and relocated without their family members knowing their whereabouts.[153]

In September 2016, the Minister of Health requested the Office of the Health Ombud (OHO), Prof. Makgoba, to investigate the deaths of mental health users that were known then. His report, which was published in 2017, uncovered gross violations of human rights and argued

[148] *About us*, Life Healthcare, accessed: 11th July, 2023, *available at* https://www.lifehealthcare.co.za/about-us/life-esidimeni.
[149] Gauteng Province Mental Health Strategy and Action Plan 2019 - 2023, GDH, 2019, p. 19.
[150] Families of Mental Health Care Users affected by the Gauteng Mental Health Marathon Project and the Government of South Africa and Gauteng Province, Arbitration Award, para. 2.
[151] GDH, 2019, p. 84 – 88.
[152] *Life Esidimeni Timeline*, South African Depression and Anxiety Group and Section 27, accessed: 4th September, 2022, *available at* https://www.lifeesidimeni.org.za/what-happened/timeline.
[153] Malegapuru W Makgoba, The report into the circumstances surrounding the deaths of mentaly ill patients: Gauteng Provice (Health Ombud: Republic of South Africa 2017).

that officials and NGOs violated the Constitution, and several of laws.[154] The OHO issued a number of recommendations including the de-establishment of the Marathon Project, disciplinary proceedings of those involved, and that when DI is conducted the focus must be on CBS, which may incur additional costs in initial phases.[155]

The process was flawed and mistake-ridden from the start, involving both competent authorities and care providers. The National Mental Health Policy Framework (NMHPF) 2013-2020 reflects an understanding of DI which includes accommodation of persons with disabilities in group residential care in facilities that are smaller than old, large institutions and closer to communities.[156] Such an approach falls short of aligning with the CRPD and the CRPD Committee's position and may perpetuate all dangers of institutional care in large institutions. Accordingly, less than 20% of 1800 people were transferred to families. Others were sent to smaller institutional care and specialized hospitals, and eventually ended up in much worse conditions than in Life Esidimeni. Considering that the Gauteng project was largely based on the transition to other forms of institutional care, it should be regarded as a process of trans-institutionalisation and not a DI process.[157] Justice Moseneke noted that the plan of the GDH did not align with the NMPHF as it omitted to develop appropriate CBS.[158]

Furthermore, the GDH published that one of the objectives of this action was to decrease the costs of care in the Life Esidimeni institution and align the practice with DI standards. Arguably, this was the main objective of the GDH, even though an audit body had previously assessed the service provided in Life Esidimeni as cost-effective.[159] The cost of care per user per day in NGOs amounted to R112, compared to R320 in Life Esidimeni.[160] Also, the money that was about to be saved up was not allocated to the development and provision of community-based services and support. Justice Moseneke criticized this aspect of the action, as it was obvious that where such an endeavour is cost-saving, then the people will receive poor quality service, which may even threaten their lives.[161] In the long run, community-based

[154] Id. at.
[155] Id. at, p. 54 - 55.
[156] National Mental Health Policy Framework and Strategic Plan 2013 - 2020, Department of Health, 2013. Objective 4.
[157] Steve Lurie, *Comparative mental health policy: Are there lessons to be learned?*, 17 17 INTERNATIONAL REVIEW OF PSYCHIATRY (2005). LAZAR STEFANOVIĆ, TRANS-INSTITUTIONALISATION OF DISABLED PEOPLE. A CRITICAL APPRAISAL OF SOME DEINSTITUTIONALISATION STRATEGIES IN SOUTH AFRICA AND EUROPE § 5 (Provincial Ombudsman and the Institute for Criminological and Sociological Research Belgrade. 2022).
[158] Arbitration Award, para. 29.
[159] Id. at, para. 33.
[160] Id. at. para 38.
[161] Id. at.

care is cost-effective, but at the onset of DI reforms, when two parallel systems are run and when it is imperative to develop quality community-based services, the costs are likely to be high. However, the policy of the GDH, which arguably focuses primarily on reducing public expenditure, is part of a long-standing South African policy. This approach is evidenced in the GEAR document from 1996, which stipulated the need to cut costs and seek "affordable" support for families and children in need.[162]

Another major issue in the process was that residents were not prepared for this transfer in any way, nor had they or their families been consulted, which amounted to forced displacement.[163] DPOs and human rights NGOs were not consulted or involved in the process either. Also, none of the NGOs that provided residential care had valid licenses to provide such care, their capacities were insufficient and they had been established just before the transfer, according to Health Ombud who investigated the case.[164] This and other indications led Justice Moseneke to imply that the goal of GDH was not even the cost reduction of GDH, but that this was rather a case of corruption.[165]

An arbitration between the families of victims and responsible authorities (Government of South Africa, Government of the Province Gauteng, Premier of the Province of Gauteng and MEC of Health in Gauteng Province) was settled in 2018. Justice Moseneke, an arbitrator, awarded respondents to pay R1.180.000 to each of the 67 claimants whose family members died in the process and 68 claimants who survived but experienced trauma in the process.[166] The arbitration ordered the GDH to prepare a recovery plan with an aim to achieve systemic change and improve mental health care in Gauteng.[167] The GDH formed a task team to develop a recovery plan in May 2018.[168] The Gauteng Province Mental Health Strategy and Action Plan 2019-2023 succeeded the recovery plan.[169]

The SAHRC conducted an investigative hearing into the status of mental health care, following a recommendation by the OHO. The institution issued a report on the systemic review in 2017, where one of the key findings was that mental health care for children with intellectual and

[162] Department of Finance, 1996, p. 15.
[163] Arbitration Award, para. 45.
[164] W Makgoba. 2017, p. 1.
[165] Arbitration Award, p. 34 – 37.
[166] Id. at, para. 226 (1-4).
[167] Id. at, para. 226 (7).
[168] LJ Robertson, et al., *Strengthening of district mental health services in Gauteng Province, South Africa*, 111 111 SOUTH AFRICAN MEDICAL JOURNAL (2021).
[169] For the document, please contact the author via email at lazar.m.stefanovic@gmail.com.

psychosocial disabilities is especially under-prioritised.[170] The SAHRC noted the exclusion from education and the lack of beds in facilities. Despite focusing on the lack of residential capacities, the SAHRC also recognises that institutionalisation is not compatible with a human rights approach to mental health and disability.[171] The further integration in the community, the provision of CBS and the use of hospitalisation only as a last resort option is advised.[172]

The National Prosecutor Authority (NPA) announced in 2019 that there were no sufficient indications to press charges against individuals serving at competent authorities and representatives of NGOs who were involved in the tragedy. An inquest (a public inquiry) was launched in 2021 to establish the causes of those deaths and whether there are some evidences of potential criminal responsibility, by 2023.[173] Based on this investigation, the NPA may decide to press charges.

Ornellas and Engelbrecht focus their critique of the Life Esidimeni case on the systemic issues within South Africa's health sector and the broader socio-economic agenda.[174] They highlight the delegation of significant responsibility to NGOs and the private sector, while emphasising the GDH's cost-saving measures in the process. Ornellas and Engelbrecht argue that the South Africa of the present is similar to the United States of America in the 1980s and their commitment to reduce the responsibility and costs for the federal government for mental health and shift it to NGOs and the private sector, in line with a neoliberal agenda.[175] However, the authors remind us that a proper and sustainable DI is not merely a cost-saving measure motivated by reducing public expenses and increasing gains for the private sector. Quite the contrary, DI is likely to incur additional short-term costs, which benefit people with disabilities and society as a whole in the long term.

The CRPD Committee and interviewees pointed out that this tragedy may further distance Gauteng and the entire country from a proper DI process, and solidify the support for care in large, medical, residential institutions, such as Life Esidimeni. All that despite the fact that

[170] Report of the National Investigative Hearing into the Status of Mental Health Care in South Africa, (2017), SAHRC, p. 7.
[171] Id. at.
[172] Id. at.
[173] Life Esidimeni Inquest Fact Sheet (Section 27 ed., 2023). Accessed 23 June 2022, Available https://section27.org.za/wp-content/uploads/2022/06/LE-Inquest-Factsheet-updated.pdf
[174] Ornellas & Engelbrecht, SOCIAL WORK, (2018).
[175] Id. at, p. 300.

actions by GDH were a far cry from a just and proper DI process, and potentially riddled with corruption, as explained.

3. Legal and Political Implementation

It was already noted that the internalisation of international norms, according to TLP scholarship, occurs through the executive, the legislative, and the judiciary. Thus, this section, as in the other two country studies, explores the implementation of relevant CRC and CRPD norms in South Africa through the Constitution, laws, regulations, and case law. Relevant public policy documents related to the implementation of the CRC and the CRPD are analysed to assess whether and how they contribute to the realisation of the right to live in a family environment for CWD.

Separate attention is devoted to the work of the SAHRC and the SALRC. The study also explores the role and impact of structures mandated to support the implementation of IHRL in South Africa.

Legal implementation is permeated with political implementation, and sometimes it is hard to distinguish the two, such as in the case of Serbia. This may be bolstered by the insufficient separation of powers, lack of independence of the judiciary, and independent human rights institutions, and other circumstances. However, strictly differentiating between the two forms of implementation is unnecessary for this study. The Department of Women, Youth, and Persons with Disabilities (DWYPD) is tasked with developing and implementing legislation and policies aimed at improving the situation for these groups in South Africa. Still, judging by the involvement with law and policymaking, the DSD is a major Government department for the development and implementation of laws and policies related to persons with disabilities.

The Republic of South Africa has gone through a period of intensive legal and political reforms since 1994 and the fall of apartheid. The reform has also encompassed issues of children and persons with disabilities, as mentioned in the introductory chapter to this country study. Exploration of legal implementation begins with an analysis of relevant national statutory laws and regulations. Acts and regulations that are analysed in the following subsections are: the Constitution, Children's Act, Social Assistance Act, Mental Health Care Act and other relevant laws and regulations adopted to further elaborate those acts and regulate their enforcement. The legal framework on children is in constant reshaping in South Africa, and the present analysis captures only the legal order as of June 2023.

3.1. Legal Measures

3.1.1. The Constitution

The South African Constitution is based on the principles of "substantive equality" or "equality of outcomes".[176] The Constitution was carved with a profound understanding of the inequality generated from systemic, societal, political, and economic barriers which upheld deep discrimination, including segregation and disenfranchisement of black South Africans. The CRPD also relies on substantive equality and the removal of barriers to ensure the human rights of persons with disabilities including the right to live within the community and the right to be cared for by one's own family and in a family environment, as opposed to segregating institutional settings.[177]

The constitutional Bill of Rights includes the protection of children's rights. Section 28 contains a list of the rights of the child that are protected by the Constitution, of which some are non-derogable.[178] Section 28 reads as follows:

Children

28. (1) Every child has the right -

(a) to a name and a nationality from birth;

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

(c) to basic nutrition, shelter, basic health care services and social services;

[176] Issue paper No. 39, SALRC, 2020, para. 14, 17.
[177] For more on the equality and the CRPD: Andrea Broderick, The Long and Winding Road to Equality and Inclusion for Persons with Disabilities: The United Nations Convention on the Rights of Persons with Disabilities (2015), (Doctor, Maastricht University).
[178] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. Chapter 2. Table of Non-Derogable Rights.

(d) to be protected from maltreatment, neglect, abuse or degradation;

(e) to be protected from exploitative labour practices;

(f) not to be required or permitted to perform work or provide services that—

(i) are inappropriate for a person of that child's age; or

(ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;

(g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be—

(i) kept separately from detained persons over the age of 18 years; and

(ii) treated in a manner, and kept in conditions, that take account of the child's age;

(h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and

(i) not to be used directly in armed conflict, and to be protected in times of armed conflict.

(2) A child's best interests are of paramount importance in every matter concerning the child.

(3) In this section "child" means a person under the age of 18 years.

Especially relevant is the right to "family or parental care" and if the child is removed from the family environment, the right to "appropriate alternative care", of the subparagraph (b). The Constitution clearly follows the Article 7 ¶1 CRC in relation to the right of the child to be cared for, as far as possible, by his/her parents, and couples it with the right to alternative care from Article 20 CRC.

The right to family care, stipulated in the Constitution, is not mentioned in the CRC. "Family care" and "parental care" clearly are types of "family environment". Thus, children have the right to be cared for in a family environment, from which they may be removed under certain conditions. Skelton argues that during the drafting phase, communication between the Constitutional Assembly and the CC clarified that the aim was not to establish a "general right to family life". However, the CC noted that the drafters could have approached the issue differently.[179] Skelton's account does not offer enough information for a further inquiry into what the "general right to family life" would entail, but in another piece she argues that children are the only "people who do have a clearly expressed right to family" in the Bill of Rights.[180]

The phrase "appropriate alternative care" follows the norms of Article 20 of the CRC. The Constitution does not go into forms of alternative care that can be provided to a child but upholds that such care must be appropriate. The omission of institutional care is significant, considering the fact that the provision follows the CRC, which does mention "suitable institutions for the care of children" as one of the possible forms of alternative care. Skelton claims that South Africa already at that time declaratively distanced itself from institutional care.[181]

Here the phrase "(or to) appropriate alternative care when removed from the family environment" adds some confusion to the understanding of what alternative care may entail. The "appropriate alternative care" could be understood as exclusive of alternative care in a family environment, judging only by the text. Still, such an interpretation would be absurd, considering that family-based alternative care forms are well established both in IHRL and in practice in South Africa and much of the world.

A judgment of the Constitutional Court, C v Department of Health, Gauteng, provides an interpretation of § 28 (1)(b), which is particularly important for this study. [182] Judge Skweyiya held that children first and foremost have the right to family care or parental care, and then the right to alternative care. Therefore, a child's right to family care can be violated even when he/she is provided alternative care in an institution. This is the only effective interpretation of

[179] Skelton, Incorporating the CRC in South Africa. 2021.p. 159.
[180] Ann Skelton, *South Africa*, *in* LITIGATING THE RIGHTS OF THE CHILD. THE UN CONVENTION ON THE RIGHTS OF THE CHILD IN DOMESTIC AND INTERNATIONAL JURISPRUDENCE (Ton Liefaard & E. Japp Doek eds., 2015), p. 22.
[181] Skelton, Incorporating the CRC in South Africa. 2021, p. 159
[182] C v Department of Health and Social Development, Gauteng, Constitutional Court of South Africa, Case CCT 55/11 [2012] ZACC 1.

that provision, held Skweyiya. The judgment is analysed in the subsection on the implementation by the CC.[183]

In opposition to that, in 2014 the Supreme Court of Appeal (SCA), in another case, interpreted the same provision differently. It was a case where a father died in custody and his children claimed constitutional damages for the loss of parental care.[184] The North Gauteng High Court had previously awarded the damages, but the SCA upheld the appeal and referred the case back to the High Court. Namely, Judge Wallis held that: the right to parental care is part of the whole, and the children have "the right to family care or parental care or appropriate alternative care".[185]In other words, the right to family care or parental care cannot be violated, if a child is provided an appropriate alternative care. Thus, the core of § 28 (1)(b), according to Judge Wallis, is that the care for a child is provided in any given way. It seems evident that the SCA judge took a completely different approach to § 28 (1)(b) of the Constitution, which, according to CC Judge Skweyiya's approach, amounts to a meaningless and ineffective interpretation of the provision.

In an earlier SCA judgment, which did not explicitly aim to address the interpretation of the critical constitutional provision, Judge Heher differentiated between the right to family or parental care on one side, and the right to appropriate alternative care on the other.[186] Moreover, Judge Heher argued that if the child in question was not adopted and ended up in an institution, her right to family or parental care would not be satisfied.[187]

Children in South Africa also have the right to basic health care services and social services, while their best interests are of "paramount importance" in any matters concerning them. The best interest principle is commonplace in many domestic legislations around the world. The Constitution of South Africa increases the importance of the best interests of the child by making it "paramount" rather than "primary" consideration, as it is in the CRC. The CRC Committee commended South African courts for the application of the best interests principle.[188]

[183] See below Constitutional *Court*.
[184] Minister of Police v Mboweni, Supreme Court of Appeal, 657/2013.
[185] Id. at, para. 10.
[186] AD and Another v DW and others, Supreme Court of Appeal of South Africa, 379/06, para. 40.
[187] Id. at.
[188] CRC/C/ZAF/CO/2*, Committee on the Rights of the Child, 2016, para. 25.

Concerning specifically persons with disabilities, Nhlapo *et al.* report that during the drafting phase of the Constitution, a DPO called Disabled People South Africa influenced the ANC to include disability as a prohibited ground of discrimination in §9 (3) of the Constitution.[189]

3.1.2. Children's Act

The Children's Act of 2005 was enacted to give effect to the children's rights outlined in the Constitution. It regulates principles of care and protection of children, early development, foster care, alternative care, and residential care. Additionally, it regulates domestic and inter-country adoptions, addresses issues related to children's courts, and deals with other related matters.[190] The Act became fully operational in 2010. According to Sloth-Nielsen, the SALRC led the drafting of the Act, which featured a broad consultative process.[191] As of June 2023, the DSD invited interested parties to submit their comments on a draft amendment of the Act concerning child protection norms.

The Preamble of the Children's Act clearly indicates its alignment with the CRC, referring to the treaty and emphasizing that children should grow up in a family environment filled with happiness, love, and understanding. Section 11 stipulates that CWD are provided "parental care, family care and special care as and when appropriate". This provision aligns with the Constitution, although it reverses the order of "parental" and "family" care. This indicates the "family care" is synonymous to the family-based care (kinship, foster or another such a form of care), hence it is placed after the care in a primary family and before the "special care". The term "special care", as used in the remainder of the Children's Act, includes residential forms of care.

The Act further prescribes the provision of support and services to a disabled child and his/her carer, and stipulates providing conditions that ensure dignity, promote self-reliance and participation in the community. The Act thus incorporates Article 23 CRC on CWD and Article 20 CRC in the context of CWD to a large degree.

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[189] CM Nhlapo, et al., *Disability and human rights: the South African Human Rights Commission*, A SOUTH AFRICAN AGENDA (2006), p. 99.
[190] "Official Gazzette RSA" No. 108 of 1996, amend. 2013.
[191] Sloth-Nielsen. 2023, p. 546.

The Act prescribes that early child development programmes must be appropriate for CWD and prioritises funding to make those programmes available to CWD.[192] A report, however, shows that despite this obligation, CWD are actually not prioritised in those programmes.[193] Chapter 8 regulates early intervention and prevention measures, which are not limited only to immediate family but are available to children and caregivers in a family environment. The purpose of those programmes is, *inter alia*, to promote the development of the capacities of families to care for CWD.[194] Importantly, these programmes, funded by competent provincial authorities, must include CWD.[195]

Regulations stipulate that outreach services are aimed at developing community-based services and include home-based care and support to CWD in their families.[196] Family preservation services identify children at risk of separation, they are intensive and multi-disciplinary, home-based and family-centred, aimed at reunification where needed.[197] Skills development programmes, *inter alia*, aim to develop skills of families to care for CWD, while information programmes provide them with information and support.[198]

Section 167 stipulates that a child is in alternative care when he/she is placed in foster care, CYCC or safe temporary care.[199] Therefore, kinship care is not recognised as a form of alternative care, but a family member who is not a guardian can be a foster parent. Such a solution was criticized as contributing to the foster care system crisis in South Africa.[200]

Foster care is defined as the care of the child by a person who is not the parent or a guardian, and excludes the care for a child in a CYCC and in temporary safe care.[201] A child is placed in foster care by a court order or by a competent provincial authority.[202] When a court places a child in foster care it will order reunification measures, when it is possible and in the best

[192] Children's Act 2005, §93 (4)(b). Children's Act 2005 as amended 2007, § 94 (3).
[193] Andre Viviers, et al., *Strengthening ECD service delivery: Addressing systemic challenges*, *in* SOUTH AFRICAN CHILD GAUGE 2013 (Lizette Berry, et al. eds., 2013), p. 42.
[194] Id at. §144 (1)(c).
[195] Id. at. § 146 (1), (4)(b).
[196] Children's Act 2005, General Regulations Regarding Children 2010, Part IV, § 1.
[197] Id. at. Part IV, § 4.
[198] Id. at. Part IV § 5, 2(g).
[199] Children's Act 2005, § 167 (1).
[200] Samantha Arlene Yell, A Proposed Comprehensive Legal Solution to the Foster Care Crisis (2019), (LLM, University of Pretoria).
[201] Children' Act am. 2006. § 180.
[202] Ibid.

interest of the child.[203] Those measures can be terminated when there are no prospects of reunification.

A foster carer can be a family member who is not a guardian, or a person who is not a family member. A child can be also placed in a family that is part of a "foster care cluster".[204] Further, the Act defines the purpose of foster care and standards that foster care must uphold. Foster care may last until the child reaches the age of 18, and foster parents may adopt a foster child.[205] The 2022 amendments increased the monitoring of foster families from once every two years to annual visits.[206]

Foster care clusters are especially interesting because they were formed as an alternative to Western type of foster care, argue Matthias and Zall.[207] The authors explain that the cluster foster care was a response to a growing number of orphans, therefore a need to accommodate a larger number of children by fewer foster carers arose.[208] The number of children per cluster can be more than six, while the number of children per foster household must not exceed six.[209] The latest amendments limited the number of children in a household which is part of a cluster scheme to six, but did not limit the number of children per cluster.[210] A proposed Draft amendments of the Act, of June 2023, aims to limit the number of children per cluster to 60.

CWD can also be cared for in cluster foster care. Still, cluster schemes which provide care for CWD and children with chronic illness must provide psychological, rehabilitation and therapeutic programmes for them.[211] Although this norm ensures that the specific needs of CWD and children with chronic illnesses are met, it may deter organisations from offering such care. Perhaps, a better solution would be if CWD would receive any additional support from providers of services for the general population, while they stay in such foster care, in accordance with Article 19 (c) CRPD. However, given that this form of cluster care is on the edge regarding its suitability from the perspective of life in a family environment - for example, it is debatable whether children in such care can truly be said to live in a family environment -

[203] Children' Act 2005, § 187.
[204] Ibid.
[205] Children's Act 2005 §231 (1)(e).
[206] Children's Amendment Act 2022, para. 14..
[207] In Serbia up to 3, and if they have disabilities up to 2. Matthias & Zaal, INTERNATIONAL JOURNAL OF SOCIAL WELFARE, (2009), p. 292.
[208] Id. at.
[209] Children's Act, amend. 2007, § 185.
[210] Children's Act, amend. 2023, para. 13.
[211] Children's Act, General Regulations Regarding Children 2010. § 71 (b)(ii).

any definitive recommendation regarding its organisation should be contingent upon such an evaluation.

Another change was introduced with regard to cluster care. Until the latest amendments the Act prescribed that a child can be placed in "foster care with a group of persons or an organisation operating a cluster foster care scheme". This was substituted with a provision that a child can be placed in "foster care with an identified foster parent who is part of a cluster foster care scheme". The difference in wording is significant, and the latter clearly seeks to specify that children must be placed with a specific foster parent, instead of a group. The former provision resembled a form of group care, which seems to be remedied by the new amendments.

