

DRUMMING TOGETHER FOR CHANGE

A child's right to quality care
in Sub-Saharan Africa



Centre for excellence
for looked after children in Scotland



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PREFACE



Globally, we face a sobering challenge and a profound responsibility in our care for children who are at risk or living without parental care. Courage, leadership and knowledge are the cornerstones to the fundamental reforms that are needed to rise to this challenge. But we now have the beginnings of hope, as the implementation of the *Guidelines for the Alternative Care of Children* take root internationally.

We have felt honoured at CELCIS to be a part of this partnership project as it has come alive with the help of passionate and dedicated individuals and organisations, who are often working in very difficult circumstances. It has been exciting to closely explore how eight countries in Sub-Saharan Africa in particular are taking steps to be 'Moving Forward' towards greater rights and better care for these too often forgotten children.

On behalf of all of us at CELCIS, we are grateful to our new friends and colleagues across the continents, particularly those at the University of Malawi and SOS Children's Villages International, whose vision, hard work and dedication are improving life chances for some of our world's most vulnerable children.

Jennifer Davidson
Director of CELCIS
University of Strathclyde



The future of our nations can be secured if we guarantee quality care to our children. In that case, we cannot overemphasise the importance of this publication. This could not come at an any more important time than this, when we are commemorating five years of the *Guidelines for the Alternative Care of Children* and when we have started talking of the post-2015 development agenda. With the challenging economic, political, and social environments in our region the current situation is still promising and it just requires more concerted efforts by state and non-state agencies.

The cooperation from colleagues from CELCIS at the University of Strathclyde and SOS Children's Villages International made this work easier than it should have been.

Levison Chiwaula
Dean of Social Science
University of Malawi



We began to envision this book as a joint partnership under a grey sky almost a year ago, and now the clouds have broken and we see that our book has come at a wonderful time for children's rights.

It is clear that all countries have made fantastic strides forwards in implementing children's rights, now we offer some ideas for the next steps for some of Africa's most vulnerable and invisible children; those in alternative care or at risk of losing their parents.

I want to thank Jennifer and Levison for their commitment to children and to our book. And to John Paul and Becky: without whom this book would not exist.

Emmanuel Sherwin
Care for ME! Global Project Manager
SOS Children's Villages International



FOREWORD



The issue of children without appropriate and quality care is a global problem. However, as a result of, among others, poverty, HIV/AIDS, and conflict, Sub-Saharan Africa is home to a large number of children that are deprived of their family environments.

In 2009, at the time of the 20th anniversary of the *UN Convention on the Rights of the Child* (UNCRC), the General Assembly adopted the *Guidelines for the Alternative Care of Children* by UN Resolution (64/142). The Guidelines are intended to enhance the implementation of the UNCRC, and in the context of Africa, the *African Charter on the Rights and Welfare of the Child* (ACRWC) too.

It is now five years since the adoption of the Guidelines. This report, which coincides with the 25th and 24th anniversaries of the adoption of the UNCRC and the ACRWC respectively, provides a timely complement to our understanding of the challenges faced by governments, and the various opportunities for improvement, in implementing the Guidelines in Sub-Saharan Africa.

The Guidelines are an essential tool for governments as they set out desirable orientations for law, policy, and practice to protect the rights and wellbeing of children deprived of parental care or at risk of being so. However, it is the responsibility of all stakeholders to ensure that they are implemented effectively in all contexts where children need assistance and care.

In recognising this duty, the report contributes by acknowledging the progress governments have made so far, and provides an evidence-base to ensure that, where

necessary, children have access to suitable alternative care, appropriate for their individual needs.

On the basis of independent research conducted on the implementation of the Guidelines in eight Sub-Saharan African countries, this civil society report takes a novel approach to providing a synthesis of experiences. It identifies overarching issues that affect governments in different social, cultural, economic and political situations, with the consequent variation in legislation, policy, and practice. The report also provides evidence that, in many instances, governments are challenged in their ability to provide effective coordination and oversight of alternative care measures. They are also challenged in their progress as a result of limited knowledge of their child population and the services available, and by insufficient and unpredictable resources for policy and law implementation to provide alternative care. In understanding these challenges, the report seeks to provide recommendations to facilitate a discussion of how progress can be made in ensuring the full and appropriate implementation of the Guidelines.

On behalf of the African Committee of Experts on the Rights and Welfare of the Child, I urge African states, donors, partners and other stakeholders including children to work together to realise the opportunity the Guidelines afford to improve the alternative care experience of all children in the region.

Benyam Dawit Mezmur

Chairperson, African Committee of Experts
on the Rights and Welfare of the Child

ACKNOWLEDGEMENTS

This report is the product of a successful collaboration between SOS Children's Villages International, CELCIS at the University of Strathclyde, and the University of Malawi.

It would have been impossible, however, without the researchers and authors in each of the eight countries producing original and insightful work on which to base our study. We acknowledge the substantial contribution of the following authors and their supporters:

In **Benin** SOS Villages d'Enfants Bénin, the Ministry of Family, Social Affairs, National Solidarity, the Disabled and People of the Third Age, Network of Organisations for the Protection of Children in Need.

In **Gambia** SOS Children's Villages the Gambia.

In **Kenya** SOS Children's Village Association Kenya and Brilliant Technologies (K) Limited.

In **Malawi** SOS Children's Village of Malawi Trust and, Humphrey Mdyetseni (team leader), Chiza Nyirongo, and Idrissa Mwale.

In **Tanzania** SOS Children's Village of Tanzania Trust.

In **Togo** EUREKA EDU Consulting Firm and SOS Villages d'Enfants Togo.

In **Zambia** School of Medicine, Department of Public Health, University of Zambia and SOS Children's Village of Zambia Trust.

In **Zimbabwe** Mr Musa Chibwana and SOS Children's Village Association of Zimbabwe.

The studies in each country also relied on generous contributions of time and insight from their own informants including government ministries; social work departments; international organisations; state, NGO and private sector care providers; and children in alternative care.

Thanks are due to members of the external review group including contributions from Nigel Cantwell, Ian Milligan and Garton Kamchedzera who helped to guide our thoughts and understanding on the Guidelines and frame messages for effective advocacy.

Support was also provided by colleagues from within SOS Children Villages in the Sub-Saharan Africa region, in terms of guidance on specific rights-based issues and overall oversight of the report's contents. Thanks go to Naitore Gituma, Hope Msosa and Mzi Ntuli. At the international office support was given by Alan Kikuchi-White and Véronique Lerch.

We would also like to acknowledge the invaluable contribution of John Paul Fitzpatrick for his energy, enthusiasm and highly competent project leadership.

An indispensable resource in the final stages of the report's preparation, Michael Rodgers provided proof-reading support for the publication and Susan Reid and Lesley Sneddon from CELCIS provided ongoing assistance with project coordination.



TERMINOLOGY & ABBREVIATIONS

ACRWC	African Charter on the Rights and Welfare of the Child 1999
AIDS	Acquired Immunodeficiency Syndrome
Beijing Rules	Standard Minimum Rules for the Administration of Juvenile Justice
CELCIS	Centre for Excellence for Looked After Children in Scotland
Guidelines	Guidelines for the Alternative Care of Children 2009
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goals
Moving Forward	Moving Forward: Implementing the Guidelines for the Alternative Care of Children (see reading list)
NGO	Non-governmental organisation
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child 1989
UNICEF	United Nations Children's Fund

Symbol

§	A paragraph within the Guidelines
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Terminology

Necessity Principle	Care is genuinely needed ¹
Suitability Principle	Care is provided in an appropriate manner ²
Alternative Care	Care for '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...' ³

¹ Moving Forward, p.22.

² Ibid.

³ UNCRC, Article 20(1).



EXECUTIVE SUMMARY

***Drumming Together for Change* joins a chorus of international voices with its drumbeat for change: a beat that calls on all of us to step up to our collective responsibility to care for our most vulnerable children.¹**

The report is based on a synthesis of eight assessments of the implementation of the *Guidelines for the Alternative Care of Children* (the Guidelines) in Benin, Gambia, Kenya, Malawi, Tanzania, Togo, Zambia and Zimbabwe.²

It considers common challenges to implementing the Guidelines identified in the eight countries and provides a platform for effective advocacy to promote every child's right to quality care.

In December 2009, the UN adopted the Guidelines (Resolution 64/142) with the aim of enhancing the implementation of the *UN Convention on the Rights of the Child* (UNCRC) for the protection and wellbeing of children deprived of parental care or at risk of being so. These children are some of the most vulnerable in society and are made more vulnerable when the systems designed to care for them fail to work in their interests or meet their needs.

The Guidelines provide direction for governments committed to the rights of these children by setting out desirable orientations for policy and practice. They also provide a reference point for assessing the quality of alternative care provision within national, regional and local contexts. Using this reference point, research groups in the eight countries produced assessments of the implementation of the Guidelines.³

This report analyses the findings from these countries and uses them as the basis for advocating for positive change. At the end of each chapter, the report provides solution-based recommendations to guide governments in improving implementation and, at pertinent points in the report, illustrated roadmaps detail the first steps governments need to take towards implementation.

The concluding chapter contextualises the recommendations to promote local advocacy focused on context-specific challenges and solutions. It provides

solution-based recommendations and calls on all stakeholders – governments, non-state organisations, civil society, local communities and children – to engage and participate in finding solutions to implementing the Guidelines effectively for children and families in need.

Overview of findings

The report's findings indicate that despite varying social, economic, legal and political contexts, common themes and challenges emerged to implementing the Guidelines.

Preventing the need for alternative care

A family tie is like a tree, it can bend but it cannot break

Preventing children entering alternative care is a way of protecting them from harm – children are often better cared for within their families and communities. Many children currently in formal alternative care could be living with their parents, extended families or members of their communities if the right support were in place.

The research found that there was insufficient provision of prevention services, that they were primarily funded by non-governmental organisations, and that these services were poorly coordinated and only reached a small proportion of the population in need.

Governments were failing to live up to the principle of 'necessity' in the provision of alternative care: children were unnecessarily admitted to alternative care and remained there for longer than necessary.

Provision of alternative care services

It takes a village to raise a child

There was a lack of formal care provision – in particular formal family-based care – and an increasing burden placed on informal forms of care without the corresponding support from the state to assist carers.

In many cases, there was a limited range of formal alternative care services, constraining choice and the ability

¹ The *UN Convention on the Rights of the Child* (UNCRC) was adopted in 1989 and has since been supplemented with three optional protocols.

² The assessments are based on SOS Children's Villages International's *Assessment Tool for the Implementation of the UN Guidelines for the Alternative Care of Children*, available online at: www.sos-childrensvillages.org/What-we-do/Child-Care/Quality-in-Care/Advocating-Quality-Care/Pages/Quality-care-assessment.aspx.

³ These assessments, or country reports, are available online at: www.care-for-me.org.

In Zambia up to 50% of children could be reintegrated with their families with adequate funding.



Source: Referenced to MCDSS Zambia; figure also cited in UNICEF, *Alternative Care for Children in Southern Africa: Progress, Challenges and Future Directions*, Nairobi: UNICEF, 2008, p.13.

of decision-makers to provide children with alternative care placements 'suitable' for their individual needs.

The most common form of formal alternative care was residential care. However, the quality of this care was inconsistent, with many children living in environments unable to address their individual needs. Residential care was largely provided by non-state organisations with limited oversight by the government (covered in detail in chapter 3).

Leaving care provision was similarly found to be inconsistent in quality and coverage, and left children without support when reintegrating into their communities.

Protection from harm

Children are the reward of life

There were high levels of risk around child protection in the region and limited systems in place to protect them. While there were examples of good practice, with community-based child protection mechanisms and complaints procedures for children in formal care, systems were assessed to be inconsistent and inadequately monitored on the whole.

Advocacy messages

*With urgency and a focus on step changes, leaders will act in a planned way based on collaborative discussion.*⁴

The report offers ample evidence that failure to implement the Guidelines implies serious inadequacies in the services aimed at preventing the separation of children from their families, providing appropriate alternative care, and protecting children from harm.

The aim of the report, however, is not just to reiterate the importance of the Guidelines and highlight failures in the system. Instead, it aims to encourage an understanding of the challenges governments face in implementing the Guidelines and provide some assistance in finding ways to create an environment where change is possible.

This report is aimed at policy-makers and others who wish to advocate for and make decisions based on implementing the Guidelines to improve children's experiences of alternative care.

Effective advocacy will be tailored to national, regional and local challenges, and will require local knowledge and strategies to influence particular actors, decision-makers and power-holders. The report sets out some starting points to catalyse action by asking the following questions:

- Why are governments in the region finding it so difficult to effectively implement the Guidelines?
- What can be done to nurture an environment in which implementation is possible and ultimately ensure that children and families have their needs met in ways that respect their rights?

It is impossible, of course, to answer these questions in their entirety. This is a task for local-level advocates and policy-makers working in their own particular local conditions and with knowledge of their stakeholders and political complexities. However, some overarching themes were identified to help local level efforts for understanding and advocacy.

⁴ Nigel Cantwell, Davidson, J., Easley, S., Milligan, I, Quinn, N., *Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children'*, Glasgow: Centre for Excellence for Looked After Children in Scotland, 2012, p.127.

Why are governments in the region finding it so difficult to implement the Guidelines?

This question is answered by reference to the policy implementation framework and the common challenges that emerged across the country reports. Recurring themes through the research included weak leadership by governments in planning and coordinating services, low levels of financial and human resource provision for the coordination and provision of alternative care, and lack of data and information to inform evidence-based planning and policy-making.

What can be done to nurture an environment in which implementation is possible?

This question is addressed with reference to three overarching policy messages for encouraging change. Successful implementation will require first:

- **Active engagement with local communities, families and children.** As the beneficiaries of alternative care, they should be given both a voice and a stake in the services that are designed for them and the decisions that are made in their interests.
- **Empowered governments to take a leadership role in governing alternative care provision.** This means leading the oversight and coordination of alternative care provision and developing cooperative partnerships with other stakeholders.
- **Cooperative accountable non-state organisations.** Ranging from international donors, the private sector and civil society, to non-governmental organisations, non-state actors should aim to cooperate with and empower governments with resources and knowledge to ensure quality alternative care.

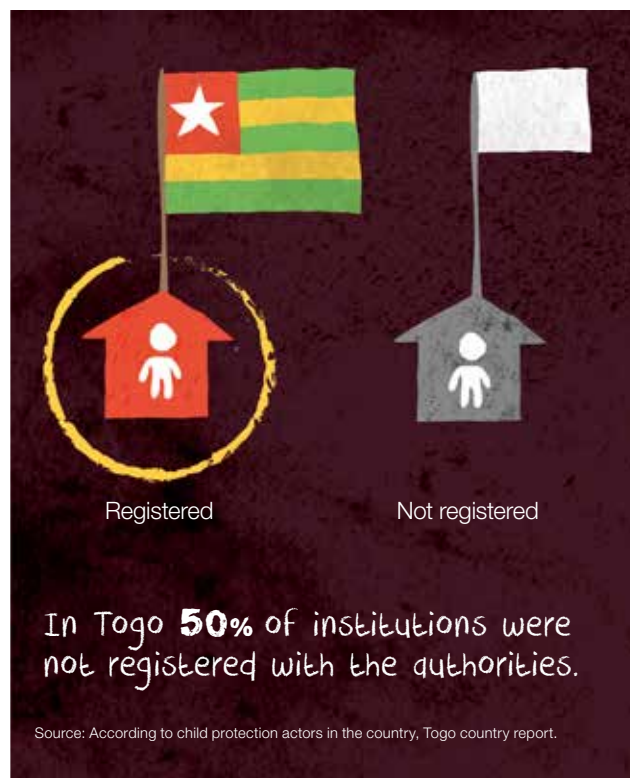
Conclusion

There can be no keener revelation of a society's soul than the way in which it treats its children.


Nelson Mandela

This is the fifth anniversary of the Guidelines and it is important that we begin examining the ways in which they are successfully implemented and understanding the reasons why they are not. This report shines a spotlight on eight Sub-Saharan African countries. From their shared experiences, it starts to unpick some of the challenges they have faced in implementation and offers some ways forward.

This report is clear: change will demand action from us all – action based on understanding that is constructive and, most importantly, reflects innovative approaches. There is no one pathway for change. In each context, we will be drumming with different rhythms but together these rhythms, in all their syncopation, must be heard and felt as a collective call for positive, real change in the lives of the most vulnerable members of our societies.



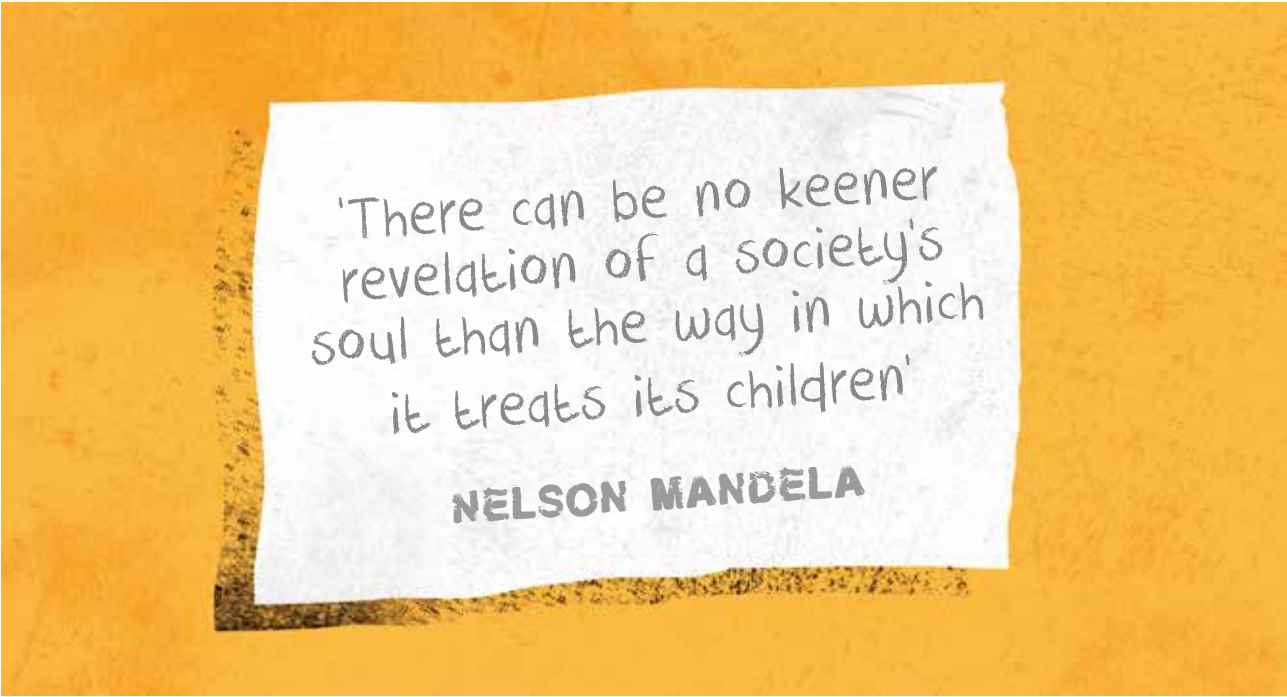




Introduction



1.1 METHODOLOGY



'There can be no keener
revelation of a society's
soul than the way in which
it treats its children'

NELSON MANDELA

1. INTRODUCTION

This is a report about how we care for the most vulnerable children in our society. It is a snapshot of experience and progress in implementing the *Guidelines for the Alternative Care of Children in the eight Sub-Saharan countries of Benin, Gambia, Kenya, Malawi, Tanzania, Togo, Zambia and Zimbabwe.*

By synthesising these countries' experiences, the report provides rich insight into how alternative care is planned and practised in the region. Through a comprehensive analysis of the challenges of implementing the *Guidelines for the Alternative Care of Children* (the Guidelines), it also offers guidance on how effective advocacy can catalyse real change for vulnerable communities, families and children.

The report is the result of a collaborative research project between SOS Children's Villages International,¹ the Centre for Excellence for Looked After Children in Scotland (CELCIS) at the University of Strathclyde,² and the University of Malawi.³ These organisations cooperated across three countries – the UK, Austria and Malawi – in bringing together their varied expertise and collective passion for the rights of children in order to encourage advocacy on the implementation of the Guidelines.

A UN Resolution (64/142) endorsed the Guidelines on 18 December 2009. As instruments designed to promote

desirable orientations for policy and practice, they are not binding commitments on states. Instead, they include 167 paragraphs to guide governments in enhancing the implementation of the *UN Convention on the Rights of the Child* (UNCRC) and meeting their international commitments for children without parental care or at risk of losing it.

As a result, there is no official follow-up or monitoring mechanism to ensure governments' compliance with the Guidelines, although the Committee on the Rights of the Child have begun to refer to the Guidelines when making concluding observations on countries' implementation of the UNCRC.

In order to address this gap, SOS Children's Villages International has been conducting assessments in countries around the world since 2011, using in-country experts to measure their success in implementing the Guidelines. These assessments are based on an *Assessment Tool for the Implementation of the UN Guidelines for the Alternative Care of Children* which, to date, has been used in 20 countries worldwide.⁴

At the end of 2013, with eight comprehensive country assessments completed in the Sub-Saharan region, SOS Children's Villages International, CELCIS and the University of Malawi identified 2014 as a critical moment to synthesise the assessments' findings. With increasing economic progress in the region and the development of a post-2015

¹ SOS Children's Villages International: www.sos-childrensvillages.org.

² CELCIS: www.celcis.org.

³ University of Malawi: www.unima.mw.

⁴ The original version of the tool can be found online at: www.sos-childrensvillages.org/What-we-do/Child-Care/Quality-in-Care/Advocating-Quality-Care/Pages/Quality-care-assessment.aspx.

agenda following the end of the Millennium Development Goals timeframe, now is the time to make children a top priority.

The report includes representative countries from eastern, western and southern Africa and acknowledges their various political, economic and social contexts. However, it also provides the opportunity to understand in greater depth and breadth the common challenges that governments face in implementing the Guidelines and distil advocacy messages for real change in the region.

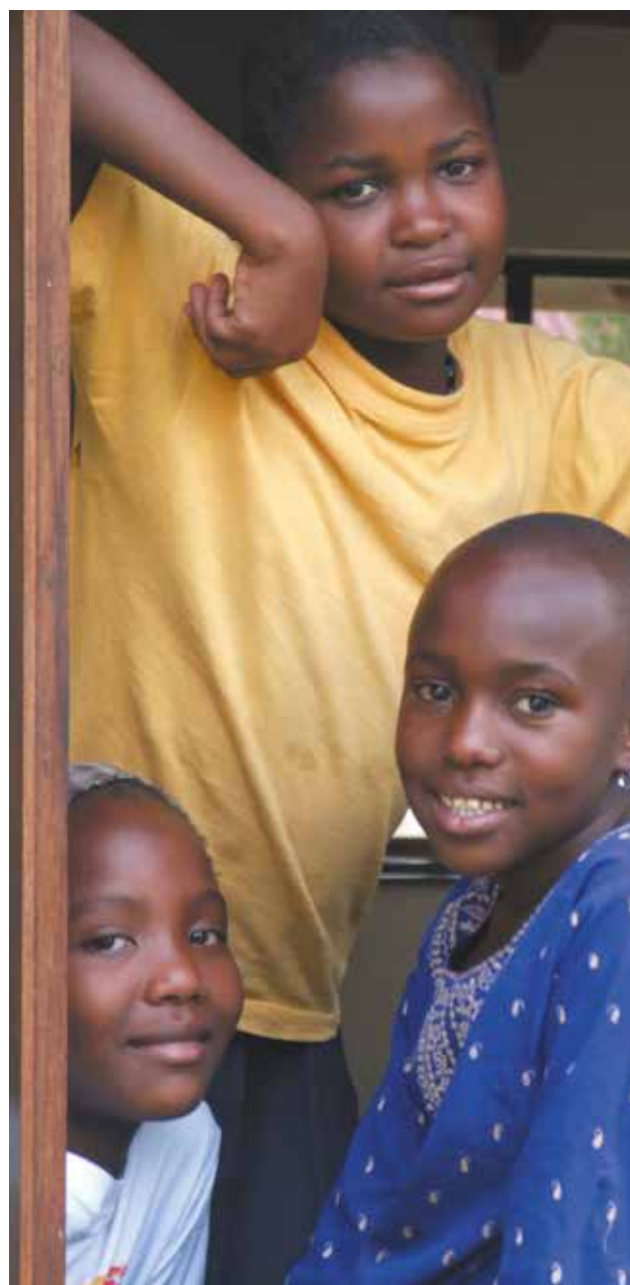
Following this introduction, the study is structured into six parts:

- **Chapter 2** provides a legal, social and economic context to the region and argues that the rights of children without parental care in the region should be at the forefront of all new governmental and developmental policy agendas.
- **Chapter 3** discusses the policy implementation framework that surrounds alternative care. It highlights the role of government as the lead agency in determining the shape of alternative care for children, alongside other stakeholders such as donors and other non-state organisations. It also provides analysis of government oversight and monitoring capacity, as well as documenting the importance of reliable information and data for evidence-based decision-making and the need for sufficient and predictable funding for the provision of services.
- **Chapter 4** highlights the importance of investing in preventive services in order to ensure that alternative care is only used as a last resort and when it is necessary in the interests of the child.
- **Chapter 5** focuses on the provision of services for children in need of alternative care and explores the role of decision-making for ensuring that children are provided with suitable and appropriate care options. This is followed by an analysis of family-based and residential care and finishes with an assessment of leaving care provision.
- **Chapter 6** takes up the challenge of effective child protection and gives an overview of mechanisms in place both at the community level and in formal care settings.
- **Chapter 7** completes the study by discussing the overarching messages arising from the report, contextualising the findings and setting the stage for effective advocacy and change.

As illustrated in the title *Drumming Together for Change: A Child's Right to Quality Care in Sub-Saharan Africa*, we have taken the metaphor of the drum as a cultural and inspirational symbol for change in the region.

Although the report notes progress and good practice in both country and local contexts, it is primarily a call for change. It seeks to provide a platform for effective advocacy at all levels; in international, regional, national and local settings. While acknowledging the primary responsibility of governments to implement change, it also challenges other stakeholders – international and regional organisations, donors, NGOs, the private sector and civil society – to collaborate in order to make change a reality.

Children have a right to quality care when their families are unable to care for them and it is our responsibility to ensure that this right is fulfilled. In doing so, we not only meet their current needs and nurture their development, but also empower them in securing the health and wellbeing of our future societies.



1.1 METHODOLOGY

The data set and research tool

The country reports for **Benin, Gambia, Kenya, Malawi, Tanzania, Togo, Zambia** and **Zimbabwe** were researched and written by in-country research teams between 2011 and 2013 in response to a monitoring tool titled *Assessment Tool for the Implementation of the UN Guidelines for the Alternative Care of Children*.⁵

SOS Children's Villages International, along with child rights experts Nigel Cantwell and Professor June Thoburn, designed the tool in 2011. It is a long and complex diagnostic instrument tasked with measuring the implementation of the Guidelines and serves as the foundation for SOS Children's Villages' global advocacy campaign: Care for ME! *Quality Care for Every Child*.⁶

Each report was written by different authors and used various research methodologies and approaches. As such, **comparisons cannot be made across the region or between countries**. Please see Appendix 2 for a table describing the research methods employed in the eight studies.

Research and analysis team

The analysis was carried out by a team of five researchers from three organisations: an independent researcher for SOS Children's Villages International, an independent researcher based at CELCIS at the University of Strathclyde, and three researchers from the University of Malawi. Each researcher brought with them a different set of research skills and expertise including child protection, alternative care, social work, children's rights, international law, economics and research methods.

Oversight, review and accountability

The analysis was overseen and quality controlled by lead experts from each institution. An external review group was set up to provide peer review for the report's findings and presentation.

A first draft of the report was also made available for review in each of the countries included in the research in order to ensure accountability and essential feedback processes.

The final draft of the report was fact-checked and considered ready for publication based on available information and knowledge at June 2014.

Analysis

Analysis involved an overview of the eight reports and a desk review of existing literature in the field (listed in the bibliography).

In January 2014, a meeting in Glasgow led to an initial mapping of the themes emerging from the reports and the construction of an analytical matrix. This was completed by two members of the research team and validated by the other team members. The matrix formed a framework for further analysis of the material found in the reports and an in-depth assessment of the emerging issues across the countries.

Limitations and ethical considerations

The main limitation to the research was a lack of available and reliable information. This issue was cited by Gambia, Kenya and Malawi specifically, but was evident across the reports. The lack of available information in many of the countries means that it was impossible for the researchers working on this report to verify all information and sources. The current study relies on the veracity of the eight country reports as written by in-country experts.

Although recommendations are derived from the analysis and findings across the reports, this does not mean that they are necessarily representative across the region, or even for all the countries analysed in this study. As such, caution should be exercised in making generalisations across a region with considerable social, cultural, economic and political differences.

A large amount of the material cited in the reports is secondary data, but primary data was collected from expert practitioners, government officials and included the voices of a limited number of children in the region. The ethical considerations related to working directly with these groups were considered individually as appropriate in each country.

Methodology for roadmaps

The roadmaps for change are based on the concept of theory of change: 'The label theory of change is often referred to by other terms, such as pathway of change, engine of change, blueprint, logic model and theory of action'.⁷ A theory of change offers certain steps in a route towards a desired destination.

⁵ See: www.sos-childrensvillages.org/what-we-do/child-care/quality-in-care/advocating-quality-care/quality-care-assessment.

⁶ See Care for ME! online at: www.sos-childrensvillages.org/what-we-do/child-care/quality-in-care/advocating-quality-care/care-for-me.

⁷ Organisational Research Services, *Theory of Change: A Practical Tool For Action, Results and Learning*, prepared for the Annie E. Casey Foundation, 2004, p.1, www.aect.org/upload/PublicationFiles/CC2977K440.pdf.



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For this report the roadmaps were based on the best information available at the time. They are indicative, not prescriptive. They are grounded in the research evidence from the initial eight country assessment reports, complemented by the academic, NGO and UN discourse around improving the outcomes for children.

Each roadmap has several steps, and was made as simple and as practical as possible. Many countries covered in this report have already completed some of the steps in each of these roadmaps; however there is a need for everyone to deliver the next steps together. This allows all levels of stakeholders to easily understand what is required in terms of change.