From the perspective of a strive to provide family-based alternative care, it could be questioned whether cluster care could be regarded as a form of family-based alternative care. Matthias and Zaal criticized specifically this aspect of cluster care in 2009, long before the latest amendments.[212] The latest legal changes, which limit the number of children per household in a cluster scheme to six, and specify that children are placed in care of specific foster parents who are part of a cluster scheme arguably reflect an attempt to address this issue. Further changes are anticipated with the proposed draft amendments that homes constituting a cluster must be "community-based and with separate addresses".[213] The proposed draft indicates the further intention to address the possible institutional nature of cluster foster care, by regulating the location and making sure that homes are actually separate dwellings and not group homes, such as for example children's villages. The latter may be contained of several houses formally and functionally part of one facility, often not situated in the community but in estates on the outskirts of urban areas, such as the children's village in Serbia, near Kraljevo.[214] There is a similarity with the clustering of SGHs in Austria, particularly in Vienna, but also with professional foster care provided by SOS Kinderdorf.[215] No more than six children can be placed in a single SGH in Vienna, yet these SGHs are often grouped into clusters, sometimes comprising as many as ten units. This arrangement has been criticized in Austria as a covert form of residential care in large groups. The "family-like" care provided by "SOS Kinderdorf

[212] Matthias & Zaal, INTERNATIONAL JOURNAL OF SOCIAL WELFARE, (2009), p. 295
[213] Draft Amendment Regulations Regarding Children No. 3608, (Department of Social Development), 2023. § 9.
[214] See Part III, Serbia, Chapter 2.2. Residential care.
[215] See Part II, Austria, Chapter 2.3.3. Residential care & 3.6. Domestic and international organisations.

families" in Austria includes a professional foster carer who takes care of normally 5 children in a facility provided by the organisation. Sometimes, there are multiple such facilities within a single perimeter. Still, in order to evaluate whether a certain form of care is family-based or institutional, more than an analysis of legal acts is needed.

The newest amendments of the Act introduce a potentially significant change by stipulating that the "cluster foster care schemes" are managed and operated by a designated child protection organisation or the provincial body for social development.[216] Previously, the foster care was managed only by non-profit organisations, registered for that purpose.[217] Arguably, the lawmakers intended to address these issues with management and monitoring of the foster care system. The issues in the system were noted by the CRC Committee,[218] while the CCL led a legal action against the Ministry for Social Development to address insufficiencies in foster care management.[219]

The provincial head for social development makes decisions on transferring children from one alternative care option to a less restrictive form for a trial period of up to six months.[220] During or after that period the provincial head confirms or revokes the transfer, or confirms the discharge from alternative care.[221] A child can be placed without a court order in a facility for up to six months.[222]

The Act defines CYCC as institutions for the care of children, which must be differentiated from partial care facilities, drop-in centres, boarding schools, other residential facilities attached to schools, and prisons.[223] CYCC can also provide institutional care for CWD.[224] These institutions receive funding from the provincial budget when they meet requirements established by law and the appropriate authorities.[225] They can be established by national and provincial organs for social development, municipal organs or private organisations.[226]

[216] Children's Act, amend. 2022. §1(1)(b).
[217] Children's Act, amend. 2007. §3 (e)
[218] CRC/C/ZAF/CO/2*, Committee on the Rights of the Child, 2016, para. 41, 42.
[219] See Constitutional Court.
[220] Id. at. § 174.
[221] Id. at. § 174 (4).
[222] Id. at. § 167 (2).
[223] Id. at. §191.
[224] Children's Act 2007, § 191.
[225] Id. at. § 193.
[226] Children's act 2007, § 197.

The court decides on the placement in the CYCC "only if another option is not appropriate".[227] The provision contains interesting wording to reflect the principle of institutional placements as a measure of last resort, and adequacy and suitability of such a form of alternative care. The critical phrase rather places an emphasis on the lack of appropriateness of other forms of care than the appropriateness of a CYCC. From the wording of the provision, it could be inferred that CYCCs are resorted to only as a last measure, however, steps in determining that other less-restrictive options are appropriate are not stipulated, but rather implied.

When placing a child in a CYCC, the court orders the residential programme in which the child shall be placed, while the competent provincial authority determines the specifics of the placement, including the "permanency plan". The permanency plan, which includes the reunification plan, must be reviewed once every six months, according to the regulation.[228]

Drop-in centres are not residential care facilities; instead, they provide various basic and community-based support services.[229] Those include the promotion of family preservation and reunification, outreach services, prevention and early intervention. Provincial competent authorities are not obligated to fund this type of care facilities and services, but may do so. They are supposed to be made accessible to CWD, with the help of public funds.[230] Section 150 lists situations in which a child is in need of care and protection, specifically when it is necessary to remove the child from their environment and place them in temporary safe care.

The Children's Act Chapter 5 deals with questions of "partial care". Partial care is a form of care where a person cares for more than six children on behalf of their parents temporarily, or during specific hours of the day, with or without compensation. This form of care excludes care in relation to schools and medical facilities. Matthias and Noel Zall explain that facilities for this form of care are mostly nurseries, day-care centres, and after-school care. Competent ministries are obligated to consider CWD and children with chronic illness when planning the development and provision of partial care.[231] Partial care providers may provide respite care for CWD, in accordance with regulation.[232]

[227] Children's Act 2005, § 158.
[228] Children's Act 2005, General Regulations Regarding Children 2010. Part V, § 5.
[229] Children's Act 2007, § 213.
[230] Children's Act 2007, § 215 §4(b).
[231] Children's Act am. 2007. § 77.
[232] Children's Act 2005, General Regulations Regarding Children 2010. Chapter 4, § 12.

The explicit recognition of the importance to make these forms of care available to CWD and the optional provision of respite care is significant, considering the exclusion of CWD from those kinds of services worldwide or their inexistence. They can help parents of CWD to get the necessary rest and retain their jobs.

3.1.3. Social Assistance Act

This Act is another significant law concerning the realisation of the right of CWD to live in a family environment in South Africa, as it prescribes various social protection rights and measures. It repealed the previous act on social assistance from 1992 and has been amended several times until the latest amendments in 2020.

The Act prescribes material assistance specifically to children, including those with disabilities, as well as general assistance to persons with disabilities. Those include a child support grant, a care dependency grant, a foster child grant, and a grant-in-aid for which an application must be made.[233] Funding for these grants is secured at the national level, rather than from provincial budgets.

Primary caregivers, depending on their income and provided they do not receive remuneration for caregiving, are eligible for a child support grant until the child reaches the age of 14.[234][235][236] Additionally, children who head child-headed households are also eligible for child support. Foster parents are eligible for foster child grants, regardless of the income of the parents, and when the income of the child is not higher than the amount of two foster child grants.[237][238]

A care dependency grant is provided to a parent, primary caregiver or foster parent of a child who receives permanent support and services due to disability.[239] If such a child is in 24-hour institutional care provided by the state for at least 6 months, parents and caregivers are not eligible for this grant.[240] A foster parent is eligible to a care dependency grant regardless from

[233] Social Assistance Amendment Act, 2020, "Official Gazette RSA" Nr. 44035, 2020. § 3.
[234] "Government Gazette RSA" Nr. 27316. § 4 (2).
[235] "Official Gazette RSA" Nr. 26446. § 6.
[236] "Government Gazette RSA" Nr. 27316. § 32 (2)(b).
[237] "Official Gazette RSA" Nr. 26446. §8.
[238] "Government Gazette RSA" Nr. 27316. § 5(2, 3).
[239] "Official Gazette RSA" Nr. 26446. § 7 (a).
[240] Id. at. ¶7 (b).

his / her income.[241] Parents' and caregivers' income is taken into account and may render them ineligible if above a certain threshold, which is determined by the competent authority.[242]

A Grant-In-Aid functionally corresponds to personal assistance grants, as described in Article 19(b) of the CRPD. Persons who due to their physical and mental condition require assistance from another person may be eligible for this social grant.[243] A disability grant is available to adults with disabilities and not to CWD.[244]

When a grant recipient is admitted to an institution, a social grant is reduced to 25% of the maximum amount, while the Grant-in-Aid is terminated.[245] Therefore, although the law prescribes a money-follows-the-person model in these cases, the amount is significantly reduced when the person is in an institution. Such an approach may discourage institutionalisation.

3.1.4. Mental Health Care Act

The Mental Health Care Act establishes care centres for persons with intellectual disabilities.[246] These centres accommodate people with disabilities and provide care and treatment.[247] Therefore, they serve as forms of socio-medical institutions. This form of care can be provided by both public and private entities, as well as community care providers.[248] Community care includes "residential community accommodation", day-care centres, psychotherapy, psychosocial support, and other services.[249] Children can be accommodated in care centres and residential community accommodation. Providers of residential community accommodation for fewer than five users do not require a license from the competent provincial authority.[250]

[241] "Government Gazette RSA" Nr. 27316. § 6 (2).
[242] Id. at. § 6 (1)(b).
[243] Id. at. § 8.
[244] Id. at. § 3.
[245] Id. at. § 53.
[246] "Government Gazette RSA", Nr. 24024. §1 (v), §5.
[247] Id. at. §7 (b).
[248] General Regulations for Mental Health Care Act, 2002, "Government Gazette RSA" Nr. 24384, 2003. § 5 (2).
[249] Id. at. §5 (3).
[250] Id. at. §48 (1).

Review Boards are bodies mandated to control the work of mental health establishments and protect the rights of users.[251] SADA argued that review boards are mostly non-functional and do not protect users of mental health services and facilities, which impedes DI and results in rights violations.[252]

Therefore, the support to CWD and care for CWD is parallelly organized in the system of health protection and the system of social protection. The latter nominally upholds the CRC and the standards enshrined in the UN Guidelines, aiming to inspire protection of life in a family environment for all children. In contrast, the former barely upholds any such standards.

3.2. Judicial measures

South Africa's jurisprudence is widely known for its robust and innovative protection of human rights. Successes of strategic litigation for human rights, and more specifically the rights of children are well documented. South African courts have produced a large amount of jurisprudence with regard to child rights. Accordingly, different authors have extensively researched and many of them have praised the strategic litigation for children's rights in the country and the courts' approach to the CRC. The abundance of jurisprudence and research has generated an extensive body of knowledge on this issue.

Sloth-Nielsen and Skelton argued in separate papers that several years after the adoption of the Constitution the strategic litigation of children's rights was "disappointing" because it was dominated by private law cases, where children featured as objects rather than subjects of concern.[253] Sloth-Nielsen found the reason for this in the need of advocates to engage in law reforms during the 1990s, before there was a firm legal framework, which they could base their litigation on, and the lack of funding post-1996.[254] Authors further argued that groups of litigators who emerged in 2000s, brought some changes in the following years on how the child-rights were litigated. Namely, the cases reflected the deep penetration of constitutional

[251] "Government Gazette RSA", Nr. 24024. § 18 - 24.
[252] SADA, 2023, p. 20.
[253] Skelton, Incorporating the CRC in South Africa. 2021; Sloth-Nielsen & Kruuse, THE INTERNATIONAL JOURNAL OF CHILDREN'S RIGHTS, (2013), p. 166.
[254] Julia Sloth-Nielsen, *Children's rights in the South African Courts: An overview since ratification of the UN Convention on the Rights of the Child*, 10 10 INT'L J. CHILD. RTS. (2002), p. 150.

and international law into child rights jurisprudence.[255] Such a trend continued, and the task hereby is to identify and analyse cases relevant to the present topic. In the rich case law of the South African jurisprudence on children's rights, only a few cases directly address relevant issues with regard to CWD or are indirectly relevant to CWD and their right to parental and family care.

As written above, judgments of the CC and the Supreme Court of Appeal are binding on all other courts in the country. Decisions of the High Court are binding on other courts in that province and persuasive for courts in other provinces. Therefore, only decisions of the named courts are identified and analysed, due to their power to have an impact beyond a specific case.

Apart from well-known cases, that feature in a number of academic papers, the present section seeks to identify additional relevant case law. A systematic search was done in an online database provided by the South African Legal Information Institute, a trusted, open-access source of case law in South Africa.[256] Terms searched are: right to family care, right to parental care, right to family or parental care, alternative care, Convention on the Rights of Persons with Disabilities, child with a disability, disabled child, family environment, special care centre/er, care centre/er, CYCC.

3.2.1. Constitutional Court

In a body of case law related to the separation of children from their parents, one decision is especially important due to the CC's interpretation of the right to family care and parental care of § 28(1)(b) of the Constitution.

In the case of C, M and CCL v Department of Health and Social Development, Gauteng, Judge Skweyiya affirmed that any separation of the child from their parents is a limitation of the right to parental care, which if not subject to immediate judicial review, cannot be reasonable.[257] This judgment is important primarily for the enforcement of Article 9 CRC which prescribes that a child can be separated only on the basis of a decision which is subject

[255] Sloth-Nielsen & Kruuse, THE INTERNATIONAL JOURNAL OF CHILDREN'S RIGHTS, (2013).
[256] *South African Databases*, SAFLII, (2023), accessed: 21 July, 2023, *available at* http://www.saflii.org/content/databases.
[257] Constitutional Court of South Africa, Case CCT 55/11 [2012] ZACC 1.

to judicial review, which at that time had serious deficiencies in South Africa's law. However, for this thesis, the judgment is particularly significant because the CC engaged with the interpretation of the right to family or parental care and made some important breakthroughs. Also, Judge Skweyiya upheld that any removal of a child from a family is a violation of the right to family care or parental care, which, depending on the circumstances of a specific case, may be justifiable.[258] The judge upheld that the right to family care or parental care is separate from the right to alternative care of § 28 (1)(b) of the Constitution, and as such, the placement of a child in alternative care "(…) does not necessarily render a removal constitutionally compatible with the primary right to family care or parental care".[259]

If alternative care (out of family environment) would be able to fully substitute the right to family care or parental care, then the latter would be "entirely superfluous and legally meaningless", argued Judge Skweyiya.[260] Under such an interpretation, § 28(1)(b) would only protect the right to appropriate, care regardless from the environment (whether in a family or out of a family environment).[261] Therefore, the CC held that the right to family care or parental care protects the life in a family environment.

An earlier, important case before the CC, the Government and others v Grootboom and others set the foundation for the approach argued by Judge Skweyiya. In that case, Judge Yacoob argued that the child "has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking".[262] Following that and the § 25, 26 and 27 of the Constitution, the state has an obligation to assist families with children where needed.[263] This is also important for cases where loss of the right to family or parental care for CWD occurs due to the lack of community-based support and services.

The understanding of the constitutional right to family or parental care provided in this study, under the subsection which addresses the implementation through the Constitution, is compatible with the interpretation by Judge Skweyiya. The Constitution thus provides extraordinarily robust protection of the right of the child to be cared for in a family environment. An understanding that the deprivation of family environment is a limitation of a

[258] Id. at, para. 24.
[259] Id. at.
[260] Id. at.
[261] Id. at.
[262] The Government and others v Grootboom and others, Constitutional Court, CCT 11/00, para. 77.
[263] Id. at, para. 78.

constitutional right is extremely important, it further strengthens the obligation to provide family care for a child. Constitutional rights can be limited only in accordance with § 36(1) of the Constitution, which prescribes a test that any limitation must pass.

3.2.2. Supreme Court of Appeal

Two judgments of the SCA, relevant to the interpretation of § 28 (1)(b) of the Constitution, were addressed in the section on the Constitution, and are not revisited here. Other relevant cases before the SCA were not identified using the terms listed above.

3.2.3. High Court

The case involving the Centre for Child Law against the national and provincial departments of social development regarding the administration of foster child grants was previously mentioned. The litigation was seen as a success because the High Court in Gauteng identified violations by those authorities and ordered measures to remedy the situation.

In 2011, the court issued an order to the national DSD to amend the Children's Act, aiming to create a comprehensive legal solution for the foster care crisis. Additionally, it established an interim regime for foster care orders for the next two years. The minister of social development then submitted an application seeking an extension. The second order from 2014 condoned the failure of the national DSD to amend relevant legislation in three years. The court then extended the interim regime for foster care payments until 2017, or until the Children's Act is amended. Due to the failure to comply with a previous order, the court imposed a reporting obligation to the national DSD on the clearing of a backlog of foster care orders to the Court and the CCL every 6 months.

The CCL submitted another application in 2017, due to the respondents' failure to comply with the previous order, which resulted in having no legal solution to the crisis. Moreover, the CCL argued that several hundreds of thousands of children ceased receiving FCG because the national DSD did not extend foster care orders, in accordance with the 2011 court order. The 2017 order reiterated the obligation to prepare comprehensive legal amendments to the foster

care system by modifying the Children's Act and/or the Social Assistance Act.[264] The amendments were to be presented in Parliament within 15 months of the court order's issuance, with progress reports submitted every six months.[265] The Court once again extended the interim regime for foster carer orders. [266]

In 2019, the court issued another order due to the responsible authorities' failure to fulfil the previous court order. The national DSD received a request to expedite the legal amendments process, and the interim regime for foster care grants was extended by another 12 months.[267] The reporting periods for the national and provincial DSD and provincial premiers were shortened to three months.[268] By July 2023, the amendments had been passed but were not enacted due to the absence of regulations.

This case portrays an onerous road towards reaching a comprehensive solution for the foster care system in South Africa. The responsible authorities repeatedly failed to comply with court orders, which impacted a large number of children for whom foster care orders were not extended due to backlogs. Although it is not known how many of those children are disabled, the crisis has likely impacted CWD severely. Answering questions related to the courts' role in the implementation of the CRC and the CRPD, some interviewees expressed scepticism regarding the enforcement of court decisions, which is often delayed or completely lacking, as in the present case.

A group of NGOs filed a suit against the Free State DSD and the national DSD for the lack of funding for NGOs that provided social welfare services to people in need in the Free State province.[269] The applicants claimed that authorities breached their constitutional and statutory duties, including § 27, 28 (social security, children' rights) of the Constitution, and § 4(2), 6(2) and 8 (2) of Children's Act.[270]

The information provided in the judgment uncovers the vast presence of NGOs, and the provincial DSD's reliance on those entities for the provision of statutory social welfare

[264] CCL v Minister of Social Development and others, High Court of South Africa, Gauteng Division, 72513/17. Annexure A, para. 4
[265] Id. at, para. 4, 7.
[266] Id. at, para. 5, 6, 8.
[267] Id. at. Court order of 26 November 2019, para. 2.2.1., 2.2.3.
[268] Id. at, para. 4.
[269] National Association of Welfare Organisations and Non-Governmental Organisations and others v MEC for Social Development and others, Free State High Court, 1719/2010.
[270] Id. at, para. 6.

services. NGOs provided residential care with a capacity of over 700 beds. While some of those facilities were very large (over 100 beds), others were "emulating normal family homes" and accommodated 12 – 30 children per facility, in accordance with provincial DSD's policy of "decentralisation" of care.[271] The insufficient funding led the largest provider of residential care for children, which offers 700 beds, to cut food costs, spending less than R11 per child per day on food.[272]

Justice Van der Merwe found the DSD's funding policy, which considers funds collected independently by NGOs, to be generally reasonable but not fairly implemented. The problem was found in the fact that the provincial DSD did not duly consider the realities of fundraising, eventually leaving the service providers severely underfunded. [273] Justice Van der Merwe found that the funding policy of the Free State DSD was inconsistent with the obligations of the department coming from the Constitution §26, 27 and 28 and Children's Act § 4 (2). The court ordered the provincial DSD to amend its funding policy in a way to create a methodology for determining realistic and sufficient subsidies for NGOs, and to report on the progress.[274]

Other cases, namely in the Western Cape, and later in the Eastern Cape, concerned the right of CWD to education. The case in the Western Cape concerned the underfunding of "Special Care Centres", residential institutions which provide education for children with "severe and profound disabilities". Around 1000 children with severe disabilities were cared for in those special care centres, which also provide education.[275] NGOs running those institutions were funded much less than educational institutions for non-disabled children and children with milder disabilities.[276]

The WCFID argued that the exclusion of those children violated their right to education, equality and dignity and the right to be protected from neglect and abuse. The Western Cape Division of the High Court found that the provincial government and the Republic had infringed these rights and ordered measures to ensure education for all children with severe disabilities. However, within 10 years of the judgment, the responsible authorities failed to

[271] Id. at, para. 12, 13.
[272] Id. at, para. 34.
[273] Id. at, para. 49.
[274] Id. at, para. 56.
[275] WCFID v Government of the Republic of South Africa, High Court, Western Cape Divison, 18678/2007, para. 3.4.
[276] Id. at, para. 3.8.1. – 3.8.3.

implement the judgment and the court order, and the WCFID agreed to launch a follow-up litigation with the help of the CCL in 2023.

Therefore, although the case concerned CWD in institutional care it was unrelated to their right to family care or parental care, and it did not contest this form of alternative care in any way. Yet, the issue with the implementation of the judgment and the court order is another worrisome testimony to the efficacy of litigation, and at the same time a reflection of the cooperation between service providers and litigation experts, such as the CCL. Also, litigation appears as a good way to collect and make public previously inexistent or unavailable data, for example on the number of CWD in special care centres in the Western Cape, or a total number of CWD in the province, the amount of state funding, etc. This was confirmed by interviewees too.

Another case in the Eastern Cape concerned the abuse of residents and understaffing at Vukuhambe Special School, a facility that accommodates 100 learners with disabilities. Learners uncovered deeply disturbing treatment and living conditions they were subjected to in this residential school, which they referred to as "prison".[277] The case is not analysed here as it would not render any additional value to the main issue of this study.

3.3. Strategic policy documents

This section explores relevant policy documents effective as of 2023 and those significant ones that preceded them. Policy documents before 1994 are not revisited, although they have for a good part shaped the present situation of families and childcare to an extent. The National Policy Development Framework 2020 sets standards for policymaking in South Africa. The document specifies, among other things, that an effective public policy should have well-planned funding and approved costings; it should be focused, evidence-driven, coordinated, monitored, and regularly evaluated.[278] The document explains the process of policymaking and types of public policy documents in South Africa.

[277] Parents of the Governing Body of Vukuhambe School v Minister for Basic Education and others, High Court, Eastern Cape Division: Grahamstown, 5551/2015.
[278] National Policy Development Framework 2020, (The Presidency of the Republic of South Africa), 2020, p. 10 – 11.

Policy documents revisited here are:

- White Paper on the Rights of Persons with Disabilities (WPRPD);
- White Paper on Families;
- White Paper on Special Needs Education;
- National Mental Health Policy Framework 2013 - 2020 and 2023 - 2030 (NMHPF);
- Integrated Disability Strategy;
- Social Welfare White Paper;
- Draft National Disability Policy;
- National Integrated Early Child Development Policy 2015;
- National Plan of Action for Children 2019 – 2024 (NPAC);
- Medium-term Strategic Framework 2019 – 2024 (MTSF);
- National Development Plan 2030 (NDP);
- Growth, Employment and Redistribution: A Macroeconomic Strategy from 1996 (GEAR).

3.3.1. White Paper on the Rights of Persons with Disabilities

The White Paper on the Rights of Persons with Disabilities (WPRPD) adopted in 2016, is a document whose purpose is to update the Integrated Disability Strategy from 1997, to guide legislative changes in incorporating the CRPD norms and standards, and removing barriers that obstruct participation and realisation of the rights of persons with disabilities. [279] It includes an implementation plan covering 2015 (sic.) to 2030.

One of the main pillars of the WPRPD is the support to CWD. Life in a family environment is recognised as the most appropriate for CWD, and the reasons for the deprivation of the family environment are found in the lack of community-based services, access to education, and stereotypes.[280] The WPRPD uncovers that state support to families is often inexistent, and that help is sought from service providers and parents' organisations.[281]

[279] "Government Gazette RSA" Nr. 39792, p. 51.
[280] Id. at, p. 74.
[281] Id. at.

Under the subsection on living independently and being included in the community, the WPRPD foresees measures that should facilitate DI. Supported and assisted living and independent living programmes, according to the WPRPD, should help establish "units/homes that are more open, and smaller and within the community". Furthermore, the WPRPD asserts these living arrangements are suitable only for people who already have some independence and who do not require 24-hour care. First of all, it should be noted that based on the wording there is nothing to indicate that the programmes were intended to encompass children. Therefore, it should not be critical for the present analysis. Still, it does at least reflect an understanding of the DI of adults with disabilities by the DSD. The Department likely understood DI as a transition from large residential care (detached from the community) to smaller residential care within the community. If such an approach were applied to CWD, it would align with neither the CRC nor the CRPD. Furthermore, such an approach would fall short of international standards, which, although conflicted as explained, allow any form of residential care only as an exception and in the smallest scope possible, at best.

The implementation matrix contains a number of measures related to CWD, which include measures aimed at supporting families and their preservation. Residential care is only mentioned in relation to older persons with disabilities.[282] Concerning children, the matrix foresees the development of a plan to support families caring for persons with disabilities, which should be inter-sectoral and costed, and fully subsidised.[283]

Further, CWD should have equitable access to all early childhood development programmes, disability-specific services which must be subsidised, and compulsory education.[284] The improvement of information of parents of CWD on the availability of support and services is foreseen, as well as making programmes for all children available and accessible to CWD too.[285] Regarding housing, single mothers of CWD should have access to subsidized housing.[286] Also, a national integrated referral and tracking system and database on CWD must be developed.[287] Measures to reduce disability-related costs for families are planned and additional subsidies for service delivery in deep rural and isolated communities.[288] The

[282] Id. at. Implementation matrix, Goal 3.
[283] Id. at. Goals 3, 4.
[284] Id. at. Goal 4.
[285] Id. at. Goals 4, 7.
[286] Id. at. Goal 3.
[287] Id. at. Goal 4.
[288] Id. at. Goal 5.

WPRPD foresees the adoption of new disability legislation based on a gap analysis, which integrates the CRPD.[289]

3.3.2. White Paper on Families

The DSD issued the Revised White Paper on Families (WPF), which includes general measures to support families, with specific provisions for families of CWD. The first WPF was adopted in 2013. The WPF focuses on family well-being, strengthening, and support for vulnerable families. The document specifically mentions CWD only in relation to the need for increased access to information of their families on the availability of services. Regardless, everything related to families with children in general and families at risk of separation more specifically, also encompasses CWD. Still, the past has shown that where the rights and needs of persons with disabilities are not explicitly recognised, they stay unfulfilled more often than not. After all, that is precisely why the need for a disability-specific international treaty appeared in the first place.

The WPF stipulates that families must be ensured access to different services and CYCC, where necessary.[290] Where children are separated from their families, they will be placed in alternative care, primarily within a wider family, then in community networks, and finally in a CYCC.[291]

The document stipulates measures to strengthen and prevent family separation. It promotes foster care in extended families (kin care), as the most appropriate and cost-effective form of placement.[292] It also aims to strengthen and expand foster care in general and adoption mechanisms, to ensure that displaced children are cared for in a family environment.[293]

The WPF also establishes the National Family Service Forum, a body, which is composed of governmental agencies, NGOs, the private sector, religious organisations, and other

[289] Id. at. Goal 7.
[290] "Government Gazette RSA" Nr. 44724, p. 30.
[291] Id. at, p. 9.
[292] Id. at.
[293] Id. at, p. 31.

stakeholders, to monitor and guide the implementation of the WPF.[294] Provincial Family Services Forums must be established in each province as well.

Authors of a report on the implementation of the WPF argue "the policy exists on paper but not in practice".[295] Some of the reasons for this are related to human resources in the sector and their capacities, the lack of monitoring and evaluation, the lack of clear budget allocations for designated measures, uneven provincial allocation etc.[296]

3.3.3. National Mental Health Policy Framework

NHMPF 2013 – 2020, is a public policy document developed by the DH. In their review after the Life Esidimeni tragedy, the SAHRC criticized the NMHPF 2013 for focusing too much on long-term care in psychiatric hospitals, rather than on CBS.[297] According to them, the reason for this was that the funding was primarily allocated to psychiatric hospitals, while primary care and CBS were underfunded and the dominance of a bio-medical approach to intellectual and psychosocial disability in the policy.[298] The NMHPF 2013 notes that DI in South Africa advanced swiftly, but without necessary development of CBS and support, eventually resulting in increased homelessness, imprisonment and frequent hospitalisations.[299]

The Strategic Plan, which followed the NMHPF 2013, had an objective to improve the infrastructure and capacities of mental health facilities. Under that objective, one of the measures was to develop community-based residential group care "to provide accommodation to deinstitutionalised service users".[300] This measure reveals the DH's vision of DI, based on transitioning to different institutional forms rather than promoting family living or independent, supported community living—a concept also highlighted by the Life Esidimeni tragedy. Such a measure aligns with the old Integral Disability Strategy White Paper, as shown below, which

[294] Id. at.
[295] Reviewing the Implementation of the White Paper on Families: Lessons Learned for Future Practice Policy and Research, (2018), Center for Social Development in Africa, University of Johannesburg. Chapter 5.
[296] Id. at. Chapter 5.
[297] SAHRC, 2017, p. 10.
[298] Id. at.
[299] Department of Health, 2013, p. 16.
[300] Id. at, p. 36 – 37.

also inspired the WPRPD, as explained above. The NHMPF 2013 also aimed to increase access to social grants for persons with disabilities.

The National Mental Health Policy Framework and Strategic Plan 2023 – 2030 (NHMPF 2023) succeeded the previous one. In this document, policymakers had an opportunity to correct deficiencies of the previous document and incorporate recommendations from the SAHRC, the CRC and the CRPD Committee, the OHO and other stakeholders. The NHMPF 2023 reiterates virtually all issues noted in the older one, including the underdevelopment of CBS.[301] Moreover, services for children and adolescents are found to be "severely lacking".[302] Such a description of the situation indicates that the previous NHMPF 2013 stayed largely unimplemented (except some improvements in inter-sectoral cooperation). The repetitions of issues and goals throughout successive, substantively related policy documents, indicate an issue with the implementation, despite the recognition of the problem.

The NMHPF 2023 predicts that, following WHO's recommendations, all long-stay psychiatric hospitals will be downscaled and replaced with community-based residential services and day-care facilities as part of DI efforts.[303] It also stipulates that authorities will undertake this only after ensuring the availability of CBS.[304] This may be the first resolute statement in a South African policy document on DI. The fact that the NMHPF only refers to the WHO's recommendation, indicates that policymakers were not ready to embrace a more far-reaching CPRD Committee's position on DI, which virtually excludes the use of long-term residential care. Still, the document acknowledges the CRPD and the need for inter-sectoral cooperation to implement CRPD norms and standards.[305] NGOs are seen as the main service providers of residential services, together with for-profit organisations.[306] A general reliance of the South African public policy in this sphere on NGOs and for profits, indicates the intention of the state to pull-out of service provision as much as possible, and keep the number and size of state-run service providers as low as possible.

The most important part of the strategic document – the Strategic plan, sets time-bound goals, including the functional Review Boards in line with the law, improved data collection and

[301] National Mental Health Policy Framework and Strategic Plan 2023 - 2030, Department of Health, 2023, p. 25.
[302] IJzendoorn M. H. van, et al., *Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on development*, 7 7 LANCET PSYCHIATRY (2020).
[303] Department of Health, 2023, p. 35, 49.
[304] Id. at.
[305] Id. at, p. 42, 50.
[306] Id. at, p. 50.

research, and the development of long-term residential care facilities in the community for people with intellectual and psychosocial disabilities.[307] The latter services include also assisted living, which, depending on the way it is implemented, may align with the CRPD too. However, such a service is rarely made available to children. The Strategic Plan establishes a baseline of 297 community-based residential care facilities across the country but fails to specify the target goal or estimate the costs associated with expanding the network.

3.3.4. Other policy documents

Growth, Employment and Redistribution Strategy (GEAR) was adopted in 1996. V Importantly, GEAR reflected clear tendencies towards reduction of public expenditure, including in the sphere of social welfare. It explicitly called for the search for "affordable" support for families and children in need. Therefore, already in mid-1990s the cost reduction and the provision of low-cost services was set as a goal. In such a discourse it is not surprising that DI efforts are seen as money-saving action, which results in poor development of CBS and knee-jerk actions, which may end in a tragedy such as the Life Esidimeni tragedy. Bond and other critiques argued that the GEAR "cemented" the neoliberal agenda of the South African government, which was adopted with the help from, among others, the IMF, and the World Bank.[308]

The Integral Disability Strategy White Paper was adopted in 1997.[309] Among other objectives, it foresaw better data collection and disability research, and the development of a range of services that contribute to the integration of persons with disabilities into the community. The Strategy recognised problems associated with large institutional care and called for community integration and the development of "more open smaller and based within the community" residential care. The exact same phrase to support moving towards community-based and smaller institutional care is used in the WPRPD, which was adopted in 2016.

The document also outlines several reasons for the over-reliance on large institutions, including the lack of community-based services, the lack of affordable housing, inadequate subsidisation

[307] Id. at. 50 - 58.
[308] BOND. 2014.
[309] Integrated Disability Strategy - White Paper, (Office of the Deputy President), 1997.

and regulatory mechanisms and the lack of representation of persons with disabilities.[310] The Strategy did not specifically address the institutionalisation of CWD.

The aged Social Welfare White Paper from 1997 addressed the rights of persons with disabilities, without mentioning and addressing the alternative care or the institutionalisation of CWD. It did emphasise the importance of supporting families and promoting the integration into the community.[311] The document also notes the lack of data on people with intellectual and psychosocial disabilities.[312]

The Special Needs Education White Paper from 2001 aimed to increase the access to education of learners with disabilities by increasing the capacities of the educational system. It did not specifically address the issue of life in a family environment or the institutionalisation of CWD. Still, CWD in South Africa often end up living in residential care in order to attend schools, hence there is a connection between the lack of access to inclusive education in the community and the deprivation of the family environment. This was recognised in the White Paper, which noted the legacy of apartheid reflected in a higher density of special schools in Gauteng and the Western Cape. This situation requires many CWD from other provinces to leave their homes when they reach schooling age and move into a residential facility attached to a school in another province.[313]

The White paper acknowledged that the primary choice should be neighbourhood schools and full-service schools (general schools offering a range of accommodations and support), and boarding policies reviewed having that in mind.[314] Despite the recognition of the issue of distant schools for many CWD, the White Paper does not delve in the issue of being deprived of family environment in any of its aspects. The reform towards inclusive education, according to the DBE, includes further establishment, and capacity and quality increase of special schools.[315] The provision of residence is supposed to be available in special schools after the

[310] Id. at.
[311] Social Welfare White Paper, (Department of Welfare), 1997, para. 116.
[312] Id. at, para. 121.
[313] Department of Education, 2001, p. 14.
[314] Id. at, p. 27.
[315] Id. at, p. 45.

reform too.[316] The understanding about special schools being compatible with inclusive education goals is contrary to the CRPD Committee's view of inclusive education.

Some of the main points of the reform of education for CWD is the upgrading of special schools into "special schools/resource centres". This should contribute to more CWD attending mainstream schools, while resource centres provide services to its students and other schools as well. According to the same plan, a limited number of mainstream schools should be converted into full-service schools. Full-service schools are established to accommodate learners with different types of disabilities. The DBE established an intersectoral group in 2021, to address the underwhelming levels of implementation of this White Paper.[317] The White Paper was described by SADA as obsolete, in conflict with later legislation and in need of immediate update.[318]

The Draft National Disability Policy from 2015 is a document that was seemingly abandoned, considering that its adoption has not taken place in eight years since the draft was issued. This policy document was supposed to be the first to take decisive steps towards domestication of the CRPD. It noted the lack of data and foresaw the establishment of a new group at the South Africa Statistical Office, to collect relevant data on disability.[319] One of the outcomes of this strategic document was increased access to family support and preservation services for CWD.[320]

The National Integrated Early Child Development Policy 2015 (NIECDP) sets out the inclusion of CWD in all programmes as a priority.[321] It stipulates that by 2030 all CWD should have access to different services and support including parenting support, community-based services, quality child care, and increased material support.[322] Perhaps, the most important novelty of the NIECDP is the plan to shift from private to completely public provisioning of ECD for all children.[323] This means the development of an ECD public system which ensures

[316] Guidelines to Ensure Quality Education and Support in Special Schools Rresource Centres, (Department of Basic Education), 2014, p. 19.
[317] SADA, 2023, p. 23.
[318] SADA, 2018.
[319] Draft National Disability Policy, "Government Gazette RSA" Nr. 38471, (Department of Social Development), 2015, p. 22 – 23.
[320] Id. at, p. 46.
[321] DSD, 2015.
[322] Id. at, p. 67.
[323] Id. at, p. 23-24.

universal availability to all children.[324] If implemented, the policy could result in the improvement of the position of the youngest CWD and potentially prevent institutionalisation for some of them.

The National Plan of Action for Children 2019 – 2024 is another public policy document addressing children's rights in South Africa. The document is followed by a five-year implementation plan. Some of the measures and goals of the NPAC are the establishment of a Child Rights Office on the national level, and supported child rights delivery mechanisms in provinces and districts.[325] The NPAC does not outline any actions specifically aimed at CWD. The South African Children Manifesto, which is a part of the NPAC, criticizes the lack of services for CWD and stigma, which results in their isolation from the community.[326] They demand to provide health and social services for CWD, ensure inclusive education as well as special education, and raise awareness on disability in the South African society.

The NPAC implementation period is aligned with Medium-term Strategic Framework 2019 – 2024 (MTSF). MTSF is the sixth democratic administration's strategic document which comprehensively addresses South Africa's socio-economic issues.[327] MTSF aims, among other things, to strengthen the protection of CWD in all institutional settings, such as special boarding schools, mental health care institutions, and residential institutions in social care.[328] It notes the lack of services and issues with access to care dependency grants for CWD as a result of stringent procedures and medical assessments.[329] In that light, MTSF aims to significantly increase access of all persons with disabilities to social grants. Some of the measures include drafting and adopting a white paper on comprehensive social security, a Draft Social Security Bill, and consolidating disability assessment procedures.[330]

MTSF relies on external donors, primarily the Japan International Cooperation Assistance (JICA), to support the increase of availability of disability-specific services, including respite

[324] Id. at.
[325] South Africa's National Plan of Action for Children (NPAC) 2019 - 2024, (2019), DSD, p. 302.
[326] Id. at, p. 117.
[327] Medium-term Strategic Framework 2019 - 2024, (Monitoring and Evaluation Department Planning), 2019.
[328] Id. at, p. 232.
[329] Id. at, p. 120.
[330] Id. at, p. 133, 142.

care and personal assistance.[331] The plan is to increase screening and ensure individualized support for all children with developmental delays and disabilities who may need it.[332]

National Development Plan 2030 (NDP) aims to increase access to early childhood development services including for CWD.[333] The NDP acknowledges the inadequacy of social grants, especially the child support grant.[334] National Child Care and Protection Policy does not address issues related to life in a family environment for CWD.[335]

3.3.5. Budgeting

Alternative reports of DPOs, NGOs and other stakeholders provide evidence for other issues such as budgeting. Namely, the Gauteng DSD significantly decreased the budget for social welfare services for the year 2022/2023.[336] Lisa Vetten of Wits University reported that the budget for services for people with disabilities was cut by 28.4%, family services by 21.1%, and childcare by 18.2%.[337] Considering that policy documents emphasised increasing the availability of CBS and support for families with CWD, the funding cuts will almost certainly impede the realisation of these goals and leave policies unimplemented. The DPO correctly assessed that such budgeting falls short of fulfilling the requirements of the CRPD Article 4(1a), (2).[338]

SADA acknowledged issues with the funding mechanism based on the National Lottery Commission, which, according to SADA, is burdened with corruption.[339] They attribute the underfunding of services for people with disabilities to a lack of political will, accountability, and prevalent corruption.[340] Additionally, SADA notes that subsidies for community-based

[331] Id. at, p. 142.
[332] Id. at, p. 143.
[333] National Development Plan 2030 - Our Future - Make it Work, (The Presidency).p. 300.
[334] Id. at, p. 367.
[335] National Child Care and Protection Policy 2019, "Government Gazette RSA", No. 44636, (Department of Social Development), 2019.
[336] List of Issues Prior to Reporting- South Africa (18th Pre-Sessional Working Group), (2023), Maat for Peace, Development and Human Rights, p. 2.
[337] *Gauteng's R216m budget cut will strip thousands of vulnerable people of critical services – researcher*, Daily Maverick, (2023), accessed: 10th July, 2023, *available at* https://www.dailymaverick.co.za/article/2023-04-19-gautengs-r216m-budget-cut-will-strip-thousands-of-vulnerable-people-of-critical-services-researcher/.
[338] SADA, 2023.
[339] Id. at.
[340] Id. at.

services vary greatly between provinces and should be standardized.[341] Equalisation of subsidies should contribute to higher access to CBS especially in less developed areas. Furthermore, SADA has expressed concerns about the lack of transparency regarding the use of foreign funding for disability programmes and services, urging the government to disclose this information.[342]

3.4. National Human Rights Institutions, monitoring bodies and other structures to facilitate the implementation of human rights treaties

As already explained, NHRIs may have a significant role in promoting and protecting human rights and in the implementation of international norms in a domestic context. These institutions may be equipped with an array of tools, such as investigations of human rights abuses, sanctioning, awareness raising, education, and research, which can ideally constitute an independent staple of human rights implementation and enforcement in a country. A list of institutions that "strengthen constitutional democracy" in South Africa, including the SAHRC and the Public Protector, is listed in Chapter 9 of the Constitution.[343]

This study has already touched upon the role and activities of the SAHRC, which is here further examined with an aim to identify and analyse the body's work in relation to the right to family or parental care and alternative care of CWD in South Africa, and other related issues.

3.4.1. South African Human Rights Commission

The South African Human Rights Commission (SAHRC) is a major national human rights institution in the country. Its mandate is based on the Constitution Chapter 9, alongside other institutions that support democracy in South Africa. The SAHRC is independent and other persons or state organs must not interfere with its independence.[344] The SAHRC promotes

[341] DSD, 2016, p. 124. SADA, 2023, p. 22.
[342] SADA, 2023, p. 22.
[343] "Official Gazzette RSA" No. 108 of 1996, amend. 2013. § 181 (1).
[344] Id. at. § 181 (1),(3).

human rights and has the power to investigate the state of human rights and take steps to provide redress where human rights are violated.[345] It is obliged to, *inter alia*, issue recommendations to state organs, undertake studies, request and receive information from state organs, educate, cooperate with human rights CSOs, monitor the implementation of regional and international human rights law, propose legislation.[346] The SAHRC has mandate to receive complaints, and where it find appropriate, undertake investigation, or bring the issue before a competent court in its own name or in the name of complainants, or financially assist complainants in bringing the issue before of competent court.[347]

The Anti-Discrimination Act requires that the SAHRC specifically include in its reports the situation concerning discrimination based on race, gender, and disability.[348] However, the regulations needed to operationalize this act have not yet been promulgated, which is also a serious concern for the CESCR Committee.[349]

The body also acts as the National Preventive Mechanism in the sense of OPCAT, thus its teams are authorized to enter all premisses where children are or may be deprived of liberty. Based on those visits, the SAHRC creates reports with recommendations aimed at preventing torture and other cruel, inhuman, or degrading treatment or punishment.[350] NPM's sometimes recommend DI as the only sustainable solution to the prevention of ill-treatment of children in institutional settings. A map of visited places of detention on the SAHRC's website does not show any of care and rehabilitation centres, community residential care facilities, schools with hostels for children with disabilities, or "special care centres". [351] Also, the annual reports of the NPM do not contain any information on their work in relation to CWD.

One of the SAHRC's more notable engagements involved its response to the Life Esidimeni tragedy. The SAHRC was tasked with conducting an investigation, on the basis of the OHO's report. The institution issued a report on an investigative hearing containing a number of recommendations.[352] Among other issues, the SAHRC recommended the national DH ensure

[345] Id. at. § 184 (1), (2).
[346] Human Rights Commission Act, No. 40 of 2013, "Government Gazette RSA", No. 37253. § 13.
[347] Id. at. § 13 (3).
[348] "RSA Government Gazette", Act No. 4, 2000. § 28.
[349] Concluding Observations on the Initial Report of South Africa, E/C.12/ZAF/CO/1, (Committee on Economic Social and Cultural Rights), 2018, para. 21.
[350] The author participated in one of the NPM visits of the SAHRC to a CYCC, as a member of the CCL's team.
[351] *Places visited*, South African Human Rights Commission, (2023), accessed: 27th July, 2023, *available at* https://sahrc.org.za/npm/index.php/places-visited.
[352] SAHRC, 2017.

that children with intellectual and psychosocial disabilities are not placed in wards with adult users, and to create such health infrastructure to guarantee intersectoral cooperation in ensuring the CBS for those children.[353] It also noted that budget allocation is inadequate for the DI of mental health care, and recognised that perhaps a prevalent approach to disability in South Africa is bio-medical.[354]

The SAHRC also conducted an investigation of the deaths of 3 learners with disabilities in a school for deaf learners in the North West Province. Three disabled girls died, and dozens were injured in a fire at the school. The SAHRC concluded, among other things, that the learners' right to freedom and security of a person was violated in part because the doors that they could evacuate through were locked from the outside and without a just reason.[355] They were effectively deprived of their liberty. The SAHRC did not look into the broader problem of institutionalisation of CWD in special schools.

The attention to the development of CBS and the intersectoral cooperation is significant, considering that DSD, DH, and DBE are all involved in ensuring different kinds of support and care for CWD. Still, the omission to recognise the issue with the institutionalisation of children as it is, and the lack of specific measures to reduce the reliance or more specifically the numbers of CWD in institutional care, indicate that DI and the question of life in a family environment for CWD is simply out of the picture.

In their submission for the List of Issues to the CRPD Committee in 2018, the SAHRC drew attention to safety concerns in residential care and in school hostels for CWD. The body suggested that the CRPD Committee recommends the state party improve conditions in school hostels, monitor the situation in residential care, and ask the state about measures taken to monitor liberty of persons with disabilities.[356] In a report to the CRC Committee in 2015, the SAHRC did not address issues pertaining to life in a family environment and alternative care.

[353] Id. at, p. 60.
[354] Id. at, p. 6.
[355] Investigative Report North West School for the Deaf, (South African Human Rights Commission), 2018, p. 53.
[356] National Human Rights Institution Report On The South African Government's Initial Country Report Under The International Convention On The Rights Of Persons With Disabilities, (2018), South African Human Rights Commission, p. 18.

Ann Skelton argues that the SAHRC has been a "weak mechanism for the enforcement of children's rights".[357] Interviewees raised concerns on the independence of the SAHRC, which may be related to the way the institution is funded, according to them.

3.4.2. Public Protector

The Public Protector is another Chapter 9 institution tasked with the oversight of state affairs. The institution can investigate, report and remedy improper conduct of any institution of which the state is the majority shareholder or controller and of any public entity, and improper conduct of employees of those institutions.[358] Therefore, Public Protector may intervene in a wide array of cases, including issues concerning the payment of social grants and the provision of social services (e.g. denials, undue delays and backlogs), including state-run residential care for CWD (e.g. misconduct by employees).

The examination of annual reports, complaints and investigative reports did not identify any relevant issue being addressed by this institution. However, the Public Protector has intervened in disability-related cases, including those concerning compensation for work-related disablement and the processing of disability claims by responsible authorities. Activities related to orphanages and institutions for CWD were identified in two annual reports, under the section where the Public Protector notes their socially responsible actions in the past year. In 2017 it was a visit (not a monitoring visit) of the Public Protector's staff to an orphanage in the Northern Cape.[359] In 2020 the body sent humanitarian aid to an institution for CWD which was left without food supply during the national lockdown.[360]

Therefore, based on the examined documentation, it can be concluded that the Public Protector has not engaged meaningfully with the issue of life in a family environment, institutionalisation, and alternative care for CWD.