For ministerial staff they offer a clean project plan when developing the national strategy for children in alternative care.

For advocacy colleagues, they are a visual aid for presentations, to help easily get complicated messages across.

For all actors, they are a didactic tool; referencing back to the text and showing the full picture of change.



2

Regional context



2.1 LEGAL CONTEXT

2.2 SOCIO-ECONOMIC CONTEXT

2.3 FUTURE TRENDS

2. REGIONAL CONTEXT

This report charts the progress of eight countries in Sub-Saharan Africa – **Benin, Gambia, Kenya, Malawi, Tanzania, Togo, Zambia and Zimbabwe** – in implementing the *Guidelines on the Alternative Care of Children*.

Although eight countries cannot represent an entire region, particularly one that has such great contrasts in terms of its legal, social, economic and political contexts, the variety of these country reports provides an extremely useful preliminary grouping for understanding some of the implementation challenges for the Guidelines across the region.

This section contextualises the chapters that follow by addressing the legal and socio-economic context of the region in relation to the provision of alternative care. First, it identifies progress in the development of legislation for children and their rights, including children without parental care. Second, it provides a brief introduction to some of the social and economic issues impacting on the provision of, and demand for, alternative care in the region. Finally, with reference to broader global challenges, it makes the case for the continuing and increasing importance of focusing on the rights and needs of children without parental care now and into the future.

2.1 LEGAL CONTEXT

Each country in the study has ratified the *UN Convention on the Rights of the Child* (1989) (UNCRC) which commits governments to provide ‘special protection and assistance’ to children permanently or temporarily deprived of their family environment.¹

In Sub-Saharan Africa, each country is party to the *African Charter on the Rights and Welfare of the Child* (1999) (ACRWC).² This charter also entitles children who are deprived of their family environment to ‘special protection and assistance’, including alternative care in the child’s best interests.³

The Guidelines for the Alternative Care of Children are non-binding UN-approved principles, meaning that they ‘comprise no obligation on the part of States or any other concerned parties’.⁴ Instead, they represent desirable orientations for policy and practice to assist governments in fulfilling their UNCRC commitments and to guide other actors concerned in developing their programmes.

The UN Committee on the Rights of the Child, which reviews state reports on their fulfilment of their UNCRC

commitments, now uses the Guidelines to assess compliance with ‘family environment and alternative care’ provisions and to frame its concluding observations on this question. However, as not all of the countries in this report have been reviewed since 2009, only general comments on the state of alternative care can be found in Appendix 3.

Considering these observations, there is evidence that, in terms of national constitutions, legislation and policy, there has been some progress towards integrating the Guidelines’ standards into national policy.

Each country has enacted legislation on children’s rights and welfare since the ratification of the UNCRC and the ACRWC. Some of this legislation was put in place post-2009 following the approval of the Guidelines, but it is unclear from the country report analyses whether this legislation has succeeded in incorporating the Guidelines’ standards.⁵

Therefore, although there are positive signs of legislative activity, there is limited evidence in the reports that this

1 Article 20 UN Convention on the Rights of the Child 1989.

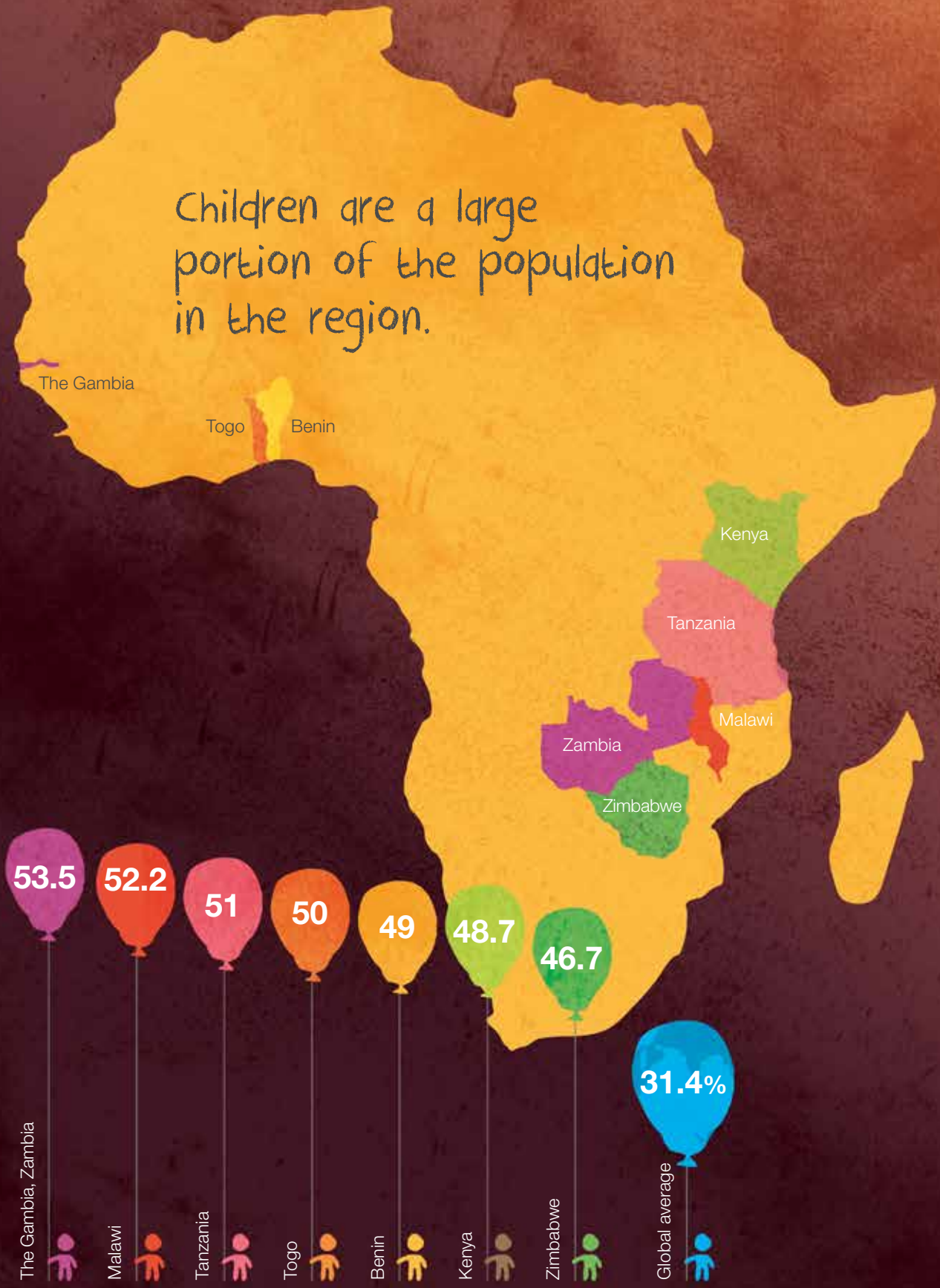
2 See: <http://pages.au.int/acerwc/pages/acerwc-ratifications-table>.

3 Article 25 African Charter on the Rights and Welfare of the Child 1999.

4 Moving Forward, p.20.

5 Decree No.416 2012 in Benin provides norms and lays the foundation for alternative care reform, 2012 Guidelines on Quality Care for Children in Alternative Care in Gambia; Child Care Protection and Justice Act 2010 in Malawi, Child Act 2009 in Tanzania and Zanzibar’s Children’s Act 2011, Decree No. 100 2010 in Togo sets norms and provides standards for alternative care and protection.

Children are a large portion of the population in the region.



Children as of % of population

Source: UNICEF Statistics, www.unicef.org/infobycountry/ used as the basis for working out percentages.

has resulted in the necessary harmonisation of domestic legislation with international standards or that reforms have been appropriately implemented.

Implementation of legislation was a challenge echoed across the research. Laws and policies are of limited value in the absence of effective enforcement and implementation mechanisms. This is demonstrated by the country reports, which highlight that despite the flurry of legislative reforms it has generally been difficult to translate these reforms into practice – partly due to the short timeframe for change since 2009.



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2.2 SOCIO-ECONOMIC CONTEXT

The socio-economic context inevitably varies across the region yet the *State of the World's Children report (2006)* recognised 'poverty, armed conflict and HIV/AIDS [as] among the greatest threats to childhood' in the region.⁶ Although this research did not raise armed conflict as an issue in the countries studied, it is likely that not much has changed in eight years.

Poverty and the HIV/AIDS epidemic were consistent themes in the research. The country reports regularly cited both as background issues contributing to child protection concerns and increasing demand for both formal and informal alternative care provision.

Poverty and HIV/AIDS are intimately entwined: poverty puts women, men and children at greater risk of acquiring HIV while HIV puts them and their families at greater risk of poverty as their ability to work diminishes.⁷

Ultimately, poverty and HIV/AIDS makes families more vulnerable, traditional alternative care networks more fragile, and places children at greater child protection risk. This, in turn, increases the need for collaboration between state and non-state agencies in the provision of adequate protection and care for vulnerable groups.

Poverty

Although Sub-Saharan Africa has made great progress towards the Millennium Development Goals (MDG) and has succeeded in reducing the proportion of people living in extreme poverty from 56.5% in 1990 to 48.5% in 2010,⁸ chronic poverty remains a prominent feature of life across the region.

With populations living close to the poverty line – 68.5% of people in **Zambia** live on less than US \$1.25 a day⁹ and 55% of Zimbabweans do not have enough to eat and suffer from chronic hunger¹⁰ – families are vulnerable and find it difficult to provide for their children.

In 2012, Sub-Saharan Africa had a Human Development Index value of 0.475 on a scale of 0 to 1,¹¹ and this pattern of low human development is reflected across the countries in this study:

Country	Human Development Index 2012
Benin	0.436
Gambia	0.439
Kenya	0.519
Malawi	0.418
Tanzania	0.476
Togo	0.459
Zambia	0.448
Zimbabwe	0.397

Source: Human Development Report 2013.

6 UNICEF, *State of the World's Children: Excluded and Invisible*, New York: UNICEF, 2006, p.12.

7 For more details on this relationship, see *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*, New York, Geneva, Washington DC, UNICEF, UNAIDS and US President's Emergency Plan for AIDS Relief, 2006.

8 See *MDG Report 2013: Assessing Progress in Africa Towards the Millennium Development Goals*, New York: UNDP, UN Economic Commission for Africa, African Union, African Development Bank Group, 2013, p.7.

9 See: <http://hdrstats.undp.org/en/countries/profiles/ZMB.html>; <http://hdr.undp.org/sites/default/files/Country-Profiles/ZMB.pdf>.

10 A. Wyatt, Mupedziswa, R., Rayment, C., *Institutional Capacity Assessment Zimbabwe Final Report*, Harare: UNICEF and the Department for Social Services, Ministry of Labour and Social Services, 2010, p.7.

11 UNDP, *Human Development Report 2013: The Rise of the South*, New York: UNDP, 2013, p.23.

Many vulnerable children in the region are orphaned by the HIV / AIDS epidemic

HIV/AIDS orphans as a % of total orphans:



Source: UNICEF Statistics, www.unicef.org/infobycountry/ used as the basis for working out percentages.

The Human Development Index provides a framework for measuring social and economic development along three dimensions: life expectancy, educational attainment and income,¹² demonstrating the multiple disadvantages facing families in the region. As a result, their ability to function and take care of their children depends, to a large extent, on the support that they can access.

This support is recognised in the Guidelines under 'promoting parental care' in section IV, and discussed in detail in chapter 4.

HIV/AIDS epidemic

Despite the success in recent years to halt HIV/AIDS – prevalence rates went down from 5.9% in 2001 to 4.9% in 2011¹³ – the epidemic has led to a rise in the number of orphans by approximately 50% since 1990.¹⁴

HIV/AIDS devastates whole families, often affecting the main breadwinner and leaving their children vulnerable. It places unprecedented burden on extended families and communities to care for the children and requires specialist healthcare for children who are directly affected by the virus.

Even without the effects of the HIV/AIDS epidemic levels, the data suggest that formal alternative care provision would be woefully low. Yet, with the epidemic levels, lack of quality alternative care provision is likely to disadvantage a whole generation of children in the region.

¹² See: <http://hdr.undp.org/en/statistics/hdi>.

¹³ MDG Report 2013, p.8.

¹⁴ *EveryChild, Missing: Children without Parental care in International Development Policy*, London: EveryChild, 2009, p.4.

2.3

FUTURE TRENDS – WE NEED TO FOCUS ON CHILDREN

The moral case for protecting children could not be stronger. Yet the importance of effective and nurturing alternative care becomes even more apparent when looking towards the future. This future is unknown, but there are indications that social, economic and political changes will impact on governments' ability to provide for such vulnerable children.

Sub-Saharan Africa has a growing vulnerable child population

Africa's population is likely to increase from 1.1 billion in 2013 to 2.4 billion by 2050.¹⁵ Its people are also already young: 20% of Africa's population is under six years old.¹⁶

As described above, there is evidence to suggest that the number of children without parental care is also on the increase, with a 50% increase in the number of orphans in the region since 1990.¹⁷

Although consistent information across the region is absent, the figures that are available are stark. In **Kenya**, the Department of Children's Services recorded an almost two-fold increase in cases of abandonment and neglect between 2007 and 2008 from 14,453 to 37,082.¹⁸ This was supported by anecdotal evidence through interviews with local chiefs and police departments.

Environmental change will increase vulnerability and social instability

Food insecurity is a 'recurring challenge' for countries in the region,¹⁹ and likely to be exacerbated by the changing climate leading to food and water shortages.

Sub-Saharan Africa is particularly vulnerable to climate change; populations are already vulnerable and children are likely to suffer most, with adverse health and developmental outcomes.²⁰

Given that climate change intersects with social, economic and political stresses,²¹ it is also likely to lead to greater social instability, increasing migration and the likelihood of conflict and social unrest.

Children's rights and welfare suffer in emergency situations, particularly when effective systems are not in place to protect them.



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Economic instability and shrinking donor aid will affect service provision

The countries in this study rely heavily on donor assistance and non-state support to run their child protection and alternative care services.

Donors have failed, so far, to live up to their 1970 commitment to provide 0.7% of GNI for development.²² Instead, levels of development aid have fluctuated and remain unpredictable, particularly in times of global financial instability. According to the MDG report (2013), official development assistance to the least developed countries is falling: in 2012, it fell by 4% following a decline of 3% in 2011.²³

This situation implies increased vulnerability for children without parental care unless sustained and predictable funding can be found by governments to implement the Guidelines.

Investing in children is essential for achieving long-term development goals

Failing to support families or implement nurturing alternative care provision means sacrificing the potential of future generations: it means failing to invest in a generation of children at great cost.

In this respect, the Guidelines are an essential component not only of protecting children, but also for sustaining human development into the future.

15 See: www.prb.org/Publications/Datasheets/2013/2013-world-population-data-sheet/data-sheet.aspx.

16 World Bank see: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTCY/EXTCY0_0,contentMDK:20426142~hPK:547714~menuPK:1114015~pagePK:148956~piPK:216618~theSitePK:344939,00.html.

17 Mostly due to the HIV/AIDS epidemic, see EveryChild 2009, p.4.

18 Department of Social Services, case-load reports.

19 MDG 2013, p.8.

20 See UNICEF, www.unicef.org/rightsite/sowc/pdfs/panels/Climate%20change%20and%20child%20rights.pdf.

21 Ibid.

22 UN General Assembly Resolution 2626 1970, para. 43.

23 MDG 2013, p.8.



The policy implementation framework for alternative care



3.1 INTRODUCTION

3.2 ANALYSIS

- 3.2.1 The role of the state
- 3.2.2 Oversight and monitoring capacity
- 3.2.3 Financing alternative care
- 3.2.4 Availability of data

3.3 CONCLUSION

3.

THE POLICY IMPLEMENTATION FRAMEWORK FOR ALTERNATIVE CARE

3.1 INTRODUCTION

The state has the main responsibilities for implementing policy and ensuring that provision meets consistent standards. It has a duty to uphold the rights of children and their families. These are complex tasks and, unsurprisingly, the research identified that there were common structural issues that hindered the implementation of policy across the region and that impacted on the provision of services and outcomes for children.

This chapter therefore focuses on four overarching issues that emerged from the analysis of the reports: appropriate state coordination; state oversight and monitoring capacity; the availability of financial resources for alternative care; and the collection of data on alternative care.

These were consistently identified as challenging across the region due to a lack of comprehensive oversight and monitoring of alternative care, low levels of financing for services and insufficient availability of data that could provide a basis for planning and monitoring.

As the Guidelines and *Moving Forward* point out, these areas are fundamental to the effectiveness of alternative care policies and practice, and highlight the central importance of the state in coordinating and monitoring public services and those of non-state actors. The overarching responsibilities for these areas rest with government, requiring state leadership in the development, implementation and monitoring of the necessary infrastructure for alternative care.

Key messages:

- There was insufficient state coordination and oversight of the role and contributions of non-state actors in the provision of alternative care.
- There had been developments in state legislation and policy guidance across the eight countries. However, gaps remained between national policy and planning and implementation of services at the local level.
- State oversight through licensing and inspection systems was inadequate and inconsistently undertaken with high levels of unregistered and uninspected services.
- Recognising the demands on national budgets, current levels of state funding were inadequate to meet the needs of children who were at risk of, or required, alternative care.
- Decline in non-state funding from donors had an impact on alternative care provision in the absence of sufficient state funding.
- There was a significant lack of evidence and data on all areas of alternative care across the region to support planning, implementation and monitoring, although some data was collected in most countries.

Guidelines for the Alternative Care of Children

State coordination: §8, §24, §25, §69, §70

Financial resources: §18, §20, §24, §108, §127

Availability of data: §69, §109-112

State oversight: §128-129, §105



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3.2 ANALYSIS

3.2.1 THE ROLE OF THE STATE

The role of the state in providing coordination and oversight is fundamental to the provision of quality alternative care. This covers a wide range of areas and is specifically outlined in the Guidelines (§8, §24 and §25).

Each state is expected to develop policy and services that meet the needs of its own political, social, cultural and economic environment. This activity needs to take into account specific policy commitments and strategic responsibilities for children and families.¹ It includes ensuring that human rights conventions, standards and guidelines are implemented while also providing leadership in the national frameworks for supporting, protecting and caring for children.

These areas were explored by the country reports, highlighting areas where the state effectively led this activity. However, the reports also identified a series of challenges for the state in undertaking the role of implementing legislation and policy and facilitating cooperation with non-state actors.

Implementing legislation and policy

A range of legislation and policy guidance has been developed across the countries to support children's wellbeing and, more specifically, the systems, procedures and provision associated with alternative care.

Some of these policy instruments have been enacted or put in place recently (see chapter 2). Some may not have been fully implemented while others have been in place for many years. Several reports stated that policy was not consistently implemented, querying whether alternative care policy was adequately reflected in provision and support to children and families.

This inconsistent policy implementation was reflected in a number of ways. In **Malawi**, there were gaps in policy instruments at national level that made it difficult to implement alternative care systems in the country. At the same time, there were limited resources for implementation of policy. In **Tanzania**, the legal and policy framework was regarded as good although the country report suggested that there needed to be further attention paid to monitoring implementation.

¹ Moving Forward, p.47.

In **Benin**, planned reforms were not implemented due to the low budget allocated by government. In **Togo**, although the legal and political framework provided support to care programmes, there was no national development of family strengthening policy. The legal framework was put in place before the Guidelines were developed so several areas considered in the Guidelines had not been taken into account.

In **Zambia**, components of alternative care such as preventive services, motives for placement, the need for a range of care options as well as guidelines for authorisation, inspection, accreditation and licensing of institutions had not been adequately reflected in the national child policy. These examples highlight the challenges in ensuring that policy intentions at national level are appropriately implemented.

Relationship between state and non-state actors

The Guidelines point out that the state has a role in facilitating cooperation between all authorities (§24). This is highly relevant in the region where foreign and international NGOs and agencies had major roles across the eight countries in providing services and financing alternative care. These contributions were seen as important and necessary, particularly where the state was not able to finance, resource or implement alternative care provision without support from other agencies.

With the contribution of different stakeholders, the reports identified that there was a need for close collaboration and partnership between state agencies, donors, NGOs and other organisations such as religious institutions. However, the extent of the role of non-state actors within countries was not consistently known.

In **Malawi**, there was not a clear picture of funding levels for alternative care among non-state actors due to a lack of information. In **Zambia**, provision for children who required formal care in residential homes had been largely left to non-governmental organisations.

At the same time, support from government ministries had dropped. In **Zimbabwe**, there was a high level of state dependence on non-state actors and donors to undertake the statutory duties associated with the government and its ministries. In **Togo**, alternative care was mainly provided by non-state organisations such as religious institutions or NGOs, with four being publicly or state-run out of a total of 98. In **Benin**, UN agencies were key actors in the protection of children as well as in the definition of policies that support the provision of services. They were also the main funders of alternative care organisations. The findings from the countries indicate that there were different patterns of involvement by both states and non-state actors and that there needed to be greater awareness about these levels of engagement.

There were concerns associated with this high level of non-state provision. In **Togo**, uncontrolled development of alternative care provision did not meet the minimum state-defined conditions. There was concern about the employment of low skilled and under-paid staff in private facilities. It was queried whether NGOs' contributions were sustainable in **Togo**, particularly in the light of their fragmented interventions. Similarly, in **Tanzania**, it was emphasised that there was a need to ensure overall coordination so that programmes conformed to the state guidelines. Although the contribution of non-state actors in **Benin** was seen as important, this could also be subject to the changing priorities of donors and organisations. These contributions may not be in accord with the socio-economic and political situation of the country.

In the light of these challenges, state coordination and oversight of non-state agencies is required in order to ensure that non-state provision adheres with the Guidelines. Although the role of non-state actors was of great importance in the provision of alternative care, states had a significant role in monitoring these agencies and ensuring that they met national standards. As discussed below, this role was not consistently undertaken. At the same time, there was wide recognition that foreign and international NGOs and agencies had a crucial and central role in providing both technical and financial support in the absence of a state's capacity.

3.2.2

OVERSIGHT AND MONITORING CAPACITY

Since the development of the Guidelines, there has been an increasing focus on the responsibilities of government to develop independent mechanisms for (a) accrediting, registering and licensing alternative care providers; and (b) ensuring ongoing monitoring and inspections of facilities.

This section provides insight into existing structures for the oversight and monitoring of alternative care providers in the region, and illustrates the considerable gaps in the states' oversight role.

Although the evidence from the reports focuses mainly on the oversight and monitoring of residential care facilities (see chapters 5.2 and 5.3), any systems of oversight should also extend to all programmes and individuals responsible for the care of children.

Registration, accreditation and licensing

According to the Guidelines, states are 'responsible for... ensuring appropriate alternative care, with or through competent local authorities and duly authorized civil society organizations' (§5).

The registration and authorisation of alternative care providers should be the basis of their establishment and ensure that they are 'subject to regular monitoring and review... [to assess] the professional and ethical fitness of care providers for their accreditation, monitoring and supervision' (§55).

According to the Guidelines, the power to register, accredit and licence alternative care providers should be delegated by the government to a competent authority. In each of the countries, such a competent authority could be identified, although their activities were difficult to discern.

Across the countries, there were considerable concerns about the capacity of governments to effectively register, accredit and licence residential care facilities. Although it is impossible to know the number of unregistered residential care facilities – there is no data collected on them – estimates across the region are alarming.

In most of the countries, evidence supported the claim that large numbers of children were living in unregistered residential care facilities:

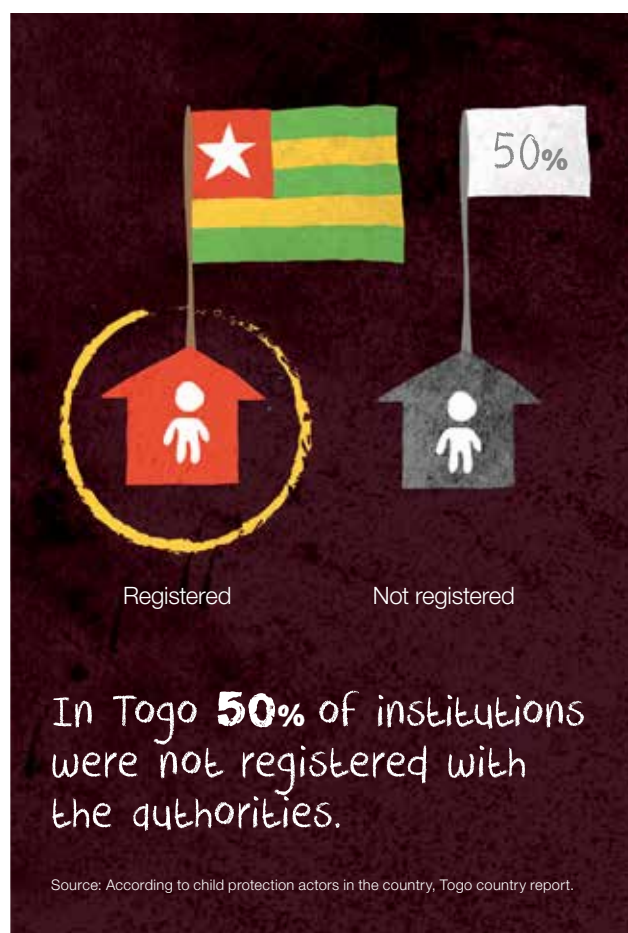
- In **Malawi**, only 10 of the 32 care centres sampled in the research were formally registered – representing 31%.
- In **Togo**, only 50% of the operating institutions were registered with the authorities.²
- In **Tanzania**, it was estimated that there were more unregistered facilities than registered ones.³
- In **Kenya**, 2% of children in formal care were found to be in unregistered facilities.
- In **Benin, Gambia and Zimbabwe**, there was also evidence of unregistered facilities.

Facilities continued to operate without being registered, licensed or accredited, despite policy and legislation to the contrary. Legislation was often too new to have been effectively implemented: in **Benin**, it had been in place only since 2012 and in **Malawi** since 2009.

Regulations were also found to be confusing: in **Benin, Tanzania and Malawi** there was a lack of clarity over the requirements for registration; when some organisations attempted to register they found themselves registered with the wrong authority or their registration was incomplete.

In other cases, the processes were opaque and there was limited information on the way they functioned. In **Malawi**, bureaucracy was blamed for making organisations wait for registration, resulting in them operating for years without it.

In **Gambia**, only four organisations had been authorised to run residential care facilities, despite clear evidence that other organisations operated in the country. No data could be found on the number of applicants that had been refused accreditation in recent years.



Monitoring and inspections

An effective and independent inspection and monitoring system is essential to ensure that residential care facilities meet basic quality standards for the rights and wellbeing of children in their care.⁴

The Guidelines provide standards for governments to ensure that 'agencies, facilities and professionals [are] accountable to a specific public authority, which should ensure, inter alia, frequent inspections comprising both scheduled and unannounced visits, involving discussion with and observation of the staff and children' (§128).

The provisions for inspections – though limited (§128 to §129) – build on the requirements for effective authorisation of facilities.⁵ Inspections thus form an essential component of an independent monitoring mechanism that includes regular reviews of facilities to ensure that they meet basic quality standards. Evidence from the research suggests that systems for inspections and monitoring were largely non-existent or ineffective.

According to the Guidelines, in order to effectively monitor residential care, criteria and standards need to be established, along with a competent and responsible authority.

² According to child protection actors in the country.

³ Referenced to the *Institutional Care Assessment Situation Analysis Report*, Dar es Salaam: Department of Social Welfare, 2011.

⁴ Moving Forward, p.108.

⁵ Ibid.

There was evidence that standards for monitoring and inspection were present in many of the countries, but that the ability of the authorities to monitor and inspect compliance was limited.

In **Zambia**, guidelines were in place for the accreditation and licensing of facilities and checking basic standards of staffing and quality of accommodation and care, but these regulations were difficult to enforce given limited financial and human resources.

The lack of coordination between agencies and absence of resources for ensuring frequent inspections and accountability were recurring themes throughout the reports.

The Guidelines highlight that inspections should be 'frequent... comprising both scheduled and unannounced visits' (§128). In some cases, residential care was subject to regular monitoring and inspection – including impromptu inspections. However, across the region, countries reported a lack of effective inspections.

In **Kenya**, although the law mandates inspections, a lack of resources at the district level meant that it was a challenge to conduct regular reviews. This also affected the ability of officers to follow up on reviews once they had been conducted to ensure that recommendations for improvement were implemented.

In **Malawi**, there were serious concerns over the frequency of inspections, despite regulations that require the authorities to visit registered facilities twice a year – with or without prior notice. For example, according to a 2012 report, only 32% of registered private residential facilities were inspected.⁶ Reports from officers suggested that this was due to lack of financial resources, making the quarterly visits impossible. Again, lack of resources meant that follow-up was difficult and, where facilities were found lacking and recommended for closure, no alternative placements were available.

In **Tanzania** and **Togo**, it was reported that there were no effective systems for monitoring residential care. In **Togo**, occasional inspections had provided evidence that many facilities failed to meet the standards: in one region of the 12 facilities on the official list, only one was found to be at an acceptable standard.

Under the Guidelines (§105), failing to register alternative care provision should be 'an offence punishable by law'. The authorisation to work should also be 'regularly reviewed by the competent authorities on the basis of standard criteria'.

There was no evidence from the country reports that unregistered facilities were subject to legal sanctions: on the contrary, large numbers of unregistered facilities

were functioning openly without authorisation or government oversight.

There was also evidence that even organisations that succeeded in registering the first time were often not reviewed regularly to ensure that they continued to meet standard criteria. In **Malawi**, it was reported that registration was supposed to be reviewed every two years, but organisations were rarely followed up or required to renew their licences.⁷

As a result, there appeared to be a group of unregistered facilities working with children. They were largely unknown to the authorities and, as a consequence, the quality of care they offered to children was also unknown. This puts children at considerable risk without any of the formal channels for child protection available to them (discussed in more detail in chapter 6).

The lack of control over the establishment of residential care facilities and poor inspection and monitoring fail to protect children from organisations that may operate for reasons other than the best interests of the child.