[357] Skelton, Incorporating the CRC in South Africa. 2021, p. 153.
[358] Public Protector Act No. 23, 1994, "Government Gazette RSA" No. 16107. § 6.
[359] Annual Report 2017/2018 Financial Year, (Public Protector South Africa), 2018, p. 60.
[360] Annual Report 2020/2021 Financial Year, (Public Protector South Africa), 2021, p. 73.

3.4.3. National Office on the Rights of the Child

The National Office on the Rights of the Child (ORC) is a body tasked with facilitating the realisation of child rights in the country and reporting to regional and international treaty bodies. The body was established in 1994 to ensure that children are the focus of all policies of the new government and is currently part of the DSD. Apart from the national level ORC, there are provincial and municipal child rights offices tasked with guiding the implementation of the NPC in municipalities and provinces. The NPC plans to re-establish the ORC in the Presidency, alongside the existing Office on the Rights of Persons with Disabilities, in order to strengthen the position of the ORC.[361]

South Africa lacks an independent mechanism for monitoring the implementation of the CRPD, as required by Article 33(2) of the treaty. Accordingly, the CRPD Committee recommended establishing such a mechanism as part of the SAHRC, and improving the participation of DPOs in policymaking.[362]

3.4.4. South Africa Law Reform Commission

Although not originally designed to facilitate human rights law implementation, the SALRC, a prominent and independent statutory body, has contributed to this area. It was established with South African Law Reform Commission Act in 1973, to support the development, modernization, improvement, and reform of South African law.[363] Recently, the SALRC was requested by the Department of Justice and Constitutional Development to study how the CRPD could be incorporated into South African legislation.[364] After a three-stage process, the issue paper will eventually become a report or a draft bill. The SALRC issued a paper and opened it for comments, representations, and request of interested parties. The issue paper reflects on CRPD norms and their domestication, on the CRPD Committee's General Comments, including the one on Article 19 CRPD, and makes a case for law reform. It also identifies gaps in legislation and mechanisms for the enforcement of the human rights of persons with disabilities.

[361] DSD, 2019, p. 27.
[362] CRPD/C/ZAF/CO/1, 2018, para. 55.
[363] South African Law Reform Commission Act 19 of 1973, "Government Gazette RSA", No. 4010 of 1973. § 4.
[364] Issue paper No. 39, SALRC, 2020.

The issue paper is in its first phase in 2023, and waits for amendments in accordance with comments and requests of interested parties.[365] An amended issue paper, now a discussion paper, is again open for public consultations.[366] A final draft bill is developed in the last phase, after the public consultations and the consideration of those inputs finishes.[367] The issue paper is frequently referred to in this study, as an authoritative source of information for the assessment of characteristics of the implementation of relevant CRPD norms.

In a section on Article 7 CRPD in CWD, the SALRC deals mainly with the issue of exclusion from education, but also addresses the issue of long-term institutionalisation.[368] It reiterates a solution based on the better monitoring and protection from abuse in such settings, but also notes the importance of prevention, support and services to families. Concerning Article 19 CRPD, the SALRC notes the absence of DI programmes and expresses concerns about the possible effect of the Life Esidimeni tragedy on future DI efforts.[369]Article 23 CRPD on family life, including alternative care, was completely omitted in this stage of the issue paper.

The issue paper, thus, superficially addresses the issues related to the institutionalisation of persons with disabilities, including children. The loss of life in a family environment is not addressed as suChapter Whether these questions will be addressed in more detail, including the specific attention to family life and family-based alternative care for CWD, will likely depend on the inputs by the civil society, academia, and other interested parties.

3.4.5. National Disability Rights Machinery

The National Disability Rights Machinery (NDRM) falls under the DWYPD and is tasked with inter-sectoral collaboration and coordination of disability-related actions, together with CSOs. The body was approved in 2007, and seemingly became operational in 2012, after which it went through restructuring.[370] The NDRM led the drafting process of the WPRPD with the

[365] Id. at, para. 4.
[366] Id. at, para. 5.
[367] Id. at, para. 6.
[368] Id. at, p. 73.
[369] Id. at, p. 83.
[370] *Department restructures National Disability Machinery*, Department of Women, Children and People with Disabilities, (2012), accessed: 1st August, 2023, *available at* https://www.gov.za/department-restructures-national-disability-machinery.

involvement of DPOs.[371] Despite its promising name, there are no available evaluations or accounts measuring satisfaction with the NDRM's work.

3.5. International and domestic organisations

This section examines the potential impact of international governmental and non-governmental organizations, as well as domestic NGOs, on the realisation of the right to live in a family environment for CWD in South Africa. The aim is to identify potential issue linkages, facilitators, and blockages in realising the right to live in a family environment for CWD that are related to the work of those organisations.

South Africa and the EU are longstanding strategic partners. Two parties entered the Trade, Development and Cooperation Agreement (TDCA) in 2001. The TDCA stipulates that parties will engage in discussions on social issues, including children's rights, while the rights of persons with disabilities are not mentioned in the document. Other major documents from South Africa-EU cooperation include the South Africa-EU Strategic Partnership from 2006, [372] the Joint Action Plan of 2007, [373] and the Multiannual Indicative Programmes for 2014-2020 and 2021-2027 (MIP).[374] Official documents between the EU and South Africa, as well as information obtained through interviews indicate that the EU does not have a substantial impact on issues relevant to this study, either through funding programmes, in law- and policymaking or by conditioning the realisation of benefits of South Africa (e.g. development aid) with the advancement in the sphere of rights of CWD (no issue linkages). Only the latest MIP 2021-2027 contains objectives directed at the improvement of the position of persons with disabilities in South Africa.[375] This should be achieved through the support to Chapter 9 institutions of the

[371] "Government Gazette RSA" Nr. 39792, p. 10.
[372] Communication from the Commission to the Council and the European Parliament: Towards an EU-South Africa Strategic Partnership, COM(2006) 347 final (Commission of the European Communities), 2006.
[373] The South Africa-European Union Strategic Partnership Joint Action Plan, 9650/07 (Presse 105), (Council of the European Union), 2007.
[374] Multiannual Indicative Programme between the Republic of South Africa and the European Union for the period 2014-2020.
[375] Multiannual Indicative Programme between the Republic of South Africa and the European Union for the period 2021-2027, p. 13.

South African Constitution and by supporting grass-root CSOs.[376] Therefore, more intensive engagement from the EU is expected in the 2021-2027 programming period.

UNICEF has been active in South Africa and the region for several decades, playing a significant role both before and after the end of apartheid in 1994. More recently, the agency has conducted and published important studies that have enhanced the data and knowledge regarding the situation of CWD in South Africa. UNICEF's work is aligned with international standards, meaning that a strong emphasis is put on family support and family-based alternative care. In 2021, UNICEF supported the use of small institutional settings for children in accordance with the UN Guidelines in the region. However, concerning CWD, it advocated a more cautious approach and acknowledged the CRPD Committee's and the Special Rapporteur on the rights of persons with disabilities' opposition to any residential care for CWD.[377] Earlier, UNICEF was active in raising awareness of South African decision-makers on children's rights, including the appropriate allocation of public funds for children.[378]

South African NGOs focused on child rights and advocacy are well-known for their successful advocacy efforts, particularly in strategic litigation concerning children's rights. Some of these organisations, like the CCL, were mentioned with regard to relevant cases before the courts. Still, while the evidence and other authors suggest those organisations have been significant actors in the implementation of international child rights law, this was not confirmed in relation to the relevant rights of CWD in this researChapter Significantly, these organisations have not pursued legal cases related to the family or parental care of CWD, alternative care, or institutionalisation. Also, an examination of their portfolios, including the information obtained through interviews, indicate that the institutionalisation of CWD is not a topic of interest to those organisations at the moment.

Furthermore, the examination of alternative reports by civil society to UN human rights bodies evidences the lack of the relevant issue in the agendas of those organisations. More precisely, only SADA have had meaningfully engaged with the issue of institutionalisation of CWD, but only in the system of basic education, and rather in relation to abuse and prevention of abuse.

[376] Id. at. Attachment I Intervention Framework.
[377] ESARO, 2021.
[378] Reforming Child Law in South Africa: Budgeting and Implementation Planning, (2009), UNICEF Innocenti Research Centre.

It should be emphasised that CSOs may have submitted confidential reports to the UN bodies, which are not publicly available in the UN treaty body database.

Private organisations, including NGOs, faith-based organizations, and companies that provide social services, are key stakeholders in South Africa's social welfare system. They are responsible for the delivery of the largest portion of services in the country, including residential care. Indeed, data on the ownership of CYCC across provinces shows that over 90% of those institutions are run by private organisations.[379] Also, a major provider of care and support for children worldwide, SOS Children's Villages, is present in South Africa. The organisation provides care in orphanages for over 600 children, according to the DSD,[380] and is actively involved in law- and policymaking.[381] Considering their significance for the system of social welfare in South Africa, private organisations are capable of delivering substantial impact on law- and policymaking.

Disability rights advocates often contend that the privatization of residential care poses significant risks, citing it as an inherent conflict of interest. They contend that the interest of private organisations providing residential care to children and adults with disabilities is to maximise and expand their bed capacities, which contradicts DI efforts. Additionally, residential care service providers may encourage states to allocate funds to residential facilities rather than to CBS. The CRPD Committee was very direct when it stipulated the following: "Service providers, charities, professional and religious groups, trade unions and those with financial or other interests in keeping institutions open should be prevented from influencing decision-making processes related to deinstitutionalization".[382]

[379] Number 16 - 2022, 2022, p. 5.
[380] Id. at.
[381] Annual Report 2020, (2020), SOS Children's Villages South Africa.
[382] Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 34.

4. Key Findings

4.1. The lack of data and recurrent crises

Unfortunately, the lack of available data on CWD plagues virtually all aspects of child welfare, although data collection has slightly improved recently. This is confirmed by a majority if not all studies, reports, policy documents, UN treaty bodies' observations and by interviewees. Therefore, it is hard to make any conclusive statements about whether the situation for CWD is improving and in what way in South Africa. After all, any law, policy, and practice related to children are as good as they are capable of having real-life impact on the lives of children. Perhaps, amid the lack of quantitative data, empirical qualitative-quantitative mixed method research with children, their parents and other stakeholders will provide a better insight into the potential changes in quality of life and the realisation of their rights in the last 30 years in South Africa.

A key aspect of South African society is its concept of family, which experts argue differs from the Western notion of the nuclear family. Data shows that only one-third of children live with both parents, and another third do not live with their parents at all, results stemming from various historical, social, and economic factors. Additionally, the HIV epidemic has severely impacted South African society, leaving a large number of children without parental care. This, and the pervasive poverty, generated a significant burden on responsible authorities to provide support, services and care for children, including CWD.

Arguably, based on available data, the most significant progress was achieved regarding the availability of social care grants – CSG, FCG and CDG. The numbers of children and parents who were receiving these grants, including CWD, increased dramatically by the end of the 1990s and in the first decade 21st century. Also, a top-up on the CSG was introduced for members of the wider family who care for orphaned children. This could have improved the position of children, and potentially prevented a number of separations and institutionalisations. Still, it is not known how many eligible CWD and their parents/carers are receiving these benefits.

At the same time, the system of administration of these grants, more specifically the foster child grant, nearly collapsed, resulting in a large number of children in foster care staying without material support. According to experts, the collapse is mainly the consequence of the lack of institutional capacity to administer hundreds of thousands of grants, amidst the fact that wider family members were actually eligible and receiving FCG, because kinship care is not recognised.

In South Africa, kinship care is not officially recognised as a form of alternative care, contributing to the crises in the foster care system. Experts attribute the collapse primarily to the lack of institutional capacity to administer hundreds of thousands of grants, compounded by the fact that wider family members, effectively serving as kinship carers, were receiving FCG without official recognition.[383] The administration of FCG was burdensome, which led to its collapse. This was only in part remedied by the introduction of a top-up on CSG for wider family members and primary caregivers (any person over the age of 16) who care for orphaned children.

The recovery of the foster care system has been slow, as responsible authorities have prolonged the fulfilment of court orders for years. Regulations which should remedy the problem have not entered operation by July 2023. Although, there is no available data, such a collapse of the foster care system may have resulted in an increased demand for institutional care. Such a causal relationship was observed in the case of Serbia, at the end of the 1990s.

Although there is no data on the number of CWD in foster care, UNICEF and other actors assume that this form of alternative care is rarely used for CWD. The same goes for in-country adoptions, while inter-country adoptions of CWD may be more common.

Apart from material assistance, support and services for families of CWD are severely lacking, especially in rural areas. It was estimated that only 5% of CWD under the schooling age were attending early childhood development programmes.[384] The shift for the provision of ECD from the DSD to the DBE was finalised in 2022 and is expected to improve the availability of ECD to CWD. Services, such as help in home, or personal assistance for CWD were not identified in the country. The delivery of basic services, primarily electricity, may

[383] See Family-based care.
[384] See note 141.

disproportionately affect families with disabled children and contribute to parents deciding to place their child in an institution.

A major characteristic of South Africa's institutional care for CWD is that it is provided via three governmental sectors – social protection, (mental) health and basic education. Therefore, in order to start addressing the issue of institutionalisation, even only by doing baseline research, intersectoral cooperation is essential.

The sector of basic education provides residential care alongside schooling for CWD. The question of the loss of family care by being away from home for schooling is not as clear-cut as the institutionalisation in a social care, or a mental health care facility. Still, CWD in South Africa have no choice but to leave home at a young age if they are to attend school and stay in an institutional setting which is characterised by institutional culture, according to information published in court judgments and reports. This amounts to institutionalisation and effectively loss of family care, due to systemic and attitudinal barriers. Only the number of CWD in residential care for the purpose of education is approximately 35.000.[385]

Another key characteristic is that the majority of institutional care facilities for CWD in the mental health and social sectors are operated by private organisations. This has implications for the funding of institutional care, monitoring and control, responsibility in case of violations of the rights of used, and decisive effects on future planning of care for CWD. The NPM has not yet conducted monitoring visits to institutions for the care of CWD, according to their reports. The involvement of private providers of institutional care in law and policymaking can have a major impact on delaying, slowing down or redefining DI efforts.

Lastly, the Life Esidimeni tragedy, which resulted in over 140 deaths and was incorrectly branded as a DI process, may have negatively impacted public opinion on DI. In fact, the process was aimed at transferring mental health care users to other forms of institutional care. The case has also triggered more intensive policymaking, especially in Gauteng, and an increased focus on the development of CBS. It has not, however, radically changed the approach to the reform of care, and policymakers are still relying heavily on institutional care in their visions, but of a smaller size and closer to the local community, including for children with profound intellectual disabilities.

[385] See note 117.

4.2. Internalisation journey

4.2.1. Uneven legal incorporation

The Constitution strongly protects the life of all children in a family environment by prescribing their right to family or parental care. While the Constitution avoids directly mentioning institutional care, it leaves room for such arrangements under the term "appropriate alternative care". Section 28 was strongly inspired by the CRC, and this was the first step towards the domestication of the CRC by the first democratic Government. Ann Skelton's accounts of drafting the Constitution highlight the significant political will to break away from the previous regime, known for its exceptionally poor human rights record. Therefore, the beginnings of the CRC's domestication in South Africa were driven by political motives, evidencing an arguably unbreakable connection between legal and political implementation of children's rights, especially in a transitional society such as South Africa.

Care and assistance for CWD and their families are regulated by mental health care and social protection laws and are enshrined in the Constitution. Both types of regulations prescribe forms of institutional care, alternatives to such care, and prevention of institutionalisation. Arguably, the social protection legislation is significantly more advanced in protecting the rights of CWD than the mental health legislation. In that light, SADA plead that Mental Health Act is amended to align with the CRPD.[386]

The mental health legislation prescribes long-term care in psychiatric hospitals, care centres, and community residential group care as forms of institutional/residential care for children and adults with mental disabilities. The care centres are functionally socio-medical institutions, as they are stipulated to provide medical treatment and basic social protection for CWD. CYCCs are part of the social protection legislation system and provide, *inter alia*, residential care for CWD. Residential care may be provided both by public and private agencies, such as NGOs, companies, or faith-based organisations.

The social protection, assistance and childcare legislation prioritizes family care in general, and the care in a family environment, which is much less the case with mental health legislation. The social care legislation provides an incremental approach to forms of care, starting with parental care, then family care, and in the end institutional care, unlike mental health law. It

[386] SADA, 2023.

largely domesticates the CRC, including Article 23 CRC on CWD. Several norms mandate the provision of home-based care, support, and services for families with CWD.

The Children's Act prescribes foster care, and interestingly it does not recognise kinship care as a form of alternative care *per se*, which is seen as one of the issues for the foster care system. This has been to an extent remedied with amendments that enable the DSD to introduce top-up grants for family members who care for orphaned children, on top of the basic CSG. Furthermore, the Act has undergone several amendments since its adoption, including those related to the provision of cluster foster care, arguably with an aim to increase quality and oversight, and to ensure that such care is truly family-based, and not institutional. The structure of cluster foster care, as outlined in the regulation, more closely resembles group care than family-based care; proposed amendments seek to further address this issue.

The Act makes sure that stakeholders are obligated to make services and programmes for children available to CWD, which is an especially important feature of this law. Still, the Act prescribes the provision of institutional care in CYCC, but only as a last resort measure. The Social Assistance Act prescribes several social grants, to which CWD and their families may be entitled to. Some of the social grants are not available or significantly reduced when a disabled child is placed in an institution. Such an approach may discourage institutionalisation.

The child rights law and social protection law are more advanced than the mental health law from the perspective of its alignment with the IHRL on children's rights and the rights of persons with disabilities. For example, although subtly, the Children's Act prioritizes family care over institutional care, which is supposed to be used as a last measure option. Despite that norm, it is suspected that CWD are often placed in residential care as a first option. This is not surprising considering the underwhelming support and services to families and the underdeveloped foster care for CWD. Such a gradation, however, does not exist in the mental health legislation, while many, especially children with severe and profound disabilities, are placed in mental health facilities for long-term care.

Also, the Children's Act prescribes that all programmes for children must be available to CWD. The legislation on social material assistance generally aligns with relevant IHRL, though eligibility assessment for CWD under the CDG relies exclusively on a medical approach, applying only to severely disabled children. Therefore, the implementation of relevant IHRL norms related to the right of CWD to life in a family environment through legislation is

underwhelming. Firstly, the incorporation of IHRL norms is only partial, and in relation to the CRPD profoundly disappointing. For that reason, the SADA demanded the adoption of a Disability Act and further alignment, especially of mental health laws with the CRPD. Secondly, the enforcement of those norms is questionable, such as the choice to place a child in an institution as a last resort measure, in accordance with Children's Act. While there are signs of significant incorporation of relevant CRC norms and a more limited incorporation of the CRPD in legislation on children and social protection, such incorporation is missing from the mental health legislation. Therefore, while the legislation on children is constantly evolving and reflecting intentions to make family life for children a reality, CWD that are placed or at risk to be placed in institutions under the DH may have little to no benefits from the reforms.

The poor incorporation of the CRPD is aggravated by challenges in the enforcement of domestic law. It is utterly hard to assess the success of enforcement of norms when data on the situation that the norms are supposed to address are missing. The most straightforward way to assess the effectiveness of some norms is to compare the practice or data on, for example, families of CWD receiving social grants, family support, data on accessibility to general services, numbers of CWD in foster care, kinship care and different forms of institutional care before and after relevant legislation is passed, and control other possible factors of influence. The lack of available data virtually precludes such an analysis. A researcher then must rely on secondary sources which suggest a certain state of enforcement. Additionally, interviews with key informants are a significant source of information, as they reflect observations of well-positioned individuals who are able to provide valuable insights where other data is missing.

Namely, a number of reports and academic sources suggest that enforcement of laws and policies is a great issue and there is a significant gap between the paper and the practice. Reportedly, those gaps are considerable in relation to early child development and parenting support, availability of community-based services;[387] information available to parents of CWD;[388] payment of foster child grants;[389] placement in institutional care as last resort (reports suggest children are placed in residential care as the first option); data collection.[390] Some

[387] Viviers, et al. 2013, p. 34. Linda Richter, et al., *Diagnostic Review of Early Childhood Development*, (2012). PATRICIA MARTIN, ANALYSIS OF CHILDREN'S SECTOR IN SOUTH AFRICA (Save the Children. 2015), p. 9. DSD, 2015, p. 44-45.
[388] DSD, 2015. SADA, 2023, p. 21.
[389] Hall, et al., SOUTH AFRICAN CHILD GAUGE, (2016). Skelton, INT'L SURV. FAM. L., (2012).
[390] Starting with the Integrated Disability Strategy (1997) and ending with Draft National Disability Policy (2015), each and every public policy document acknowledged the lack of data and the need to improve the collection and management, which has not been achieved still.

interviewees suggested that an abundance of laws and policies stay unimplemented, describing the situations as a "policy graveyard".[391] The issue with the foster care system is evident, as it was elaborated, and data suggest that many children and families stay without this significant type of support, despite their right to FCG, in accordance with the law.

One issue with the oversight of mental health establishments for long-term care was noted by SADA. Namely, review boards tasked with reviewing decisions and actions of those establishments are reportedly non-functional, and failing to protect the rights of users.[392] This lack of functional oversight can ultimately lead to long-term institutionalisations. This indicates the existence of a gap in enforcing those safeguarding norms of the mental health legislation.

Despite the underwhelming domestication of the CRPD, recent reforms and proposed changes provide encouraging signs of progress. The adoption of the WPRPD, amendments to Children's Act concerning cluster foster care schemes, the work of the SALRC on the domestication of the CRPD and the involvement of the SADA with issues of institutionalisation indicate a wind of change in South Africa.

4.2.2. Absence of the right to family care for CWD from judicial practice

A systematic review of case law revealed no relevant results concerning the right of disabled children to family or parental care. The High Court has adjudicated cases directly involving CWD, addressing issues such as underfunding, understaffing, and abuse in residential educational and social welfare facilities.

In selected cases, Constitutional Court judges provided significant interpretations of the critical Section 28(1)(b) of the Constitution, which concerns the right to family or parental care and alternative care for all children. Judge Skweyiya upheld an approach that the right to family or parental care is distinct from the right to appropriate alternative care, and that it deserves special protection. It follows that the placement of a child in appropriate alternative care does not automatically remedy the loss of family or parental care.[393] Judge Heher of the SCA shared a similar viewpoint, recognising that the right to family or parental care is distinct and deserves

[391] H., et al., Interview Stefanovic, 29th June, 2022.
[392] SADA, 2023, p. 20.
[393] See note 259.

separate consideration.[394] Conversely, in a different SCA case, Judge Wallis interpreted Section 28(1)(b) as an overarching obligation to ensure a child receives appropriate care. He argued that this obligation is fulfilled regardless of the care environment, suggesting that there is no right to family or parental care violation as long as appropriate alternative care is provided.[395] Such a restrictive interpretation has not been identified in other judgments.

In *Grootboom*, Judge Yacoob similarly to Judge Skweyiya, held that the right to family or parental care is protected primarily, and only when that is lost alternative care is provided. This means, that the state has an obligation to protect family life for children.[396] It would be crucial to see how courts adjudicate cases where a disabled child loses family or parental care and is placed in an institution due to the authorities' failure to provide necessary support and services to the family and community. In such a case, the child's right to family or parental care would be effectively limited by the lack of family- and community-based support and services, and also due to the lack of family-based alternative care options (foster/kinship care).

Advocacy NGOs, primarily the CCL at the University of Pretoria, played a crucial role in key, including those concerning the recovery of the foster care system and the right to family care.[397]Other mentioned sources emphasise the importance of the involvement of advocacy NGOs for the strategic litigation of child rights, which is evident in the selected cases too. Based on interviews and some of the cases presented here, the enforcement of court orders in strategic litigation cases is challenging and presents a significant obstacle to the success of such litigation.