According to the Guidelines (§20), alternative care should not be undertaken to further 'political, religious or economic goals', and the financing of care provision should not 'encourage a child's unnecessary placement or prolonged stay in care arrangements' (§108).

In **Malawi**, cases were reported of facilities failing to release children from their care on financial grounds,⁸ and unregistered facilities 'recruiting' children from local communities to increase the donor funds allocated to them. In **Kenya**, where inspections supported closing facilities, slow legal processes meant that children remained in unsuitable care even after the competent authorities had inspected them and there were concerns that, where inspections fail, institutions may be used as a source and transit point for child trafficking.

6 Malawi Human Rights Commission: <http://www.hrcmalawi.org/>.

7 Reported by the Samaritan Trust.

8 Reported by the Malawi Council of Churches.

3.2.3

FINANCING ALTERNATIVE CARE

Adequate levels of financing are essential for the provision of good quality alternative care. This is emphasised in the Guidelines, which state that governments should provide finance to the 'maximum extent' that they can (§24).

Providing appropriate financing for alternative care indicates state leadership on the wellbeing of children. The African Report on Well-being states that 'a government that is child-friendly is more likely to commit itself to allocated budgets to children, and to ensuring positive outcomes through appropriate laws'.⁹

Financing of alternative care is about more than the resourcing of alternative care provision. It is also about ensuring that funding arrangements comply with the 'necessity' and 'suitability' principles contained in the Guidelines.¹⁰ These require resources to be allocated to support families so that children do not require formal care (the 'necessity' principle). However, where children do require formal care, adequate resources should also be provided to ensure children's wellbeing (the 'suitability' principle). Financing of alternative care should be influenced by both principles.

The Guidelines indicate that there can be some challenges in financing alternative care, which states need to take into account. The resourcing of formal care through donors and government funding can lead to inappropriate placements in order to maintain or expand numbers in care arrangements (see §20 which states that there should be a ban on alternative care services for economic goals and §127 which outlines a prohibition on actively procuring children for care in residential facilities). Alternative care financing should therefore focus on the wellbeing of children rather than economic benefits for services.

The global economic context is also impacting on financing alternative care (see chapter 2). The country reports highlighted that there was a decline in funding from overseas donors. This is challenging for states where resourcing for alternative care is heavily reliant on this form of support.

Arrangements for financing alternative care

Funding of alternative care was provided by a range of organisations: states at national or local level; in-country or foreign and international NGOs; religious organisations; private donors and commercial income.

Across all the eight countries, financing of care was identified as a significant area of concern with all reports highlighting that there was state underfunding of alternative care. In **Zambia**, funding levels were poor and there were



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scarce resources at the district level. In **Gambia**, there was limited support from the state for child care which, in turn, made it difficult for the state to ensure that alternative care facilities were compliant with national standards. In **Malawi**, a lack of funding impacted at national and local levels with concerns expressed about the lack of financing of alternative care in comparison with other ministerial areas such as education and agriculture. Financial allocations to the responsible ministry had fluctuated in the past four years.

Foreign and international agencies and private donors provided substantial levels of funding to all the countries. In **Gambia**, the majority of care providers received funding or support through international donors who mostly financed their day-to-day operations. In **Kenya**, private residential facilities were managed and fully funded by non-state actors with government funding of public residential facilities. The role of international agencies and donors was therefore significant in financing alternative care.

This level of funding also gave rise to concerns due to changing demands and less funding being available from donors. In **Zambia**, there was dwindling support from foreign institutions with consequent implications for alternative care provision. On the other hand, needs were changing with a resulting increasing in demand for provision.

⁹ African Child Policy Forum, *The African Report on Well-being: Child Budgeting for Children*, Addis Ababa: The African Child Policy Forum, 2011, p.28.

¹⁰ Moving Forward, p.104.

In **Tanzania**, it was pointed out that there was a need for additional resources. In **Gambia**, it was recommended that collaboration with other stakeholders in financing care was essential for the state to improve the alternative care system. States were not always sufficiently involved in providing oversight of financing by out-of-country agencies, however. Both the **Gambia** and **Kenya** country reports called for more effective government monitoring and oversight of the financing of alternative care.

In addition to overall budgets for alternative care, the reports identified limited resources for specific alternative care options, such as residential care, foster care, aftercare and family support. In **Malawi**, there was no budget allocation to prevent family breakdown. In **Zambia**, there was limited state funding for residential care and foster care. In **Kenya**, there was no state funding of foster care. There was inadequate financial support for aftercare in **Malawi** with most publicly funded facilities not providing post-care support. Similarly, there were no resources for children returning from care in **Zambia**. Where these gaps were not filled by other funders, this meant an absence of provision in these areas.

Overall, the country reports called for an increase in state financing of alternative care in the face of the demands on services due to low levels of funding and the increasing needs of children and their families. Where countries were heavily reliant on non-state actors for funding, there were challenges in ensuring adequate resourcing because of declining contributions from donors. Better government coordination, monitoring and oversight of these non-state financial arrangements were needed in order to make sure that resources were used for appropriate purposes and could meet the needs of children.

3.2.4

AVAILABILITY OF DATA

The Guidelines point out that alternative care should be informed by the collection and analysis of data and information on alternative care in order to ensure evidence-based approaches to the implementation of policy (§69 and §70). Having access to robust evidence can inform planning, resource allocation, implementation and reviewing of alternative provision and the needs of children and their families.

Moving Forward highlights ways in which states can support evidence-based approaches to policy-making. These include:

- The regular collection and analysis of data on children who need alternative care and are at risk of being placed in care.
- Data collection should include detail on care settings, disaggregated information on age and gender, and length of stay.
- Collaboration with others to implement an information system that is used by all providers.
- Collecting data on factors which may lead to children being placed in care.
- Protecting the confidentiality of children and families when sharing information.¹¹





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Data collection

Data collection was identified as a challenging area for all of the countries. This was reflected in the lack of consistent and systematically collected information available in the region. Across the reports, there was an absence of detailed information on which children were at risk of being placed in care or were placed in informal or formal alternative care.

Where this information was available, it did not consistently provide detail about the population of children in alternative care, specifically their age and gender. In **Zambia** and **Malawi**, for example, the reports stated that there was a lack of data that disaggregated the different populations of children. Without this, states have insufficient information to plan services. Having this information can help to identify specific needs and provide tools for monitoring and evaluation of alternative care.

There was an absence of data on the numbers of children placed in informal care with little information available on who children were living with in informal arrangements (see chapter 5.2). Although there was some data collected on formal care, specifically residential care, there was a lack of detailed data across the different formal care options. This included residential homes, but also family-based care such as foster care or formal kinship care, where there was little up to date information available (see also chapter 5.2 and chapter 5.3).

The reports highlight areas where better data collection would be helpful across all the countries. In **Malawi** and **Kenya**, there was a need for information on children in foster care. In **Gambia**, there was insufficient information available on which children required care. There was not a systematic collection of information in **Zimbabwe**, **Benin** or **Togo**. In **Kenya**, there was a need to strengthen data collection in order to develop a national databank on aspects of care, as the lack of systematic and regular data collection meant that the government was not sufficiently informed to take adequate measures to protect children. In **Tanzania**, it was recommended that data should be collected at village, ward, district, regional and national levels using agreed national data collection tools.

These examples demonstrate that all the countries faced challenges in collecting data in line with the Guidelines. The absence of this information inhibited effective planning, policy development, and provision of services. Without adequate information, it was not possible to monitor and measure the effectiveness of provision for children and their families.

3.3.

CONCLUSION

This chapter has explored central issues that impact on policy-making and provision in alternative care across the eight countries: appropriate state coordination, state oversight and monitoring, the availability of resources for alternative care, and the availability of data on alternative care.

These have a major influence on the capacity of states and non-state actors to deliver support to families and alternative care that meets the needs of children and encompasses a wide range of areas. Although there was effective and developing state policy and practice, there were also significant challenges across the region in ensuring that these elements were in place to support alternative care. These could be summarised as the following:

Governments faced major challenges in their leadership role across the region with inconsistent policy implementation and coordination of alternative care. The oversight and monitoring function of an independent body with delegated state powers was effectively absent in the countries surveyed. It was difficult to discern any effective or comprehensive systems for either: (a) registration, accreditation and licencing of facilities, or (b) inspecting and monitoring standards.

The failure to put in place effective oversight mechanisms to ensure that facilities are working in the best interests of the child, and that they have adequate standards for their safety and wellbeing, places children at considerable risk of harm and poor quality of care.

The current financing of alternative care was not sufficient to meet the needs of children and the services that supported them. Non-state actors contributed significant levels of financial resources yet there were challenges associated with relying on this financing due to the difficult global economic context and the changing priorities of donors.

There was a lack of information and availability of data. Information was not systematically collected and was not disaggregated by age, gender, disability or other circumstances. This lack of data meant that there could only be a partial understanding of the circumstances of children and their families and the provision of services and monitoring across the region.

Solution-based recommendations:

The reports highlight that there needs to be further action taken to ensure that alternative care is adequately supported through effective oversight and monitoring, financing, information gathering, relationships with non-state actors and policy implementation.

In order to do this, the reports suggested that there should be: the development of more effective strategic relationships between states and non-state actors; further attention given to the implementation of national policy at local level; more effective and independent monitoring and inspection processes; better financing of alternative care; and more effective collection and monitoring of evidence and data relating to children, families and alternative care.

State coordination

- States should provide leadership to ensure the coordination and oversight of all matters relating to alternative care.
- States should review legislation and policy guidance to ensure that it is appropriately implemented at district or local level.
- States should ensure that all alternative care policy reflects the Guidelines and international conventions such as the UNCRC and the ACRWC.
- States should ensure that the contributions of non-state actors in service provision, technical support and financing are monitored in order to assess current support and future sustainability.

Oversight and monitoring

- States should ensure that all facilities operating and caring for children are required to meet care standards. They should be registered and apply for accreditation and licences to operate. All accreditation should be subject to review and monitoring processes.
- States should ensure that an independent competent authority regularly assesses all alternative care provision standards according to set criteria. States should provide the competent authority with the resources to conduct regular visits.
- States should ensure that facilities that do not meet the required standards are first provided with guidance on their shortcomings and, where appropriate, assistance to improve their services. Failure to meet required standards within a reasonable set time period should result in loss of authorisation to operate.
- Where standards are such that a care provider's accredited status and licence is revoked, states should provide for sanctions for the care provider, and appropriate alternative care placements for the children affected should be found.

Roadmap to the oversight of children at risk and children in alternative care

1

MAP ALL PROVIDERS AND FACILITIES

2

APPOINT CENTRAL BODY FOR OVERSIGHT OF ALTERNATIVE CARE

3

CREATE A CYCLICAL INSPECTION MECHANISM

4

ESTABLISH CRITERIA FOR AUTHORISING CARE PROVIDERS AND PROCESS ALL THOSE IDENTIFIED

5

INITIATE A FORMAL GATEKEEPING MECHANISM

(ensuring all new arrivals are registered and departures recorded with the state body)

6

ESTABLISH AN INDEPENDENT COMPLAINTS MECHANISM FOR CHILDREN



Financial resourcing of alternative care

- States should ensure national budgets for child care provide adequate support to families so that children do not enter formal alternative care where it is not necessary. This support should include cash transfer schemes for families, including those providing informal care, where needed, as well as other preventive support to families.
- States should ensure that national budgets can adequately support alternative care provision where children need this form of support in line with the principles of the Guidelines.
- Donors should ensure that they contribute responsibly to alternative care by providing adequate, predictable and sustainable funding.
- More funding should be available to support district or local children's services so that they are able to discharge their statutory duties in relation to children's wellbeing.

Availability of data

- States should strengthen data collection in order to systematically gather information on the population of children in both informal and formal care. This should include the collection of data on family risk factors so that it can be used as a basis to develop policies and services for vulnerable families.
- States should ensure that they collect data on the range of care options that are provided (for example, availability of fostering and residential homes and which organisations provide these services).
- States should ensure that information is gathered about admission processes, placement capacity, staff capacity, care planning and reviews, and child participation in order to monitor and review the provision of alternative care.
- States should ensure that they gather evidence on the effectiveness of different forms of family support and care options in order to inform policy development and service provision.

4

Prevention: Preventing unnecessary alternative care

4.1 INTRODUCTION

4.2 CONCEPTS AND DEFINITIONS

4.3 ANALYSIS

- 4.3.1 Causes of alternative care
- 4.3.2 Primary level of prevention
- 4.3.3 Secondary level of prevention
- 4.3.4 Tertiary level of prevention

4.4 CONCLUSION

4. PREVENTION: PREVENTING UNNECESSARY ALTERNATIVE CARE

4.1 INTRODUCTION

The Guidelines emphasise the need to prevent children entering alternative care whenever possible. This is based on the understanding that children are usually better cared for in their own homes, with kin, and within their communities.

Preventive measures are driven by the 'necessity' principle, which aims to ensure that children only enter alternative care when such provision is necessary. This implies that there is an effective 'gatekeeping' mechanism in place that is 'capable of ensuring that children are admitted to the alternative care system only if all possible means of keeping them with their parents or wider (extended) family have been examined'.¹

This chapter considers the services that are available in the region to prevent the unnecessary admission of children into alternative care. This involves activities aimed at 'combat[ing] the factors that contribute to family breakdown'.² A focus on prevention acknowledges the concern that there are many children in alternative care who do not necessarily need to be there: with adequate support,

it would be possible for them to remain with or return to their parents.

Key messages:

- State involvement in preventing alternative care was inadequate because of limited resources (financial and human). Lack of data also hindered planning and development of initiatives. Most programmes in the region were financed by development partners and were therefore not well coordinated.
- Interventions focused on prevention were characterised by inconsistent quality and low geographical coverage. There was also a lack of, or limited, supervision and coordination at state, district and local levels.

Guidelines for the Alternative Care of Children
Preventing the need for alternative care: Section IV
Promoting parental care: §32-38
Preventing family separation: §39-48
Promoting family reintegration: §49-52



¹ Moving Forward, p.22.
² Moving Forward, p.50.

4.2 CONCEPTS AND DEFINITIONS

Prevention refers to policies, principles and practices that are used to avoid the need to place a child in alternative care.

The Guidelines highlight the importance of ensuring that there is national policy and resources to support interventions which prevent the need for children to be separated unnecessarily from their families. Interventions that ensure the 'necessity' principle is upheld and promote parental care include the following initiatives: family strengthening, supportive social services and empowering youth (§32 to §38), preventing family separation (§39 to §48) and promoting family reintegration (§49 to §52).

The Guidelines highlight three levels of prevention which are discussed in this chapter:

- **Primary level of prevention** ensures the general population's access to basic services, social justice and the protection of rights without discrimination.
- **Secondary level of prevention** ensures that safety nets are targeted at individuals, families and groups who are identified as, or have declared themselves to be, vulnerable and for whom primary prevention measures have proved inadequate.
- **Tertiary level prevention** refers to actions taken in cases where neither primary nor secondary levels of prevention have been successful in making entry into the alternative care system unavoidable. In this case, prevention is aimed at returning a child in alternative care to the care of his or her parents whenever possible, promoting reintegration of the child under appropriate conditions, and preventing a return to alternative care.³

4.3 ANALYSIS

4.3.1 CAUSES OF ALTERNATIVE CARE

In order to design effective prevention mechanisms, it is important to understand the root causes that lead children into alternative care. The Guidelines require states to address these root causes (§32).

Some of these causes have been elaborated in the regional context section (chapter 2) – high levels of poverty and HIV/AIDS, in particular, are seen as contextual problems surrounding the entry of children into alternative care. Other causes of children entering alternative care include child protection concerns and rights violations.

Poverty and lack of basic needs

The Guidelines are clear that states should pursue policies that ensure access to adequate housing and basic health, education and social welfare services, as well as promoting measures to combat poverty (§32). As emphasised in chapter 2, however, the region is characterised by high levels of poverty.

Although it is clear that poverty should never be the sole justification for placing children in alternative care (§15), there is evidence from the reports that household poverty and the lack of basic needs is one of the major causes of children entering alternative care.

HIV/AIDS

The Guidelines require that states should provide children living with, or affected by, HIV/AIDS with appropriate care and protection to prevent them from being separated from their parents (§9b). States should tackle discrimination on the basis of HIV/AIDS status of children and their parents (§10), and children with HIV/AIDS should be provided with the right to develop (§86 and §117).

As highlighted in chapter 2, rates of HIV/AIDS are high in the region and can leave children vulnerable to alternative care through the death of their parents (direct effect) or its influence on increasing poverty in the family (indirect effect).

3 Moving Forward, pp.50-65.

Child rights violations

Child right violations include discrimination, marginalisation, stigmatisation, violence, child maltreatment, child trafficking, child labour, sexual abuse, and substance abuse.

The Guidelines highlight that states should pursue policies that reduce various forms of discrimination and abuses of children (§32 and §10); single and adolescent parents should be supported (§36); and families should be empowered with attitudes, skills, capacities and tools to enable them to provide adequately for the protection, care and development of their children (§36).

CHILDREN WITH DISABILITIES

Disability is one of the major causes for children being placed in alternative care. Children with disabilities may be discriminated against by parents, friends, and relations and in their communities. Parents that have a disability may face problems in providing quality care if they are not supported. Unfortunately, few country case studies reported programmes that aimed at preventing alternative care in light of disability to either parents or children.

There was also limited evidence that adequate provision was made for children with disabilities once they were admitted into formal alternative care.

In Zimbabwe the Children's Act states that children who have a mental or physical disability are in need and require treatment, training or facilities when the parents or guardian are unable to provide support.

4.3.2

PRIMARY LEVEL OF PREVENTION

Although the reports did not comprehensively deal with the provision of basic services, one primary level of prevention that was highlighted consistently was the lack of registration of children to ensure governments' awareness of their child population and their specific needs.

Birth registration

The Guidelines assert the fundamental requirement that states register all children at birth as a way of preventing alternative care (§32). There are similar provisions in Article 7(1) of the UNCRC and Article 6(2) of the ACRWC.

Despite these commitments, the failure to register children – providing them with birth certificates and collecting information about their needs and vulnerabilities – was identified across the reports as a major impediment to preventing alternative care and establishing effective child protection mechanisms.

Birth registration is a fundamental step towards good governance.⁴ Children who are not registered are vulnerable to countless possible human rights violations and, as they are not counted, it is impossible for governments to effectively plan and provide the necessary support for them and their families.

Despite the importance attributed to birth registration by international treaties, progress in achieving universal birth registration has been very slow. The table below shows the status of birth registration in the studied countries.

Birth registration: Percentage of children registered between 2005 and 2011

Country	Percentage of children registered between 2005 and 2011
Benin	60%
Gambia	53%
Kenya	60%
Malawi	no data
Togo	78%
Tanzania	16%
Zambia	14%
Zimbabwe	49%

Source: State of the World's Children Report 2013 (Table 9)

⁴ Marta Santos Pais, *Birth Registration: Right From The Start*, Florence: UNICEF, 2002.

Zambia had the lowest birth registration rate of the countries studied with only 14% of children under 5 registered.



Source: www.childinfo.org/tables/BirthRegistration_2013.xlsx.

Weaknesses in child registration were recorded across the region. Children in alternative care appeared to be less likely than average to be registered legally, with registration varying according to region.

In **Benin**, up to 78% of children in residential care centres were recorded as being without legal status in 2011.⁵ In **Zimbabwe**, in 2009, it was estimated that 45% of children in urban areas and 70% of children in rural areas did not have birth certificates.⁶ **Zambia** had the lowest birth registration rate of the countries studied with only 14% of children under five registered.⁷

The reasons for lack of birth registration differ according to the socio-political context in each country. However, lack of resources for the responsible authorities was a major reason why governments were unable to comply with their commitments to register all children.⁸

In **Zimbabwe**, a number of challenges to obtaining registration and birth certificates were raised, despite

the existence of the Births and Deaths Registration Act. These included excessive bureaucracy; the lack of local registration points requiring parents to travel long distances to register their children; the limited understanding by families and communities, especially in rural areas, of the importance of registration; and the migration tendencies of foreign farm labourers who did not possess formal Zimbabwean registration papers. As a result, the report claimed that there is a whole generation of unregistered children.

The low levels of birth registration in the region may lead to uninformed service planning and development, and restrict the ability of parents to access appropriate services and support.

⁵ Referenced as *Studies about Norms and Standards in Child Protection Centres in Benin*, 2011.

⁶ No external reference provided, estimates.

⁷ See: www.childinfo.org/tables/BirthRegistration_2013.xlsx.

⁸ Plan International, *Universal Birth Registration: Permanent Proof of Identity in a Turbulent World*, Woking: Plan International, 2005.

4.3.3

SECONDARY LEVEL OF PREVENTION

This section focuses on the social safety nets available that are targeted at families and groups who have been identified as vulnerable and for whom primary prevention measures have proven inadequate. The reports identified three types of secondary level support: social protection programmes, family strengthening programmes, and supportive social services.

Social protection programmes

To ensure that poverty is not the primary reason for removing children from parental care (§15), states are required to provide families with opportunities for employment and income generation (§34a). This is meant to enable parents to provide adequately for the protection, care and development of their children.

Social protection programmes in the region took different forms, but supported vulnerable groups with cash and materials, or provided resources for a specific service such as school fees or medical care. These were provided in the form of social cash transfers or other safety net

programmes and were mostly funded by national governments and their development partners.

In **Zambia**, the social cash transfer programme targeted family-based support to those with challenges such as widowhood, old age, orphaned/vulnerable children, illness, and disability. There was also a public welfare assistance scheme which targeted those facing destitution, vulnerability or poverty through in-kind support, and a social protection fund targeting households that needed start-up capital for new ventures.

In **Benin**, the Ministry for the Family implemented the support fund for national solidarity and social action that provided support for emergency assistance, assistance for the poor, medical care, assistance for needy children, and child care for families with multiple births, such as triplets.

Social protection interventions in **Zimbabwe** included the basic education assistance module, which provided education funding for poverty alleviation programmes, the AMTO (assisting citizens to pay for medical expenses), and the cash transfer programme that was offered under the National Action Plan for orphaned and vulnerable children.

In **Malawi**, the social cash transfer programme provided small cash grants to ultra-poor households without any able-bodied adult household members.



Social protection programmes were increasingly receiving additional support. For example, cash transfers to orphaned and vulnerable children in **Kenya** increased from 500 households in 2004 to 144,829 households in 2012 and the number of districts increased from 10 in 2005 to 36 in 2012.⁹ The social cash transfer programme in **Malawi** increased coverage from one district (Mchinji) in 2006 to seven districts in 2013, and reached over 26,000 households.¹⁰ Plans were already in place in **Togo** to reach up to 8,000 children in 81 villages by 2013 with social cash transfers.¹¹

One of the common challenges in the region was that, despite significant need for these forms of support, national governments had not allocated sufficient resources to these programmes due to limited resources at their disposal.

In almost all countries where the social cash transfer programmes were implemented, the programmes were highly dependent on financial resources provided by donors. This threatens the sustainability of the programmes and it is necessary to encourage national governments to come up with sustainable financing strategies.

Family strengthening programmes

The Guidelines require that state policies and practices should aim at keeping children in, or return them to, their families (§2a, §3, §11, §14, §15, §44, §155, §156). Siblings who have lost their parents or caregivers and choose to remain together in their household should be supported with services (§37) and states should develop and implement policies that promote and strengthen parents' ability to care for children (§32 to §34).

In most of the countries, governments had put in place frameworks and policies for the provision of family strengthening programmes but there were weak implementation arrangements in making these a reality.

In **Tanzania**, parents could access parenting education by attending meetings, workshops and seminars at schools, NGOs, private sector organisations and work places, but it was emphasised that more work was needed to mainstream this provision. The **Malawi** Council of Churches ran marriage counselling programmes and provided informal counselling services through traditional marriage counsellors. As there was no data on their success, however, the extent to which the traditional system strengthens families is unknown.¹²

SOS Children's Villages and Terres des Hommes provided family strengthening services in **Benin**. SOS Children's Villages ran the Family of Origin programme that supported 700 children in their biological families. In **Togo**, SOS

Children's Villages, Plan Togo, Borne Fonden, Terre des Hommes and the International Catholic Child Bureau also ran family strengthening programmes.

Common challenges for the implementation of the family strengthening interventions included the uncoordinated ways in which these interventions were implemented and low levels of financing, which was largely from external sources to the government. This was highlighted specifically in the **Tanzania** report.¹³

Providing supportive social services

The Guidelines highlight that states should provide supportive social services for recipients, families, and communities in order to support parents with their responsibilities (§34b and §38). In addition, states should base decisions regarding removal or reintegration of children on proper and professional criteria for assessing the family's actual and potential capacity to care for the child (§39 to §40).

Supportive social services (or children and family services) aim to reduce the perceived need for alternative care. Interventions that can be implemented include the provision of day care, mediation and conciliation services, substance abuse treatment, financial assistance and services for parents and children with disabilities.

States are required to ensure that a comprehensive assessment process is put in place so that families can be supported in areas where it is needed from services such as health, social welfare, housing, justice and education.¹⁴

Supportive services mentioned in the reports included day care centres, conflict resolution services and mediation. In **Malawi**, the day care centres were available nationwide but mainly in the urban areas and mostly provided by the private sector.¹⁵ A similar situation existed in **Tanzania** and **Kenya**.

Conflict resolution services in **Tanzania** were provided by community development officers. The Child Care, Protection and Justice Act in **Malawi** provided parents and children with the opportunity to undergo counselling in order to prevent separation or, indeed, reverse it where it has already occurred.

The level of provision of family support services in the region was low. The lack of state involvement undermined the quality and sustainability of the services. This was mainly attributed to the lack of funding and data collection on the needs of vulnerable children which could consequently inform planning and the development of appropriate services.

9 Referenced to the OVC programme.

10 Referenced to *Weekend Nation*, 2013.

11 No external reference provided.

12 Referenced to the Malawi Council of Churches.

13 Referenced to REPOA, NBS and UNICEF, *Childhood Poverty in Tanzania: Deprivations and Disparities in Child Well-Being*, Dar es Salaam: REPOA, NBS and UNICEF, 2009.

14 Moving Forward, p.55.

15 Referenced to UNICEF, 2011.

4.3.4

TERTIARY LEVEL OF PREVENTION

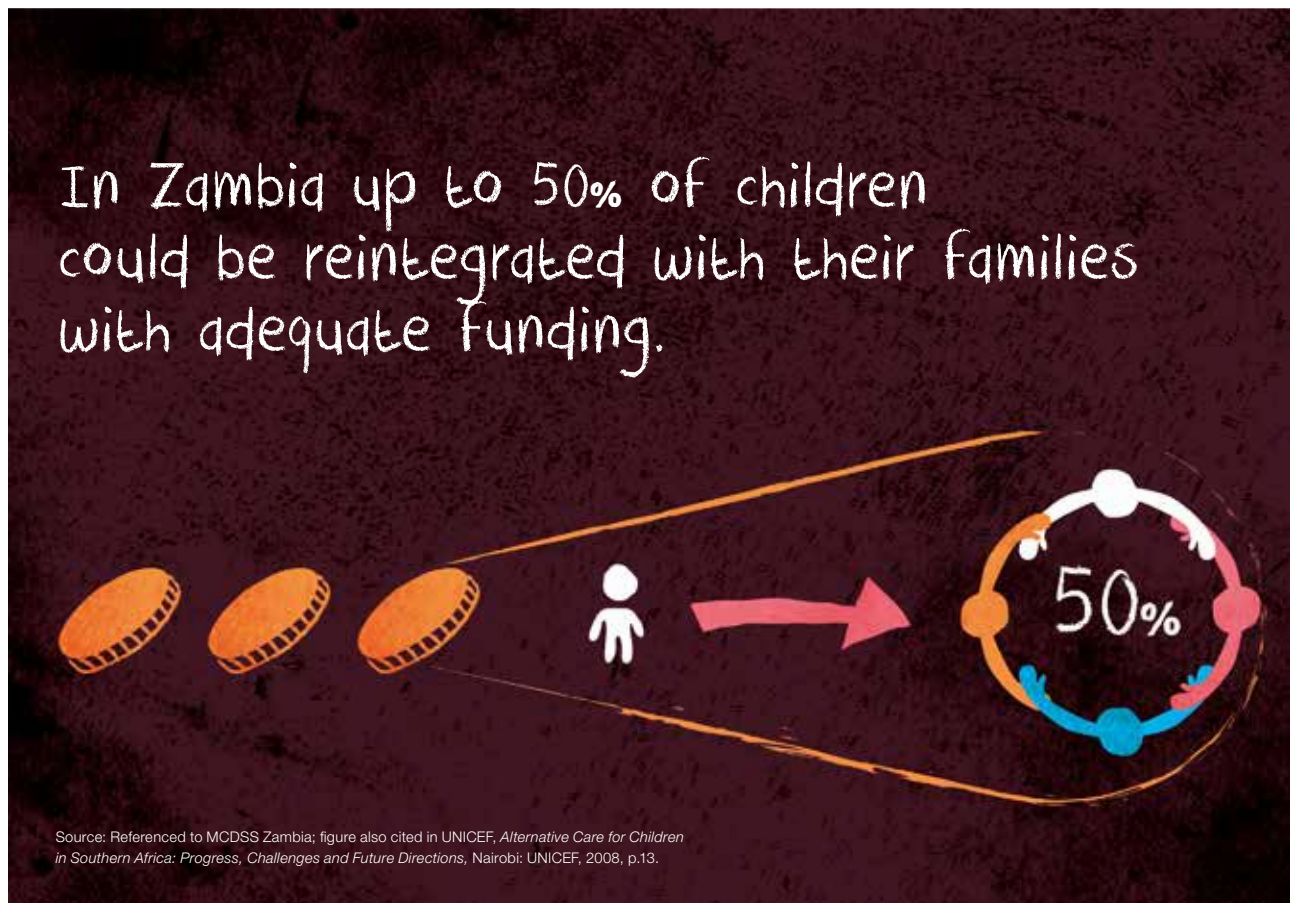
Promoting family reintegration

The Guidelines state that efforts should be made to return children to their families from alternative care (§2a and §3); the removal of a child from home should, where possible, be temporary (§14, §60 and §123); and proper procedures should be followed in order to return the child to his/her family (§49 to §52).

Family reintegration aims to return a child in alternative care to his or her parents wherever possible, at an appropriate moment, and under appropriate conditions.¹⁶ Proper reintegration can also assist in preventing future placements of the child into alternative care.