To sum up, despite extensive case law on children's rights, there are no cases specifically concerning the right of disabled children to family or parental care. This could be a consequence of any number of reasons, however, it is reasonable to suspect that the overall low awareness of this right in the context of disabled children contributes to the lack of such litigation. The low awareness was confirmed in interviews, where virtually the only right of CWD that featured either in the work of interviewees or that they were aware of as being addressed was the right to education. Also, submissions to the regional and international treaty bodies are nearly completely free of the discussion on the issue of institutionalisation and life

[394] See note 186.
[395] See note 185.
[396] See note 263.
[397] See The Constitution, High Court.

in a family environment for CWD. Therefore, in spite of the potential that strategic litigation possesses in South Africa's system, it has not been a significant driver of implementation of the right to live in a family environment for CWD.

4.2.3. Declarative dedication to human rights in policy documents and implementation challenges

Public policy documents generously express the intention to incorporate relevant IHRL. For example, the goals of the WPRPD are mostly aligned with the CRPD. Still, the WPRPD, like virtually all other public policy documents, have a notoriously low level of implementation. The widespread issue of policies not being satisfactorily implemented is endemic and forms a significant barrier to the deeper realisation of IHRL. Moreover, policy documents rarely focus on CWD, particularly concerning institutional care.

The implementation gap of strategic policy documents is a major issue in South Africa. It is not entirely clear why many policies stay unimplemented. While new documents continue to acknowledge one and the same issue for decades (e.g. the issue with the lack of data), responsible authorities still fail to adequately address them. Attributing the gap to a lack of political will is simplistic, and as "political will" is a vacuous term, it fails to provide a substantial explanation. Still, the implementation gap does reflect a tendency of policymakers to draft documents emanating human rights standards such as the inclusion of CWD in all spheres of life, but steps to ensure that those programmes and measures are implemented are lacking. Relevant public policies are not costed, which may be one of the major reasons for the lack of their implementation. The overall cost-saving approach to public expenditure, evidenced in policies such as the late 1990s' GEAR macroeconomic policy and recent budget cuts in provincial budgets, may critically obstruct DI and other inclusive policies aimed at preventing institutionalisation.

Moreover, an overall approach of the South African government towards public spending reduction, the shrinking of state apparatus and privatisation of social services since the late 1990s is not conducive to the planned development of sustainable support and services for CWD and their families. Within this context, any DI efforts undertaken are likely motivated by reducing public costs rather than genuinely improving the quality of life and upholding the human rights of disabled individuals. This was evidenced in the Life Esidimeni tragedy. The cost reduction in the short term is not compatible with DI efforts, which in the long term should

be cost-effective, especially in the case of disabled children. The recent public budget of Gauteng shows a reduced expenditure for persons with disabilities two years in a row, while increasing the spending for other issues such as recycling, indicating a low level of prioritization of disabled South Africans. Also, some funding mechanisms are likely to be riddled with corruption, according to SADA, and funding of CBS is grossly uneven throughout provinces. The corruption in relation to the Life Esidimeni tragedy, more specifically the founding and licensing of residential care, was indicated in the arbitration between families of victims and responsible authorities. Bond reminds us that, apart from cost reductions associated with neoliberal policies, the issue with privatising public services - including those for CWD - is that they are inevitably debased and perverted by vested private interests.[398]

Policies related to specifically alternative care, family-based care, and institutional care for CWD have been developed primarily by the DSD. Other government departments, mostly the DH, have dealt with issues related to persons with disabilities through mental health-oriented policies. The intensity of CWD-related policymaking post-1994 is evident, as well as a declaratory dedication to the promotion and domestication of regional and international human rights instruments, including the CRPD. Virtually none of the documents missed mentioning relevant IHRL norms, indicating policymakers' awareness of the relevance of the IHRL for the development of domestic standards. Overall, South Africa has made significant progress in developing policy documents relevant to children and families over the past 26 years, but the implementation of these policies has been severely limited.

Notwithstanding, several interviewees described the landscape of relevant public policy documents in South Africa as a "policy graveyard", and claimed that such documents often stay unimplemented due to the lack of political will.[399] The issue with the lack of implementation of policy documents is acknowledged by several stakeholders and experts, and even by the DSD in their policy documents.[400] All national policy documents examined here lack costed plans for implementation. Moreover, the CRPD Committee emphasised the issue of the lack of participation of DPOs, especially those representing people with intellectual and psychosocial disabilities, which has a negative impact on the effect of those policies on the rights and lives of people with disabilities. Finally, meaningful independent monitoring of the implementation of disability-related policy documents is, contrary to the CRPD, inexistent.

[398] BOND. 2014, p. 254 - 255.
[399] H., et al., Interview Stefanovic, 29th June, 2022.
[400] Viviers, et al. 2013, p. 34. Richter, et al., (2012).

This can all contribute to the creation of strategic policy documents of underwhelming quality, and to a dissatisfying implementation.

Comprehensive national or provincial DI policy documents regarding CWD are non-existent. DI is rarely mentioned and seemingly not part of the overall approach of both the social protection and the healthcare sector. The SADA noted this issue and criticized the absence of policy documents to guide this process.[401] The reason for that, the SADA finds is the lack of political will.[402] The issue of institutionalisation in special schools seems completely unaddressed. The mental health sector sees DI predominantly as a transition to residential group care within the community, which should be delivered by NGOs. Arguably, the mental health sector had approached DI as a cost-saving measure, in accordance with an overall approach to the reduction of public expenditures already set during the 1990s. The current NMHPF 2023 is the first policy document that emphasises the imperative of developing CBS before descaling institutional care, most likely under the influence of the Life Esidimeni tragedy and recommendations received thereof.

Furthermore, most analysed policy documents use outdated terminology like "special needs" and "integration" for CWD, which may indicate an underwhelming level of understanding of the "paradigm shift" introduced into the IHRL by the CRPD and the transition to a human rights approach to disability. This paradigmatic issue extends beyond terminology, as evidenced by the frequent conflation of mental illness and intellectual disability in both law and policy. Likewise, Philpott and Muthukrishna criticize the approach in South African public policies that portrays CWD as intrinsically marginalized and vulnerable, a homogenous group, and the issue with the portrayal of inclusion "as an ideology rather than a practice".[403]

Nonetheless, several policy documents merit praise for their focus on preserving families and supporting families of CWD. The WPRPD excels in recognising causes of CWD separation, such as the lack of community-based support and services. All measures and goals foreseen by the WPRPD integrate CRPD norms to a large extent. SADA, however, argues that the WPRPD

[401] SADA, 2023. Submission for the List of Issues for South Africa, (2018), SADA, p. 19.
[402] SADA, 2023, p. 21.
[403] Susan Philpott & Nithi Muthukrishna, *A critical analysis of key policies shaping services for young children with disabilities in South Africa*, 23 23 EDUCATION AS CHANGE (2019). Abstract.

has not been implemented to a satisfying degree until 2023, and that the adoption of a Disability Act is a priority.[404]

Another strength of South Africa's policy documents is found in the WPF, which directs all efforts at family support, prevention, and family preservation. It promotes alternative care in extended family, then foster care and only in the end in residential care. A major issue of this document is that CWD are only mentioned in relation to the information their parents should have access to. Also, it does not address the situation of children in CYCC and other forms of institutional care, as a form of deprivation of the family environment which should be remedied.

Despite its comprehensiveness, the WPRPD notably omits measures for transitioning from institutional to family-based care. Moreover, there are no measures to reduce the number of CWD in institutional care or measures strictly aimed at the prevention of institutionalisation of children under the age of three. The early Integrated Disability Strategy noted the issue with institutionalisation in large residential care and called for transformation into other, smaller, community-based residential care. This was reiterated by the WPRPD, arguably only in relation to adults with disabilities. If such a policy would be undertaken regarding CWD, it would be contrary to all contemporary international norms and standards.

Given that most DSD policies aim to improve children's welfare, including that of CWD, those residing in DH-provided or supervised institutions provided or overseen by the DH, namely psychiatric hospitals, care and rehabilitation centres, and other facilities, are potentially left out of DSD reforms. Those institutions accommodate children and adults with disabilities, especially those with intellectual and severe disabilities, who may remain left behind by policymakers. This could be a major impediment to the realisation of life in a family environment for many CWD, especially those with severe or profound disabilities, and many other human rights of theirs. The same goes for residential schools for CWD.

Finally, the near-total absence of institutionalisation as a recognised form of deprivation of family or parental care for CWD in public policy speaks volumes about its perception in the country. Namely, it is an indication that policymakers (and other actors that participate in the process of policymaking), do not see this as a problem, hence it does not deserve a specific

[404] SADA, 2023.

action aimed at alleviating it. This further suggests that the first steps in addressing the problem should be awareness-raising and education.

4.2.4. Indifference of NHRIs and limitations of other structures

Despite the SAHRC's critical role in establishing a post-1994 human rights-based society, [405] there is little evidence of its promotion of the right to family or parental care for CWD. This conclusion is derived from the lack of sufficient evidence that the SAHRC has engaged with the relevant issue throughout its work, by reviewing their reports, submissions to regional and international human rights bodies, their publications, and through interviews.

Neither the SAHRC nor the Public Protector has made tangible contributions to realising the right to a family environment for CWD. Their work contains little to no actions related to this critical issue. Moreover, the National Preventive Mechanism, operating under the SAHRC, has yet to conduct visits to any institution for disabled children.

The only engagement observed with the relevant issue is in the SAHRC's report following the investigative hearing on South Africa's mental health care status after the Life Esidimeni tragedy. The SAHRC acknowledged the issue with an overall approach to disability in mental health policy in their report. The body contributed greatly to the investigations of the Life Esidimeni tragedy and the tragedy in the school for deaf children in the Nort West Province. In the former case, the SAHRC noted the incompatibility of institutionalisation with human rights and advised the development of CBS.[406] In the latter case, the SAHRC failed to address the issue of institutionalisation and the deprivation of liberty for CWD in school hostels. Therefore, the SAHRC has not engaged with the issue of institutionalisation regularly and decidedly. Despite its potential, the effects of the SAHRC's work on the rights of CWD to family or parental care have been negligible, constituting an impeding to the realisation of the right in question. However, this alone does not suffice to conclude that the SAHRC has played a significant role in implementing relevant international norms. It may indicate the start of the institution's more intensive engagement with the rights of children and adults with disabilities.

[405] For example: Tseliso Thipanyane, *Strengthening Constitutional Democracy: Progress and Challenges of the South African Human Rights Commission and Public Protector*, 60 60 NYL SCHAPTER L. REV. (2015).
[406] Ibid

Another body, the SALRC is involved as an expert legal body in the process of domestication of the CRPD since 2020. The process led by the SALRC should result in the statutory domestication of critical CRPD norms. The fact that the process is ongoing and addressed by this authoritative body is evidence that recommendations by the CRPD and other stakeholders to domesticate norms of the CRPD are acted on. The initial issue paper by the SALRC unfortunately does not address provisions of Article 23 CRPD. It is unclear why this article was omitted; however, it could still be addressed in the consultative phases of the process, especially if NGOs raise this issue. The SALRC addressed the issue of institutionalisation of CWD in schools and DI, as well as the potential negative effects of the Gauteng tragedy on DI processes in the country. Finally, the SALRC is potentially a significant actor in the domestication of the CRPD and norms that should improve the realisation of their rights including the right family life for CWD.

4.2.5. Silent advocates and strong service providers

South Africa and the EU are longstanding strategic partners, with several bilateral agreements concluded between the two.[407] Official documents between the EU and South Africa, as well as information obtained through interviews indicate that the EU does not have a substantial impact on issues relevant to this study, either through funding programmes, in law- and policymaking or by conditioning the realisation of benefits of South Africa (e.g. development aid) with the advancement in the sphere of rights of CWD (no issue linkages). Only the latest MIP 2021-2027 contains objectives directed at the improvement of the position of persons with disabilities in South Africa.[408] This should be achieved through the support to Chapter 9 institutions of the South African Constitution and by supporting grass-root CSOs. Therefore, more intensive engagement from the EU is expected in the 2021-2027 programming period.

UNICEF has been active in South Africa and the region for several decades, while more recently it contributed to the availability of data by publishing reports. In their work in South Africa and the region, a strong emphasis is put on family support and family-based alternative care, however UNICEF supported the use of small institutional settings for children, although

[407] See notes **Error! Bookmark not defined.** - 375.
[408] See note 375.

it expressed that a more cautious approach to the use of such care should be taken when it comes to CWD.[409]

The analysis reveals a significant oversight in the advocacy strategies of South African child rights and advocacy-oriented NGOs, particularly in their engagement with issues surrounding the rights and welfare of CWD, except in the area of inclusive education. These organisations have excelled in advocating for children's rights through advocacy and strategic litigation. However, they have hesitated to address family or parental care, alternative care, and the institutionalisation of CWD. This disconnect is further highlighted by the absence of these critical issues in alternative reports to UN human rights bodies, with SADA being the sole exception in addressing the institutionalisation within the realm of basic education. Human rights organisations have yet to fully address the challenges faced by CWD in institutional settings, which if highlighted, could raise national concerns, and potentially impact South Africa's international reputation. Such recognition could attract international support to improve the situation, suggesting that the lack of focus by human rights groups on CWD in institutions is a missed opportunity, obstructing the fulfilment of their rights.

The discussion on residential care in South Africa highlights the significant role of private entities. These span NGOs, faith-based organisations, and firms offering social services, all emerging as pivotal stakeholders within South Africa's social welfare landscape. These organisations predominantly manage residential care services, underscoring their potential to significantly influence legal and policy frameworks. The operational footprint of entities like SOS Children’s Villages, which provides orphanage care for over 600 children, exemplifies the substantive role that private organisations play in the social welfare ecosystem, potentially shaping law and policy direction.

However, the privatisation of residential care for CWD is met with criticism from disability rights advocates, who argue that it presents an inherent conflict of interest, potentially derailing DI efforts, and notably from the CRPD Committee.[410] The critique is rooted in the concern that private providers of institutional care may attempt to hinder or redefine DI, by pushing for solutions that include residential care, but under certain conditions which should be more acceptable (e.g. smaller facilities and physically closer to or within local communities). This

[409] See note 377.
[410] See note 382.

approach could lead to trans-institutionalisation, a phenomenon highlighted in the Life Esidimeni case. Additionally, another potential issue with the privatisation of residential care for CWD could be the intensive proliferation of private facilities, possibly surpassing the pace of expansion of state-provided residential care. This tendency would be driven by the profit-oriented incentives of private providers. Given the complexity and significance of these concerns, this is an under-researched issue that demands further consideration.

The resistance to DI can also exist where the state is a sole or major provider of residential care, as in Serbia.[411] The major difference is that where a substantial private financial interest is involved (where providers of institutional care are private organisations), this may be a larger impediment for change, than the resistance coming from employees in some parts of the social welfare system. Also, the latter are arguably more willing to accept solutions which will enable them to keep jobs in other sectors of the social welfare system and in the provision of family- and community-based services. However, this receptiveness may depend on the strength of employees' syndicates and the centralisation of power: stronger syndicates increase employees' bargaining power, whereas more centralised decision-making reduces their ability to influence outcomes. Such a policy solution is identified in Serbia, where a transformation of institutions from providers of residential care for children to providers of family-based care and family support in the context of DI is an adopted public policy.[412]

Table IV.1 List of identified facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in South Africa.

South Africa		
	Facilitators	Impediments
1.	The tradition of care for children which includes members of the wider family and the community;	Stigma and prejudice against persons with disabilities;
2.	The Bill of Rights based on the equality of outcomes and the solid protection of children's rights and the right to family or parental care;	1/3 of children not having parental care, and only 1/3 of children living with both parents;

[411] See Part III, Serbia, Chapter 3.1.3. Law on Social Protection.
[412] See Part III, Serbia, Chapter. 3.4.1. Deinstitutionalisation Strategy.

3.	The obligation to make all programmes and forms of care including respite care available to CWD, per Children's Act;	The lack of awareness of the harms of institutionalisation and the rights of CWD amongst lawmakers and NGOs;
4.	The law of precedent and the proclivity of judges of higher courts to interpret domestic law in line with international children's rights;	The loss of public support for DI due to the Life Esidimeni tragedy, and the association of DI with public cost-cutting;
5.	Strategic litigation-oriented advocacy organisations;	The lack of data on CWD living in families or in institutional care, the lack of available data on spending on support to disabled children and their families;
6.	A developed system of social care grants;	The lack of foster care programmes specifically aimed at promoting and delivering such care for CWD;
7.	The work of the SALRC on the domestication of the CRPD;	The lack of in-country adoptions of CWD;
8.	Recent advocacy efforts of the SADA.	The institutionalisation of CWD across three sectors - social care, healthcare and education;
9.		The reforms of the social sector may not encompass CWD who are in residential care in the healthcare sector;
10.		Ineffectiveness of bodies mandated with the control and monitoring of residential care, such as Review Boards per Mental Health Act;
11.		The lack of "full-service schools" and the institutionalisation of children in special schools;
12.		Mental health legislation that is not compliant with the CRC and the

		CRPD, it enables long-term institutionalisation of children with disabilities, and does not prescribe placement in an institution only as a last resort option;
13.		The lack of prohibition of placement of children under the age of 3 in institutional care;
14.		Delayed and partial enforcement of court orders in strategic litigation cases;
15.		The lack of either sectoral or intersectoral policies that address the issue of institutionalisation;
16.		The lack of tailored family- and community-based services for CWD and their families;
17.		Public policies that address related issues stay largely unimplemented;
18.		Strategic policy documents lack cost analysis and planning;
19.		The lack of a mechanism to monitor the implementation of policies, especially an independent mechanism;
20.		Tendency of some provinces to decrease budgets aimed at persons with disabilities;
21.		The dominance of private organisations in the provision of institutional care and their potential to impact DI-related law- and policy-making;

22.		Reported existence of unregistered institutions for the care of children;
23.		The lack of relevant political issue linkages;
24.		Advocacy organisations focused on strategic litigation do not address the issue of institutionalisation of CWD;
25.		The lack of human rights watchdogs interested in the position of CWD in institutional care.

Concluding chapter

As this dissertation is drawing to a close, it is imperative to reflect on the answers to the central research question: *Which factors facilitate and impede the implementation of the right to live in a family environment for children with disabilities in Austria, Serbia, and South Africa, and how do they do so?* The answer to the central research question is comprehensive and is addressed for each country separately in the following subchapter of this conclusion 'Facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities'. The subsidiary research questions are addressed through the central question and will not be separately discussed.

The main research question for Part I of the dissertation: *What are the international legal standards on the right to live in a family environment for CWD, and are there divergences between the CRC and the CRPD in that regard?* is addressed below in the subchapter 'Towards the CRC and the CRPD unified perspective on alternative care for children with disabilities'. The dissertation explores the discord and synergy between the CRC and the CRPD, particularly regarding alternative care and the use of institutional care for CWD. The life in institutional care is posited as antithetical to family life. Therefore, the permissibility of institutional care for CWD, from the perspective of international human rights law and alternative care standards is the main question in the exploration of the interaction between the CRC and the CRPD and international stakeholders involved with the interpretation and promotion of two treaties.

This study began with an ambitious goal: to dissect and understand the implementation of the right to live in a family environment for CWD within three distinct jurisdictions - Austria, Serbia, and South Africa. The investigation roots itself in an analysis of the CRC and the CRPD, framed within the broader discourse of IHRL. This research navigates the intricacies of these conventions and their application within the varied socio-political and legal landscapes of Austria, Serbia, and South Africa to illuminate the challenges and strategies underpinning the effective realisation of the rights of CWD. This journey was guided by an interdisciplinary approach, blending legal analysis with methods from political science and sociology, to capture the multifaceted nature of human rights implementation.

It identifies several facilitators and impediments in the realisation of the rights of CWD to live in a family environment and examines the reasons behind their existence in the three countries. Selected for their diverse legal, political, and social landscapes, Austria, Serbia, and South Africa provide insights into the challenges and strategies underpinning the effective implementation of CRC and CRPD norms in radically different contexts. The rationale behind this choice is the critical need to understand how different jurisdictions approach the CRC and the CRPD, and more specifically, how they implement the right of CWD to live in a family environment.[1] This enabled a nuanced analysis of international norms' implementation in significantly different contexts. To encompass various aspects relevant to the implementation of the CRC and the CRPD, the dissertation explores legislative incorporation, the role of the judiciary, public policy development, and other pivotal factors influencing norm implementation, such as deeply rooted practices concerning the systems of child welfare and the welfare of persons with disabilities. Despite the differences between the examined states, the study shows overlapping enablers and impediments. However, while some of those factors may be shared, the mechanisms behind them are largely found to differ, as shown below, in the chapter 'A cross-country perspective on enablers and impediments'.

Furthermore, the study was built on theoretical frameworks, primarily the Conditional International Law theory, and Koh's Transnational Legal Process. These theoretical lenses helped to design the study, to contextualise the empirical findings and offered a foundation for discussing the potential implications of the study's outcomes. Engaging with these theories not only enriched the analysis but also contributed to the ongoing scholarly conversation about the mechanisms of IHRL compliance and implementation.

As we approach the concluding remarks, it is essential to revisit the primary objectives of this research: to critically examine the realisation of the right to live in a family environment for CWD in the selected countries and to understand what drives and impedes different jurisdictions' implementation of the CRC and the CRPD. This final chapter aims to synthesise the main findings, reflect on the theoretical contributions of the study, and consider the implications for future research.

[1] For more information on the selection of countries see: Introductory chapter, 3.1.1. Country selection.

1. Towards the CRC and the CRPD unified perspective on alternative care for children with disabilities

The approaches of the CRC and CRPD to alternative care, particularly institutional care, subtly diverge rather than outright conflict. The divergence is subtle because the state obligations stemming from the norms (primarily Article 20 and 23 CRC and 19 and 23(5) CRPD) are largely convergent.[2] This divergence, rooted in the slightly differing purposes of the norms, could deepen through their interpretation based on the commonly employed effectiveness approach in human rights norms.[3] Namely, standards of alternative care coming from the CRC, the work of the CRC Committee, then the UN resolutions on the rights of the child, and especially the UN Guidelines on Alternative Care, stipulate a certain use of residential care for all children, including those with disabilities.[4] Contrary to that, an interpretation of the CRPD offered in this dissertation, and promoted by the CRPD Committee, contends that residential care is impermissible for CWD.[5]

A comprehensive analysis in Part I of this dissertation shows that CRPD provisions (Article 19 and 23(5)) aim to end the institutionalisation of CWD, mandating strictly family-based placements.[6] This interpretation, rooted in the effectiveness approach that aligns with the norm's purpose, wording, and context, mandates that states must halt the prevalent practice of placing CWD in institutions, ensuring instead their right to live in a family environment. Conversely, the CRC primarily aims to ensure that children deprived of their family environment are provided with alternative care, including institutional options if necessary. This contrasts with the CRPD, which seeks to address the historical injustices experienced by disabled children, who have been disproportionately institutionalised compared to their non-disabled peers. While the norms of these conventions show only minor differences, the underlying objectives do diverge.

[2] Part I, Chapter 2.3. Identifying a conflict.
[3] Part I, Chapter 2.4. Conflict of purposes.
[4] Part I, Chapter 3.6. Conclusion on UN resolutions and alternative care for children with disabilities.
[5] Part I, Chapter 1.2.1 Article 23 CRPD – Respect for the home and family, 1.2.2 Article 19 - Living independently and being included in the community, 4.3 CRPD Committee.
[6] Part I, Chapter 2.6. Conclusion on the norm divergence.

Despite recent attempts by two committees to address overlapping issues,[7] the divergence will not be resolved without a dedicated effort to align the rules and standards related to alternative care. This is increasingly important given the siloing of the respective transnational issue networks (or advocacy communities) of the CRC Committee and the CRPD Committee.[8] The lack of a consensus between the major stakeholders on the interpretation of the treaties and the international standards of care for CWD can instil considerable confusion and challenges in treaty implementation.

Arguably, the path to resolving the highlighted disagreements necessitates both procedural and substantive measures. This implies that a balanced 'mixed approach', detailed in Part I of this dissertation, could achieve broad stakeholder consensus.[9] It underscores the importance for development and adoption processes to meet the criteria of a 'thick stakeholder consensus', as advocated by Pauwelyn, Wessel and Wouters.[10] The absence of such consensus risks leaving any new resolutions unsupported, devoid of normativity, and overshadowed by the highly authoritative UN Guidelines for the Alternative Care of Children, which, at the moment, do not integrate the CRPD norms and its objectives sufficiently.[11] Engaging key stakeholders - including UNICEF, international and domestic DPOs, NGOs, and service providers - is crucial to achieving a meaningful resolution..[12] Findings from country studies on the importance of international and domestic children's rights and disability rights organisations to push for the implementation, support the argument for reaching a thick consensus of broad array of stakeholders, which include UNICEF, treaty bodies, international domestic DPOs and NGOs, rather than focusing on reaching a thin state consent.

[7] Part I, Chapter 4.4. Joint statement of the CRC and the CRPD Committees on the rights of children with disabilities.
[8] Part I, Chapter 3.4.1 Drafting process and the divide.
[9] Part I, Chapter 5.9.4. A mixed approach.
[10] JOOST PAUWELYN, et al., INFORMAL INTERNATIONAL LAWMAKING (Oxford University Press. 2012), p. 160-161.
[11] Part I, Chapter 3.2 UNGA Guidelines for the Alternative Care of Children (2009).
[12] Part I, Chapter 5.9.3 A mixed approach.

2. Facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities

The following subchapters summarise the key findings for each country, answering the central research question: *'Which factors facilitate and impede the implementation of the right to live in a family environment for children with disabilities in Austria, Serbia, and South Africa, and how do they do so?*'

The key findings related to the central research question are presented for each country separately, followed by a cross-country analysis. Answers to subsidiary research questions are integral to answering the central research question, hence the subsidiary questions are not separately addressed in this conclusion.

The subsidiary research questions are:

1. *How have statutory laws incorporated the relevant CRC and CRPD norms?*
2. *Have the judiciary contributed to the implementation of the relevant CRC and the CRPD norms and how?*
3. *How have policymakers addressed the right to live in a family environment for CWD in strategic public policy documents?*
4. *How have national human rights institutions and structures that facilitate the implementation of the CRC and the CRPD addressed the right to live in a family environment for CWD?*
5. *How has civil society, primarily disabled people's organisations and human rights NGO addressed the right to live in a family environment for CWD?*
6. *What other significant factors have impacted the implementation of the right to live in a family environment for CWD?*

2.1. Austria

Austria's journey towards fulfilling the right of CWD to live in a family environment showcases a complex interplay between a robust social protection framework and entrenched systemic challenges. Despite possessing the foundational elements for transformative progress, the nation grapples with institutional legacies and fragmented approaches, necessitating a concerted effort to align with the principles of the CRPD.

Austria's robust social protection system represents a formidable facilitator in the realisation of the right to live in a family environment for CWD. This system is based on strong financial support for families and for CWD,[13] coupled with access to ESI Funds, which can support the development and expansion of vital support and services to families.[14]

Austria has the potential to enhance existing community-based services, such as mobile early support, personal assistance, and assisted living for adolescents with disabilities, and to create new comprehensive and individualised services. The possibility of establishing binding agreements between the Federation and provinces (Länder) concerning social care provision can enable the country-wide implementation of deinstitutionalisation. With a robust foster care system for non-disabled children already in place, [15] Austria has the network and expertise to significantly expand foster care for CWD.

The nation's rule of law and willingness to confront past transgressions within public and private health and social care organisations could facilitate the transition to family-based care and living for CWD.[16] The potential for positive change is strengthened by the full implementation of Article 33 (2) of the CRPD, and the potential for productive workings of both the Independent Monitoring Committee for the implementation of the CRPD and monitoring bodies in each province.[17] The improved joint Federation-provinces drafting of the NAPD 2021, compared to the older NAPD 2011,[18] the potential for the development of inclusive education forms, and an overall human rights culture receptive to international norms provide a basis for progress.

[13] Part II, Austria, Chapter 2.3.1. Support and services to children with disabilities and their families.
[14] Part II, Austria, Chapter 3.5.2. ESI Funds and institutional care in Austria and the EU.
[15] Part II, Austria, Chapter 2.3.2. Family-based alternative care.
[16] Part II, Austria, Chapter 2.1. Historical human rights violations and reform of institutional care.
[17] Part II, Austria, Chapter 3.4.2. Independent Monitoring Committee.
[18] Part II, Austria, Chapter 3.3.2. National Action Plan on Disability 2022 – 2030.

However, Austria's path to realising the right to live in a family environment for CWD is severely hindered. A significant impediment is the absence of comprehensive data on CWD, reflecting the low priority given to such data collection by authorities.[19] The extensive network of institutional care is difficult to scale down, hindered by resistance from service providers and potentially by their employees.[20] The European Expert Group on Transition from Institutionalisation to Community-based Care also believes that service providers may have blocked DI in Austria.[21] Private providers of residential care potentially wield significant policymaking influence, which is generally one of the major concerns of the CRPD Committee.[22]

Austria's social protection system's tendency towards incremental changes is at odds with the paradigmatic changes required by the CRPD to realise the right to live in a family environment.[23] The social protection trajectory for children and adults with disabilities established during the 1980s and early 1990s persists, resulting in the parallel expansion of community-based services and residential care.[24] Additionally, the endorsement for small-scale residential care, including from independent human rights bodies like the Independent Monitoring Committee for the implementation of the CRPD (although subtle), poses additional difficulties.[25] Moreover, the ingrained tradition of out-of-home care for disabled persons, including CWD, is an additional obstacle preventing swift reforms.[26]

The seemingly low regard by provincial authorities for the CRPD implementation and the absence of litigation efforts in the sphere of family living and care present major obstacles.[27] The lack of strategic litigation is directly related to the insufficient legal domestication of CRPD norms and the impossibility of directly applying human rights treaties before the court. Additionally, the limited awareness among NGOs and potential litigators of the right to live in a family environment and of the CRPD more broadly, coupled with the absence of the *stare decisis* doctrine in the legal system, may contribute to the reduced use of strategic litigation.

[19] Part II, Austria, Chapter 4.1. The lack of data and resistance to change.
[20] Ibid.
[21] Report on the state of play of the deinstitutionalisation process and the development of community-based Care in the European Union, The European Expert Group on Transition from Institutionalisation to Community-based Care, 2016, p. 4, 5.
[22] Guidelines on Deinstitutionalization, Including in Emergencies, CRPD/C/5, Committee on the Rights of Persons with Disabilities, 2022, para. 34.
[23] Part II, Austria, Chapter 4.1. The lack of data and resistance to change.
[24] Part II, Austria, Chapter 2.2. Reform of the long-term care system and residential care.
[25] Ibid.
[26] Part II, Austria, Chapter 2.1. Historical human rights violations and reform of institutional care.
[27] Part II, Austria, Chapter 4.2.3. Limited use of strategic litigation.

The dual-track approach in the social protection and education systems, with separate laws and institutions for children with and without disabilities and minimal coordination, underscores major systemic issues hindering the implementation of comprehensive policies regarding CWD.[28]

The impossibility of directly applying the CRPD[29] and the insufficient incorporation of its norms into domestic law are major obstacles.[30] Austria's federal structure, granting provinces autonomy over welfare services pertaining to children and persons with disabilities, coupled with inadequate cooperation between the Federation and provinces, exacerbates the issue of CRPD implementation.[31]

Media, at times, has facilitated the dissemination of information about gross human rights violations in homes for children, including CWD, leading to heightened public awareness of crimes in those establishments.[32] Conversely, the media reportedly often depicts CWD as objects of charity and tragedy, arguably undermining the public's understanding of their rights and agency.[33]

The use of ESI Funds for the development of institutional care highlights a controversial use of EU resources.[34] The EU's endorsement of institutional care under certain conditions further complicates the situation.[35] An opportunity to generate an 'issue linkage' was missed, despite the regulatory possibility. If the EU had halted funding to projects that expand residential care for CWD, an 'issue linkage' would have been created between the right to live in a family environment and the allocation and absorption of ESI Funds, potentially facilitating the development of community-based services and discouraging the expansion of residential care.[36]

The representation and advocacy efforts by DPOs and NGOs regarding institutional care for CWD seem insufficient. The discourse surrounding the rights of CWD seldom addresses the

[28] Part II, Austria, Chapter 4.2.1. Differing levels of the CRC and the CRPD incorporations.
[29] Part II, Austria, Chapter 1.1. Legal System, the Constitution and international treaties.
[30] Part II, Austria, Chapter 3.1. Legal measures, 4.2.1. Differing level of the CRC and the CRPD incorporation.
[31] Part II, Austria, Chapter 2.3. Contemporary social protection, 3.1.1. The Federal Constitutional Law B-VG.
[32] Part II, Austria, Chapter 2.1. Historical human rights violations and reform of institutional care.
[33] Part II, Austria, Chapter 2.2. Reform of the long-term care system and residential care.
[34] Part II, Austria, Chapter 3.5.2. ESI Funds and institutional care in Austria and the EU.
[35] Part II, Austria, Chapter 4.2.6. European Union's ambivalence.
[36] Part II, Austria, Chapter 3.5.2. ESI Funds and Institutional care in Austria and the EU.

critical issue of institutional care.[37] The absence of international IGOs and NGOs working on the DI of care for CWD is striking, arguably impeding awareness raising and the implementation of concrete measures, such as the development of community-based services.[38]

In conclusion, while Austria demonstrates strong foundational support for the right of CWD to live in a family environment, it must navigate through and dismantle a legacy of institutionalisation and fragmented systems to achieve transformative progress in line with the CRPD.

A more detailed analysis of facilitators and impediments to the implementation of the right to family life for CWD in Austria can be found in Part II of this dissertation. A list of identified facilitators and impediments is provided in *Table II.13 List of facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in Austria.*

2.2. Serbia

Serbia has one of the lowest rates of institutionalisation of children, including CWD, in the world.[39,40] However, the proportion of CWD in institutional care in Serbia is markedly adverse, with over 70% of children in such care being disabled.[41] This situation, combined with several reports from domestic and international NGOs about deplorable conditions in institutional care, positions Serbia as one of the most cited examples of the institutionalisation of CWD in Europe.[42] Although the official quantitative data do not portray a completely positive picture, the existence and public availability of it is commendable, and serves as an important starting point for any exploration and planning.

The long tradition of family-based care provided to orphans, and the adoption of legal regulation prioritising kinship and foster care over institutional care almost 100 years ago,

[37] Part II, Austria, Chapter 3.6. Domestic and foreign organisations.
[38] Ibid.
[39] Part III, Serbia, 2.2. Institutional (residential) care.
[40] MANFRED NOWAK, UN GLOBAL STUDY ON CHILDREN DEPRIVED OF LIBERTY (United Nations. 2019), p. 503.
[41] Ibid, p. 190.
[42] Part III, Serbia, Chapter 3.6. International and domestic organisations

worked in favour of having a robust system of family-based alternative care in Serbia today.[43] Legislation already from the early 20th century prioritised family-based alternative care over institutional care, by stipulating that a child should be placed primarily in a wider family, and if that is not possible with a foster family, and only than in an institution.[44] Despite the long tradition of family-based care for children in general, the institutional care for disabled people, including CWD, was formed after the WWII and modelled after the Soviet Union's approach to care for people with disabilities, while community-based services were reportedly absent.[45] Therefore, Serbia's historical approaches to alternative care of children can both facilitate and impede the realisation of the right to live in a family environment today.

The wars, economic and international isolation during the 1990s significantly regressed the state of human rights in Serbia, particularly through cost-cutting measures that resulted in more institutionalisation, less support and services for families, and less CBS for all children, acting as a major impediment.[46] The family-based alternative care suffered another blow with the public cost-cutting policy from 2013 onwards, indicating that the lack of resources and cost-cutting are more likely to decrease the provision of care in a family environment than in residential care.[47]

The democratic transition was a significant driving factor in improving children's rights in several ways. The motivation of new democratic political elites to improve the human rights record in contrast to the preceding regime's grave violations was evident.[48] Soon after the regime change, cooperation with the EU intensified, and EU funds were transferred to Serbia. Progress in accession negotiations was conditioned on, among other things, the improvement of the human rights of CWD.[49] This issue linkage is possibly one of the most significant facilitators of Serbia's transformation of the child welfare system, considering that most laws and public policies were adopted to fulfil EU criteria, but it is highly dependent on the quality of the Serbia – EU relationship. [50]

[43] Part III, Serbia, Chapter 2. Situation of children with disabilities.
[44] Ibid.
[45] Ibid.
[46] Part III, Serbia, Chapter 4.1. The situation in alternative care.
[47] Part III, Serbia, Chapter 2.5. Centres for Social Work.
[48] Part III, Serbia, Chapter 3.5. European Union.
[49] Ibid.
[50] Ibid.

Conversely, considering the position of the EC in relation to the residential care for CWD,[51] the EU's engagement in Serbia could also lead to other forms of institutionalisation. However, Serbia-EU documents and projects that the EU funded do not indicate that the EU supports any forms of care for CWD other than life in a biological family and family-based alternative care, confirming the positive impact of EU negotiations for the realisation of the rights of CWD, including the right to live in a family environment.[52]

Family-based care for CWD is grossly underdeveloped compared to the same type of care for other children, which, according to some authors, is partly due to the prejudice of potential foster parents and the stigma against disability.[53] This is also reflected in the lack of adoptions of CWD in the country.[54] At the same time, reunification-related interventions are reportedly insufficient, resulting in life-long institutionalisation for most CWD who enter institutional care.[55] However, it must be recognised that the lack of foster carers and adoptive parents for CWD is in part a result of the lack of adequate support and services for CWD.

Other facts point to the omnipresent prejudice and lack of awareness among the general public and authorities, such as the large number of cases before the Commissioner for Equality and the Ombudsperson concerning the discrimination against people with disabilities and violations of their rights.[56] Additionally, this dissertation shows that foster care for CWD was intentionally left aside by policymakers during the first phase of reforms (after 2000) due to presumed concerns about the safety of CWD in foster care, indicating a lack of will and possibly prejudice among the highest-positioned policymakers themselves.[57] Therefore, despite the expansion of family-based care in the past two decades, CWD could barely benefit from it, at least to an extent due to prejudice and the lack of readiness of the administration to invest effort, as this research shows.

The aforementioned post-2013 cost-cutting policy increased understaffing and brought precarious working conditions in Centres for Social Work, the critical link in the social protection system, posing another major impediment to the quality provision of community-

[51] Part II, Austria, Chapter 3.5.2. ESI Funds and institutional care in Austria and the EU.
[52] Part III, Serbia, Chapter 3.5. Chapter European Union.
[53] Part III, Serbia, Chapter 2.3. Family-based alternative care.
[54] Part III, Serbia, Chapter 2.4. Adoption.
[55] Part III, Serbia, Chapter 2.2 Institutional (residential) care.
[56] Redovan godišnji izveštaj Poverenika za zaštitu ravnopravnosti za 2022. godinu, Commissioner for the Protection of Equality, 2023. Redovan godišnji izveštaj Zaštitnika građana za 2022. godinu, 3411- 56 / 23 Protector of Citizens, 2023.
[57] Part III, Serbia, Chapter 2.3. Family-based alternative care.

based services, support, and family-based alternative care.[58] While cost-cutting measures were applied in Centres for Social Work and Centres for Family Placement and Adoption, the state still funded expensive renovations of residential institutions for CWD.[59] The reduction of public expenditure measures was planned together with international financial institutions and implemented by the government led by the right-wing SNS, indicating that such arrangements can indirectly impede the realisation of the right to live in a family environment for CWD.[60]

The fact that all residential institutions are state-owned can act as both a facilitator and an impediment in the process of realising the right to live in a family environment for CWD. The resistance and influence on decision-making in the competent ministry by directors and employees of residential institutions may represent an impediment to the process. The solution was to transform institutions to providers of community-based services rather than close them in the context of DI.[61] Additionally, the fact that there are no private providers of residential care for CWD, including faith-based organisations, eliminates the potentially powerful resistance of business and religious organisations to DI.

One of the challenges in realising the rights of CWD is related to the funding and provision of CBS, due to the lack of capacities of municipalities.[62] Therefore, the decentralisation of social services - their funding and provision - at least for now, acts as an impediment to the development of a better network of services on the local level. Although, such a situation was anticipated by the World Bank, effective measures to prevent it have not been implemented.[63] Moreover, the lack of private service providers of community-based services, *inter alia*, due to the burdensome licensing requirements, decreases the availability of such services for CWD, potentially failing to prevent the separation of CWD from their families or to facilitate their reunification.[64] Such problems do not exist with institutional care because it is funded from the state budget.

The lack of consistency among authorities in adopting and implementing relevant laws and policies is a major impediment to reforms.[65] The proliferation of regulations and their

[58] Ibid.
[59] Part III, Serbia, Chapter 4.2.5. Public policy planning and realisation gap.
[60] Ibid.
[61] Part III, Serbia, Chapter 3.4.1. Deinstitutionalisation Strategy.
[62] Part III, Serbia, Chapter 3.4.2 Other policy documents.
[63] Ibid.
[64] Part III, Serbia, Chapter 4.1. The situation in alternative care.
[65] Part III, Serbia, Chapter 3.1.5. Enforcement gap, 4.2.5 Public policy planning and realisation gap.

underenforcement may have resulted from the need to progress in EU accession negotiations by conducting legal and policy reforms without genuine intentions and capacities to implement them.[66] he lack of accountability among authorities is also due to the lack of independent controlling mechanisms, including the ineffective Council for the Rights of the Child, but more importantly an inadequate judiciary, and an overall insufficient level of rule of law, marking another serious barrier to more profound implementation. Consequently, strategic litigation for the rights of CWD is practically non-existent in Serbia, except for one constitutional review case.[67]

NHRIs facilitate the process but have limited influence and are apprehensive about using their most powerful competences.[68] Serbia has only recently incorporated Article 33 (2) CRPD on independent monitoring mechanisms, which should commence its function in the near future under the auspices of the Protector of Citizens (Ombudsperson), with the aim of promoting the incorporation and implementation of the CRPD.[69] The late incorporation of this norm has evidently not helped the implementation of the CRPD since its ratification. The best result was achieved when NGOs and NHRIs acted complementarily.[70] The largest DPOs lack independence from the Government and are focused on cooperation rather than confrontation in case of human rights violations, which is another missed opportunity considering the massive infrastructure of DPOs throughout Serbia.[71]

Some human rights NGOs' work on uncovering human rights violations was instrumental in the process by increasing the visibility of issues faced by CWD and instilling government actions, such as the moratorium to further placements of children in one of institutions.[72] Additionally, the visibility of rights violations in institutional care, thanks to NGO reports, may have dissuaded some parents from deciding to place their child in such care. The monitoring visits and reporting from institutions would not have been possible without the authorities' permissions, indicating that the relative openness of Serbia's authorities is a facilitator in the implementation process. However, the presence of human rights NGOs working on the rights

[66] Part III, Serbia, Chapter 4.2.1. Commendable incorporation and poor enforcement.
[67] Part III, Serbia, Chapter 4.2.3. The lack of strategic litigation.
[68] Part III, Serbia, Chapter 4.2.4. Large potential of NHRIs and futility of advisory bodies.
[69] Part III, Serbia, Chapter 3.3.1. Protector of Citizens (Ombud).
[70] Ibid.
[71] Part III, Serbia, Chapter 3.6. International and domestic organisations.
[72] Ibid.

of CWD is scarce, and the implementation of human rights norms could benefit from a larger presence of these organisations.

A more detailed analysis of facilitators and impediments to the implementation of the right to family life for CWD in Serbia can be found in Part III of this dissertation. A list of identified facilitators and impediments is provided in *Table II.1 List of facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in Serbia.*

2.3. South Africa

In South Africa, the process of implementing the right of CWD to live in a family environment is marked by commendable legal strides and cultural strengths, yet it faces significant obstacles.

The level of implementation of the right of CWD to live in a family environment can be described as shallow or incomplete, at best. The legal incorporation has achieved a certain level of alignment with the CRC, but much less with the CRPD.[73] Recent developments, such as increased attention from a major DPO to the matter of institutionalisation and the South African Law Reform Commission's study on the implementation of the CRPD, may be understood as an awakening of stakeholders.[74]

The South African tradition of care for children, which often includes members of the extended family (e.g. grandmothers, aunts, uncles) and even neighbours, may contribute to less institutionalisation.[75] An extended family will have more resources, especially time and personal energy, to care for multiple children, including those with disabilities. Such networks of support from close individuals can be an indispensable asset in preventing institutionalisation, signifying an important socio-cultural aspect of South African society that can facilitate the realisation of the right to live in a family environment for CWD.

[73] Part IV, South Africa, Chapter 3.1. Legal measures, 4.2.1. Uneven legal incorporation.
[74] Part IV, South Africa, Chapter 3.5. International and domestic organisations, 3.4. National Human Rights Institutions, monitoring bodies and other structures to facilitate the implementation of human rights treaties.
[75] Part IV, South Africa, Chapter 1. Context.

Conversely, the fact that over two-thirds of children in South Africa live without one or both parents, combined with other factors such as unemployment, poverty, and issues with the delivery of basic services, may contribute to the institutionalisation of CWD.[76] Additionally, stigma and prejudice against persons with disabilities are present in South Africa, as in many other countries worldwide. This may drive some parents to abandon their child, place them in an institution, or hide them from the public.[77] Despite the seemingly strong potential connection between these phenomena and institutionalisation, further research into the lives of families with CWD is needed to clarify their relationship, which is beyond the scope of this study.

Transitioning to a broader perspective, the democratic transition drove the most significant changes in South African law and society concerning children's rights. Riding on these positive pro-democratic and pro-human rights winds, the new Constitution based on the concept of substantive equality was adopted.[78] The Constitution incorporated critical norms of the CRC, setting the path for the development and realisation of children's rights in the new Republic.[79] Thus, the potential of a democratic transition to kick-start the incorporation and implementation of IHRL is evident in the case of South Africa too. Although the democratic transition drove the implementation of children's rights, the rights of CWD have arguably not been addressed to the same extent in the post-apartheid era.

During the 1990s, NGOs reportedly played a crucial role in advocating for legal reforms.[80] Following the adoption of the new Constitution and various legislation, these organisations emerged as a significant force, utilising strategic litigation to enforce the children's rights from the Constitution, but only after a period of civil society consolidation.[81] The robust Bill of Rights and its justiciability arguably encouraged NGOs and advocates to employ strategic litigation as a main tool for advancing children's rights.

This approach, however, would have been considerably less effective if the South African judiciary and legal system lacked several key characteristics. Firstly, the law of precedent is virtually a systemic prerequisite for a society that relies on strategic litigation to refine legal rules and policies. The ability to alter the law through litigation, thereby effecting positive

[76] Ibid.
[77] Part IV, South Africa, Chapter 2.1.1. Family-based care.
[78] Part IV, South Africa, Chapter 3.1.1. The Constitution.
[79] Ibid.
[80] Part IV, South Africa, Chapter 3.2. Judicial measures.
[81] Ibid.

change beyond a specific case, generates interest in strategic litigation, attracting advocates to this approach. Furthermore, a tendency among judges to interpret domestic law favourably, aligning with applicable IHRL (and even soft law), is another critical aspect.[82] Additionally, a sufficient level of judicial independence from other branches and external influence is necessary for strategic litigation to be a meaningful tool and for the internalisation of IHRL through courts to be an option. Lastly, the awareness and education of advocates and legal experts in specialised fields, such as children's rights or the rights of persons with disabilities, are paramount. In summary, strategic litigation and NGOs pursuing such cases, combined with the judiciary's unique approach to international children's rights, potentially represent the most critical facilitator of the rights in question, yet to be fully utilised.