In **Togo**, the Center for Reference, Guidance and Care for Children in Difficult Situations set up a mobile team organising mediation between caregivers or parents and children to facilitate family reintegration. In **Malawi**, family reintegration is supposed to be coordinated through the Ministry of Gender. Although non-governmental organisations carried out home assessments to assist in the reintegration of children, there was no system to monitor this.¹⁷ Similarly, the Africa KidSAFE Network, in collaboration with the **Zambian** government, reintegrated 1,000 street children between 2004 and 2010.¹⁸

Non-existent or limited resources were highlighted as the major challenge across the reports. In **Zambia**, social work staff reported that 50% of children in one region could be reintegrated if the proper funds were available.¹⁹ Reintegration efforts were also hampered by the failure to collect adequate data on children so that it was sometimes difficult to locate their families in order to reunite them.



¹⁶ Moving Forward, p.62.

¹⁷ Referenced to Malawi Human Rights Commission.

¹⁸ Referenced to Africa KidSAFE Alliance for Street Children in Zambia, *Quarterly Program Performance Report Cooperative Agreement No. 690-A-00-04-00343-00*, Project Concern International, 1 April 1 to 30 June 2010.

¹⁹ Referenced to MCDSS Zambia; figure also cited in UNICEF, *Alternative Care for Children in Southern Africa: Progress, Challenges and Future Directions*, Nairobi: UNICEF, 2008, p.13.

Roadmap to Prevention: preventing the alternative care of children

1

ESTABLISH SUFFICIENT POLICY AND LAW FOR ALL PREVENTION SERVICES

Ask UNICEF and the international community for support where necessary

2

MAP ALL PROVIDERS OF PREVENTION SERVICES

3

MAKE ALL MAPPING DATA AVAILABLE TO NATIONAL STATISTICAL AGENCIES SO ALL ACTORS MAY ACCESS THE INFORMATION

4

PROVIDE STATE GUIDELINES FOR THE DELIVERY OF PREVENTION SERVICES AND OFFER CONTINUING TRAINING

5

COORDINATE ALL ACTORS TO ENSURE A GOOD GEOGRAPHICAL SPREAD OF SERVICES



The ‘necessity’ principle asserts that state governments and stakeholders should prioritise preventing alternative care. Evidence from the eight Sub-Saharan African countries suggests that most countries were aware of the principle demonstrated in the legislation and policy had been developed (see chapter 2).

However, implementation of preventive approaches is inconsistent and often promoted by non-governmental organisations rather than coordinated through the state. The lack of state involvement in planning, coordinating and funding preventive measures means that there is an uneven distribution of preventive services and support across geographical areas, as well as a lack of data for monitoring and evaluating interventions.

Solution-based recommendations:

- States should design sustainable financing strategies for prevention of alternative care. These could be supported through proactive efforts to make sure that adequate allocations have been made in national budgets and in coordination with donors and other stakeholders.
- States that do not have legal frameworks and policies that explicitly tackle prevention of alternative care for children should develop legislation and guidance in line with the Guidelines.
- States should design policies and provide resources to increase rates of birth registration in order to ensure that every child is counted. In turn, effective support services can be designed to prevent the need for alternative care.
- State agencies that are mandated with the implementation of prevention activities should coordinate and support non-state agencies that are implementing such programmes. This state support can be in the form of producing policy guidance on prevention including, for example, training for providers and general oversight of these or similar programmes.
- All care providers must undertake a responsibility to provide support to reintegrated families when children return home from alternative care.
- States should ensure that families and children’s voices are fully integrated into the development of such policies and programmes in order to ensure eventual independence rather than creating a culture of dependency.
- States should develop effective data collection and management systems for prevention of alternative care and these systems should be supported by adequate financial and human resources. National statistical agencies should collaborate with implementing agencies to understand data needs.

5

Provision: Providing suitable alternative care



5.1 DECISION-MAKING

- 5.1.1 Introduction
- 5.1.2 Concepts and definitions
- 5.1.3 Analysis
 - » Range of placements
 - » Decision-making in the best interests of the child
 - » Participation of children and families
- 5.1.4 Conclusion

5.2 INFORMAL CARE, FORMAL FAMILY-BASED CARE AND PRE-ADOPTION

- 5.2.1 Introduction
- 5.2.2 Concepts and definitions
- 5.2.3 Analysis
 - » Extent of informal care and its challenges
 - » Extent of formal family-based care and its challenges
 - » Extent of adoption and its challenges
 - » Participation
- 5.2.4 Conclusion

5.3 RESIDENTIAL CARE

- 5.3.1 Introduction
- 5.3.2 Concepts and definitions
 - » Residential care versus institutional care
 - » Institutional care and child development
- 5.3.3 Analysis
 - » Deinstitutionalisation
 - » Standards for residential care
 - » Staff qualifications and recruitment
- 5.3.4 Conclusion

5.4 LEAVING CARE AND AFTERCARE SUPPORT

- 5.4.1 Introduction
- 5.4.2 Concepts and definitions
- 5.4.3 Analysis
 - » Planning and preparation
 - » Provision of support
 - » Follow up and monitoring
- 5.4.4 Conclusion

5.1

Decision-making: Gatekeeping & ensuring ongoing suitable care for children

5.1.1 Introduction

5.1.2 Concepts and definitions

5.1.3 Analysis

Range of placements

Decision-making in the best interests of the child

Participation of children and families

5.1.4 Conclusion



5.1 DECISION-MAKING: GATEKEEPING AND ENSURING ONGOING SUITABLE CARE FOR CHILDREN

5.1.1 INTRODUCTION

The decision-making process for alternative care under the Guidelines is led by the principles of ‘necessity’ and ‘suitability’.¹

These principles establish first whether alternative care is necessary, or ‘genuinely needed’.² The Guidelines are clear that poverty, for example, should never be the sole reason for removing children from parental care (§15). Instead, they place emphasis on the provision of measures to prevent the ‘situations and conditions that can lead to alternative care being foreseen or required’.³ These prevention measures are discussed in more detail in chapter 4.

Ensuring that alternative care is necessary also implies that there is a ‘gatekeeping’ mechanism in place to ensure that all possible alternatives to removal from the family unit or the extended family have been considered. These procedures should ensure that referrals are screened, assessed for need, and that placements are authorised by a competent authority.⁴

According to the Guidelines, gatekeeping mechanisms and decision-making processes should be guided by the principle of suitability. This means that care must be ‘provided in an appropriate way’.⁵ In addition to the assessment, authorisation and licensing of appropriate alternative care facilities (discussed in more detail in chapter 3), this entails ‘matching the care setting with the individual child concerned’.⁶

This chapter focuses on the decision-making that surrounds the processes ensuring that alternative care placements are ‘suitable’ for children. The assessment is based on three criteria: the provision of alternative care placements that enable choice; the use of the ‘best interests of the child’ principle in making decisions to exercise that ‘choice’ from admissions through reviews and finally exiting the alternative care system; and the participation of children and their principal carers in these decision-making processes.

1 See Moving Forward, pp.22-29.

2 Moving Forward, p.22.

3 Ibid.

4 Moving Forward, p.16.

5 Moving Forward, p.22.

6 Ibid.



5.1.2

CONCEPTS AND DEFINITIONS

The Guidelines state that decisions on the placement of children should be made on the basis of the 'best interests of the child', and that 'the most suitable forms of alternative care are identified and provided, under conditions that promote the child's full and harmonious development' (§2).

In the decision-making process, the Guidelines are clear that decisions should be made on a case-by-case basis in conformity with the principle of non-discrimination (§6), with consideration of the 'child's personal and developmental characteristics, ethnic, cultural, linguistic and religious background, family and social environment, medical history and any special needs' (§58).

In determining the most appropriate form of care for children, the Guidelines recommend decision-making to be led by a competent authority (§57) with legal safeguards, including the right of all parties to adequate information and participation in the process and the right to make representations (§66).

This implies that there is a range of options to choose from, including provision for emergency, short-term and long-term care (§54). The Guidelines specifically emphasise that these choices should prioritise 'family and community-based' provision (§53), although they also acknowledge that residential care can complement family-based care in the range of care options (§23).

In regard to residential-based care, the Guidelines provide for a competent authority to screen for appropriate admissions (§125) and in particular that laws and policies should prohibit the recruitment of children by agencies, facilities or individuals (§127).

Where children are placed in temporary care, there should be regular and thorough reviews of the suitability of their placements 'taking into account... [the child's] personal development and any changing needs' (§67). Frequent changes in setting are damaging to children's development and their ability to form attachments (§60).

Parents, legal guardians and children should be fully informed of the alternative care options available (§64), and their implications, and consulted in any decision-making processes (§65).

In short, all decisions should be made to ensure that care is provided in a way that is 'best suited to satisfying [children's] needs and rights' (§7).

Key messages:

- Due to a lack of choice and range in alternative care facilities and specialist care provision, children were not always placed in the most suitable form of care.
- There were weak decision-making processes that did not necessarily take into account the best interests of the child.
- Participation of children and their legal guardians or parents was lacking in the decision-making process.

Guidelines for the Alternative Care of Children

Gatekeeping: §15, §21, §25, §44, §48, §57, §125, §127

Best interests of the child: §2, §6, §7, §14, §58

Determining the most appropriate forms of care: §57-68

Range of options: §54, §53, §23

Reviews of placement: §67

Participation: §6, §7, §64-65

5.1.3 ANALYSIS

5.1.3.1 Range of alternative care placement options

As will be discussed in the following sections (5.2 and 5.3), there is often a limited range of care options for children as a means of ensuring that their placements are suitable for their individual needs.

The majority of children without parental care are cared for in informal care settings where there is limited support provided by the authorities for their individual needs – such placements within their own extended families or communities, however, are also recognised as often the most appropriate and suitable form of care (see 5.2).

The reports found a lack of formal family-based care options, with few established programmes for foster care (see 5.2). As a result, formal alternative care relies on residential-based solutions that are often inadequate to cater to the specific situation and needs of each child (see 5.3).

Lack of coordination of alternative care provision by the state appeared to be a concern shared across the reports: where there is no centralised organisation of alternative care provision, individual providers follow their own agendas according to their own policies and funding capacity.

This means that gaps emerged in the range of alternative care placements available, particularly for children with special needs such as children with disabilities, large sibling groups and children with particular social or emotional problems.

In **Benin**, there were alternative care facilities throughout the country, but they were few and tended to be far from the children's own communities. Likewise, in **Togo**, the lack of facilities to meet children's specific needs meant that, to find suitable placements, children were often moved from region to region. The lack of choice meant that children's views were rarely taken into consideration and it was difficult for them to remain in contact with their families and communities.

SIBLING RELATIONSHIPS

Sibling relationships play a key role in the development of a child. They can reduce trauma and help the recovery of a child who has been deprived of parental care.¹

The Guidelines discourage the separation of siblings, except in circumstances where there is a risk of abuse or it is in the children's best interests, and children should remain in contact unless it is against their wishes or interests (§17).

In many of the countries in the region there was not adequate oversight and planning processes to ensure that siblings were routinely kept together. Many of the research reports did not even mention the consideration of sibling groups.

However, in Kenya and Zambia there was national legislation and guidelines on keeping children together and on the whole the research revealed that this was abided by where possible. In Malawi, although there was no official policy on siblings, it was acknowledged that there was an 'unwritten rule' that generally prevented their separation.

Despite this, concerns were raised about the difficulty of keeping children together and maintaining their contact. In Kenya it was noted that it could be difficult to keep siblings together where facilities separate boys and girls, where there were age differences, or where one child in the family enters the justice system. In Togo emphasis was placed on maintaining contact with family members and in Zambia concerns were raised about the capacity of alternative care providers to accommodate large sibling groups.

The implications of this was that where there is lack of capacity for many children's needs, and weak decision-making mechanisms it is unlikely that the needs and rights of siblings are always given the attention they deserve.

¹ Sara Wise, *All Together Now: Research Examining the Separation of Siblings in Out-of-Home Care*, Collingwood: Anglicare Victoria, 2011, p.10.



HIV/AIDS

HIV/AIDS casts a long shadow over the Sub-Saharan region. Although progress has been made in halting the spread of the virus, it remains one of the key reasons children require alternative care (see chapter 2).

It is therefore imperative that children are provided with specialist services tailored to their particular needs – and that the effects of HIV/AIDS on their lives is taken into consideration in decision-making processes

that consider their best interests in finding ‘suitable’ alternative care placements.

The country reports provided limited information on the services available to children in alternative care affected by HIV/AIDS. This indicates that more focus is needed in the alternative care sector on meeting the needs of this vulnerable population.

5.1.3.2 Decision-making in the best interests of the child

As discussed in section 5.2, the majority of children without parental care in the region are cared for informally by extended families and local communities without the knowledge or oversight of the state.

Evidence from the research demonstrated that lack of information collected on children in informal care can mean that governments are unable to respond to any child protection risks (see chapter 6) or ensure that services are in the child’s best interests. In **Kenya**, for example, it was emphasised that a lack of data and information on children in informal care meant it was difficult for the authorities to guarantee that placements were in the best interests of the child.

Formal care procedures for the placement of children were detailed in the country reports. In particular, competent authorities were tasked with making decisions related to the placement of children. In many of the reports, there was reference to decisions being made in the best interests of the child (see appendix 3 for a legal analysis of the best interests of the child in national legislation).

However, as indicated in chapter 3, the gap between policy and practice led to gaps in the implementation of effective standards and processes. Despite evidence that competent authorities were in place to make decisions relating to the placement of children, lack of resources and information collection meant that assessments of the best interests of the child were difficult to undertake.

Admissions

The processes for admitting children to alternative care were generally found to be inconsistent and incapable of guaranteeing decision-making in the best interests of the child. Lack of control over admissions processes can mean children are admitted into alternative care unnecessarily – for reasons related to ‘furthering the political, religious or economic goals of the providers’ (§20), for example.

Even where centralised policies and processes were in place, they were not applied in every case or by every organisation. A lack of knowledge and data collection meant that it was difficult for decision-makers to understand the underlying causes of separation and make decisions on that basis.

As a result, the gatekeeping capacity of the authorities in each country was weak and there was little control over whether the principle of the ‘best interest of the child’ was applied reliably.

In **Benin**, admissions procedures were poorly defined. Despite a new 2012 Decree 416 that would better define processes, in reality each facility admitted children according to their own budgets and services.

Similarly, in **Tanzania**, the admission of children and review processes varied according to the institutions – although government placements went through a court, private organisations could admit children on their own criteria.

In **Kenya**, although children were admitted to formal care through court orders, the system did not guarantee that the assessment process identified or sought to address the root causes of separation. Without such an assessment, children may be unnecessarily separated from their parents.

There was a similar finding in **Malawi** where, although the concept of the best interests of the child was enshrined in the Constitution, the lack of data or oversight of the reasons why children were taken into alternative care meant that it was difficult to apply the principle in practice. As a result, there was evidence that children were recruited to alternative care (mostly by unregistered organisations) as a means of increasing donor sponsorship.⁷

In **Togo**, an NGO facility was recently taken over by the government to act as a central referral centre for children. Although this was a positive move for centralising and improving the admission process for children to alternative care, the centre was not used consistently by care providers and did not cover the whole country.

⁷ No external reference provided.

Reviews of placement

Regular reviews of children's placements and care plans considering their continued suitability and whether they remain in the best interests of the child were not conducted consistently throughout the region.⁸

In **Kenya**, reviews of foster placements should be conducted every three months but, due to lack of resources, it was a challenge for field officers to conduct regular reviews. In **Gambia**, reviews should be undertaken every six months but had not been undertaken regularly in recent years. As such, many children did not have adequate care plans.

In **Malawi**, there were regulations regarding the regular reviewing of care plans but still many organisations did not develop them: on average, only 9.2% of the children surveyed in the research had a care plan while only 2.3% of children had had their care plan reviewed in the previous three months.



Exits and changes in placement

Where children's placements are reviewed and found to be no longer suitable, they may either have their placement changed or begin the process of exiting from the alternative care system.

As discussed in section 5.4, decisions and planning around leaving care and the provision of aftercare were found to be generally insufficient across the reports. There were similar concerns over the basis of the decision-making surrounding these processes, and whether they took into consideration the best interests of the child.

In some cases, no exit decisions were made, particularly in cases where aftercare would be insufficient to support the individual. In other cases, exit decisions were delayed or did not take place resulting in children remaining in alternative care longer than necessary or permanently. In **Kenya**, the lack of government monitoring of the length of stay of children in alternative care was considered a risk in terms of making placements permanent.

In **Malawi**, there was a lack of data on why children's placements were changed although evidence from the children reviewed suggested that it was often due to behavioural problems. There was also evidence that registers were not adequately kept on children leaving care, making it impossible for the authorities to keep track of the number of children in alternative care at any one time. It was noted that some children might be kept for extended periods of time in order to draw more money from donors.⁹

5.1.3.3 Participation of children and their principal carers in decision-making

In each of these decision-making processes, the participation of children and their carers is fundamental to the Guidelines, but also reflected in Article 12 of the UNCRC. The UN Committee on the Rights of the Child General Comment No. 12 (2009) explores this in more detail, emphasising the right of a child to participate in administrative systems and proceedings.

There was little evidence, however, that children's participation (or that of their parents) was respected or that facilities and authorities gave consideration to the capacity of the child to participate in the decision-making process. The absence of children's participation in decision-making processes was of significant concern.

In **Benin**, it was reported that only in exceptional cases were children's views taken into consideration in the placement process. Children were generally considered to be too immature to participate meaningfully.

⁸ Reviews and monitoring of alternative care providers and facilities are covered in chapter 3.

⁹ Referenced to Malawi Council of Churches.

In **Gambia**, parents were often not consulted when reviews of their children's placements were conducted and, in **Malawi**, there was limited evidence that parents and children were able to participate in decision-making and review processes.

In **Kenya**, consultation with the child depended on the age and special needs of the child, but there was no evidence for the participation of children in the preparations for leaving care and family participation in the placement of children was found to be 'minimal'.

In **Zambia**, children were entitled to participate in the decision-making processes surrounding their movement between placements or their reintegration back with their families. However, in some cases, it was observed that children's participation did not take place due to perceptions that they were 'incapable of making sound decisions'.

5.1.4

CONCLUSION

There appear to be assumptions in some of the country reports around the capacity of a child to participate in research, systems and proceedings. This is in direct contradiction of emerging practice and guidance around children's participation. The UN Committee on the Rights of the Child General Comment No. 12 (2009)¹⁰ states that the onus is on states to assess whether a child can give their opinion, rather than assuming that a child cannot participate due to age or other assumptions about capacity. Instead, states should assume that children can form and give their views without imposing an age limit.

The inadequate mechanisms around children's participation have implications for the suitability of placements of children: not only may initial placements be inappropriate but, without effective review processes and opportunities to exit the system, children may remain in unsuitable placements long-term.

Facilities without gatekeeping principles in place may have high numbers of children who have parents or other kin carers alive who could provide parental care to these children more appropriately.

Without children's participation in decision-making processes and the promotion of children's views generally in systems and services, children are disempowered and denied their rights. This can lead to poor quality decision-making which may not be in child's best interests. It also means that policy and provision is not well-informed by children's perspectives and experiences.

The decision-making processes surrounding the placement, review and exit of children from alternative care were assessed to be weak: they did not promote choice to enable children to access suitable placements; they did not consistently apply the principle of the best interests of the child; and they did not facilitate children's participation in decision-making.

Solution-based recommendations:

- Governments should ensure that there is a range of suitable alternative care for children in each area of the country so that their needs can be met locally and appropriately, including for children with specialised needs.
- Decision-making processes should ensure that, in all decisions, the primary consideration is the child's best interests. This entails empowering competent authorities to oversee the collection of data on decision-making and to conduct regular monitoring.
- Children's participation should be encouraged and enabled throughout the decision-making process, without imposing age limits on participation or making assumptions about a child's ability to participate.
- Parents and legal guardians should (where appropriate) be encouraged to participate in decision-making processes and be fully informed of any decisions made in relation to their children.

¹⁰ See paragraph 20.

Roadmap to gatekeeping and ensuring ongoing suitable care for children

1

MAKE REPORTING OF ALL ARRIVALS AND DEPARTURES OF CHILDREN FROM ALTERNATIVE CARE MANDATORY WITH A STATE BODY

2

PROVIDE A DETAILED GATEKEEPING POLICY INCLUDING:

- The assessment of children's situations
- Considering possible alternative care forms specific to individual child needs

- Referring child to the most appropriate care provider
- Referring the family to suitable preventive services instead of alternative care for support where necessary

3

REGULAR REVIEW

Ensure regular review of suitability of care setting and need for continuing alternative care and long-term stability for child if appropriate

4

CHILD AND FAMILY PARTICIPATION

Child and family participation should be encouraged and enabled throughout the decision-making process



5.2

Informal care, formal family-based care and pre-adoption

5.2.1 Introduction

5.2.2 Concepts and definitions

5.2.3 Analysis

Extent of informal care and its challenges

Extent of formal family-based care and its challenges

Extent of adoption and its challenges

Participation

5.2.4 Conclusion

5.2 INFORMAL CARE, FORMAL FAMILY-BASED CARE AND PRE-ADOPTION

5.2.1 INTRODUCTION

This is the first of two sections on care options for children (see also section 5.3). It focuses on three areas: informal care; formal family-based care (foster care and formal kinship care); and adoption (the systems and processes prior to formal adoption).

Informal care and formal family-based care are two important ways in which care is provided for children without parental care. Informal care is widely used across the region where children are cared for with their extended families and in their own communities. Formal family-based care, on the other hand, is a form of alternative care which is based within a family and is formally registered with the state. This form of care is among a range of care options outlined by the Guidelines.

This section examines findings from the country reports in order to consider the extent to which informal and formal family-based care are used; the processes in place prior to formal adoption; the different models of support and services in place; and the challenges that arise in these care options.

Key messages:

- Informal care was the most widely used care option for children without parental care, based on traditional and customary practices in communities.
- There was a lack of data and other information on the numbers of children living in informal care arrangements. This information was not disaggregated by age, gender and other circumstances such as disability.
- Formal family-based care was available, but not developed to a significant extent across countries. There were models of foster care provision being developed on a small-scale basis and with the support of NGOs.
- There were legal procedures in place on adoption. The numbers of children who were adopted were very low although data may be not fully up to date. Complex and expensive processes can prevent families going through adoption processes.
- There was little information available on how children's views informed formal and informal decision-making in these different care arrangements.

Guidelines for the Alternative Care of Children

General provisions: §11-23

Informal care: §18, §56, §76-79

Formal family-based care: §118-122

Placement with view to adoption: §30b, §152



5.2.2 CONCEPTS AND DEFINITIONS

The Guidelines highlight that, where alternative care is needed for children without parental care, priority should be given to solutions that are ‘family and community-based’ (§53). These may be customary, formal or informal. This chapter focuses on these different approaches to care, taking into account the importance of the ‘suitability’ principle (whether the care is appropriate for the child).¹

Informal care

Informal care is when a child is placed in the care of the extended family or other members of the community without the state being directly involved. It is used extensively and widely accepted as an option for caring for children without parental care:

Alternative care for most children who cannot live with their parents is, in fact, informal in nature. In other words, the majority of alternative care throughout the world is organised spontaneously between private individuals – most often parent(s) and relatives – through informal, societally accepted practices.²

The Guidelines set out principles that should be followed by the state, emphasising that care arrangements should be in the best interests of children; that all children are protected and their wellbeing ensured (§76 to §79). Informal care should be supported by the state in order to ensure ‘optimal provision’ (§76) and that children are protected from ‘abuse, neglect, child labour and all other forms of exploitation’ (§79).

In addition, the Guidelines emphasise that decision-making regarding children in alternative care, including informal care, should always have due regard for ensuring that children have a ‘stable home’ and meet a basic need for ‘safe and continuous attachment to their caregivers’ (§12).

The Guidelines make a distinction between the role of the state in informal and formal care settings with the state not directly involved in informal care arrangements. This does not mean that there should be no oversight of arrangements. It is helpful, for example, for the state to know where children are placed in informal care so that services and support can be offered to families and children as appropriate.³ The importance of this state awareness is especially relevant when considering the extensive use of informal care across all the countries in this study.

Formal family-based care

Formal care is provided where their families or others cannot care for children without parental care (see §80 to §100 for general conditions applying to all forms of formal alternative care arrangements). The Guidelines identify formal family-based care as:

... all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as result of administrative or judicial measures (§29b(ii)).

It includes foster care and formal kinship care rather than residential care or institutional care (see section 5.3). ‘Foster care’ and formal ‘kinship care’ are here used to describe formal family-based care for children subject to state oversight and administrative processes. Foster care covers short-term emergency care as well as much longer-term care. Other family-based care arrangements may exist which are not called foster care, but where a family or individual undertakes a similar role or are acting as long term carers or ‘guardians’ (§29c(iii)).⁴

Adoption

Care of children by adoptive parents is not covered by the Guidelines as this is considered care for a child within their own family; however the systems and processes leading up to adoption are considered here (§30b).

The report also takes account of forms of care that are part of traditional customary practices. This may have different meanings in different communities and countries. The practice of kafala takes many forms and is widely used among the Muslim community. It is where a child lives with a family on a permanent basis, but is not entitled to inherit or use the family’s name.

¹ Moving Forward, p.23. See also section 5.1 (decision-making) for a fuller discussion of the suitability principle in decision-making for children.

² Moving Forward, p.31.

³ Moving Forward, p.77.

⁴ Moving Forward, p.33 for further details on terminology and definitions.

5.2.3

ANALYSIS

5.2.3.1 Extent of informal care and its challenges

Across all eight countries, informal care was identified as a widely used and significant form of care for children without parental care, although there was little formal data collected across the region.

Use of this care option was based on traditional and customary approaches to care across different communities and cultures.⁵ In these situations, informal care was provided by members of the extended family, such as aunts or uncles, grandparents, siblings or other relatives, or by those in the wider community.

There were different contexts and practice for informal care across the region. In **Togo**, this form of care extended beyond the family to members of the community, friends or professional contacts of parents and could include putting children in the care of an older member of the community.

Decisions to place children in informal care were made by families in **Tanzania** and the community with arrangements not usually monitored by the state. In **Zambia**, the extended family system of informal care was supported by communities' cultural beliefs, norms and practices with no apparent wish for this form of care to change. Children were therefore frequently cared for informally by other family members or members of the community rather than placed in formal care such as fostering, formal kinship care, or residential homes.

CHILD-HEADED HOUSEHOLDS

Child-headed households are an increasingly common phenomenon in the region, mainly due to the HIV/AIDS epidemic. This research reported that in Malawi 12,000 children were living in child-headed households,¹ while in Tanzania the figure was closer to 200,000,² and in Zimbabwe there were 50,000 households headed by children under 18 years old.³

These children are considered briefly by the Guidelines (§37), which place emphasis on providing support to the family unit – usually of siblings – to remain together in their family home in the absence of an adult parent or guardian.

Of particular importance is the state's responsibility to ensure that the rights of the eldest children are provided with services to ensure that their inherent rights are not compromised by their position as a household head – i.e. the rights to education and leisure time.

Evidence from the region on child-headed households was scarce. In Tanzania it was reported that without support and supervision, children were not attending school and accessing their right to education. However, in Zimbabwe there had been efforts to target child-headed households in the distribution of resources through cash transfer programmes.

- 1 Referenced to UNAIDS.
- 2 Referenced to CRSA: *Child Rights Based Situational Analysis of Children without Parental Care and at Risk of Losing Parental Care*, Dar es Salaam: SOS Children's Villages Tanzania, 2012.
- 3 Referenced to Zimbabwe Ministry of Public Service, Labour and Social Welfare, *National Action Plan for Orphans and Vulnerable Children 2004-2010*, 2008. Part of the reason for this disparity is the relative size of the populations.

⁵ Moving Forward, p.82, for importance of supporting traditional care responses.

Information and oversight of informal care

In spite of the extensive use of informal care, the reports identified that there was very little administrative data on the numbers of children living in informal care arrangements.

In **Kenya**, it was pointed out that there was a lack of credible data on informal care in spite of it being known that significant numbers of children were orphaned and vulnerable. **Zambia** was able to provide an estimate of 710,000 children in informal care, of whom 670,000 were orphaned due to HIV/AIDS.⁶ However data was not available on the numbers of children in informal care. As a result, there was also little disaggregated information on the age and gender of children, whether children had disabilities, or other needs.

This lack of data makes it difficult to assess the scope and range of informal care across the eight countries and give consideration to the support that might be required by caregivers. The impact of the lack of disaggregated data in **Tanzania** made it difficult for children's officers to monitor informal care arrangements.

There were additional problems in identifying information on the extent of informal care. Incentivising voluntary registration by informal carers, for example, ensures that children are known to the authorities for monitoring purposes and can facilitate access to support and services (§77).

However, countries had different approaches to encouraging voluntary registration so that they could access services and other forms of support. In **Malawi**, there was voluntary registration of informal carers, although it was not always actively encouraged by the state. In **Kenya**, the government had established systems to encourage voluntary registration of informal care through registered guardianship initiatives. These approaches did not appear to be implemented consistently across all the countries.

Overall, the reports identified that there was insufficient information on the country populations of children living in informal care. It was difficult to identify whether there were trends that should be taken into account by policy-makers and practitioners. However, there was a general awareness that this was the most significant care option for children without parental care.

Support for informal care and increasing demand

The reasons that children were in informal care across the countries included children being without parental care; family breakdown; illness including HIV/AIDS; economic necessity; and poverty.

Several countries stated that the need for care was increasing due to the impact of poverty, HIV/AIDS and other demands on families with an accompanying increase

in child-headed households. These factors meant that more children were being cared for in informal care. The level of need was a significant area of concern across countries, particularly due to the lack of other forms of support for families. Generally, the pressures on families had implications for children's wellbeing, the effectiveness of informal care and the potential for child protection issues to arise.

The reports found that there was insufficient support for informal caregivers in spite of children and families needing this input. This was compounded by the impact of social and economic factors with countries highlighting that these have, in some instances, worsened. In **Tanzania**, for example, families providing informal care faced increasing challenges in meeting the basic needs of their children while, in **Zambia**, the impact of economic factors had reduced the capacity of families to undertake informal care. In **Benin**, the impact of growing poverty and more children who were orphaned because of HIV/AIDS had led to growth of the institutional care centres that encourage the placement of children in alternative care.

There were a number of suggestions for how support could be improved across the countries. In **Malawi**, a state cash transfer system was available for families providing informal care where they met the application criteria. In **Tanzania**, it was suggested that family-strengthening programmes would help to support informal care arrangements and enable more families to support children.⁷

In **Kenya**, a cash transfer programme for orphans and vulnerable children was aimed at supporting very poor households that take care of orphans and vulnerable children. It provided regular and predictable cash transfers to encourage fostering and retention of the children within families, to improve civil registration of guardians/caregivers, to promote human capital development, and to enhance guardians' knowledge on appropriate care. Although weaknesses had been identified in these programmes, the government had recently created a parliamentary committee to oversee their distribution.

Although the Guidelines suggest that states should recognise the role of informal care and support it where necessary (§76), there was not a significant level of support to families who were informal carers across the countries.

Good practice in supporting informal care includes encouraging schemes for voluntary registration of informal carers, the provision of financial allowances on application, the provision of support services and ensuring that any exploitative practices are combated. Although some of these practices were in place in some countries, they did not appear to be routinely and consistently implemented.

⁶ No external reference provided.

⁷ For more details on family strengthening more generally, see chapter 4.

In Kenya 0.25%
of the total
child population
were in formal
residential care
settings.

0.25%

Source: Kenya country report, at December 2012.

Child protection concerns

The country reports highlighted that children could be subject to exploitation, neglect and abuse when living in informal care (see also chapter 6). The lack of regulation and oversight of informal care could result in these abuses going unreported although many of the reports identify that these were areas of concern.

The **Togo** report, for example, highlighted that the well-being of many children was adequately supported by informal care arrangements, but also raised concerns about children having to contribute to family income through working in agriculture, the commercial sector or craft activities. In **Kenya**, district children's officers and local committees monitored issues of child protection with chiefs and village elders handling child protection issues although no formal records were kept. In **Zambia**, the authorities were rarely involved in children's informal care unless there were concerns about children's vulnerability. These arrangements were often unregulated with a lack of guidelines and appropriate legislation on how they could be regularly monitored.

This lack of state intervention is in contrast with the Guidelines' emphasis on state responsibility for ensuring that there are measures in place to protect children from abuse, neglect, child labour and other forms of exploitation (§79).

5.2.3.2 Extent of formal family-based care and its challenges

Although formal family-based care covers a range of different approaches, fostering was the main formal family-based option mentioned with formal family-based kinship care very uncommon. This may be because the two approaches to care can overlap.

Fostering was not widely used as a care option – only small-scale initiatives were available in some of the

eight countries. There was no state-led approach to the systematic development of fostering services as a family-based care option, highlighting a gap in alternative care systems across the region. The lack of fostering services is not unique to this region. Family-based care provided by formal fostering is not commonplace and unknown in most countries in the world.⁸

This care option was not necessarily viewed as being in line with customary practice in traditional communities. The **Zambia** research, for example, reported that fostering was seen to conflict with African culture where families cared for children in informal care arrangements. Apart from longstanding customs and values that might deter potential carers, there may not be the administrative systems in place to support this form of care.⁹ These different factors also appeared to influence the availability of formal family-based care provision across the eight countries.

Most of the reports found that there were very small numbers of children in foster care. In **Gambia**, there were difficulties in identifying details about foster care applications with only 10 applications noted.¹⁰ In **Zambia**, fostering was extremely limited.

Where there were developments in foster care, these tended to be initiatives supported by UNICEF and other international organisations, often in partnership with government. In **Togo**, for example, representatives from state ministries, UNICEF, Terre des Homes, Handicap International and Plan Togo were developing a project on fostering and accreditation systems for foster families. This pilot work on foster care was mirrored in **Benin** with the state working with UNICEF and Terre des Hommes to provide training and support for host families in order that they could care for children with experience of exploitation, trafficking and abuse. Although this was not a major form of care provision in **Benin**, it was identified as an alternative to institutional care.

8 Moving Forward, p.91.

9 Ibid.

10 Referenced to Adoption and Foster Care Unit.

Oversight and support for foster care

Analysis of the reports indicates that there was a lack of support mechanisms for foster carers except in discrete initiatives. Details on accredited foster carers were often not available, although the **Kenya** government was developing greater awareness around the registration of foster carers. The **Kenya** report found that there was no evidence of vetting processes for foster carers, regular monitoring or training provided.

However, where there were collaborative projects between the state and non-state organisations, systems and processes were in line with effective foster care practice (such as appropriate preparation and training for foster carers).¹¹ In **Togo**, the foster families' project being developed (see above) had mechanisms for training and support in place.

There was little indication that there were support mechanisms in place to support foster care. The **Kenya** Adoption and Foster Care Act resulted in guidelines for foster care, but these were not monitored (it was suggested that more effective support could be provided). In addition, the fostering options that were available did not necessarily adhere to good practice. In **Gambia**, it was noted that most children in foster care did not have an individual care plan. Across the reports more generally, there was little mention of care planning or review being in place. This suggests that there was limited formal oversight of fostering arrangements for children and a lack of opportunities for children to participate in these systems and processes.

5.2.3.3 Extent of adoption and its challenges

As in the other forms of care explored in this chapter, data on the number of annual adoptions was difficult to identify across the eight countries. In **Zambia**, for example, there were no recent figures. In other countries, the low figures indicated that adoption was not commonly used. In **Gambia**, for example it was reported that there had been 23 adoption applications during one unspecified period.

Challenges in adoption processes

Although there were legal processes for adoption in place in most states, there were challenges that inhibited the adoption process. First and foremost, adoption was not generally seen as compatible with cultural practices, as reflected in attitudes to foster care. Although there was resistance to adoption, there were increasing numbers of children who required care but did not have access to informal care arrangements, as reported in **Tanzania** and **Kenya**. There was therefore a tension between traditional values about caring for children and the challenge of being unable to meet the needs of all children without parental care through informal care arrangements.

Additionally, adoption processes could be complex and expensive. In **Togo**, for example, it was suggested that costs related to national adoption needed to be reduced in order to encourage families to adopt children. In **Kenya**, costs were similarly high and potentially disbarred families who wanted to adopt. Single parents were not able to adopt a child of the opposite sex, resulting in most single women adopting girls. This suggests that current systems do not proactively support adoption where it is appropriate for children.

Inter-country adoption did take place, although the reports indicated that recorded numbers were very low. It may be that figures were not-up-to date or consistent: **Tanzania**, for example, pointed out that there were inconsistencies in the figures that were currently available. In **Malawi**, the Adoption of Children Act highlights the principle of the best interest of the child. This was used to inform High Court decision-making on inter-country adoption. Only two of the countries – **Kenya** and **Togo** – had ratified the *International Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption*, however, suggesting that states were not adhering to these widely agreed international principles and standards.¹²

From the reports, it appears that adoption as a permanent option for children in need of parental care was underutilised because of attitudes to the care of children and complex and expensive processes. There was a lack of regularly collected data and little focus on promoting adoption as a valid option for children without parental care where there were no other appropriate care options.

5.2.3.4 Participation

As highlighted in section 5.1, there was little mention throughout the reports on how children's views were taken into account in informal or formal decision-making around care options. Neither were their participation rights, under Article 12 UNCRC, supported by systems and processes associated with formal family-based care and pre-adoption processes and procedures.

As a general principle of the Guidelines, participation was not profiled to any great extent in the reports.¹³ This suggests that there was an absence of systems and processes that involve children formally or informally in giving their views across the region.

¹¹ Moving Forward, p.90.

¹² See: www.hcch.net/upload/conventions/txt33en

¹³ Moving Forward, p.27.

Formal care provision is too low



BENIN



THE GAMBIA



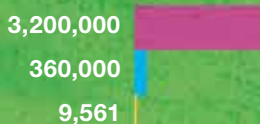
KENYA



MALAWI



TOGO



TANZANIA



ZAMBIA



ZIMBABWE





5.2.4 CONCLUSION

The dominant care option in these countries is informal care for children who are without parental care or vulnerable. However, without formal oversight of informal care, and with weak processes for encouraging the voluntary registration of informal care arrangements, the state role in ensuring the safety and wellbeing of children is underutilised.

One of the most significant challenges for informal care is that there are no accurate figures on how many children are living in informal care across the eight countries. As a result, there is also a lack of detailed disaggregated information on who children are living with, and no information on age, gender, disability or whether siblings are able to live together.

Consequently, there were few arrangements to support children and the families they live with, even though some informal carers were not able to meet children's basic needs. This absence of support is of particular concern where children have special needs due to disability or other circumstances. Several of the reports raised concerns about rights violations of children in these situations, with children subject to abuse or exploitation often for economic reasons.

Similarly, the lack of alternative formal family-based care options means that children were more likely to be placed in residential or institutional care which, as discussed in section 5.3, can have negative implications for their wellbeing and development.

Although adoption was available, it was not necessarily considered an option because it did not adhere with customary practice around the care of children. Although many countries have legal processes in place for adoption, there were problems associated with the process including its complexity and associated high costs. There was a lack of data on the number of children who were adopted and figures for inter-country adoptions were limited.

The reports identify that there is an opportunity to strengthen informal and formal family-based care, where it is appropriate for children in need of care, to ensure that care options meet the best interests of the child and that children have access to the most 'suitable' forms of care to meet their individual needs.

Solution-based recommendations:

The following are recommendations to promote changes in these care arrangements. Most of these focus on the leadership role of the state in each country, but also relate to the role of local and international NGOs and other non-state providers.

Informal care:

- States should identify ways to collect data on the number of children living in informal care arrangements including details of the carers and families children live with, and disaggregated data on children's age, gender and disability. Having this information would then help with planning support for caregivers.
- States should promote initiatives that encourage the voluntary registration of informal carers. This could also help to identify carers who may need support, specifically older carers or those who are not able to meet children's basic needs because of financial hardship.
- States should increase awareness and provide information to communities on child welfare and protection issues in order to ensure that children are protected. This should include families, chiefs and elders as well as general members of the community.

Formal family-based care

- States should consider developing more formal family-based care through fostering, particularly for children who do not have access to appropriate informal care. This could be informed by developing work that has been undertaken in partnership with NGOs in some countries.¹⁴
- There should be more promotion of the potential benefits and opportunities for fostering in order to encourage communities to consider this family-based care option where this can meet the needs of children. This should be seen as complementary to informal care.
- Support should be available to foster carers through training, support and ongoing monitoring.

Adoption

- Data should be regularly collected on the number of children who are adopted.
- Costs associated with the pre-adoption should be reduced in order to encourage families who wish to adopt.
- States should promote domestic adoption as a valid option for children without parental care, where there are no other appropriate care options possible.
- States should ensure that procedures and mechanisms are in place to enable the Hague Convention to be ratified, so that all inter-country adoptions are undertaken in accordance with its principles.

¹⁴ Moving Forward, p.92.

5.3

Residential care

5.3.1 Introduction

5.3.2 Concepts and definitions

Residential care versus institutional care

Institutional care and child development

5.3.3 Analysis

Deinstitutionalisation

Standards for residential care

Staff qualifications and recruitment

5.3.4 Conclusion

5.3 RESIDENTIAL CARE

5.3.1 INTRODUCTION

The chapter examines findings from the country reports on residential care. As the primary form of formal alternative care in the region, the extent of its provision and the quality of care available provides a necessary insight into the common circumstances of children without parental care.

Focusing on the provision of services and their quality and 'suitability' for the care of vulnerable children, this chapter first addresses the concerns around the provision of inappropriate residential care for the development of the child and its ability to cater for the child's individual needs. Second, it highlights the extent of residential care in the region and argues that, on the whole, it can be characterised as 'institutional' care. Finally, the chapter addresses some of the structural challenges in providing quality care: the creation and implementation of quality care standards and the recruitment, retention and training of qualified staff.

Key messages:

- Residential care was popular in the region despite its known negative effects. However, it was difficult to determine its exact prevalence because of lack of information. There was no regular census in individual countries to count and monitor facilities.

- Many of the residential care facilities in the region would be considered 'institutions' due to the sheer number of children placed in residential care compared to the number of registered facilities.
- There had been a proliferation of child care facilities in the region, but many of these institutions were operating illegally.
- Although regulations, standards and guidelines existed on different aspects of institutional care, they were not followed and enforced as required. This was mainly due to the absence of appropriately qualified staff and inadequate material resources. Consequently, the quality of care offered to children was compromised.
- There was a notable lack of government financial support for residential care. Many facilities found it challenging to maintain the required standards of care due to financial constraints.

Guidelines for the Alternative Care of Children

Definition of residential care: §123-127

Appropriate care: §21, §23, §29

Deinstitutionalisation: §23

Quality of care: §71, §105

5.3.2

CONCEPTS AND DEFINITIONS

The Guidelines classify all alternative care settings that are not within the context of a family-based group as residential (§29civ). The term ‘residential care’ thus embraces a broad spectrum of care settings.¹

Residential care is recognised as a ‘necessary component in the range of alternative care options that must be in place’ (see §23),² but should ‘be limited to cases where such a setting is specifically appropriate’ (§21) as long as it ‘satisfies a number of conditions’.³

In this respect, the placement of children in residential care should be in line with the ‘suitability’ principle (discussed in section 5.1). Residential care may be the most suitable form of care for certain children in particular circumstances, such as children with disabilities or large sibling groups.⁴ Despite this acknowledgement, the Guidelines suggest that ‘alternatives should be developed in the context of an overall deinstitutionalisation strategy’ (§23).

In general, residential care should be ‘small and organised around the rights and needs of the child’ (§123), should not at the same time provide accommodation to children within the criminal justice system (§124), and should employ sufficient carers to allow individualised attention and the opportunity for children to bond with an individual carer (§126), and maintain the quality of facilities with ‘regard to the professional skills, selection, training and supervision of carers’ (§71).

5.3.2.1 Residential care vs institutional care

The Guidelines make a distinction between ‘residential’ and ‘institutional’ care. ‘Institutional’ care is defined as alternative care that occurs in large residential facilities as opposed to ordinary residential homes (§23). While the term ‘large’ is relative and varies with context, many specialists consider that facilities housing more than 10 children fall within this category. Institutions also have an ‘organised, routine and impersonal structure ... [resulting in] a professional relationship, rather than a personal relationship, between adults and children’.⁵

This distinction recognises the fact that there is a higher likelihood for care in large facilities to adversely impact on the wellbeing and development of children. It also recognises that large institutions may be less able to safeguard and promote the rights of children under their care than smaller residential homes.⁶ Research has consistently shown that this form of care has ‘negative consequences for children’s development’.⁷

1 Moving Forward, p.33.

2 Ibid.

3 Ibid.

4 Ibid.

5 Kevin Browne, 2009, *The Risk of Harm to Young Children in Institutional Care*, Save the Children, p.1.

6 Moving Forward, p.34.

7 The Risk of Harm, p.1.

8 Moving Forward, p.43.

CHILDREN IN THE JUSTICE SYSTEM

The Guidelines are not designed for children who are part of the justice system. Instead the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty are standards set out for this group of children.

The Guidelines are clear, however, that children in alternative care should be accommodated separately from children who are subject to the criminal justice system (§124). While there was no evidence that children in alternative care were accommodated with children in the criminal justice system, there was evidence that the standards of accommodation for children accused of crimes was inadequate and posed considerable risk of harm.

In Tanzania, there were concerns that children were detained with adults and that during questioning they were subjected to abuse or torture, or mistreated in other ways. There was also evidence that there were delays in their cases being sent to trial and they were denied legal representation or advice before being sent to court.¹ In Zimbabwe too there were concerns that children were detained in the same cells as adults, may be abused by their fellow inmates and subjected to violence from prison guards and other prison staff. Furthermore there were concerns that very young children were sometimes detained along with their parents.²

1 No external reference provided.

2 No external reference provided.

In light of the above, the authors of the Guidelines opted, in §23, to call on each state to draw up its own strategy for progressively deinstitutionalising its alternative care system rather than proposing an outright ban on institutions. The Guidelines recognise that this may have to be a progressive strategy and requires appropriate alternatives to be available: the process of deinstitutionalisation is complex and requires support and collaboration from all agencies and staff.⁸



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5.3.2.2 Institutional care and child development

Institutional care – especially for young children under the age of three years old – can cause both physical and psychological harm.⁹

Placement of children under the age of three in all forms of residential care is generally discouraged in the light of predominant expert opinion. It is suggested that children placed in care settings where they do not receive individualised attention are prone to lasting psychological harm.¹⁰

Studies have repeatedly shown that such care for young children has ‘the potential to negatively affect brain functioning at the most critical and unparalleled period for brain development, and have long-lasting effects on social and emotional behaviour’.¹¹

The CRC Committee, in its General Comment No. 7, made the following pertinent observation:

*Research suggests that low quality institutional care is unlikely to promote healthy physical and psychological development and can have serious negative consequences for long term social adjustment, especially for children under 3 but also for children under 5 years old. To the extent that alternative care is required, early placement in family based or family like care is more likely to produce positive outcomes for young children.*¹²

Accordingly, the Committee encourages states to ‘invest in and support forms of alternative care that can ensure security and continuity of care and affection, and the opportunity for young children to form long term attachments based on mutual trust and respect’, including adoption, fostering and extended families (see section 5.2).¹³

9 The Risk of Harm, p.10.

10 Moving Forward, p.39.

11 The Risk of Harm, p.15.

12 UN CRC Committee General Comment No.7, §36.

13 Ibid.

Residential care was overcrowded – facilities caring for more than 10 children are usually considered institutions.



5.3.3 ANALYSIS

5.3.3.1 Deinstitutionalisation

The information provided in the country reports, particularly the shortcomings illustrated in this chapter, raise concerns that children in the region are disproportionately cared for in settings that could negatively affect their normal development.

There was evidence that a number of countries have recognised the need to deinstitutionalise facilities. In **Malawi**, the national policy on orphans and other vulnerable children states that institutionalisation should be a last option. In **Togo**, the national policy on child protection recognises the family as the immediate and best protective environment for children, and preferable to institutional care facilities. In **Benin**, the law emphasises the need to firstly consider family-based care for children who have lost parental care, although residential care remained the main option available.

Despite the known negative effects of institutional (in particular) and residential care (more generally), residential care was widespread in the region. In 2008, UNICEF considered it to be the ‘most prevalent type of alternative formal care’.¹⁴ Indeed, **Benin, Kenya, Malawi, Tanzania, Togo**, and **Zambia** reported having a greater number of residential care facilities compared to other formal care options such as foster care. Many of these facilities were filled to capacity and there was growing demand. In **Kenya**, in December 2010, the Children’s Services Department estimated that there were 632 residential care facilities caring for a total of 40,139 children: an average of 63 children per residential care facility. **Togo** had 98 registered residential care facilities caring for 9,561 children:¹⁵ an average of 97 children per facility. **Benin** had 7,000 children in 97 facilities:¹⁶ an average of 72 children per facility. According to the **Malawi** Human Rights Commission in

2012, there were on average 83 children per facility in the residential care placements it visited.

Therefore, evidence suggests that many of the residential care facilities in the region would be considered ‘institutions’, by the sheer number of children compared to the number of registered facilities.

5.3.3.2 Standards for residential care

Residential care, where it is present, should meet certain standards to ensure that the most harmful effects are mitigated. In many of the countries in the region, standards of care were either not adequately elaborated or were inconsistent across different forms of residential care provision.

In **Benin**, there was no procedure to control the quality of services offered in alternative care – standards tended to be set by the external funding agencies or networks that require their facilities to abide by international standards.

In **Gambia**, the Minimum Standards for Quality Care 2013 for residential child care facilities requires registered organisations to follow a set of criteria, such as having a written statement on the minimum standard on accommodation, nutrition and health care, and enabling the child’s contact with his or family and financial transparency. However, there was no data on how consistently these were applied or whether shortfalls were identified in inspections.

In **Zambia**, despite emphasis on standards by the authorities, there was a lack of capacity and funding in facilities to meet the standards, especially given the lack of finance provided by the authorities.

There were also concerns raised that knowledge of standards was not widely disseminated. It was noted in **Malawi** that knowledge of standards and legislation in relation to the care of children in alternative care was ‘sketchy’, with a particular lack in the rural areas.

¹⁴ UNICEF, *Alternative Care for Children in Southern Africa: Progress, Challenges and Future Directions*, Nairobi: UNICEF, 2008.

¹⁵ Referenced to a list of orphanages and child care facilities made by the Regional Offices for Social Action, April 2012.

¹⁶ Figures from 2008, referenced to the Orphanages List by the Ministry in Charge of Family.

5.3.3.3 Staff qualifications and recruitment

The Guidelines aim to ensure high quality recruitment of formal carers and include staff recruitment and qualifications in the minimum criteria for reviewing the operation of care facilities (§105).

Although there was some evidence of good practice – in **Benin**, new legislation required minimum standards of qualifications of staff and, in **Tanzania**, the department of social welfare had established an institute of social work which had trained many employees in public facilities – there were more commonly examples of serious shortcomings.

The reports indicated that the availability of financial resources greatly affected the quality of staff that were employed and organisations' ability to vet applicants for posts adequately. Many people working in these facilities did not have the appropriate qualifications and facilities were often understaffed. Both have implications for the quality of care that is provided to children.

In **Tanzania**, the number of staff employed by facilities was dependent upon the funding available either from the state or donor sources. In **Togo** and **Zambia**, it was noted that child care facilities relied on volunteers (often expatriate) to supplement staff shortages and expertise.

Levels of staffing were inconsistent and poorly qualified and in many cases this was due to low salaries in the sector:

in **Zimbabwe**, the lack of funds to employ professionals led to the recruitment of untrained employees to undertake social work roles; in **Malawi**, many residential care facilities operated without a trained social worker, levels of staffing were low and there was a high turnover of staff.

The provision of training by alternative care organisations was similarly weak. In **Gambia**, although there were standards in place such as staff being required to take 20 hours of training in child protection and stipulated qualification levels, there were gaps in the implementation of training and concerns raised over the capacity of staff to deliver quality care.

In **Kenya**, there were standards for background checks on staff working with children and the required levels of training and qualifications. However, levels of training for staff varied, with some organisations providing limited training (one day) compared to more comprehensive programmes, such as at SOS Children's Villages Kenya, which lasted up to a year.

In **Malawi**, it was reported that 71% of care providers were not trained in child care related issues, with standards of care varying according to the capacity of individual alternative care providers.¹⁷

In **Togo**, where each organisation has its own recruitment process, it was observed that children in facilities were exposed to violence, abuse and difficulties related to their supervision because most facilities did not have enough resources and employ unskilled staff in the care of children.

17 Referenced to the Ministry of Gender



Source: Reported by the Ministry of Gender, Malawi country report.

CONCLUSION

The emphasis on formal residential care – and, in many cases, institutional care – of children in the region is a challenge for policy-makers to implement deinstitutionalisation strategies. However, it is an essential component of any alternative care policy to take account of children's rights, including the best interests of the child and children's development needs.

It is clear that in many cases across the region, children were put at risk in terms of child protection and their developmental progress due to lack of funding, failure to guarantee standards, and poor staff training and qualification levels. In some cases, this can result in children being mistreated at the hands of unskilled and poorly supported staff.

Large numbers of children were placed in residential care facilities, which in many cases can be characterised as 'institutions'. This means that children were rarely provided with high quality care suitable to their individual needs and rights in line with the Guidelines.

While in place at the policy level in many countries, deinstitutionalisation was not practiced or implemented in reality. Rather, residential care facilities were over capacity, poorly funded and lacking in professional and consistent care provision. Quality of care standards were inconsistently applied across the region and facilities, with organisations struggling to meet standards due to capacity and funding constraints.

Solution-based recommendations:

Deinstitutionalisation

- States should develop deinstitutionalisation strategies in line with the Guidelines, recognising that these may need to be progressive and ensure that appropriate family-based options are in place to meet the needs of children, especially for children under the age of three.
- Where residential care is considered to be in the best interests of the child, standards should be maintained to ensure that children have access to basic services, as well as an individualised care plan and carers that provide individualised care in line with their assessed needs.

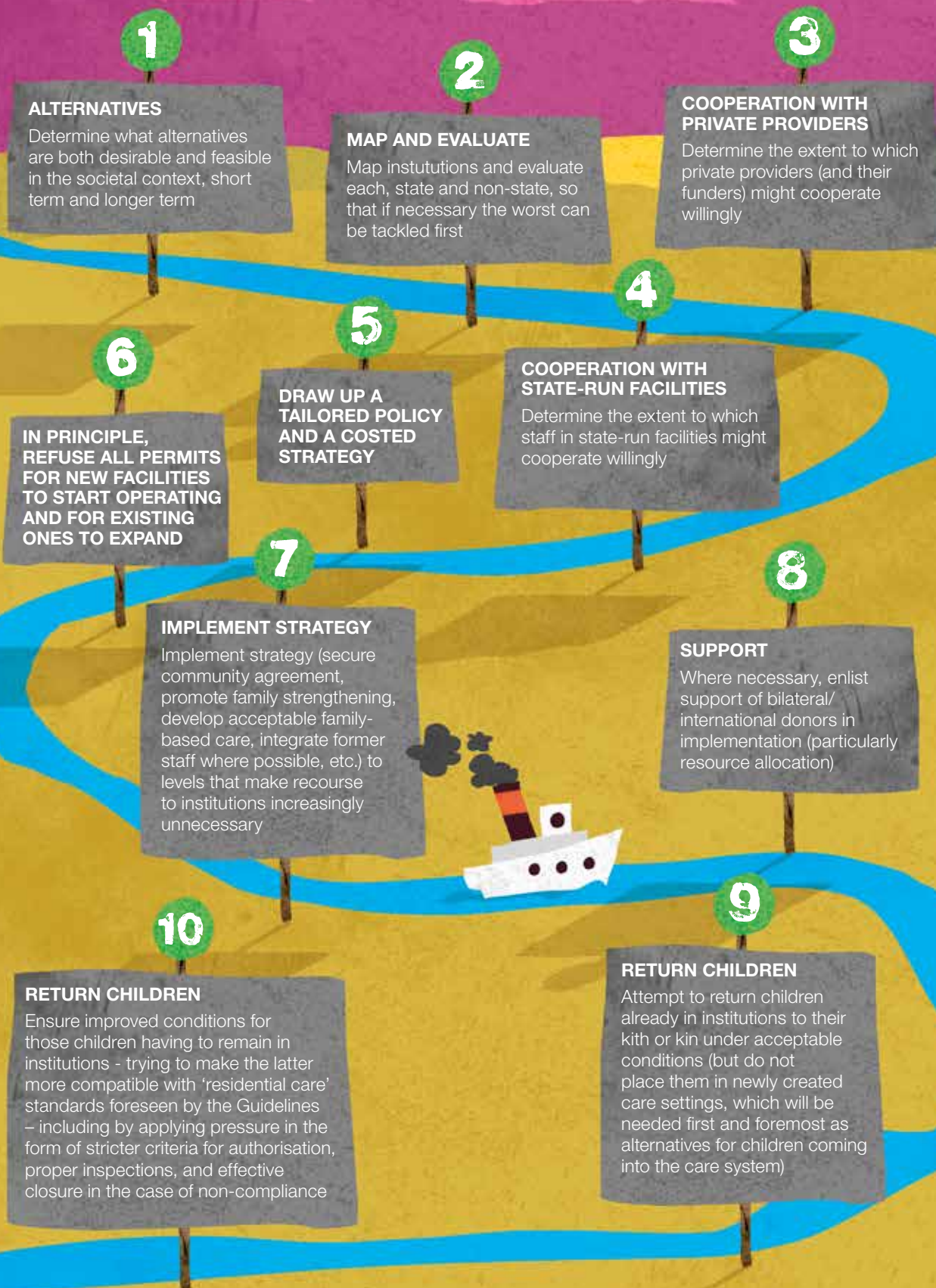
Standards for residential care

- States should ensure that there are clear standards for residential care and that facilities – whether state or non-state run – have the resources to implement them.
- Residential care standards should be widely known and disseminated by the state. The state should also put in place monitoring mechanisms to ensure that residential care providers meet the standards (see chapter 3 on inspections and monitoring).

Staff qualifications and recruitment

- States and alternative care organisations should ensure that staff recruitment processes focus on recruiting adequate numbers of qualified staff and provide checks on their suitability to work with children.
- Residential care providers should ensure that ongoing training, support and oversight is provided so that children are cared for according to their individual needs.

Roadmap to deinstitutionalisation



5.4

Leaving care and aftercare support

5.4.1 Introduction

5.4.2 Concepts and definitions

5.4.3 Analysis

Planning and preparation

Provision of support

Follow up and monitoring

5.4.4 Conclusion

5.4 LEAVING CARE AND AFTERCARE SUPPORT

5.4.1 INTRODUCTION

The Guidelines recognise that the responsibilities of the state do not end at the point that a child is ready (or required at the age of majority) to leave alternative care. They remain responsible for the effective 'aftercare and protection of these children' (§70).

Children may leave care through four separate routes: they may be reintegrated back with their parents and families (see chapter 4); enter formal adoption proceedings (see section 5.2); change placement (see section 5.1); or transition out of the alternative care system into the community and independent living.

Whatever route they take, children and their families need to be prepared and supported to ensure the successful transition of the child.¹ Evidence suggests that children who are prepared adequately for leaving care, and where changes are made gradually, are more successful, have more positive outcomes, and higher achievement levels.

Young people who leave alternative care without support may find themselves in similar situations to those that led them into care in the first place. They may also find it difficult to access health, education and other social services or opportunities. Without support young people are also more vulnerable to exploitation – they may find themselves in hazardous situations or exposed to 'indigence, homelessness, offending, substance abuse...'²

This chapter concentrates on the systems in place to ensure that children in the region are supported when leaving care. It considers whether planning processes are in place to support children and families and whether monitoring is conducted to follow-up on young people after leaving care.

Key messages:

- The research found that children were poorly prepared for leaving care and that even where procedures were in place to prepare children they were often not followed.
- Limited support was provided to children on leaving care; the level of support was usually at the discretion of the care provider and limited by the availability of funds.