In contrast, NGOs complain about the poor enforcement of court orders, including cases concerning CWD and the payment of foster care grants.[83] A case in point from the Western Cape highlights the responsible authorities' failure to adhere to a court order for a decade.[84] Consequently, while strategic litigation emerges as a potentially significant instrument for the realisation of the right in question, enforcement challenges of court orders can severely hinder these efforts.

The reasons behind the scant use of strategic litigation for the rights of CWD to parental and family care remain unclear, yet this issue is notably absent from the agendas of NGOs, including those involved in numerous litigations for children's rights. This observation does not imply that CWD are entirely overlooked by advocates and other stakeholders; rather, this specific issue has not been prioritised in their agendas and actions. Identifying the exact reason for this oversight might be challenging, if not impossible. Hence, it is reasonable to conclude that there is a general lack of awareness among professionals, including legal professionals, regarding the issues pertinent to this study.[85] The lack of awareness, prejudice, and stigma against CWD by the public, social welfare professionals and policymakers has already been captured by other authors and in various reports.[86] Ultimately, judicial measures, despite their potential, have not been key drivers in the internalisation of IHRL norms and standards concerning the rights of CWD to live in a family environment.

[82] Part IV, South Africa, Chapter 1.1.1. Status and effect of international treaties.
[83] Part IV, South Africa, Chapter 2.1.1. Family-based care.
[84] Part IV, South Africa, Chapter 3.2.3. High court.
[85] Part IV, South Africa, Chapter 3.5. International and domestic organisations.
[86] Part IV, South Africa, Chapter 2.1.4. Adoption.

Legal reforms have addressed issues relevant to CWD, but they have not directly addressed the problem of institutionalisation. For instance, the reform of the foster care system, spurred by litigation, could positively impact CWD in foster care.[87] Furthermore, the introduction of enhanced financial assistance for members of the extended family and primary caregivers looking after orphaned children (the CSG top-up) represents another step forward.[88] However, due to the scarcity of data, it remains speculative whether these legal reforms have improved the circumstances of CWD and their biological, kinship, or foster families, thereby mitigating the rate of institutionalisation.

Material social assistance is widely recognised as a key enabler of family living and social inclusion for CWD. Given the increased costs associated with disability and prevalent unemployment, parents and caregivers may find themselves in urgent need of such support. The system of social grants is developed in South Africa and paid out to an impressive number of beneficiaries.[89] However, the unknown take-up rates and the criticised eligibility assessments serve as hurdles, limiting access to these social grants for all in need. Furthermore, the value of each grant type might be inadequate to meet expenses, particularly in regions where the cost of living is high.

The crisis in the foster care system was, according to experts, at least partly due to not recognising kinship care as a form of alternative care and the lack of capacity of competent institutions to administer foster care grants, which are significant obstacles.[90] Decisive action was taken by the CCL through litigation, highlighting that advocacy organisations like the CCL play a crucial role in the implementation of rights. However, their impact on the realisation of the right to live in a family environment for CWD cannot be reliably assessed. Moreover, the impact is likely low, despite the case on foster care grants benefiting CWD too, given that no cases have specifically tackled the issue of parental and family care, as argued.

The legal incorporation of the CRC and the CRPD is uneven. The former has been domesticated to a large extent, unlike the CRPD.[91] Although both are incorporated in legislation pertaining to children and social welfare, neither the CRC nor the CRPD are sufficiently integrated into

[87] Part IV, South Africa, Chapter 2.1.1. Family-based care.
[88] Part IV, South Africa, Chapter 2.1.3. Community-based services and material assistance.
[89] Ibid.
[90] Part IV, South Africa, Chapter 2.1.1. Family-based care.
[91] Part IV, South Africa, Chapter 4.2.1. Uneven legal incorporation.

mental health legislation, which governs the institutionalisation of CWD in this sector.[92] The unsatisfactory domestication in relevant legislation, may, in part, be the consequence of the lack of more decisive advocacy by NGOs and other entities. Civil society does not seem broadly aware that the institutionalisation of CWD is an issue in itself and that it should be addressed, which is one of the impediments to implementation.[93] Furthermore, private organisations providing institutional care have an interest in influencing law- and policy-making to maintain support for the care they provide, acting as an impediment to the realisation of the right to live in a family environment. Without counteraction to the interests of residential care providers in law- and policy-making processes, primarily by DPOs and other NGOs, legal advancements favouring the realisation of the right to live in a family environment for CWD are unlikely.

South Africa's public policy documents demonstrate a profound understanding of critical IHRL norms among their authors, often reflecting primarily the standards of the CRC, but also the CRPD, including issues related to the right to live in a family environment. There has been a marked improvement in their alignment with IHRL over the past 20 to 30 years.[94] However, the examined strategic documents reveal significant limitations, such as the absence of costed action plans.[95] Numerous sources indicate the notoriously low implementation of virtually all strategic plans, suggesting that, while policymakers express dedication towards the implementation of IHRL, this might rather represent a form of virtue signalling than a real intention grounded in solid planning, coordination, funding, and monitoring of implementation.[96] Despite being declaratively advanced, public policy documents lack detailed planning and remain unimplemented, presenting a major barrier to the realisation of the right in question.

The SAHRC, the NPM, and the Public Protector have shown little to no engagement with the rights of CWD to live in a family environment and the issue of institutionalisation.[97] The NPM has not visited institutions for CWD, despite its mandate. The SAHRC greatly contributed to investigating cases where CWD were victims, such as the Life Esidimeni tragedy and the fire

[92] Ibid.
[93] Part IV, South Africa, Chapter 3.5. International and domestic organisations.
[94] Ibid. Chapter 4.2.3. Declarative dedication to human rights in policy documents and implementation challenges
[95] Ibid.
[96] Ibid.
[97] Part IV, South Africa, Chapter 4.2.4. Indifference of NHRIs and limitations of other structures.

at the school for deaf children in the North West Province. Its reports, however, sent mixed signals concerning institutionalisation, despite expressing the incompatibility of institutionalisation with human rights standards in the case of Life Esidimeni.[98] Consequently, the NHRIs have not facilitated the implementation of the right in question. Conversely, greater engagement of these institutions, including through the establishment of an independent monitoring mechanism for the implementation of the CRPD in line with Article 33 (2) CRPD, and the statutory legal-expert body the SALRC, holds tremendous potential to spur the implementation of critical IHRL norms.

Non-profit and for-profit private organisations play a crucial role as major providers of social services, including institutional care, and serve as indispensable partners in offering family- and community-based support and services.[99] Given their significance and influence, they could significantly impact public policy, including DI. However, institutional care providers might have vested interests in redefining the concept of deinstitutionalisation and delaying such reforms, a concern acknowledged by the CRPD Committee.[100]

Some domestic DPOs are well organised and have robust networks. The SADA has recently highlighted the issue of institutionalisation of CWD in their advocacy efforts, marking the beginning of potentially more intensive engagement with this matter.[101] While the impact of their work is yet to be seen, they are proponents of the internalisation of relevant norms and standards. Human rights watchdogs could significantly contribute to acknowledging the challenges CWD face in institutional care, but such actions are yet to be undertaken.[102] Highlighting this issue could provoke concern within the country and potentially affect South Africa's reputation in international fora. This, in turn, may foster broader awareness and interest in the issue, possibly drawing international assistance to address the situation. Thus, the absence of human rights watchdogs focusing on the plight and rights of CWD in institutional care represents a missed opportunity and hinders the realisation of the right in question.

[98] Ibid.
[99] Part IV, South Africa, 4.2.5. Silent advocates and strong service providers.
[100] See note 22.
[101] Part IV, South Africa, 4.2.5. Silent advocates and strong service providers.
[102] Ibid.

When examining the relationship between the EU and South Africa, no issue linkages were identified, unlike in the case with Serbia.[103] Only the most recent EU–South Africa arrangements include measures pertaining to persons with disabilities.[104] This lack of linkage is unsurprising given the entirely different contexts of the relationships between the EU and South Africa, on one hand, and the EU and Serbia, a candidate country for EU membership, on the other.

A more detailed analysis of facilitators and impediments to the implementation of the right to family life for CWD in South Africa can be found in Part IV of this dissertation. A list of identified facilitators and impediments is provided in *Table IV.1. List of identified facilitators and impediments to the realisation of the right to live in a family environment for children with disabilities in South Africa.*

3. A cross-country perspective on enablers and impediments

The present chapter provides a cross-country perspective on facilitators and impediments to the realisation of the right to live in a family environment for CWD. It does not aim to compare countries against one another regarding the level implementation of the critical norms, but rather to show similarities and differences in factors that influence it, as well as to offer possible explanations for the existing differences.

3.1. Incorporation of the CRC and the CRPD and strategic litigation

All three countries have incorporated the CRC more comprehensively than the CRPD.[105] This may be partly due to the CRC's longer-standing prominence and its broader demographic

[103] Ibid.
[104] Ibid.
[105] Part II, Austria, Chapter 4.2.3. Limited use of strategic litigation; Part III, Serbia, Chapter 4.2.3. The lack of strategic litigation; Part IV, South Africa, Chapter 4.2.2. Absence of the right to family care for CWD from judicial practice.

coverage, which enhances visibility and may result in higher prioritisation within governmental programmes. Moreover, the UN human rights mechanism focused on children's rights and improving the position of children, is arguably more robust, especially considering UNICEF's presence in almost all countries and territories in the world. It is critical to observe that, in all three countries CWD are often excluded or only marginally addressed in strategic policy documents, highlighting a deficiency in disability mainstreaming.

In South Africa, strategic litigation has notably advanced the implementation of the CRC, a trend not mirrored for the CRPD, as mentioned above. In Serbia and Austria, only one case of strategic litigation broadly related to the realisation of the right to live in a family environment for CWD was identified in each country. Serbia's legal system, although formally monist, requires in practice the incorporation of CRPD norms into domestic law before its direct application,[106] whereas Austria formally requires domestication of the CRC and the CRPD before their direct application, presenting a challenge for the implementation of the CRC and especially the CRPD in both countries. Additionally, due to the narrow powers of interpretation by judges in the legal systems of Serbia and Austria, the strategic litigation is not expected to bring much difference before the full incorporation of the CRPD into domestic legislations. Despite judges being unable to engage in 'judicial activism', a couple of instances of 'judicial advocacy' for legislative changes regarding the clusters of small group homes (SGH) and the provision of in-kind services were identified.[107]

Due to the absence of judicial decisions as a source of law from Serbia's legal system and arguably low confidence in Serbia's judiciary, NHRIs and NGOs focus on advocating for legislative changes, which is more impactful when it involves broad coalitions of stakeholders. In South Africa, NHRIs, DPOs, children's rights NGOs, and NGOs for the right of persons with disabilities are not highly aware of the right to live in a family environment for CWD, nor do they pursue strategic litigation to that end.[108]

In conclusion, this study shows the intricate layers and subtle distinctions that characterise the efforts to domesticate the rights of CWD across Serbia, Austria and South Africa. Each country's unique challenges highlight the diverse contexts and systemic issues that affect the

[106] Part III, Serbia, Chapter 1.1.2. Judicial system.
[107] Part II, Austria, Chapter 3.2.1.1. Application of the HeimAufG.
[108] Part IV, South Africa, Chapter 4.2.2. Absence of the right to family care for CWD from judicial practice, 4.2.4. Indifference of NHRIs and limitations of other structures.

realisation of the right to live in a family environment for CWD. Addressing these challenges requires tailored strategies that consider the specific legal, political, socio-economic, historical and cultural factors at play in each country.

3.2. Reliance on institutions for residential care and their ownership

All three countries face the challenge of an overreliance on residential care for CWD, albeit with notable differences. Serbia presents a concerning proportion of CWD within the population of children in institutional care, as aforementioned. However, global assessments indicate a very low overall rate of institutionalisation of children, both with and without disabilities, leading to a comparably low number of CWD in institutional care. In contrast, Austria relies heavily on institutional care for children regardless of disability status, yet the proportion of CWD in such settings cannot be reliably determined. South Africa, meanwhile, does not provide enough data to quantify the number of CWD in residential care, but a DPO estimates this number at approximately 35.000.[109] The country has at least two factors that likely drive the institutionalisation of CWD, that are not present to such an extent in Austria and Serbia. Those are issues with the supply of basic services (e.g., electricity and running water in private homes), and the large population of orphaned children, including due to HIV but other socio-economic reasons too.

This study identifies resistance to DI efforts from different stakeholders, including by policymakers and service providers, to a differing level and for different reasons across the examined countries. This research showed that resistance to the transition from institutional to family-based care may come from policymakers, private and public service providers, employees of service providers, some parents of CWD, and exceptionally by the public (such as in the case of Life Esidimeni tragedy). In Austria, the research suggests that the resistance may come primarily from the private providers of residential care, who could arguably amass considerable policymaking influence. In Serbia, some resistance was identified primarily by the management of (state-owned) residential institutions, which may participate in policymaking processes, and naturally, the employees of those institutions. This has resulted,

[109] Part IV, South Africa, Chapter 2.1.2. Institutional (residential) care.

inter alia, in a policy that aims to transform existing institutions into providers of other forms of care and support. Therefore, both in Serbia and Austria existing institutional care structures may exert resistance, although they differ significantly in ownership and scale (Austria's residential care system is larger). In South Africa, there are signs that Life Esidimeni tragedy, which garnered a lot of public attention, may have decreased public support for DI. A project labelled as DI, yet effectively a cost-cutting trans-institutionalisation, and plagued by corruption, led to more than 144 deaths of people with disabilities, fostering fear across Gauteng Province and South Africa.

One major difference between Austria and South Africa on one end, and Serbia on the other, is the ownership of institutional care services. In Serbia, institutional care for all children is provided solely by the state (although it is not prohibited for private entities to provide such care), while in Austria and South Africa private providers dominate. Arguably, the private provision of residential care may contribute to the proliferation of such facilities regardless of state policy, given the profit-oriented model of such care and other factors such as the insufficient development of community-based services. Moreover, the privatisation of residential care services is seen by disability-rights advocates as possible jeopardy to DI processes, as these providers can have substantial influence on policymaking. Authorities in South Africa recognised the problems with privatised ECD services and proposed nationalisation in a strategic policy document to ensure universal access. This response addresses the inadequate availability of essential ECD services under private providers, highlighting the need for government intervention to guarantee accessibility for all children amid inadequate provision by private entities.[110]

3.3. Approach to small-scale residential care

All three countries use SGHs (also known as small-scale residential care - SSRC) for the long-term care of CWD. In South Africa, this form of residential care is in expansion, according to the Department of Social Development, but exact numbers are unknown.[111] Austria and Serbia

[110] Part IV, South Africa, Chapter 3.3.4. Other policy documents.
[111] Part IV, South Africa, Chapter 2.1.2. Institutional (residential) care.

differ drastically in their use of this form of residential care and the position it occupies in their respective alternative care systems.

In Austria, SSRC is the most prevalent form of residential care, much more prevalent than large residential facilities, counting thousands of children placed in such settings.[112] Vienna, for instance, has no large facilities, and SGHs can accommodate up to 8 children per unit, but several such units can exist in one location.[113] In Austria, the transition from large to small residential care has been ongoing since the 1990s and before.[114] It represents a planned and a seemingly well-established policy of long-term care for children and adults with disabilities, which was also enshrined in the 1992 Disability Concept.[115] SSRC was seen as an adequate substitute to large facilities, and their development was the primary response to the gross human rights violations in large facilities during the entire 20th century.[116] This form of care is accepted by most stakeholders, including NHRIs and the Independent Monitoring Committee for the CRPD, reflecting a very high level of approval of this form of care amongst major actors.[117]

In Serbia, on the other hand, SGHs are scarcely used, with five units present in the country in total.[118] The construction of those units was not planned in advance, but rather they were the response of the responsible ministry to a crisis following an NGO report, when several dozens of residents were transferred to other institutions, and to the new, smaller facilities.[119] SGHs in Serbia are not, at least for now, considered a substitute for large residential care in strategic documents, rather it is the transformation of those large facilities into providers of support and services to families and providers of family-based care that is planned to substitute residential care.[120] Therefore, SGHs in Serbia play only a very marginal role in the system of alternative care, unlike in Austria, where SGHs have a major role.

One of the reasons for the proliferation of SGHs in Austria, unlike in Serbia, may be the fact that Austria began reforms of long-term care and opted for SGHs during the 1980s and the 1990s, much before the CRPD and other soft law instruments on children's rights and

[112] Part II, Austria, Chapter 2.3.3. Institutional (residential) care.
[113] Part II, Austria, Chapter 2.3.3. Institutional (residential) care, 3.1.3.1. Vienna Child and Youth Welfare Act.
[114] Part II, Austria, Chapter 2.2. Reform of the long-term care system and residential care.
[115] Part II, Austria, Chapter 3.3.3. Other policy documents.
[116] Part II, Austria, Chapter 2.1. Historical human rights violations and reform of institutional care.
[117] Part II, Austria, Chapter 4.2.4. NHRIs and other structures: Strong Frameworks, Limited Impact.
[118] Part III, Serbia, Chapter 2.2. Institutional (residential) care.
[119] Part III, Serbia, Chapter 3.6. International and domestic organisations.
[120] Part III, Serbia, Chapter 3.4.1. Deinstitutionalisation Strategy.

alternative care were adopted. At that time, the new Austrian policy may have been highly progressive, and without any misalignment with international treaties. Arguably, Serbia could not conduct such reforms during the 1990s, at least due to deplorable economic and political conditions, even if it had wanted to. During the early 2000s the development of hundreds of SGHs might still have been too costly an effort given the constrained state budget for social protection and the total absence of private residential care service providers. Therefore, economic difficulties and the absence of privatisation in residential care likely contributed to the underdevelopment of SGHs in Serbia, which, from the perspective of the realisation of the right to live in a family environment, could have been an impediment if hundreds of such facilities had been developed. Conversely, the same reasons likely contributed to the insufficient availability of community-based support and services for CWD and their families. Austria did not experience such economic and political conditions in the given period and, with the help of private providers, developed a massive network of SGHs as a substitute for large facilities and, to an extent, neglected the development of community-based support and services for CWD and their families.

In both Austria and South Africa, there are signs that the transition from large facilities to SSRC is seen as a process of DI, which is opposite to the approach taken by the CRPD Committee and the approach adopted in this dissertation. In South Africa, this is especially evident in relation to the process surrounding the Life Esidimeni tragedy in Gauteng, and was also confirmed by interviewees.[121] In Austria this was subtler, but the latest strategic document reflects such an understanding.[122] In Serbia, on the contrary, there are no signs that DI is understood differently than the transition from institutional care, regardless of its size, to care in a family.

3.4. Data availability

All three countries share certain challenges that significantly impede the realisation of the right to live in a family environment for CWD. Notably, these states struggle to collect, analyse, and publish data on CWD. Serbia arguably offers more comprehensive, publicly available data,

[121] Part IV, South Africa, Chapter Institutional care.
[122] Part II, Austria, Chapter 3.3.2. National Action Plan on Disability 2022 – 2030.

providing a snapshot of the situation of CWD over the past 5 to 10 years. However, Serbia's data faces challenges related to questionable reliability and changes in methodology, which sometimes prevent comparison across different time points.

In contrast, data in Austria and South Africa are severely lacking. Specifically, these countries offer little to no data on CWD, which many stakeholders identify as a critical barrier to the implementation of the CRPD. The lack of data collection in Austria is particularly concerning, given its well-developed data infrastructure. Moreover, collecting data in South Africa should hypothetically be more challenging due to its vast area, large population, and comparatively weaker data infrastructure. Yet Serbia, despite having a significantly lower data infrastructure score than the other two countries, shows better data availability.[123] It should be underscored that human rights NGOs contribute to the availability of data on CWD in Serbia. In South Africa and Austria, the contribution to data availability by NGOs and DPOs was not identified.

In relation to data availability, a distinctive feature separates Serbia from Austria and South Africa: the ownership of service providers for residential care and foster care for disabled and non-disabled children. In Serbia residential care and foster care are organised and provided solely by state agencies, unlike in the other two countries.[124] Moreover, most family-support services are also state-provided in Serbia. In contrast, Austria and South Africa rely heavily on private providers for both residential care and foster care, as well as for the provision of family-oriented support and services.[125] Arguably, data collection, or at least the public availability of data, may be impeded, for different reasons, when there are various private residential care service providers, compared to a state-led, centralised system of institutional care provision, as in the case of Serbia. Nevertheless, the private ownership of service providers should not prevent authorities from collecting and publishing data about the work of those service providers, especially concerning the number of their users, adequately disaggregated according to relevant criteria (e.g. age, sex), number of facilities, state (or provincial/municipal) funding, etc.

Furthermore, it has been noted that residential care institutions in Serbia periodically allow NGOs to conduct independent monitoring of their facilities and publish findings. This practice

[123] *Statistical Performance Indicators (SPI)*, The World Bank, (2024), accessed: 14th March, 2024, *available at* https://www.worldbank.org/en/programs/statistical-performance-indicators/explore-data#1.
[124] See 'Reliance on institutions for residential care and their ownership'.
[125] Part II, Austria, Chapter 2.3.3. Institutional (residential) care; Part IV, South Africa, Chapter 2. Situation of children with disabilities.

has not been observed in either Austria or South Africa. The publication of human rights monitoring reports, particularly those highlighting severe human rights violations in institutional care, can have far-reaching implications beyond merely increasing data availability. Such reports can mobilise a variety of stakeholders, including the media, IGOs and NGOs, as well as private foreign donors looking to support programmes related to DI.

The primary challenge for data scarcity, according to the major DPO umbrella association and other stakeholders in Austria, lies in the country's federal structure. While this system may hinder data collection to some degree, it fails to fully explain why individual provinces lack comprehensive data within their own jurisdictions. Thus, beyond federalism, contributing factors to the absence of data are likely the underwhelming transparency of private service providers, that are not open scrutiny, particularly to human rights NGOs. Additionally, the well-known secretiveness of Austrian authorities has arguably played a significant role in the limited availability of data. Access to information of public interest is notoriously restricted; therefore, ongoing reforms in this area should also contribute to improving the availability of data on CWD too.

3.5. Decentralisation

Human rights advocates generally see decentralisation as a challenge to nationwide coordinated implementation of human rights, which is to an extent confirmed in this study too.[126] Federalism and provincial autonomy lead to uneven availability of child and disability services, lack of standardisation of services, and subsequent problems with data collection, planning, and coordination across Austrian provinces.[127] In contrast, in Serbia and South Africa, disparities are likely attributed to the underdevelopment of some regions and thus the lack of services. However, the reasons for the limited development in less developed regions of Serbia and South Africa may differ significantly. In South Africa, such disparities can be attributed, at least in part, to the remnants of colonial policies, which largely neglected areas not populated by the colonizing population, a factor that does not apply to Serbia. Additionally, although South Africa is a unitary country, the findings suggest that some provincial administrations are

[126] E.g. Eva Maria Belser, *Why the affection of federalism for human rights is unrequited and how the relationship could be improved*, STUDIES IN TERRITORIAL AND CULTURAL DIVERSITY GOVERNANCE (2021).
[127] Part II, Austria, Chapter 4.1. The lack of data and resistance to change.

significantly more successful than others in the provision of child welfare services, including for CWD, indicating that decentralisation, rather than strictly federalism may be the challenge for the even implementation of human rights. Additionally, in all three countries, urban centres generally provide more community-based services than rural areas. Effective intersectoral cooperation is essential to enable the life in a family environment for CWD, and to effectuate DI efforts. However, challenges in coordination between different governmental sectors, such as sectors of child welfare, persons with disabilities welfare, education and healthcare, are prominent in the examined countries.