- There was a lack of follow-up and monitoring of children after they left alternative care, which affected the level of support they had access to and increased child protection risks.

Guidelines for the Alternative Care of Children

Responsibility for aftercare: §70

Support for aftercare: §131-136

5.4.2 CONCEPTS AND DEFINITIONS

According to the Guidelines, agencies and facilities providing alternative care should have policies on providing appropriate aftercare and follow-up of children leaving alternative care (§131).

The Guidelines do not prescribe the length of time during which children should be supported in the process of leaving care, but place emphasis on consideration of the child's individual needs, including their 'age, gender, maturity and particular circumstances' (§132).

For young people leaving care, although the age of majority may be reached and they are no longer protected under the UNCRC, other human rights conventions come into play. For example, the International Covenant on Economic, Social and Cultural Rights exists to protect employment and social protection rights.³ States are required to ensure that their most vulnerable adults are protected.

The Guidelines point out that provision and planning should take place as early as possible (§134) and prepare children with the skills to integrate fully into their communities (§131). On leaving alternative care, children should be provided with a specialised person (§133) to ensure that the child is fully supported and that there is adequate follow-up of their progress. Children should also be provided with access to basic services, such as social, legal and health services, financial support and ongoing educational and vocational training (§135 to §136).

¹ Moving Forward, p.98.

² Ibid.

³ See: www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.

The Guidelines place particular emphasis on children participating in the planning for their aftercare and that children with special needs, such as disabilities, should benefit from appropriate support systems (§132).

5.4.3 ANALYSIS

5.4.3.1 Planning and preparation

The evidence from the reports indicates that there was either no attempt to prepare children or they were insufficiently prepared for leaving care. There were rarely standards in place and, where they did exist, they were not applied consistently. Planning processes did not start early enough and competent authorities did not have the resources to ensure aftercare planning and preparation of children.

There was also limited evidence that children were encouraged to participate in the process of planning, or that children's disabilities or special needs were adequately taken into consideration.

In **Benin**, there was no statutory guidance for children leaving care and children were often poorly prepared. In **Kenya**, although national policy provides that aftercare should be planned as early as possible, the research found that it was not planned early enough and young people were poorly prepared for leaving care.

In **Malawi**, support for the reintegration of children to their families is supposed to be planned and managed by the Ministry of Gender, Children and Social Welfare, but procedures were not followed due to lack of financial resources. However, some care providers reported that mentoring schemes were in operation, with children previously in alternative care providing advice for children leaving the care system.

5.4.3.2 Provision of support

Where support for aftercare was provided in the region, it was generally inconsistent and provided at the discretion of the alternative care providers. In many cases, these providers did not have policies or the funding in place to support children leaving care appropriately.

In **Kenya**, some aftercare provision was found to be comprehensive: children were provided with semi-independent living arrangements to help their transition and support with ongoing education, and provision was made for children with special needs. However, due to limited financial resources, this was not consistent across all organisations.

In **Gambia** and **Malawi**, there was no consistent system for children leaving care. Children from different institutions

were provided with different levels of support according to the policies and resources of the respective provider organisations.

In **Togo**, links were often cut with children as soon as they left alternative care – there was no funding for preparing children or providing access to education. In **Zambia**, aftercare provision was identified, but there were concerns about the quality of the services provided.

5.4.3.3 Follow-up and monitoring

There was a lack of monitoring for children who leave care, to the extent that institutions did not have records of where the young people were and what they were doing once they had exited the formal care system.

In **Kenya**, although some data on children leaving care was provided by some of the organisations in the research, there was a poor monitoring system for collecting the data. In **Malawi** and **Togo**, there was no noted centralised monitoring system to collect data or ensure follow-up on children leaving care.

In **Tanzania**, weak monitoring systems following up on children leaving care was mainly due to a lack of coordination between organisations and a lack of staff and resources at the Department of Social Welfare. The limited data on children leaving care in **Benin** was also due to lack of financial resources.

STIGMATISATION

Stigma refers to 'a mark of disgrace' that attaches itself to children whose parents have been unable to care for them and who consequently are looked after in alternative care arrangements.

The Guidelines recognise socio-economic stigma as a status that can give rise to children entering the alternative care system (§10, §32, §36), but also makes clear state's responsibilities to ensure that children are not stigmatised by the experience of alternative care – either during or after their placement (§95).

There is a growing awareness of the effects of stigma on children who grow up in alternative care and that this will vary according to the child's circumstance and environment.

Stigma was recognised as a serious child rights violation in Benin; in Malawi the effects of stigma were documented as having an impact on children's rights to basic services, such as education, employment and healthcare; and in Tanzania the effects of stigma were recognised as a factor limiting young people's ability to successfully reintegrate into their communities after they had left alternative care.

In Benin 50% of children leaving care found adapting to life difficult.



Source: According to surveys in the country, Benin country report.

The scarcity of aftercare services for children – which appeared to only take place at the discretion of alternative care providers where there was funding available – and the lack of monitoring of children and young people who left care meant that many were unsupported and vulnerable. This had implications for their long-term development and success.

In **Benin**, the study found that 50% of children leaving care had encountered problems when adjusting to life in their communities. In **Tanzania**, it was reported that young people leaving care faced discrimination and stigmatisation that made integration into their communities more difficult.

In **Malawi**, a local NGO, Chisomo Children's Club, reported success at reintegrating children with their families, but equally identified the dangers, particularly for young girls who, on leaving care, could find themselves in risky environments such as bars and bottle shops. In another study of post-care activities, the Samaritan Trust found that up to 30% of children return to their former care setting unable to cope with life in their communities and approximately 10% were affected by sexual exploitation, criminal offending or imprisonment.



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5.4.4

CONCLUSION

Children leaving alternative care need support to ensure that they have the financial, emotional and educational resources to lead fulfilled and secure lives. Across the region, it appeared that there was good practice in some organisations that support children towards leading integrated lives with their families or independent lives in their communities. However, aftercare provision was generally poorly planned and provided only at the discretion of individual organisations and within the means of limited funding streams. Follow-up on children leaving care was also weak, making it difficult to collect information on the outcomes of children after alternative care. The evidence collected indicates that, without adequate support, children in the region face considerable challenges and many struggle to cope independently.

The reports suggest key weaknesses in the planning, provision and monitoring of aftercare. With adequate funding and political will, an improved leaving care and aftercare experience would help to ensure positive outcomes for children leaving the alternative care system.

Solution based recommendations:

- Competent authorities should ensure that organisations and individuals prepare children and young people adequately, and in a timely manner, in order to leave the alternative care system successfully.
- Children and young people (having reached the age of majority) leaving alternative care should be provided with a specialised person to assist them with the transition and provided with equal access to health, education and social services. Provision should be consistent regardless of the form of alternative care.
- Competent authorities should ensure that alternative care providers keep records of the children leaving their care and provide follow-up monitoring of their progress.
- Systems should be set up to manage data securely and centrally both on the services provided and the outcomes of children leaving the alternative care system.

Roadmap to leaving care and aftercare

1

CHILDREN SHOULD BE PREPARED INFORMALLY THROUGHOUT THEIR CARE TO BECOME INDEPENDENT

2

CHILDREN LEAVING CARE SHOULD BE TAUGHT HOW TO ACCESS FURTHER SERVICES SUCH AS HEALTH, EDUCATION AND SOCIAL SERVICES

3

CHILDREN LEAVING ALTERNATIVE CARE SHOULD BE PROVIDED WITH A SPECIALISED PERSON TO ASSIST THEM WITH THE TRANSITION

4

STATES SHOULD MAP ALL CHILDREN LEAVING CARE TO ENSURE THERE IS FOLLOW-UP MONITORING OF THEIR PROGRESS





6

Protection: Protecting children in alternative care from harm



6.1 INTRODUCTION

6.2 CONCEPTS AND DEFINITIONS

6.3 ANALYSIS

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6. CHILD PROTECTION: PROTECTING CHILDREN IN ALTERNATIVE CARE FROM HARM

6.1 INTRODUCTION

The Guidelines do not define child protection – rather, they reiterate the UNCRC (Article 19) and the right of all children to be protected from violence, exploitation and abuse, regardless of their care setting (§13).

This chapter concentrates on the child protection risks for children without parental care or those at risk of losing it. These include children who live in informal care within their extended families and communities, who benefit from community-based child protection systems, and children in formal alternative care, who have a right to access independent complaints mechanisms.

Using the framework of the Guidelines and related recommendations for effective child protection systems,¹ this chapter considers specific and focused child protection risks and the child protection mechanisms in place across the region in terms of reporting at the community level, complaints mechanisms in formal care, and record-keeping and follow-up of child protection concerns.

Key messages:

- Children without parental care were more vulnerable to child protection risks and these risks vary according to their situation.
- While child protection policies exist, they were not implemented consistently in countries.
- Community reporting mechanisms were in place in some regions, but they had poor coverage and in some cases lacked accountability.
- Complaints mechanisms for formal care were weak and did not provide children with sufficient independent support to pursue concerns.
- There was evidence of record-keeping and follow-up of child protection concerns, but child protection registers were not kept consistently and there was a lack of coordination and funding.
- There was a lack of evidence of effective child participation in child protection mechanisms.

Guidelines for the Alternative Care of Children

Preventive child protection: §3, §32, §34, §39, §84

Responsive child protection: §92-93, §96-97

Reporting complaints and follow-up: §98-99, §107

¹ See Strengthening Child Protection Systems in Sub-Saharan Africa, Joint Inter-Agency Statement.



6.2 CONCEPTS AND DEFINITIONS

State of the art social work approaches emphasise that competent child protection systems are holistic, multi-disciplinary and multi-sectoral. UNICEF defines a child protection system as:

... the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and response to protection-related risks.²

As part of the continuum of care,³ alternative care under the Guidelines involves the ‘protection and well-being of children who are deprived of parental care or who are at risk of being so’ (§1). In this sense, alternative care is part of a holistic child protection system that engages a range of stakeholders across government departments and includes services provided by non-governmental organisations, faith-based organisations, the private sector, local communities and extended families.

Child protection includes both **preventive** and **responsive** elements in the responsibility to protect children and families.

Preventive child protection

The Guidelines recognise the family as the ‘natural environment for the growth, wellbeing and protection of children’ (§3) and place an emphasis on preventing family breakdown and implementing measures to empower families ‘to provide adequately for the protection, care and development of their children’ (§34). This entails comprehensive assessments to be carried out by child protection services (§39).⁴

The Guidelines also place responsibility on governments to combat poverty, discrimination, marginalisation, stigmatisation, violence, child maltreatment and sexual abuse, and substance abuse (§32).

These preventive measures, discussed in more detail in chapter 4, include the provision of universal services, targeted measures, and awareness-raising to support vulnerable children and families.

Responsive child protection

In contrast, responsive child protection comprises effective procedures to respond to allegations and findings of violence, exploitation, neglect and abuse. The Guidelines (in line with the UNCRC Article 37) prohibit the use of behaviour management or discipline that constitutes ‘torture, cruel or inhumane treatment’ (§96) and restricts the use of force or restraints and prohibits treatment that may harm a child (§97).

Child protection mechanisms include processes for reporting and receiving complaints (§98), effective mechanisms for following-up complaints (§99), and ensuring a culture of nurturing alternative care for children in need of protection.

Responsive child protection through the provision of alternative care is also subject to monitoring by a competent authority to ensure that children are effectively protected against abuse and exploitation (§92 and §93). Issues of monitoring and inspecting alternative care providers are discussed in more detail in chapter 3.

² See UNICEF, *Child Protection Strategy*, United Nations Children’s Fund 2008, http://www.unicef.org/protection/files/CP_Strategy_English.pdf.

³ On elements of a continuum of care see, Inter-agency Group on Child Protection Systems in Sub-Saharan Africa, *Strengthening Child Protection Systems in Sub-Saharan Africa*, Working Paper, 2012, p.39.

⁴ Moving Forward, p.55.

6.3 ANALYSIS

6.3.1 CHILD PROTECTION RISKS

All children are vulnerable to violence, exploitation and abuse. A 2006 UN study on violence acknowledges that 'violence exists in every country of the world, cutting across culture, class, education, income and ethnic origin'.⁵ However, children without parental care are particularly vulnerable to these risks as 'stable family units can be a powerful source of protection from violence for children in all settings'.⁶ Evidence from **Togo** found that most cases of violence and abuse against children concerned those not living with their biological parents.⁷

Children in different forms of alternative care, and at different stages in the alternative care system, are vulnerable to different kinds of child protection risk.

Informal or kinship care is the most common form of alternative care in the region (see section 5.2). The Guidelines recognise informal or kinship care's potential for providing secure and nurturing environments for children in family-based and familiar settings, but it comes with its own risks that require appropriate protection mechanisms (§18).⁸

The reports from **Kenya, Malawi** and **Togo** provided evidence that such children were vulnerable to child labour, domestic or agricultural work, mistreated and abused in their extended families or communities, and had restricted access to health and education.

Interviews with key informants in **Kenya** found that informal carers sometimes diverted resources meant for the children in their care for other family needs or appropriated the properties or resources that children had been left by deceased parents. The report also reported concerns of sexual exploitation of children under the care of their community or other family members.

Formal care, either family-based or residential, poses its own risks, particularly where there is an absence of robust independent monitoring and accountability. Across the reports, concerns were highlighted about the treatment of some children in formal care not meeting the standards of the Guidelines on violence and discipline (§92 and §93) or the provision of healthcare (§84).

In **Benin**, evidence was provided that children were given inappropriate health remedies: 13% were provided with herbal tea, 10% with prayers, and 2% were referred to doctors without the relevant skills or qualifications.⁹

There were reports of children being disciplined inappropriately. In **Benin**, a survey of children in residential care found that children were regularly subjected to corporal punishment (caning and hitting), deprivation of food, and additional duties.¹⁰

In **Kenya**, concerns were raised over the lack of implementation of guidelines leading to some institutions being used as a source and transit point for child trafficking.

Children leaving care without adequate support mechanisms can be placed at further risk of exploitation and abuse. There was little evidence that such children were provided with support on leaving care and their welfare is rarely monitored (see section 5.4). In **Malawi**, it was reported that girls leaving care are particularly vulnerable and more likely to find themselves in risky environments such as 'bars and bottle stores'.¹¹

CORPORAL PUNISHMENT

Across the region children remain vulnerable to sanctioned corporal punishment. Of the countries covered in this report, corporal punishment of children was only prohibited by law in Kenya and Togo; with partial prohibitions in Tanzania and Malawi.

This means that in Benin, Gambia, Zambia and Zimbabwe, it remained permissible to punish children physically.¹ In Togo and Malawi, however, it was reported that corporal punishment was still practiced and in Kenya the ban on corporal punishment was generally presumed to apply only to institutions, and therefore corporal punishment in a family environment was commonly accepted.

This affects the rights of children in alternative care, as where there is a culture of accepting corporal punishment there is a fine line between punishments and abuse. This may affect children's likelihood of reporting physical abuse, and may limit the range of responses available to authorities to protect children from harm.

1 Global Initiative to End All Corporal Punishment of Children, *Global Progress towards Prohibiting all Corporal Punishment, 2014*, www.endcorporalpunishment.org/pages/pdfs/GlobalProgress.pdf

5 UN, *Report of the Independent Expert for the United Nations Study on Violence against Children*, New York: United Nations, 2006, p.5.

6 Report of the Independent Expert, p.11.

7 Referenced to Togo's National Policy for Child Protection and the MICS 4 study.

8 For more on this form of care, see Save the Children, *Kinship Care: Providing Positive and Safe Care for Children Living Away from Home*, London: Save the Children, 2007.

9 No external reference provided

10 Reference to the Ministry of Family, 2011.

11 Chisomo Children's Club

CHILDREN IN EMERGENCIES

There is a whole section of the Guidelines dealing with emergency situations (XI), which promotes the need to apply them even during armed conflict and foreign occupation (§153). In some parts of the region, where conflict involving children has been a feature of life these expectations are particularly pertinent.

In emergency situations, such as natural or man-made disasters, children are made particularly vulnerable to being separated from their families. They also become more vulnerable to child protection risks, such as recruitment to armed forces, sexual abuse, or trafficking.

There was very little mention of emergency situations in the country reports. In Kenya it was suggested that in these situations, legal provisions for the promotion of stability, permanence and adequate planning for care in the Children's Act did not apply. There was an increased need for awareness and training in communities on child care and protection during emergencies.

Generally states depend on international humanitarian organisations and NGOs to take care of children during emergency situations, and there is rarely special provision for children with disabilities. However, there was evidence that in Benin, the national support fund provided assistance to children in emergencies (see chapter 3).

In **Kenya**, such failings in the interpretation and implementation of legislation were directly related to continuing cases of child neglect, abandonment, sexual abuse and corporal punishment. In **Zimbabwe**, there was evidence of an irreconcilable disparity between frameworks that were in place to protect children and their experiences of vulnerability.

Therefore, despite efforts to develop child protection mechanisms throughout the region, lack of implementation means that they have had limited effect. These failings result in uneven coverage of child protection systems across countries and regions, disadvantaging particular groups of children.

In **Benin**, services were not available throughout the country particularly in rural areas, and in **Kenya**, there were only four statutory children's rescue centres – established under the Children Act for children in need of care and protection – in the whole country.

Furthermore, child protection standards were not consistent within countries. In **Togo**, child protection policies varied according to the institution and were often only implemented by organisations to meet the requirements of external or overseas funding.

The sections below highlight some of the efforts made in the region to improve protection for children in alternative care in line with the Guidelines. Child protection reporting at the community level is relevant for children in informal alternative care; complaints mechanisms are crucial for children in formal alternative care settings; and child protection record-keeping and follow-up is essential for any child protection system to function.

6.3.2

IMPLEMENTING CHILD PROTECTION LEGISLATION: MAKING THE GUIDELINES REALITY

Child protection systems vary between countries, but there is evidence that regulations on child protection in the region have improved and harmonised with international standards in recent years.¹²

However, despite developing legislation in line with the UNCRC, and more recently the Guidelines, many countries in the region reported failures to implement them adequately. The implementation gaps in the system are highlighted throughout this report and discussed in detail in chapter 3. An effect of failing to implement legislation and standards adequately is increased child protection risks for children in all care settings.

6.3.3

CHILD PROTECTION REPORTING AT THE COMMUNITY LEVEL

Child protection reporting at the community level is not explicitly covered in the Guidelines. However, this is an important element in the child protection system, particularly for children without parental care, or at risk of losing it, who are cared for informally by extended family and within their own communities.

In relation to informal care, the Guidelines recommend that 'states should seek to devise appropriate means... to ensure their welfare and protection... with due respect for cultural, economic, gender and religious differences and practices that do not conflict with the rights and best interests of the child' (§18).

¹² For more information on the strengthening of child protection systems in the region, see Strengthening Child Protection Systems in Sub-Saharan Africa.

Effective community-level reporting implies that there is first an awareness of child protection issues in the community and a responsibility to report any concerns. It also means establishing robust reporting mechanisms that are open to concerned community members and children.

The research found evidence of three approaches to child protection reporting at the local level: raising awareness of child protection issues; channels for reporting child protection concerns; and community child protection mechanisms.

Raising awareness of child protection issues

Across the reports, there was evidence of a reluctance to report child violence, exploitation and abuse and that this inhibited appropriate responses. Despite this, there was also evidence that reporting is slowly becoming more commonplace as child protection becomes less of a taboo subject.

In **Togo**, there was a reluctance to report due to low levels of community empowerment and awareness, and attitudes towards state interference with what is considered to be the private domain. The report asserted that this reflected a poor understanding of child protection at the local level and, in turn, promoted impunity that encouraged children's rights violations.

In **Kenya**, there had been a number of initiatives to raise awareness of child protection issues and combat exploitative practices in informal care. Innovative approaches included engaging chiefs and village elders, who traditionally handle child protection issues, to sensitise communities on the importance of child protection.¹³ Despite this, under-reporting still existed: for example, although in 2005 there were 2,053 reports of child sexual abuse made to the authorities,¹⁴ it was estimated that this figure was much higher due to under-reporting and a lack of effective monitoring mechanisms.

Channels for reporting child protection concerns

In order to allay people's fears about reporting child protection concerns, it is important to provide effective channels through which reports can be made. Official channels, such as through local social services or police stations can sometimes be intimidating and deter people from making reports (improvements to police handling of child protection cases is addressed below).

In **Kenya**, it was reported that most cases of child neglect, abandonment or abuse still went unreported. A key informant in the research indicated that there was public fear of reporting such cases to the police as they may be unnecessarily interrogated and sometimes forced to take

care of the child for an unspecified period. These types of concerns had led to alternative reporting mechanisms being implemented.

In five of the eight countries surveyed, telephone helplines had been created to assist in the reporting of child protection concerns.

In **Benin**, a 'green phone number' was in place to receive child protection reports and, in **Gambia**, there was a toll-free number to report complaints in order to increase the protection of children, along with a package of other local protection measures (discussed below).

In **Togo**, Allo 1011 was attached to the centralised detection office and enabled children and others to make free calls and report child protection concerns. Follow-up activities were coordinated by an interdisciplinary team which could refer children on to appropriate alternative care if necessary. Between January and December 2012, the number dealt with 1,935 cases.¹⁵

In **Kenya**, Child Line 116 was established as a toll-free number to enhance the protection of children from abuse and neglect. Calls were made by children and adults to report abuse, suspected abuse and access information and counselling. In addition, help desks and helplines were established in various police stations to receive and respond to child protection concerns.

In **Malawi**, reporting services were mainly run by civil society organisations, but a national helpline provided information, advice and counselling to thousands of children each year.¹⁶

Such channels are likely to improve the reporting of child protection concerns by the public. However, there is no evidence that they are accessible to all groups, as some communities will not have free access to telephones or be aware of the services available. In addition, as discussed below, reporting is only effective if it leads to meaningful follow-up processes to deal with the concerns reported.

Community child protection mechanisms

Across the region, efforts were underway to implement community level child protection mechanisms. Initiatives ranged from training and employing local child welfare officers to setting up local child protection committees with the participation of the local community.

In **Tanzania**, community development officers had responsibilities that included awareness-raising and mobilisation of the community on children's rights, and encouraging cooperation in conflict situations. They were also responsible for supervising the most vulnerable children identified at the village level and working across departments to ensure child protection.

¹³ Although there were no records of this particular programme available.

¹⁴ No external reference provided.

¹⁵ Referenced to the Annual report of the toll free number, Allo1011, 2012.

¹⁶ Referenced to UNICEF, *Malawi: Child Protection Strategy-2012-2016*. Lilongwe: UNICEF, 2011.

HARMFUL TRADITIONAL PRACTICE

Defining harmful traditional practice has led to highly contentious debate – it has usually focused on the concept of ‘harmful traditional practice’ as a means of getting ‘culturally condoned forms of violence against women included within the UN human rights agenda’.¹

It is important to recognise that there are harmful traditional practices in all cultures,² and that these do not always necessarily affect only women. Both the UNCRC (Article 24(3)) and the ACRWC (Article 21) place a responsibility of governments to abolish traditional practices that are prejudicial to the health of children.

In the research there was evidence of a number of practices that could be considered both harmful to children and arising from a traditional culture or belief system.

FEMALE GENITAL MUTILATION

Female genital mutilation is a cultural practice that affects young girls. As well as being both a physical and sexual violation, it has severe consequences for young girls’ health. In Kenya a 2010 UNICEF report estimated that 27% of girls had been subjected to female genital mutilation.³

CHILD MARRIAGE

Child marriage is recognised under the ACRWC as a harmful social and cultural practice (Article 21(2)). But, despite this across the region there was evidence that children are coerced into marriages at a young age.

In Gambia it was estimated that between 2000 and 2010, there were 321,409 cases of child marriage – 36% of the total number of marriages recorded,⁴ and in Zimbabwe it was reported that approximately 25% of girls were forced to marry before they reached the age of 18.⁵

In Kenya 427 cases of early marriage was reported to the Children’s Services Department in 2011, but an estimate by Plan International has suggested as many as 43.3% of females and 11.6% of males are married as children.⁶

SUPERSTITIOUS BELIEFS

The negative effects of ‘superstition’ were highlighted in Togo, Malawi and Zambia. In Togo allegations of child witchcraft were cited as reasons for families admitting children to alternative care, and in Zambia beliefs in spirits was one of the reasons limiting families’ willingness to foster children unrelated to them. In Malawi, however, there were concerns that some alternative care providers might be teaching witchcraft to children in their care.

1 Winter, B., D. Thompson, and S. Jeffreys, ‘The UN Approach to Harmful Traditional Practices: Some conceptual problems’, *International Feminist Journal of Politics*, 4(1), p.72.

2 Ibid.

3 Referenced to UNICEF 2010.

4 No external reference provided.

5 No external reference provided.

6 Referenced to Plan Kenya, *Kenya Country Report, Study of the Factors Influencing Girls’ Access, Retention and Completion of Primary and Secondary School Education*, 2012.

In **Benin, Gambia, Tanzania, Zambia** and **Zimbabwe**, there were variations on local child protection committees. These committees had different roles according to their location and remit and in the best cases enabled child participation.

In **Gambia**, the Department of Social Welfare had set up community child protection and vulnerable children committees. In **Benin**, there had been a number of strategies to encourage the reporting of child protection concerns to the authorities, including local committees for child protection, local leaders work groups, and local consultative children committees and executive children’s councils.

In **Kenya**, district children officers, volunteer children officers, area advisory committees, representatives of stakeholder ministries such as education, and special programmes, had been established in all districts to monitor issues of child rights and child protection.

In **Tanzania**, the ward community development officer is a member of the village development committee, and was

responsible for planning and supervising various community development works.¹⁷

In **Zambia**, a range of local structures for child protection were identified, including community crime prevention units, child protection committees, child rights clubs (in and out of school) and girls movements and empowerment programmes.

Similarly, in **Zimbabwe**, child protection committees were set up as multi-sectoral bodies with child protection stakeholders, including community members and children. There were also child-led child protection committees which met at regular intervals to deliberate on the state of children’s rights by bringing their concerns to the adult groups. It was estimated that 75% of provinces had such committees, but there was little information on the composition of the groups or the frequency of meetings.¹⁸

Despite these initiatives, there was little evidence that these mechanisms had been adequately monitored or that effective evaluations of services had taken place.

17 Referenced to the National Costed Plan of Action, 2010.

18 Referenced to UNICEF Rapid Assessment Report on CPCS.

In **Gambia**, there were concerns that there was a need for improved record-keeping, management capacity-building and support for the policy environment, and improved monitoring and evaluation.

A UNICEF evaluation of child protection committees in **Zimbabwe** also noted various shortcomings including inconsistent coverage, lack of defined roles and responsibilities without clear reporting lines, and haphazard monitoring and regulation. Levels of child involvement in committees were also considered to be erratic.¹⁹

6.3.4

COMPLAINTS MECHANISMS IN FORMAL CARE

In addition to regular inspections and monitoring – discussed in chapter 3 – that should be in place to ensure adequate standards and safety, the Guidelines provide access to complaints mechanisms for children and staff in formal care (§98, §99, §107).

This crucial right to access complaints mechanisms is supported by an optional protocol to the UNCRC, which entered into force on 14 April 2014 (OPC 3). Of the countries in this study, only **Benin** had signed this protocol to date, which recognises the capacity of children to claim their own rights.²⁰

The Guidelines emphasise the right of meaningful involvement and support for children in articulating concerns: children should have access to ‘a person of trust in whom they may confide in total confidentiality’ (§98) and they should have a ‘known, effective and impartial mechanism whereby they can notify complaints or concerns regarding their treatment or conditions of placement... includ[ing] initial consultation, feedback, implementation and further consultation’ (§99). There is also provision for ‘clear reporting procedures on allegations of misconduct by any team member’ and staff codes of conduct’ (§107).

A UN report on violence against children in 2006 found that ‘effective complaints, monitoring and inspection mechanisms and adequate government oversight are frequently absent’ in formal alternative care.²¹ Similarly, while there was some evidence of unhindered and proactive reporting of child protection concerns in alternative care services, complaints mechanisms in the region appeared to be weak on the whole.

Inadequate complaints mechanisms put children at considerable risk of abuse, as perpetrators are not held accountable for their actions.

In **Kenya**, despite a national policy that provides for complaints reporting mechanisms for children in alternative care, abuses were rarely reported to the relevant authorities. This was despite interviews with children confirming that they had an awareness of their rights, knew how to report complaints through suggestion boxes and were provided with designated officers and Child Line 116. Concerns were raised about cases not being adequately addressed when they involved care providers and there was a need for developing mechanisms for escalation of complaints to be addressed adequately.

In **Malawi**, there was a regulatory framework to oversee an open and impartial complaints procedure. It was estimated that in 2009, 86% of formal care placements had complaints mechanisms in place.²² In this context, child protection officers were mandated to make court applications on behalf of children and become a person of trust who had the remit to pursue complaints on behalf of the child. However, such mechanisms were not evident in practice despite the legislative context.

In **Togo**, complaints mechanisms varied according to the institution and often abided by international rather than national standards, and were therefore not consistent across the country.

In **Zambia**, it was reported that children in alternative care were free to report any incidents of rights violations without fear of victimisation. However, the system was hampered by a lack of detailed procedures to ensure that care providers facilitated children pursuing complaints and for the establishment of support mechanisms throughout. The research highlighted a lack of regulatory framework to ensure open and impartial complaints procedures, as there was not an independent system to provide oversight when addressing different forms of grievances.

While there was certainly some evidence of complaints mechanisms in place across the region, coverage appeared patchy and it was not clear how effective support mechanisms were for helping children raise and resolve their complaints. There was no evidence in the reports of effective evaluation and monitoring of complaints mechanisms.

19 Ibid.

20 Special Representative of the Secretary General on Violence against Children, Press release, 14 April 2014.

21 Report of the Independent Expert, p.16.

22 Referenced to the Better Care Network and UNICEF.

6.3.5

CHILD PROTECTION RECORD-KEEPING AND FOLLOW-UP

The Guidelines state that children in care should be offered access to a person of trust that they can confide in and report allegations to with confidence (§98). However, reporting systems are meaningless if they do not lead to effective responses by responsible and competent authorities to address concerns.

In order to assist with both prevention and follow-up, effective record-keeping of child protection concerns and allegations is required.