3.6. Stable democracy and democratic transition

Unlike Austria, Serbia and South Africa underwent substantial reforms at the end of the 20th century and the beginning of the 21st century, stemming from regime changes associated with widespread human rights abuses. This corroborates Beth Simmons' theory that profound changes can catalyse the adoption of IHRL norms. In particular, South Africa's transition to a democratic republic drove a growing commitment to children's rights, likely motivated by the decades of suffering endured by South African children under apartheid. The incorporation of the CRC was significant, including through strategic litigation; yet attention to children CWD was and remains insufficient. It is noteworthy that the development of South Africa's post-1994 social welfare system may have been hindered by the adoption of a distinctly neo-liberal public policy in 1997, embodied in the GEAR macroeconomic strategy. Although South Africa's more recent policy documents pertaining to CWD are commendably in line with IHRL standards, the disparity in implementation presents a starkly different reality.

In Serbia, the regime change in the year 2000 marked the beginning of intensified collaboration with the European Union and international organisations like UNICEF, focusing on child welfare among other areas. This shift also increased international aid for projects aimed at CWD welfare, including developing community-based services and launching awareness campaigns. Notably, Serbia is the only country in this study where an 'issue linkage' was identified, specifically between the rights of CWD, deinstitutionalisation, and the EU accession negotiations. Although not a high priority in the EU-Serbia negotiations, Serbia's poor human rights record regarding CWD negatively impacts its negotiation progress, thus incentivising improvements in this area. However, it has been observed that as issues such as the state of the

rule of law and normalisation with Kosovo become more pressing, the relevance of CWD concerns in the negotiation process diminishes. In Austria, an 'issue linkage' could be forged concerning the use of ESI Funds, should the European Commission revise its interpretation of obligations arising from Article 19 of the CRPD and if conditionalities for the use of ESI Funds are applied effectively. Nevertheless, Koh's concept of 'issue linkages' as significant drivers for the internalisation of international law norms was somewhat validated by this study.

In terms of governance stability and social welfare principles, Austria starkly contrasts with Serbia and South Africa. The Austrian preference for stability over radical upheaval results in a notably slow pace in adopting and implementing the CRPD. This treaty, envisioned to bring paradigmatic changes for children CWD, stands contrast to Austria's incremental approach to social and legal reform. The foundational shifts required by the treaty challenge the country's traditionally measured pace of change.

Beth Simmons, extensively cited in this dissertation, demonstrates that transitional or partly democratic states likely benefit more from treaty ratification than stable democracies do.[128] She based this argumentation on the assumption that there is a more significant discrepancy of the proclaimed international standards and the existing domestic standards in transitional/partly democratic states, while their citizens still have some means available to demand the fulfilment of IHRL standards (unlike the citizens of stable autocracies).[129] In other words, stable democracies will likely benefit less from the ratification of a treaty, considering an already satisfactory level of realisation of rights in the country.[130] This study aligns with Simmons' findings but further identifies the diminished engagement of international partners - IGOs, NGOs, and foreign development agencies - as a potential barrier to norm implementation in stable democracies such as Austria. Those entities could promote the implementation of IHRL norms including by increasing awareness of the general public and policymakers. The impact (or the absence) of international stakeholders on the implementation of the international children's rights and the rights of persons with disabilities in developed countries seems to be an under-researched issue. Most research recognizes the value of those stakeholders, but mostly in relation to developing states and states that are not fully democratic. Simmons also suggested that governments 'deserve the rhetorical and material support of the international community

[128] BETH A. SIMMONS, MOBILIZING FOR HUMAN RIGHTS: INTERNATIONAL LAW IN DOMESTIC POLITICS (2009).
[129] Id. at; Beth Simmons, *Treaty compliance and violation*, 13 ANNUAL REVIEW OF POLITICAL SCIENCE (2010), p. 291.
[130] SIMMONS. 2009.

in their good-faith efforts to live up to their commitments'.[131] This should also relate to stable and rich democracies that struggle to implement their IHRL obligations. It could be that Austria, due to its exceptionally favourable international image of a welfare state, but more importantly its success to ensure high living standards for most of its citizens, has gone under the radar of international children's rights and disability rights watchdogs, eventually slowing down the realisation of some of the rights of CWD. On the other hand, former socialist countries of Europe, including Serbia, that struggled through transitional times greatly, received considerable attention of international organisations for human rights.

Apart from the international attention, the openness to external scrutiny is another positive consequence of recent democratisation, as opposed to Austria's stable, but closed to external scrutiny, democratic governance. This is not, however, the most expected finding. Older studies had different findings regarding countries' openness to external scrutiny dependent on their regime type. One study found that 'newly transitioned democracies' were more likely to be open to external monitoring, regarding the CAT and the prevention of torture, than established democracies, while established democracies were in general more willing to submit to such scrutiny with regard to other human rights treaties.[132]

3.7. International and domestic organisations

In all three countries, domestic and international DPOs and NGOs have made some efforts to promote the right to live in a family environment for CWD. However, there is a significant difference in the frequency and the ways NGOs get involved with this matter. Arguably, the most intense involvement of NGOs and DPOs was observed in Serbia. The specialised disability rights NGO, Mental Disability Rights Initiative of Serbia, actively addresses institutional care issues for children and adults with disabilities in Serbia. This organisation, independently, or together with an international disability rights NGO, Disability Rights International, conducted several independent human rights monitoring visits and published reports aimed at both domestic and international public.[133] Additionally, Human Right Watch became involved with the issue of institutional care for CWD and published a monitoring report

[131] Ibid, p. 351.
[132] Ibid, p. 107 – 108.
[133] Part III, Serbia, Chapter 3.6. International and domestic organisations.

on Serbia's institutions in 2016.[134] It had previously been explained that this would not have been possible had the Serbian authorities not been open to scrutiny. Likewise, some children rights NGOs, including an umbrella association of children's rights organisations, advocate for deinstitutionalisation of CWD, and have submitted a request for a constitutional review in the sole relevant case of strategic litigation for this study in Serbia. An umbrella DPO advocate for deinstitutionalisation and contributes to data collection on CWD too.

In contrast to that, there seems to be a very low, almost inexistent engagement of DPOs and NGOs on this matter in South Africa. Only one instance on the involvement of SADA was identified. In Austria there are no specialised NGOs that look into institutional care for CWD, nor is there much of involvement of NGOs with this issue. The major umbrella association ACDP, in the last several years reflects on institutional care for CWD, and calls for deinstitutionalisation.

In sum, Serbia showcases a proactive and targeted approach by NGOs and DPOs, which actively challenge institutional care practices. Conversely, South Africa and Austria demonstrate markedly lower levels of involvement, with minimal to no specialised NGO activity focusing on the deinstitutionalisation and rights of CWD within institutional settings. Simmons also saw the emergence of local movements and organisation as a significant consequence of treaty ratification and an important factor of implementation of ratified treaties.[135] However, as this study shows, although all three countries ratified the CRPD, and at a similar time, the emergence of domestic formal or informal groups of citizens, with a focus on CWD and their right to live in a family environment differ greatly. It could be that Austria, due to its exceptionally favourable international image of a welfare state, but more importantly its success to ensure high living standards for most of its citizens, has gone under the radar of international children's rights and disability rights watchdogs and other organisations, eventually slowing down the realisation of some of the rights of CWD. On the other hand, former socialist countries of Europe, including Serbia, that struggled through transitional times greatly, received considerable attention of international organisations for human rights. In turn, the international attention and aid contribute to the emergence of local NGOs, through funding support and sharing of know-how. It is not surprising that transitional countries such as Serbia and South Africa receive more international attention and aid to address human rights issues,

[134] Part III, Serbia, Chapter 3.1.5. Enforcement gap.
[135] SIMMONS. 2009, p. 31-33.

than stable and rich democracies such as Austria. Despite successes of some Serbian NGOs in human rights monitoring, awareness raising about the CRPD and the rights violations in institutions, their impact on law- and policy-making remains limited, though they often participate directly in developing regulations and strategic documents.[136]

3.8. European and African human rights mechanisms

The European and African human rights mechanisms have shown varying levels of commitment and effectiveness in contributing to the implementation of right to family life for CWD. In Europe, different CoE bodies have addressed the rights of CWD through numerous binding and non-binding documents that focus on social inclusion (or integration), family life, and alternative care.[137] However, the ECtHR's case law reveals a significant gap in adjudicating the right to family life for CWD, primarily focusing on violations of Articles 2 and 3 of the ECHR and the right to education.[138] The slow integration of the CRPD into ECtHR jurisprudence and the lack of a harmonized approach impede the realisation of the right to live in a family environment for CWD in Europe. Notably, the case of L.R. v North Macedonia marked a significant step by recognising the legal standing of an NGO representative based on the victim's vulnerability, but it primarily addressed the adequacy of institutional care for a disabled child rather than the issue of institutionalisation itself.

The RESC and the ESC Committee are more disability-sensitive, emphasising the rights to independence, social inclusion, and community participation, and that children are first placed in family-based care, and only exceptionally in institutional care. Non-binding documents post-CRPD adoption have become more explicit about alternative care and DI, urging CoE Member States to provide community-based services and make general services accessible to CWD. The CPT Committee openly criticized Bulgaria's transformation of large facilities into SGHs for CWD, and called this process 'at best trans-institutionalisation', but recommended 'family-style' units in other cases.[139] The CPT Committee criticised the institutionalisation and

[136] Part III, Serbia, 3.6. International and domestic organisations.
[137] See Part I, Chapter 6.1.2. Revised European Social Charter and the European Social Committee, 6.1.3 Other CoE instruments and documents.
[138] See Part I, 6.1.1 European Convention on Human Rights and the European Court of Human Rights.
[139] Ibid.

institutional practices in its visit reports to Serbia.[140] The Commissioner for Human Rights of the CoE was opposed to any type of small-group care for CWD arguing that it does not align with Article 19 of the CRPD, perhaps reflecting the most CRPD-devoted position in the CoE human rights system.[141]

The African Committee of Experts on the Rights and Welfare of the Child emphasizes family preservation and prioritizes family-based care, recommending institutional care only as a temporary measure.[142] Despite this, there have been instances where the Committee has suggested expanding institutional capacities, revealing a less stringent commitment to family-based care. Concerns about institutional care typically arise in contexts of overcrowding and abuse, rather than from the issue of institutionalisation in itself, as a deprivation of family life and discrimination against CWD. [143]

Regarding the GACC, the African Committee's recommendations sometimes surpass the standards set by the UN document, such as advocating for temporary institutional placements. However, the Committee has not fully addressed critical issues like the institutionalisation of children under three, nor has it consistently recommended ending such practices. This inconsistency suggests a partial rather than comprehensive adoption of the GACC by the treaty body. DI and the promotion of family-based care for CWD are not consistently highlighted in the Committee's recommendations, indicating that CWD are not a primary focus. Nonetheless, the Committee has taken strong stances in certain instances, such as calling for the immediate cessation of institutionalising children with albinism in Tanzania, though this sends mixed signals about their overall approach to institutionalising CWD.

In summary, neither the European nor African human rights mechanism have significantly contributed to the implementation of Articles 19 and 23(5) of the CRPD concerning CWD in their Member States. The European mechanism demonstrates an approach influenced by international standards, primarily by the GACC. Yet, the ECtHR has not directly engaged with the issue of the right to live in a family environment, reflecting a cautious approach to the CRPD in its judgments. Other CoE bodies have not harmonised their approaches to the CRPD – some bodies fully endorse it, while others have a fragmented approach. The African

[140] Ibid.
[141] Ibid.
[142] See Part I IHRL, Chapter 6.2.3 African Committee of Experts on the Rights and Welfare of the Child.
[143] Ibid.

mechanism, although proactive in certain areas, shows inconsistencies and a less rigorous application of international standards, particularly concerning CWD. Both mechanisms need to address these gaps to contribute more significantly to the realisation of the right to family life for CWD in their Member States.

4. Implications on research and theory

This study's design was inspired by works of scholars' who focused on the compliance of states with international law, most notably Conditional International Law Theory, Koh's theory of Transnational Legal Process, and Beth Simmons' research. In her seminal work, 'Mobilizing for Human Rights', Simmons comprehensively and empirically examines the impact of human rights treaty ratification on social mobilization across various states, concluding that such ratifications indeed foster changes in domestic human rights standards and practices. Simmons, however, looked into several treaties, but not into the CRPD, limiting direct comparisons with this dissertation. The findings of the present study do not contradict the Simmons' but expand on them by suggesting that the process of compliance is significantly affected by various local legal, political, socio-economic, historical and cultural specificities, rendering broad theories somewhat limited for a comprehensive understanding of the conditions behind the implementation of the CRC and the CRPD. Simmons also acknowledged limits of her seminal study precisely in that regard.[144]

In her study, Simmons referenced Michael Ignatieff's assertion, highlighting the importance of time and the cumulative effect of efforts directed towards implementing international human rights treaties - a phenomenon more evident over a considerable temporal span.[145] Given the prolonged duration, often spanning decades, required to fulfil new IHRL obligations - a fact well-known among human rights advocates - this study ideally warrants a repetition in five to ten years to gauge progress through the lens of the factors examined herein. This is even more

[144] Simmons, ANNUAL REVIEW OF POLITICAL SCIENCE, (2010), p. 290.
[145] SIMMONS. 2009, p. 349.

critical considering relatively recent ratification of the CRPD in all three states parties examined in this dissertation. Future research could validate or challenge the significance of the enablers and barriers to the implementation of the right of CWD to live in a family environment identified here, possibly revealing new critical insights. More crucially, it could aid in refining the strategies of UN human rights mechanisms aimed at advancing the rights of CWD and beyond. Furthermore, states, international human rights NGOs, international and national DPOs, and other stakeholders could enhance their country- and organisation-specific or general strategies and roadmaps by drawing on the insights from this and subsequent studies to devise the most effective interventions.

Koh's Transnational Legal Process theory which focuses on several phases of treaty implementation (or internalisation), has shown in this study as a useful starting point when developing a research framework for the examination of the CRC and CRPD implementation in Austria, Serbia and South Africa. In her recent book on the implementation of the CRPD in Austria and Germany, Grigoryan complained that the absence of an established interdisciplinary research framework for the research of implementation of the CRPD presents a challenge for human rights scholars.[146] This dissertation develops an interdisciplinary legal approach that accounts for the impact of extra-legal factors. It first examines their influence on the interpretation and development of selected IHRL norms, then on domestic incorporation of the norms, and finally, it assesses the nature and effects of these factors on the implementation of the norms. Therefore, building on the Koh's theory, this research proposes an interdisciplinary, empirical legal approach to the examination of CRC and CRPD implementation in three phases – norm development and interpretation, domestic legal incorporation, and norm enforcement. Such an approach, although rather comprehensive, is not without limitations.

Limitations an interdisciplinary legal scholar might encounter in the examination of the implementation of human rights treaties, specifically the CRC and the CRPD, pertain to the lack of training in research methodologies, especially in disciplines distant from legal studies. Political science and history are particularly important for the understanding of law and governance, as well as sociology and anthropology when examining the law in practice.

[146] MICHAEL GANNER, IMPLEMENTATION OF THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES IN AUSTRIA AND GERMANY (Innsbruck University Press. 2021), p. 30.

Naturally, the limitations in any of the disciplines will likely impede the quality of such a comprehensive examination.

Studies interested in the compliance with IHRL benefit from the empirical evidence, specifically qualitative and quantitative data. Apart from qualitative data this study also relied on quantitative data collected and published primarily by state authorities. It is generally understood that quantitative data is valuable when assessing the implementation of some IHRL (and IL in general) norms.[147] However, this study shows, that without deeper examination of the local contexts and factors, quantitative sources cannot be used independently to determine the effects of legal and political measures on the implementation of IHRL in a state party.

This was especially visible in case of Serbia, which has a comparably very low rate of institutionalisation of CWD, which could signify a profound implementation of CRC and CRPD obligations. That, however, is not the case, and Serbia shows only superficial level of implementation of relevant norms and standards, while a comparably low number of CWD in institutions is likely a consequence of extra-legal and non-political factors, possibly cultural norms and other circumstances, such as the awareness of rights violations in institutional care, for which parents may be more reluctant to place their child in such a setting, than actions actively taken by the state to implement the CRC or the CRPD. Therefore, the Serbia's case also highlights a cautious approach with the use of quantitative data in empirical legal studies. The findings imply that such data could be misleading and that it requires corroboration with other sources when assessing the implementation of IHRL norms. On the other hand, considering that reasons for Serbia's low numbers of CWD (and especially children without disabilities) in institutional care are likely socio-cultural, a TLP scholar could imply that there is a higher level of social norm internalisation, then then of the legal and political internalisation in Serbia. The TLP posits that social internalisation can exist independently of legal and political internalisation.

[147] E.g. Tom Ginsburg & Gregory Shaffer, *The Empirical Turn in International Legal Scholarship*, 106 AMERICAN JOURNAL OF INTERNATIONAL LAW (2012).

5. Concluding remarks

In concluding this dissertation, it is hoped that this research has provided substantial insights into the complex process of implementing the right to live in a family environment for CWD across Austria, Serbia, and South Africa. This study has illuminated the diverse ways in which IHRL is applied and the myriad factors - legal, socio-political, and cultural - that influence the realisation of rights for CWD in these countries. Through detailed analysis, the dissertation has underscored the critical importance of understanding each country's unique context when assessing the factors that contribute to the effectiveness of the CRC and the CRPD.

Furthermore, this dissertation has laid the groundwork for future research by proposing an interdisciplinary, empirical legal approach to examining the implementation of the CRC and CRPD. It calls attention to the need for legal scholars to consider a wider array of factors beyond the legal texts, in their efforts to advance the rights of CWD. The findings herein serve as a call for a more nuanced and context-sensitive approach to human rights implementation, one that embraces the multifaceted realities of each state and society.

As this research concludes, it aims to inspire further investigation and to inform the efforts of those advocating for human rights. While the journey toward fully realizing the rights of CWD is challenging, it is also a path filled with potential for significant impact. This dissertation contributes to the efforts ensuring that every child, regardless of disability, has the opportunity to live and thrive in a family. Continuing on this path is essential for advancing a more inclusive and fair society for all children.

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Annex I Zusammenfassung

In dieser Dissertation wurde ich die Umsetzung des Rechts auf Familienleben für Kinder mit Behinderungen (KmB) in Österreich, Serbien und Südafrika, wie es im Übereinkommen über die Rechte des Kindes (UN-KRK) und im Übereinkommen über die Rechte von Menschen mit Behinderungen (UN-BRK) verankert ist, untersucht. Mit den Mitteln der Rechtsanalyse, der Politikwissenschaft und der Soziologie wurden die komplexen Faktoren, die die Umsetzung dieses Rechts in unterschiedlichen rechtlichen und soziopolitischen Kontexten beeinflussen, analysiert. Die Analyse erfolgte anhand einer Fallstudie für jedes Land. Dieser Untersuchung geht eine Analyse der Divergenzen zwischen der UN-KRK und der UN-BRK in Bezug auf die Eignung der Heimunterbringung von Kindern voraus, wobei deren Interpretationen und Wechselwirkungen untersucht und Lösungen für eine Harmonisierung dieser internationalen Rechtsnormen angeboten werden.

Trotz Österreichs robustem Sozialsystem und starker Rechtsstaatlichkeit stellen institutionelle Hinterlassenschaften und fragmentierte Bemühungen zur Deinstitutionalisierung wesentliche Herausforderungen für die Verwirklichung des Rechts auf ein Familienleben für viele KmB dar. Serbien, obwohl historisch gesehen eher auf familiäre Betreuung ausgerichtet, kämpft mit der Dezentralisierung von Unterstützungsdiensten für Kinder und Erwachsene mit Behinderungen, systemischen Vorurteilen und Kapazitätsengpässen bei der Umsetzung von Reformen. Südafrika sieht sich mit erheblichen sozioökonomischen Hindernissen konfrontiert, darunter die weit verbreitete Armut und die uneinheitliche Umsetzung von Rechtsreformen, obwohl in den letzten drei Jahrzehnten erhebliche Fortschritte bei den Kinderrechten erzielt wurden.

Für die unzureichende Umsetzung der UN-BRK in diesen Ländern wurden verschiedene Ursachen identifiziert. Darunter Österreichs Probleme mit bürokratischer Trägheit, schlechter Datenerfassung und fragmentierter Politikumsetzung, Serbiens Kostensenkungen im Sozialsystem und der Übergang zur dezentralen Leistungserbringung sowie Südafrikas wiederkehrende Krise im Sozialfürsorgesystem und öffentliche Sparbemühungen. Darüber hinaus zeigt die Studie verschiedene Gründe für das Fehlen strategischer Rechtsstreitigkeiten zum Recht auf Familienleben für KmB auf: Österreichs vorsichtige Rechtskultur, ein

dualistischer Ansatz in Bezug auf die UN-KRK und die UN-BRK und die oberflächliche Einbeziehung der UN-BRK; Serbiens mangelnde Unabhängigkeit der Justiz und geringes Vertrauen in das Justizsystem; ein geringes Bewusstsein für das Recht auf Familienleben für Kinder mit Behinderung bei den ansonsten wichtigen NROs für strategische Rechtsstreitigkeiten in Südafrika. Durch eine nuancierte Analyse dieser und vieler anderer Faktoren trägt diese Studie zum breiteren Diskurs über die wirksame Umsetzung der Internationalen Menschenrechte bei und schafft eine Grundlage für künftige Forschung, die darauf abzielt, die Rechte von KmB weltweit zu stärken.

Abstract

In this dissertation, I explore the realisation of the right to family life for children with disabilities (CWD) in Austria, Serbia, and South Africa, as enshrined in the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). Drawing on the tools of legal analysis, political science, and sociology, I investigate the complex factors influencing the implementation of this right across diverse legal and socio-political contexts by employing a case study design to examine each country. This examination is preceded by an analysis of the divergences between the CRC and CRPD regarding the suitability of residential care for children, exploring their interpretations and interactions, and offering solutions for harmonising these international legal standards.

Despite Austria's robust social protection system and strong rule of law, institutional legacies, and fragmented deinstitutionalisation efforts present challenges to the realisation of the right to family life for many CWD. Serbia, though historically inclined towards family-based care, grapples with decentralisation of support services for CWD, systemic biases and capacity constraints to implement reforms. South Africa faces substantial socio-economic barriers, including pervasive poverty and inconsistent implementation of legal reforms, despite significant advancements in children's rights during the last three decades.

I identify different underlying causes for the poor implementation of the CRPD across these countries, including Austria's challenges with bureaucratic inertia, poor data collection, and fragmented policy implementation; Serbia’s cost-cutting in the social protection sector and the transition to decentralised service provision; and South Africa’s recurrent crisis in the social

care system and public cost-cutting efforts. Additionally, the study reveals varied reasons for the lack of strategic litigation on the right to family life for CWD: Austria's cautious legal culture, a dualistic approach to the CRC and the CRPD, and shallow incorporation of the latter; Serbia's lack of judicial independence and low confidence in the judicial system; and low awareness among otherwise major strategic litigation NGOs in South Africa about the right to family life for CWD. By providing a nuanced analysis of this and many other factors, this study contributes to the broader discourse on effective IHRL implementation and lays a foundation for future research aimed at enhancing the rights of CWD globally.