In **Kenya**, limited records of child abuse cases in alternative care placements were available. In **Tanzania**, despite stakeholders being given specific child protection roles, challenges remained in monitoring and evaluation and record-keeping on matters of human rights violations, violence and complaints.

In **Malawi**, the law makes provision for training care providers so that they can follow and undertake all prescriptions of the law regarding violence against children, including the appropriate recording of violence. This was particularly the case for allegations of domestic violence, but there was a need for specific guidelines for children in alternative care.

A number of the reports in the study provided evidence of improved approaches to child protection concerns by the police and other responsible agencies.

In **Malawi**, the police service had established victim support and child protection units at the district level in order to provide child friendly services to children in need. In collaboration with other stakeholders, specialist training had been provided to these units and there were plans to develop an integrated community-based support system to complement the efforts of the police.

In **Kenya**, several police officers had been trained on how to handle children in need of care and protection and there were some police stations with designated police officers to handle children's issues. These had specific facilities for children, where they could be placed for up to 48 hours before more appropriate placements were identified. Other initiatives to combat child abuse included counsellors trained and deployed to courts through government and UNICEF initiatives, private counselling offered to children and caregivers who attend courts, and additional support provided by non-governmental organisations.

In **Zambia**, it was reported that law enforcement agencies, the Department of Social Welfare, and children's home staff generally did not hesitate to act when cases of child abuse were reported. In addition, there were victim support units at the police stations to deal with child protection concerns. The government had provided training on how to 'sensitively handle issues of abuse and exploitation' and, in addition, the country had established 'child-friendly courts and police units' to assist children giving testimonies in court.²³

In **Zimbabwe**, there was a victim-friendly system to facilitate the ease of access to justice for children who had suffered sexual violence. Across the country, 230 police stations had victim-friendly units manned by 483 trained police officers. Despite these improvements, the system remained riddled with challenges, including funding and coordination issues, and there was need for the system to be decentralised to all areas of the country.²⁴

23 Referenced to Save the Children UK, 2006.

24 No external reference provided.

6.4 CONCLUSION

The evidence suggests that while there were systems in place to protect children and initiatives were being implemented throughout the region, there was a lack of coordination and consistency.

According to a 2013 Joint Interagency Statement on child protection in Sub-Saharan Africa, effective systems require a multi-disciplinary approach with appropriate policies, legislation and regulation; well defined structures and functions with adequate capacity; supportive social norms; effective promotion, prevention and response actions; high-quality evidence and data for decision-making; and efficient fiscal management and sufficient resource allocation.²⁵

These standards appear to be lacking in the region, despite some evidence of good practice.

The lack of robust child protection systems that encourage children to speak out and participate in processes in both informal and formal alternative care meant that children were at considerable risk of harm and governments were failing to guarantee their rights to protection and wellbeing.

Solution-based recommendations:

Informal care

- Children in informal care are vulnerable to particular child protection risks and need appropriate mechanisms at the local level to identify and address child protection concerns.
- Community-level child protection mechanisms should be adequately funded, appropriately monitored and evaluated to ensure that they protect all children and encourage child participation.

Formal care

- Children in formal care should have universal access to complaints mechanisms and a 'person of trust'.
- Governments should ensure universal access to open, independent, confidential and effective mechanisms for making complaints as per international law stipulated by the OPC 3.
- Staff should be trained to deal with complaints and ensure that children are supported and protected throughout a complaints process.

Record-keeping and follow-up mechanisms

- Record-keeping of child protection concerns should be locally collected and monitored centrally so that it is consistently recorded and applied. This should remain confidential, with access restricted to individuals with responsibility for ensuring effective follow-up.
- All reporting mechanisms should be transparent, robust and child-friendly and managed to ensure that children are provided with justice and suitable alternative care and rehabilitation services where appropriate.

²⁵ See *Strengthening Child Protection Systems in Sub-Saharan Africa*.

7

Conclusion and advocacy messages



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- 7.1 REVISITING THE FINDINGS**
 - 7.2 THE IMPLEMENTATION GAP**
 - 7.3 REVISITING THE POLICY
IMPLEMENTATION FRAMEWORK**
 - 7.4 A COLLABORATIVE APPROACH TO CHANGE**
 - 7.5 OVERARCHING POLICY MESSAGES**
 - 7.6 CONCLUSION**

READING LIST

APPENDICES

- Appendix 1: Guidelines for the Alternative Care of Children
- Appendix 2: Care for MEI country report methodologies table
- Appendix 3: Legal tables

7.

CONCLUSION AND ADVOCACY MESSAGES

In this report, we have presented the context of alternative care and families at risk in Sub-Saharan Africa and detailed the findings to date on the implementation of the Guidelines in eight countries in the region.

As a synthesis report – an overview of research from the region – it provides a useful guide for governments and non-governmental, regional and international organisations in formulating their policy objectives and priorities.

The report offers ample evidence that failure to implement the Guidelines implies serious inadequacies in the services aimed at preventing the separation of children from their families, providing appropriate alternative care, and protecting children from harm.

The role of effective advocacy is not only to reiterate the importance of the Guidelines – standards recognised by UN resolution – but also to understand, in all their complexity, the challenges for governments in implementing them and to find ways of creating an environment in which change is possible.

For each national, regional and local authority, these challenges will be different and will require local knowledge and tailored strategies to influence particular actors, decision-makers and power-holders. However, ‘global forces’ will also inform these local strategies and influence the environments in which they are effective.

This final chapter addresses these ‘global forces’; the common features that compromise governments’ ability to effectively implement the Guidelines or act as the lead body in the provision of care and support for children.

First, we review some of the main findings to provide a brief overview of the characteristics of alternative care in the region.

Second, we identify the gap between policy-making and implementation and recognise the various political, economic and social contexts challenging implementation.

Third, we return full circle to the policy implementation framework – the infrastructure that frames and empowers the government to act – and highlight three weaknesses that can be addressed by effective advocacy.

Finally, we propose three advocacy messages for change that recognise the roles and responsibilities of each of the actors and stakeholders in the alternative care sector including government; non-state actors such as donors, the private sector, NGOs and civil society; and local communities, families and children as both beneficiaries and partners.

In effect, this chapter seeks to begin a discussion that can inform effective advocacy at different levels and lead to local answers to the following questions:

- Why are governments in the region finding it so difficult to effectively implement the Guidelines?
- What can be done to nurture an environment in which implementation is possible and ultimately ensure that children and families have their needs met in ways that respect their rights?

It is impossible, of course, to answer these questions in their entirety. This is a task for local-level advocates working in their own particular local conditions and with knowledge of their stakeholders and political complexities. In this chapter, therefore, with its snapshot of evidence from the region, we begin to map some ways forward in thinking about how the challenges in implementing the Guidelines can be tackled.

7.1 REVISITING THE FINDINGS

The most important findings – the headline issues from each chapter – are directly linked to weaknesses in governance, a lack of reliable, predictable and sustainable resources, and weak data collection and information gathering capacity. These weaknesses lead to inadequate responses to the needs of families and children.

Prevention

In the chapter on preventing children entering alternative care, we concluded that there was insufficient provision of prevention services, that these services were poorly coordinated (only reaching a small proportion of the population in need), and were primarily funded by non-state organisations.

Provision

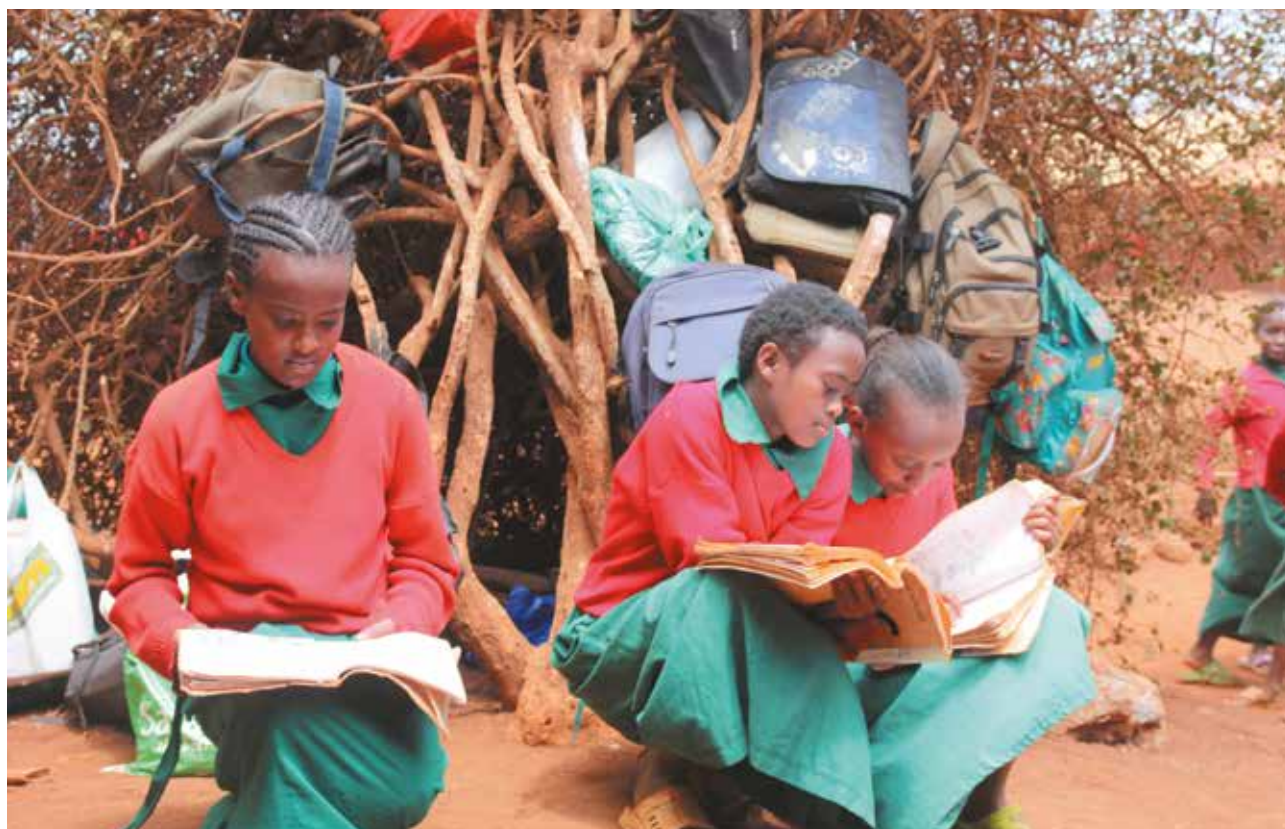
When considering the provision of alternative care services, we clearly highlighted a lack of formal care provision. We found that there was an increasing burden placed on informal forms of care, without the corresponding support from the state to assist carers.

There was also a limited range of formal service provision – in particular a shortage of family-based solutions –

to ensure that decisions were made on the basis of the best interests of the child and that suitable care was available for children according to their individual needs. In particular, the chapter highlighted that good quality residential care was not found consistently and was largely provided by non-state organisations, which did not necessarily abide by the regulations and standards of the state.

We also provided evidence that residential facilities in the region – by far the most common form of formal care provision – were often institutional in nature, with an institutional culture that takes little account of the individuality or psychological and emotional needs of children and tends to isolate them from the outside world.¹ As such, they placed children in environments that are unlikely to nurture their development and wellbeing. Referring back to the failure of the authorities to register and inspect alternative care facilities (covered in detail in chapter 3), a proliferation of unregistered and uninspected facilities were placing children at risk of harm and, in some cases, resulting in serious violations of their human rights.

Leaving care provision, found to be similarly inconsistent and of poor quality, resulted in children living without support when reintegrating into their communities and raised further child protection and child rights concerns.



1 Moving Forward, p.34.

Protection

In the child protection chapter, we illustrated the high levels of risk of abuse, violence and exploitation of vulnerable children and some of the mechanisms in place to protect them. While there were examples of good practice, from community-level child protection initiatives through to formal complaints mechanisms for alternative care, the chapter concluded that implementation was both weak and inconsistent and there was inadequate monitoring of child protection systems.

The recurring themes through the research – weak leadership, planning and coordination of services, low levels of resource provision, and the lack of data and information to inform planning and policy processes for effective provision – echo the challenges described in the policy implementation framework. They illustrate the implications of failures in governance and their impact on the quality of service and outcomes for children in the region. In effect, they highlight a serious gap in the implementation of policy at national, regional and local levels.



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7.2 THE IMPLEMENTATION GAP

The Guidelines recognise that measures are needed to promote their application (§24 to §26). These include the provision of adequate resources and the role of government in ensuring cooperation between ministries, as well as determining the need for and requesting international cooperation, and developing nationally or professionally specific guidelines. In this sense they acknowledge that the pathways to implementation will vary according to country context.

The evidence from the research suggested that implementation of the Guidelines across the board in the eight countries had been inconsistent. This implementation gap – defined as ‘the difference between what solutions have been adopted in legal documents and their actual implementation in practice’² – emerged as a common theme and is a responsibility of all actors in the alternative care system.

There was some evidence of good practice in the region, however, which suggests that implementation is possible where there is a favourable environment. This includes

political will, sufficient coordination of actors, adequate resources, and sound knowledge of what is needed to provide quality care for children.

Where implementation had not taken place however, this was ultimately the result of ‘several common underlying factors in political, economic and social and cultural spheres’.³ These are country, or even locally, specific and need to be tackled by specialist policy-makers and advocates. These weaknesses tend to be intimately linked to governance in each country and are part of the broader political, economic and social setting.

Despite this, themes emerged in the policy implementation frameworks across the countries that add to our understanding of the kinds of changes that are needed in the region in order to facilitate the implementation of the Guidelines. These inhibiting factors come together to create an environment in which it is difficult – or in some cases near impossible – for governments to ensure that the intentions set out in legislation and policy-making are ‘translated into reality’.⁴

² Anna Nadgrodkiewicz, Maiko Nakagaki, Marko Tomcic, *Improving Public Governance: Closing the Implementation Gap between Law and Practice*, Washington DC: Center for International Private Enterprise and Global Integrity, 2012, p.1.

³ *Ibid.*, p.14.

⁴ *Ibid.*, p.3.

7.3

REVISITING THE POLICY IMPLEMENTATION FRAMEWORK: IMPLICATIONS FOR ADVOCACY

While acknowledging that pathways to change will be locally specific, the research identified common factors across the countries that act to limit the governments' ability to implement the Guidelines. These limitations were highlighted under three themes:

- **Governance:** government ability to lead and coordinate activities and oversee operations.
- **Knowledge:** government capacity to collect meaningful data on the population of children without parental care in order to develop appropriate policy and ensure suitable alternative care provision.
- **Resources:** government capacity to raise, sustain and direct resources.

Without these three competencies, the ability of the state to take responsibility for the implementation of the Guidelines is severely compromised. In addition, it is clear from the research that these three features are interdependent and work together to support each other in closing the implementation gap – a weakness or strength in one area entails weakness or strength in the others. This relationship is depicted in the illustration below.

Governance is paramount

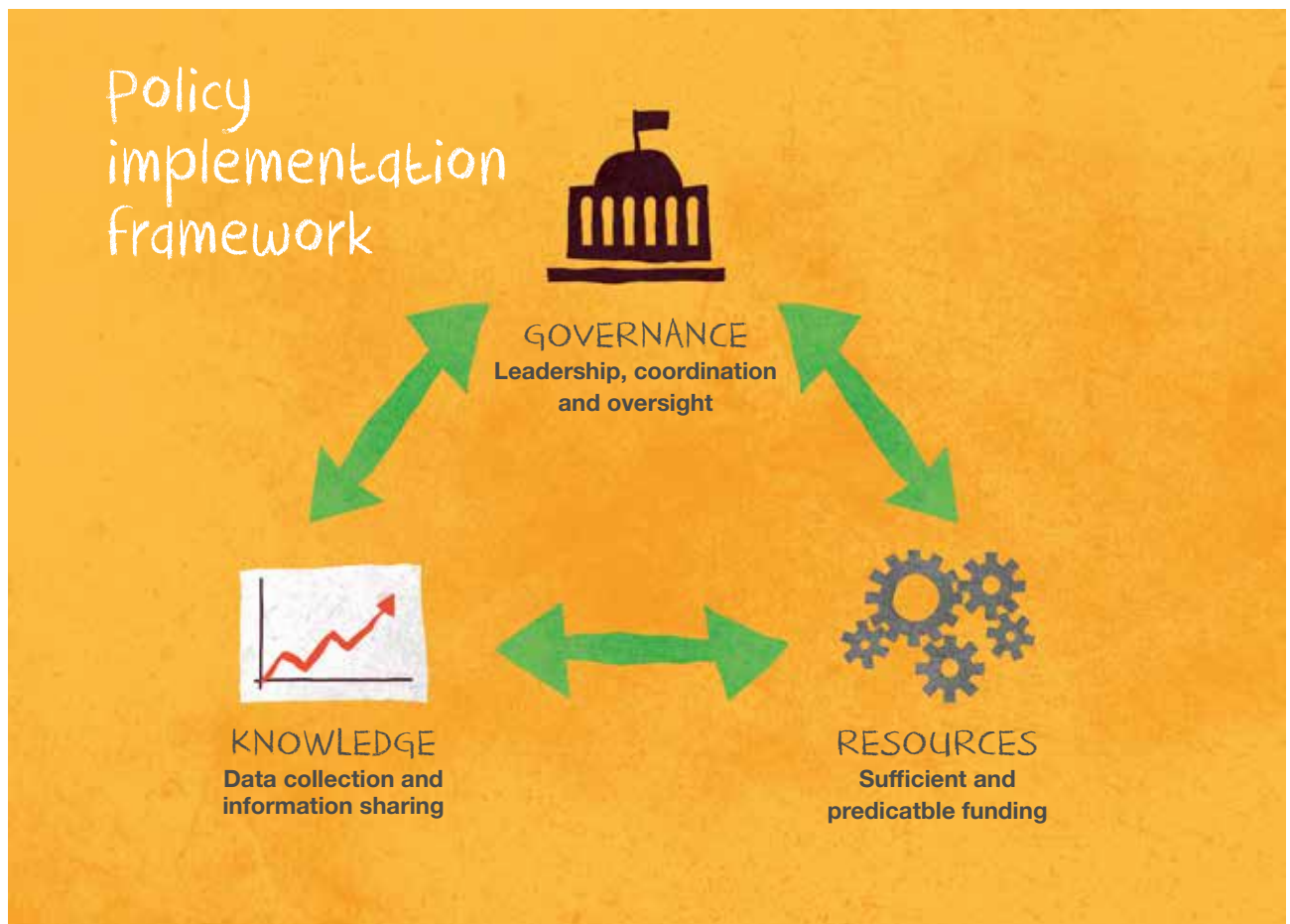
Sticks in a bundle are unbreakable

In some of the reports, it was clear that the flow of overseas development aid through foreign state agencies and NGOs had a negative effect on governments' ability to coordinate services or alternative care. There was also evidence that some aid agencies working in clusters were not required to secure the approval of the state or that states did not effectively engage these agencies in the planning of services.

Improved governance relies on governments taking a leadership role in the planning, oversight and resourcing of alternative care. In doing so, they need sufficient and sustainable resource flows and information on the child population to inform evidence-based planning and policy.

Strong leadership, coordination and strategic oversight will lead to:

- Better outcomes for children and families: more children and families will have access to services that respond to their particular needs.



Knowledge to undertake the tasks ahead

Knowledge without wisdom is like water in the sand

The Guidelines speak about the importance of information sharing and networking between agencies (§70) in the implementation of standards and emphasise the importance of developing policies ‘based on sound information and statistical data’ (§69). The overwhelming scarcity of data presented in our research, limiting the depth of knowledge of the issues to be resolved, and the absence of a singular body to question about the provision of services were common issues in most of the countries.

The collection of reliable domestic data on children’s needs and alternative care provision will:

- Allow governments to understand their care systems in more depth and detail.
- Help to inform planning processes to ensure national coverage of services.
- Offer improved outcomes for children and families through access to the services they need.

Resource management

If you want to walk fast, walk alone; if you want to walk far, walk together!

In all the countries reviewed, services were being delivered, but delivery was patchwork and many of the most vulnerable families missed out. Donors, NGOs and the state will need to work more effectively together to pool resources and ensure uniform delivery of high quality services to all children and families in need. Resources are also required to improve the collection of data for planning processes and ensure that governments are able to fulfil their leadership, oversight and coordination roles.

Pooled and coordinated resources will:

- Ensure high quality and accessible services for children and families.
- Enable governments to collect data on their most vulnerable populations and plan for their alternative care needs appropriately.
- Strengthen the leadership, oversight and coordination roles of government authorities to ensure that the services offered abide by the standards in the Guidelines.

The presence of these three elements does not lead to inevitable success for governments as other factors may also intervene – there may be a lack of political will or processes may be hindered by local elites, corruption or other governance failings at a local level. However, they do provide a basis on which to begin advocacy work for meaningful change.



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*With urgency and a focus on step changes, leaders will act in a planned way based on collaborative discussion.*⁵

UN Resolution (64/142) welcomes the *Guidelines for the Alternative Care of Children* as ‘a set of orientations to help to inform policy and practice’ and puts the onus on governments for implementation. However, it also recognises the role of a range of actors and stakeholders in making this happen.

These actors are decision-makers, care providers and care beneficiaries at all levels of the process from government ministries and officials that have delegated powers as competent authorities, through to non-state organisations such as donors, international organisations, NGOs, the private sector and civil society. These include the care providers that have direct contact with the beneficiaries of alternative care provision and the beneficiaries themselves – communities, families and children.

Engaging with beneficiaries

A group that is often forgotten in terms of their importance for the implementation of policy at the local level is the engagement and empowerment of the beneficiaries of alternative care – children, their families, and the communities in which they live. It is clear that ‘laws are only meaningful if there is political will, grassroots demand and local capacity to implement them’.⁶ At the same time, the UNCRC emphasises the importance of children’s participation as one of the four fundamental principles of the Convention. More specifically, states are ‘under strict obligation to undertake appropriate measures to fully implement’ the right of a child in expressing their views.

The country reports from the region described very limited child and family participation, weak consultation in decision-making, and limited mechanisms for children to make complaints and raise concerns. This is a significant challenge for a system that should be encouraging child, family and community participation not just in preordained processes, but in the ways in which they are designed for specific vulnerable groups.

Engagement is a key feature in closing the implementation gap. Without it there is a great risk that, even with the best ‘policies’ in the world, the experience of children and families in need of support may nevertheless be a negative one.

Greater emphasis on engaging communities, families and children is needed to encourage their participation in the design, operation and oversight of the services that are meant for them. This will improve the likelihood of effective implementation of the Guidelines, as communities are

empowered to demand quality care for the most vulnerable members of society. Engagement of this sort also ensures that governments are aware of, and able to attend to, any unintended consequences of their policies.

Government responsibilities

Governments have the responsibility for implementing the Guidelines, but need to collaborate with other agencies in order to do so. With multiple development challenges in the countries surveyed in this research, this is an eminently complex challenge.

Part of this challenge can be met by investing resources in ensuring that national level policy is in line with the Guidelines, and there is evidence that legislation and policy has been developed in the region to this end. However, as we have seen, implementing these policies requires sound governance and accountability mechanisms to ensure that policies are made reality on the ground and have meaningful impact for beneficiaries.

The strength of government leadership will be realised by putting mechanisms in place that enable collaboration across alternative care providers. Resources invested in building strong and trusting relationships with non-state actors – donors, private sector providers, NGOs and civil society – can form the basis for real change in the alternative care sector. This includes collecting data and sharing information in order to appropriately and strategically plan provision in cooperation with their partners.

In addition, the importance of government as the lead authority with adequate oversight of services will help to ensure accountability up and down and across the system. Evidence that governments have insufficient and poorly resourced mechanisms for registering facilities and monitoring the way they work signals the importance of high quality independent systems for overseeing the functioning of services in the region.

Governments should also put in place mechanisms to enable them to empower children to participate fully in decision-making processes, speak out and have their voices heard and their issues addressed where alternative care provision does not meet their individual needs or puts them at risk. This feedback loop also provides governments and policy-makers with a check-point to ensure the effectiveness and utility of the services that are in place.

⁵ Moving Forward, p.127.

⁶ Improving Public Governance, p.5.

Non-state collaboration

Non-governmental organisations, international organisations, donors and the private sector play a significant role in the provision of care in the region. In various forms, they are also responsible for the implementation of government policy, the funding of services and have direct contact with children.

International donors, in particular, have global standards that they are obliged to comply with. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action commit them to making aid more effective.⁷ This includes assisting in strengthening countries' national development strategies, providing predictable and multi-year commitments on aid flows and taking a role in effective monitoring and evaluation.

Acknowledging the context of differing country situations and capacities of governments, it is clear from our research that collaborating with governments on developing evidence-based policy, planning strategies with predictable and accountable funding streams, and ensuring that there

are monitoring mechanisms in place will go a long way to closing implementation gaps in the alternative care sector.

The private sector and other non-state organisations that act as providers of alternative care also have responsibilities to ensure that their work is in line with the Guidelines and abides by national standards. Such organisations have a role in coordinating their services with overarching priorities and planning to avoid duplication and to help ensure that service provision is consistent for families and children in need.

All non-state organisations that work with vulnerable children and families have the opportunity and responsibility to share their information in a way that is constructive, sensitive and useful for government oversight and planning purposes. Accurate and reliable data collection on the root causes of children entering alternative care, and the population of children in need of alternative care services, are of vital importance for governments and other decision-makers to plan and provide alternative care.

7.5 OVERARCHING ADVOCACY MESSAGES

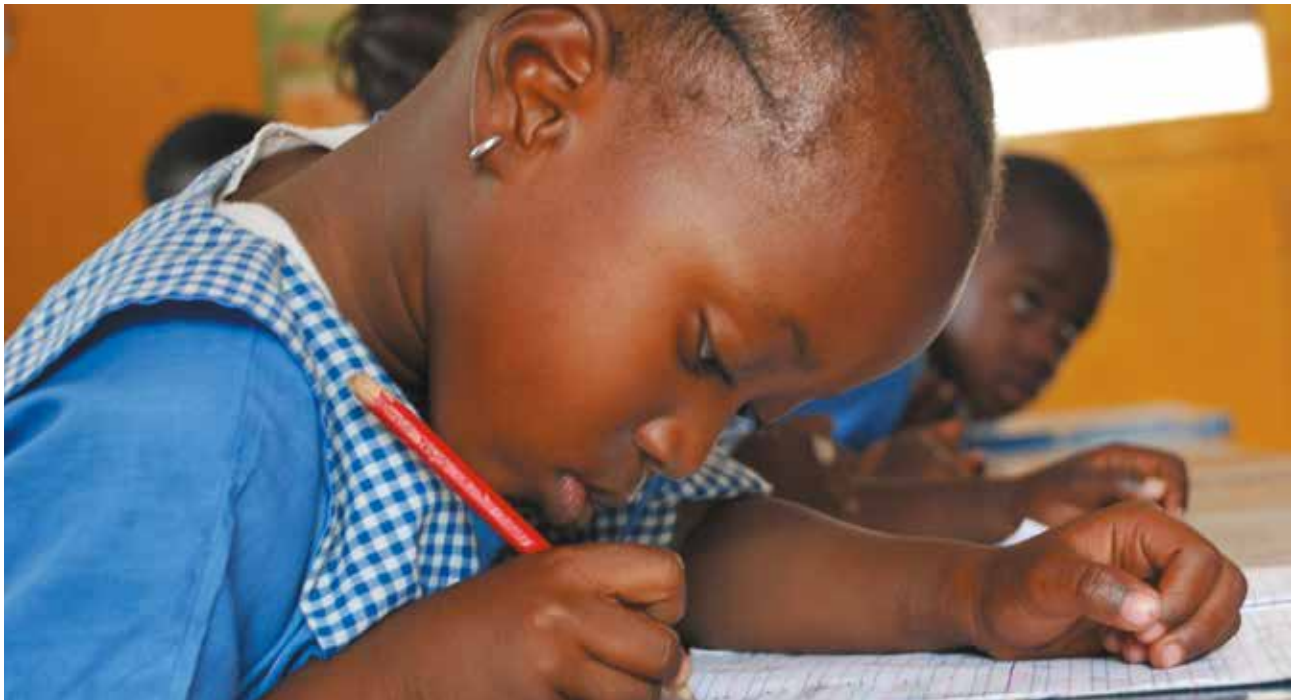
Successful implementation of the Guidelines requires:

- **Active engagement with local communities, families and children.** As the beneficiaries of alternative care, they should be given a voice and a stake in the services that are designed for them and the decisions that are made in their interests.
- **Empowered governments to take a leadership role in governing alternative care provision.** This means leading the oversight and coordination of alternative care provision and developing cooperative partnerships with other stakeholders.
- **Cooperative accountable non-state organisations.** Ranging from international donors, the private sector and civil society to non-governmental organisations, non-state actors should aim to cooperate with and empower governments with resources and knowledge to ensure quality alternative care.



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⁷ The Paris Declaration on Aid Effectiveness (2008) and the Accra Agenda for Action (2005), see: <http://www.oecd.org/development/effectiveness/34428351.pdf>.



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7.6 CONCLUSION

*To move forward, the emphasis will necessarily be on incremental progress.*⁸

In this, the fifth year of the *Guidelines for the Alternative Care of Children*, it is important that we consider them as they were intended: as actionable and realistic policy and practice within the full range of political, social and economic contexts.

This report challenges us to make a fundamental commitment to the significant strides needed to implement the Guidelines at an ever-increasing pace: to make changes to improve the lives of children that make up approximately 50% of the population in the region. This is essential in order to ensure the development and wellbeing of each individual child, and for the flourishing of our communities and society in the future.

Change will demand action from us all – action based on understanding that is constructive and, most importantly, reflects innovative approaches. There is no one pathway for change. In each context, we will be drumming with different rhythms but together these rhythms, in all their syncopation, must be heard and felt as a collective call for positive, real change in the lives of the most vulnerable members of our societies.

⁸ Moving Forward, p.127.



READING LIST

International and regional conventions

African Charter on the Rights and Welfare of the Child 1999,
www1.umn.edu/humanrts/africa/afchild.htm

The Paris Declaration on Aid Effectiveness (2008) and the Accra Agenda for Action (2005),
www.oecd.org/development/effectiveness/34428351.pdf.

UN Convention on the Rights of the Child 1989,
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The main sources of information for the drafting of this paper were the country reports, produced as part of the SOS Children's Villages International project Care for ME! They can be found online at **www.care-for-me**. African proverbs from www.afritorial.com

APPENDIX 1: GUIDELINES FOR THE ALTERNATIVE CARE OF CHILDREN

United Nations

A/RES/64/142*



General Assembly

Distr.: General
24 February 2010

Sixty-fourth session
Agenda item 64

Resolution adopted by the General Assembly on 18 December 2009

[on the report of the Third Committee (A/64/434)]

64/142. Guidelines for the Alternative Care of Children

The General Assembly,

Reaffirming the Universal Declaration of Human Rights¹ and the Convention on the Rights of the Child,² and celebrating the twentieth anniversary of the Convention in 2009,

Reaffirming also all previous resolutions on the rights of the child of the Human Rights Council, the Commission on Human Rights and the General Assembly, the most recent being Council resolutions 7/29 of 28 March 2008,³ 9/13 of 24 September 2008⁴ and 10/8 of 26 March 2009⁵ and Assembly resolution 63/241 of 24 December 2008,

Considering that the Guidelines for the Alternative Care of Children, the text of which is annexed to the present resolution, 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,

1. *Welcomes* the Guidelines for the Alternative Care of Children, as contained in the annex to the present resolution, as a set of orientations to help to inform policy and practice;

2. *Encourages* States to take the Guidelines into account and to bring them to the attention of the relevant executive, legislative and judiciary bodies of government, human rights defenders and lawyers, the media and the public in general;

* Reissued for technical reasons on 13 April 2010.

¹ Resolution 217 A (III).

² United Nations, *Treaty Series*, vol. 1577, No. 27531.

³ See *Official Records of the General Assembly, Sixty-third Session, Supplement No. 53 (A/63/53)*, chap. II.

⁴ *Ibid.*, *Supplement No. 53A (A/63/53/Add.1)*, chap. I.

⁵ *Ibid.*, *Sixty-fourth Session, Supplement No. 53 (A/64/53)*, chap. II, sect. A.

09-47035*



UN Doc. No. A/RES/64/142

3. *Requests* the Secretary-General, within existing resources, to take steps to disseminate the Guidelines in all the official languages of the United Nations, including by transmitting them to all Member States, regional commissions and relevant intergovernmental and non-governmental organizations.

*65th plenary meeting
18 December 2009*

Annex

Guidelines for the Alternative Care of Children

I. Purpose

1. The present Guidelines are intended to enhance the implementation of the Convention on the Rights of the Child² and of relevant provisions of other international instruments regarding the protection and well-being of children who are deprived of parental care or who are at risk of being so.

2. Against the background of these international instruments and taking account of the developing body of knowledge and experience in this sphere, the Guidelines set out desirable orientations for policy and practice. They are designed for wide dissemination among all sectors directly or indirectly concerned with issues relating to alternative care, and seek in particular:

(a) To support efforts to keep children in, or return them to, the care of their family or, failing this, to find another appropriate and permanent solution, including adoption and *kafala* of Islamic law;

(b) To ensure that, while such permanent solutions are being sought, or in cases where they are not possible or are not in the best interests of the child, the most suitable forms of alternative care are identified and provided, under conditions that promote the child's full and harmonious development;

(c) To assist and encourage Governments to better implement their responsibilities and obligations in these respects, bearing in mind the economic, social and cultural conditions prevailing in each State; and

(d) To guide policies, decisions and activities of all concerned with social protection and child welfare in both the public and the private sectors, including civil society.

II. General principles and perspectives

A. The child and the family

3. The family being the fundamental group of society and the natural environment for the growth, well-being and protection of children, efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members. The State should ensure that families have access to forms of support in the caregiving role.

4. Every child and young person should live in a supportive, protective and caring environment that promotes his/her full potential. Children with inadequate or no parental care are at special risk of being denied such a nurturing environment.

5. Where the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child, the State is responsible for protecting the rights of the child and ensuring appropriate alternative care, with or through competent local authorities and duly authorized civil society organizations. It is the role of the State, through its competent authorities, to ensure the supervision of the safety, well-being and development of any child placed in alternative care and the regular review of the appropriateness of the care arrangement provided.

6. All decisions, initiatives and approaches falling within the scope of the present Guidelines should be made on a case-by-case basis, with a view, notably, to ensuring the child's safety and security, and must be grounded in the best interests and rights of the child concerned, in conformity with the principle of non-discrimination and taking due account of the gender perspective. They should respect fully the child's right to be consulted and to have his/her views duly taken into account in accordance with his/her evolving capacities, and on the basis of his/her access to all necessary information. Every effort should be made to enable such consultation and information provision to be carried out in the child's preferred language.

7. In applying the present Guidelines, determination of the best interests of the child shall be designed to identify courses of action for children deprived of parental care, or at risk of being so, that are best suited to satisfying their needs and rights, taking into account the full and personal development of their rights in their family, social and cultural environment and their status as subjects of rights, both at the time of the determination and in the longer term. The determination process should take account of, *inter alia*, the right of the child to be heard and to have his/her views taken into account in accordance with his/her age and maturity.

8. States should develop and implement comprehensive child welfare and protection policies within the framework of their overall social and human development policy, with attention to the improvement of existing alternative care provision, reflecting the principles contained in the present Guidelines.

9. As part of efforts to prevent the separation of children from their parents, States should seek to ensure appropriate and culturally sensitive measures:

(a) To support family caregiving environments whose capacities are limited by factors such as disability, drug and alcohol misuse, discrimination against families with indigenous or minority backgrounds, and living in armed conflict regions or under foreign occupation;

(b) To provide appropriate care and protection for vulnerable children, such as child victims of abuse and exploitation, abandoned children, children living on the street, children born out of wedlock, unaccompanied and separated children, internally displaced and refugee children, children of migrant workers, children of asylum-seekers, or children living with or affected by HIV/AIDS and other serious illnesses.

10. Special efforts should be made to tackle discrimination on the basis of any status of the child or parents, including poverty, ethnicity, religion, sex, mental and physical disability, HIV/AIDS or other serious illnesses, whether physical or mental, birth out of wedlock, and socio-economic stigma, and all other statuses and circumstances that can give rise to relinquishment, abandonment and/or removal of a child.

B. Alternative care

11. All decisions concerning alternative care should take full account of the desirability, in principle, of maintaining the child as close as possible to his/her habitual place of residence, in order to facilitate contact and potential reintegration with his/her family and to minimize disruption of his/her educational, cultural and social life.

12. Decisions regarding children in alternative care, including those in informal care, should have due regard for the importance of ensuring children a stable home and of meeting their basic need for safe and continuous attachment to their caregivers, with permanency generally being a key goal.

13. Children must be treated with dignity and respect at all times and must benefit from effective protection from abuse, neglect and all forms of exploitation, whether on the part of care providers, peers or third parties, in whatever care setting they may find themselves.

14. Removal of a child from the care of the family should be seen as a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration. Removal decisions should be regularly reviewed and the child's return to parental care, once the original causes of removal have been resolved or have disappeared, should be in the best interests of the child, in keeping with the assessment foreseen in paragraph 49 below.

15. Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family.

16. Attention must be paid to promoting and safeguarding all other rights of special pertinence to the situation of children without parental care, including, but not limited to, access to education, health and other basic services, the right to identity, freedom of religion or belief, language and protection of property and inheritance rights.

17. Siblings with existing bonds should in principle not be separated by placements in alternative care unless there is a clear risk of abuse or other justification in the best interests of the child. In any case, every effort should be made to enable siblings to maintain contact with each other, unless this is against their wishes or interests.

18. Recognizing that, in most countries, the majority of children without parental care are looked after informally by relatives or others, States should seek to devise appropriate means, consistent with the present Guidelines, to ensure their welfare and protection while in such informal care arrangements, with due respect for cultural, economic, gender and religious differences and practices that do not conflict with the rights and best interests of the child.

19. No child should be without the support and protection of a legal guardian or other recognized responsible adult or competent public body at any time.

20. The provision of alternative care should never be undertaken with a prime purpose of furthering the political, religious or economic goals of the providers.

21. 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.

22. In accordance with the predominant opinion of experts, alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome.

23. 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 deinstitutionalization strategy, with precise goals and objectives, which will allow for their progressive elimination. To this end, States should establish care standards to ensure the quality and conditions that are conducive to the child's development, such as individualized and small-group care, and should evaluate existing facilities against these standards. Decisions regarding the establishment of, or permission to establish, new residential care facilities, whether public or private, should take full account of this deinstitutionalization objective and strategy.

Measures to promote application

24. States should, to the maximum extent of their available resources and, where appropriate, within the framework of development cooperation, allocate human and financial resources to ensure the optimal and progressive implementation of the present Guidelines throughout their respective territories in a timely manner. States should facilitate active cooperation among all relevant authorities and the mainstreaming of child and family welfare issues within all ministries directly or indirectly concerned.

25. States are responsible for determining any need for, and requesting, international cooperation in implementing the present Guidelines. Such requests should be given due consideration and should receive a favourable response wherever possible and appropriate. The enhanced implementation of the present Guidelines should figure in development cooperation programmes. When providing assistance to a State, foreign entities should abstain from any initiative inconsistent with the Guidelines.

26. Nothing in the present Guidelines should be interpreted as encouraging or condoning lower standards than those that may exist in given States, including in their legislation. Similarly, competent authorities, professional organizations and others are encouraged to develop national or professionally specific guidelines that build upon the letter and spirit of the present Guidelines.

III. Scope of the Guidelines

27. The present Guidelines apply to the appropriate use and conditions of alternative formal care for all persons under the age of 18 years, unless, under the law applicable to the child, majority is attained earlier. Only where indicated do the Guidelines also apply to informal care settings, having due regard for both the important role played by the extended family and the community and the obligations of States for all children not in the care of their parents or legal and customary caregivers, as set out in the Convention on the Rights of the Child.²

28. Principles in the present Guidelines are also applicable, as appropriate, to young persons already in alternative care and who need continuing care or support for a transitional period after reaching the age of majority under applicable law.

29. For the purposes of the present Guidelines, and subject, notably, to the exceptions listed in paragraph 30 below, the following definitions shall apply:

(a) Children without parental care: all children not in the overnight care of at least one of their parents, for whatever reason and under whatever circumstances. Children without parental care who are outside their country of habitual residence or victims of emergency situations may be designated as:

(i) “Unaccompanied” if they are not cared for by another relative or an adult who by law or custom is responsible for doing so; or

(ii) “Separated” if they are separated from a previous legal or customary primary caregiver, but who may nevertheless be accompanied by another relative;

(b) Alternative care may take the form of:

(i) Informal care: any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body;

(ii) Formal care: all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures;

(c) With respect to the environment where it is provided, alternative care may be:

(i) Kinship care: family-based care within the child’s extended family or with close friends of the family known to the child, whether formal or informal in nature;

(ii) Foster care: situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children’s own family that has been selected, qualified, approved and supervised for providing such care;

(iii) Other forms of family-based or family-like care placements;

(iv) Residential care: care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes;

(v) Supervised independent living arrangements for children;

(d) With respect to those responsible for alternative care:

(i) Agencies are the public or private bodies and services that organize alternative care for children;

(ii) Facilities are the individual public or private establishments that provide residential care for children.

30. The scope of alternative care as foreseen in the present Guidelines does not extend, however, to:

(a) Persons under the age of 18 years who are deprived of their liberty by decision of a judicial or administrative authority as a result of being alleged as, accused of or recognized as having infringed the law, and whose situation is covered by the United Nations Standard Minimum Rules for the Administration of Juvenile Justice⁶ and the United Nations Rules for the Protection of Juveniles Deprived of Their Liberty;⁷

(b) Care by adoptive parents from the moment the child concerned is effectively placed in their custody pursuant to a final adoption order, as of which moment, for the purposes of the present Guidelines, the child is considered to be in parental care. The Guidelines are, however, applicable to pre-adoption or probationary placement of a child with the prospective adoptive parents, as far as they are compatible with requirements governing such placements as stipulated in other relevant international instruments;

(c) Informal arrangements whereby a child voluntarily stays with relatives or friends for recreational purposes and reasons not connected with the parents' general inability or unwillingness to provide adequate care.

31. Competent authorities and others concerned are also encouraged to make use of the present Guidelines, as applicable, at boarding schools, hospitals, centres for children with mental and physical disabilities or other special needs, camps, the workplace and other places which may be responsible for the care of children.

IV. Preventing the need for alternative care

A. Promoting parental care

32. States should pursue policies that ensure support for families in meeting their responsibilities towards the child and promote the right of the child to have a relationship with both parents. These policies should address the root causes of child abandonment, relinquishment and separation of the child from his/her family by ensuring, inter alia, the right to birth registration, and access to adequate housing and to basic health, education and social welfare services, as well as by promoting measures to combat poverty, discrimination, marginalization, stigmatization, violence, child maltreatment and sexual abuse, and substance abuse.

33. States should develop and implement consistent and mutually reinforcing family-oriented policies designed to promote and strengthen parents' ability to care for their children.

34. States should implement effective measures to prevent child abandonment, relinquishment and separation of the child from his/her family. Social policies and programmes should, inter alia, empower families with attitudes, skills, capacities and tools to enable them to provide adequately for the protection, care and development of their children. The complementary capacities of the State and civil society, including non-governmental and community-based organizations, religious

⁶ Resolution 40/33, annex.

⁷ Resolution 45/113, annex.

leaders and the media should be engaged to this end. These social protection measures should include:

(a) Family strengthening services, such as parenting courses and sessions, the promotion of positive parent-child relationships, conflict resolution skills, opportunities for employment and income generation and, where required, social assistance;

(b) Supportive social services, such as day care, mediation and conciliation services, substance abuse treatment, financial assistance, and services for parents and children with disabilities. Such services, preferably of an integrated and non-intrusive nature, should be directly accessible at the community level and should actively involve the participation of families as partners, combining their resources with those of the community and the carer;

(c) Youth policies aiming at empowering youth to face positively the challenges of everyday life, including when they decide to leave the parental home, and preparing future parents to make informed decisions regarding their sexual and reproductive health and to fulfil their responsibilities in this respect.

35. Various complementary methods and techniques should be used for family support, varying throughout the process of support, such as home visits, group meetings with other families, case conferences and securing commitments by the family concerned. They should be directed towards both facilitating intrafamilial relationships and promoting the family's integration within its community.

36. Special attention should be paid, in accordance with local laws, to the provision and promotion of support and care services for single and adolescent parents and their children, whether or not born out of wedlock. States should ensure that adolescent parents retain all rights inherent to their status both as parents and as children, including access to all appropriate services for their own development, allowances to which parents are entitled, and their inheritance rights. Measures should be adopted to ensure the protection of pregnant adolescents and to guarantee that they do not interrupt their studies. Efforts should also be made to reduce the stigma attached to single and adolescent parenthood.

37. Support and services should be available to siblings who have lost their parents or caregivers and choose to remain together in their household, to the extent that the eldest sibling is both willing and deemed capable of acting as the household head. States should ensure, including through the appointment of a legal guardian, a recognized responsible adult or, where appropriate, a public body legally mandated to act as guardian, as stipulated in paragraph 19 above, that such households benefit from mandatory protection from all forms of exploitation and abuse, and supervision and support on the part of the local community and its competent services, such as social workers, with particular concern for the children's health, housing, education and inheritance rights. Special attention should be given to ensuring that the head of such a household retains all rights inherent to his/her child status, including access to education and leisure, in addition to his/her rights as a household head.

38. States should ensure opportunities for day care, including all-day schooling, and respite care which would enable parents better to cope with their overall responsibilities towards the family, including additional responsibilities inherent in caring for children with special needs.

Preventing family separation

39. Proper criteria based on sound professional principles should be developed and consistently applied for assessing the child's and the family's situation, including the family's actual and potential capacity to care for the child, in cases where the competent authority or agency has reasonable grounds to believe that the well-being of the child is at risk.

40. Decisions regarding removal or reintegration should be based on this assessment and should be made by suitably qualified and trained professionals, on behalf of or authorized by a competent authority, in full consultation with all concerned and bearing in mind the need to plan for the child's future.

41. States are encouraged to adopt measures for the integral protection and guarantee of rights during pregnancy, birth and the breastfeeding period, in order to ensure conditions of dignity and equality for the adequate development of the pregnancy and the care of the child. Therefore, support programmes should be provided to future mothers and fathers, particularly adolescent parents, who have difficulty exercising their parental responsibilities. Such programmes should aim at empowering mothers and fathers to exercise their parental responsibilities in conditions of dignity and at avoiding their being induced to surrender their child because of their vulnerability.

42. When a child is relinquished or abandoned, States should ensure that this may take place in conditions of confidentiality and safety for the child, respecting his/her right to access information on his/her origins where appropriate and possible under the law of the State.

43. States should formulate clear policies to address situations where a child has been abandoned anonymously, which indicate whether and how family tracing should be undertaken and reunification or placement within the extended family pursued. Policies should also allow for timely decision-making on the child's eligibility for permanent family placement and for arranging such placements expeditiously.

44. When a public or private agency or facility is approached by a parent or legal guardian wishing to relinquish a child permanently, the State should ensure that the family receives counselling and social support to encourage and enable them to continue to care for the child. If this fails, a social worker or other appropriate professional assessment should be undertaken to determine whether there are other family members who wish to take permanent responsibility for the child, and whether such arrangements would be in the best interests of the child. Where such arrangements are not possible or are not in the best interests of the child, efforts should be made to find a permanent family placement within a reasonable period.

45. When a public or private agency or facility is approached by a parent or caregiver wishing to place a child in care for a short or indefinite period, the State should ensure the availability of counselling and social support to encourage and enable him or her to continue to care for the child. A child should be admitted to alternative care only when such efforts have been exhausted and acceptable and justified reasons for entry into care exist.

46. Specific training should be provided to teachers and others working with children in order to help them to identify situations of abuse, neglect, exploitation or risk of abandonment and to refer such situations to competent bodies.

47. Any decision to remove a child against the will of his/her parents must be made by competent authorities, in accordance with applicable law and procedures and subject to judicial review, the parents being assured the right of appeal and access to appropriate legal representation.

48. When the child's sole or main carer may be the subject of deprivation of liberty as a result of preventive detention or sentencing decisions, non-custodial remand measures and sentences should be taken in appropriate cases wherever possible, the best interests of the child being given due consideration. States should take into account the best interests of the child when deciding whether to remove children born in prison and children living in prison with a parent. The removal of such children should be treated in the same way as other instances where separation is considered. Best efforts should be made to ensure that children remaining in custody with their parent benefit from adequate care and protection, while guaranteeing their own status as free individuals and access to activities in the community.

B. Promoting family reintegration

49. In order to prepare and support the child and the family for his/her possible return to the family, his/her situation should be assessed by a duly designated individual or team with access to multidisciplinary advice, in consultation with the different actors involved (the child, the family, the alternative caregiver), so as to decide whether the reintegration of the child in the family is possible and in the best interests of the child, which steps this would involve and under whose supervision.

50. The aims of the reintegration and the family's and alternative caregiver's principal tasks in this respect should be set out in writing and agreed on by all concerned.

51. Regular and appropriate contact between the child and his/her family specifically for the purpose of reintegration should be developed, supported and monitored by the competent body.

52. Once decided, the reintegration of the child in his/her family should be designed as a gradual and supervised process, accompanied by follow-up and support measures that take account of the child's age, needs and evolving capacities, as well as the cause of the separation.

V. Framework of care provision

53. In order to meet the specific psychoemotional, social and other needs of each child without parental care, States should take all necessary measures to ensure that the legislative, policy and financial conditions exist to provide for adequate alternative care options, with priority to family- and community-based solutions.

54. States should ensure the availability of a range of alternative care options, consistent with the general principles of the present Guidelines, for emergency, short-term and long-term care.

55. States should ensure that all entities and individuals engaged in the provision of alternative care for children receive due authorization to do so from a competent authority and are subject to regular monitoring and review by the latter in keeping with the present Guidelines. To this end, these authorities should develop appropriate criteria for assessing the professional and ethical fitness of care providers and for their accreditation, monitoring and supervision.

56. With regard to informal care arrangements for the child, whether within the extended family, with friends or with other parties, States should, where appropriate, encourage such carers to notify the competent authorities accordingly so that they and the child may receive any necessary financial and other support that would promote the child's welfare and protection. Where possible and appropriate, States should encourage and enable informal caregivers, with the consent of the child and parents concerned, to formalize the care arrangement after a suitable lapse of time, to the extent that the arrangement has proved to be in the best interests of the child to date and is expected to continue in the foreseeable future.

VI. Determination of the most appropriate form of care

57. Decision-making on alternative care in the best interests of the child should take place through a judicial, administrative or other adequate and recognized procedure, with legal safeguards, including, where appropriate, legal representation on behalf of children in any legal proceedings. It should be based on rigorous assessment, planning and review, through established structures and mechanisms, and should be carried out on a case-by-case basis, by suitably qualified professionals in a multidisciplinary team, wherever possible. It should involve full consultation at all stages with the child, according to his/her evolving capacities, and with his/her parents or legal guardians. To this end, all concerned should be provided with the necessary information on which to base their opinion. States should make every effort to provide adequate resources and channels for the training and recognition of the professionals responsible for determining the best form of care so as to facilitate compliance with these provisions.

58. Assessment should be carried out expeditiously, thoroughly and carefully. It should take into account the child's immediate safety and well-being, as well as his/her longer-term care and development, and should cover the child's personal and developmental characteristics, ethnic, cultural, linguistic and religious background, family and social environment, medical history and any special needs.

59. The resulting initial and review reports should be used as essential tools for planning decisions from the time of their acceptance by the competent authorities onwards, with a view to, *inter alia*, avoiding undue disruption and contradictory decisions.

60. Frequent changes in care setting are detrimental to the child's development and ability to form attachments, and should be avoided. Short-term placements should aim at enabling an appropriate permanent solution to be arranged. 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.

61. Planning for care provision and permanency should be carried out from the earliest possible time, ideally before the child enters care, taking into account the immediate and longer-term advantages and disadvantages of each option considered, and should comprise short- and long-term propositions.

62. Planning for care provision and permanency should be based on, notably, the nature and quality of the child's attachment to his/her family, the family's capacity to safeguard the child's well-being and harmonious development, the child's need or desire to feel part of a family, the desirability of the child remaining within his/her community and country, the child's cultural, linguistic and religious background, and the child's relationships with siblings, with a view to avoiding their separation.

63. The plan should clearly state, inter alia, the goals of the placement and the measures to achieve them.

64. The child and his/her parents or legal guardians should be fully informed about the alternative care options available, the implications of each option and their rights and obligations in the matter.

65. The preparation, enforcement and evaluation of a protective measure for a child should be carried out, to the greatest extent possible, with the participation of his/her parents or legal guardians and potential foster carers and caregivers, with respect to his/her particular needs, convictions and special wishes. At the request of the child, parents or legal guardians, other important persons in the child's life may also be consulted in any decision-making process, at the discretion of the competent authority.

66. States should ensure that any child who has been placed in alternative care by a properly constituted court, tribunal or administrative or other competent body, as well as his/her parents or others with parental responsibility, are given the opportunity to make representations on the placement decision before a court, are informed of their rights to make such representations and are assisted in doing so.

67. States should ensure the right of any child who has been placed in temporary care to regular and thorough review – preferably at least every three months – of the appropriateness of his/her care and treatment, taking into account, notably, his/her personal development and any changing needs, developments in his/her family environment, and the adequacy and necessity of the current placement in these circumstances. The review should be carried out by duly qualified and authorized persons, and should fully involve the child and all relevant persons in the child's life.

68. The child should be prepared for all changes of care settings resulting from the planning and review processes.

VII. Provision of alternative care

A. Policies

69. It is a responsibility of the State or appropriate level of government to ensure the development and implementation of coordinated policies regarding formal and informal care for all children who are without parental care. Such policies should be based on sound information and statistical data. They should define a process for determining who has responsibility for a child, taking into account the role of the child's parents or principal caregivers in his/her protection, care and development. Presumptive responsibility, unless shown to be otherwise, is with the child's parents or principal caregivers.

70. All State entities involved in the referral of, and assistance to, children without parental care, in cooperation with civil society, should adopt policies and procedures which favour information-sharing and networking between agencies and individuals in order to ensure effective care, aftercare and protection for these children. The location and/or design of the agency responsible for the oversight of alternative care should be established so as to maximize its accessibility to those who require the services provided.

71. Special attention should be paid to the quality of alternative care provision, both in residential and in family-based care, in particular with regard to the professional skills, selection, training and supervision of carers. Their role and functions should be clearly defined and clarified with respect to those of the child's parents or legal guardians.

72. In each country, the competent authorities should draw up a document setting out the rights of children in alternative care in keeping with the present Guidelines. Children in alternative care should be enabled to understand fully the rules, regulations and objectives of the care setting and their rights and obligations therein.

73. All alternative care provision should be based on a written statement of the provider's aims and objectives in providing the service and the nature of the provider's responsibilities to the child that reflects the standards set by the Convention on the Rights of the Child,² the present Guidelines and applicable law. All providers should be appropriately qualified or approved in accordance with legal requirements to provide alternative care services.

74. A regulatory framework should be established to ensure a standard process for the referral or admission of a child to an alternative care setting.

75. Cultural and religious practices regarding the provision of alternative care, including those related to gender perspectives, should be respected and promoted to the extent that they can be shown to be consistent with the rights and best interests of the children. The process of considering whether such practices should be promoted should be carried out in a broadly participatory way, involving the cultural and religious leaders concerned, professionals and those caring for children without parental care, parents and other relevant stakeholders, as well as the children themselves.

1. Informal care

76. With a view to ensuring that appropriate conditions of care are met in informal care provided by individuals or families, States should recognize the role played by this type of care and take adequate measures to support its optimal provision on the basis of an assessment of which particular settings may require special assistance or oversight.

77. Competent authorities should, where appropriate, encourage informal carers to notify the care arrangement and should seek to ensure their access to all available services and benefits likely to assist them in discharging their duty to care for and protect the child.

78. The State should recognize the de facto responsibility of informal carers for the child.

79. States should devise special and appropriate measures designed to protect children in informal care from abuse, neglect, child labour and all other forms of exploitation, with particular attention to informal care provided by non-relatives, or by relatives previously unknown to the children or living far from the children's habitual place of residence.

2. General conditions applying to all forms of formal alternative care arrangements

80. The transfer of a child into alternative care should be carried out with the utmost sensitivity and in a child-friendly manner, in particular involving specially trained and, in principle, non-uniformed personnel.

81. When a child is placed in alternative care, contact with his/her family, as well as with other persons close to him or her, such as friends, neighbours and previous carers, should be encouraged and facilitated, in keeping with the child's protection and best interests. The child should have access to information on the situation of his/her family members in the absence of contact with them.

82. States should pay special attention to ensuring that children in alternative care because of parental imprisonment or prolonged hospitalization have the opportunity to maintain contact with their parents and receive any necessary counselling and support in that regard.
83. Carers should ensure that children receive adequate amounts of wholesome and nutritious food in accordance with local dietary habits and relevant dietary standards, as well as with the children's religious beliefs. Appropriate nutritional supplementation should also be provided when necessary.
84. Carers should promote the health of the children for whom they are responsible and make arrangements to ensure that medical care, counselling and support are made available as required.
85. Children should have access to formal, non-formal and vocational education in accordance with their rights, to the maximum extent possible in educational facilities in the local community.
86. Carers should ensure that the right of every child, including children with disabilities, living with or affected by HIV/AIDS or having any other special needs, to develop through play and leisure activities is respected and that opportunities for such activities are created within and outside the care setting. Contact with the children and others in the local community should be encouraged and facilitated.
87. The specific safety, health, nutritional, developmental and other needs of babies and young children, including those with special needs, should be catered for in all care settings, including ensuring their ongoing attachment to a specific carer.
88. Children should be allowed to satisfy the needs of their religious and spiritual life, including by receiving visits from a qualified representative of their religion, and to freely decide whether or not to participate in religious services, religious education or counselling. The child's own religious background should be respected, and no child should be encouraged or persuaded to change his/her religion or belief during a care placement.
89. All adults responsible for children should respect and promote the right to privacy, including appropriate facilities for hygiene and sanitary needs, respecting gender differences and interaction, and adequate, secure and accessible storage space for personal possessions.
90. Carers should understand the importance of their role in developing positive, safe and nurturing relationships with children, and should be able to do so.
91. Accommodation in all alternative care settings should meet the requirements of health and safety.
92. States must ensure through their competent authorities that accommodation provided to children in alternative care, and their supervision in such placements, enable them to be effectively protected against abuse. Particular attention needs to be paid to the age, maturity and degree of vulnerability of each child in determining his/her living arrangements. Measures aimed at protecting children in care should be in conformity with the law and should not involve unreasonable constraints on their liberty and conduct in comparison with children of similar age in their community.
93. All alternative care settings should provide adequate protection to children from abduction, trafficking, sale and all other forms of exploitation. Any consequent constraints on their liberty and conduct should be no more than are strictly necessary to ensure their effective protection from such acts.

94. All carers should promote and encourage children and young people to develop and exercise informed choices, taking account of acceptable risks and the child's age, and according to his/her evolving capacities.

95. States, agencies and facilities, schools and other community services should take appropriate measures to ensure that children in alternative care are not stigmatized during or after their placement. This should include efforts to minimize the identification of children as being looked after in an alternative care setting.

96. All disciplinary measures and behaviour management constituting torture, cruel, inhuman or degrading treatment, including closed or solitary confinement or any other forms of physical or psychological violence that are likely to compromise the physical or mental health of the child, must be strictly prohibited in conformity with international human rights law. States must take all necessary measures to prevent such practices and ensure that they are punishable by law. Restriction of contact with members of the child's family and other persons of special importance to the child should never be used as a sanction.

97. Use of force and restraints of whatever nature should not be authorized unless strictly necessary for safeguarding the child's or others' physical or psychological integrity, in conformity with the law and in a reasonable and proportionate manner and with respect for the fundamental rights of the child. Restraint by means of drugs and medication should be based on therapeutic needs and should never be employed without evaluation and prescription by a specialist.

98. Children in care should be offered access to a person of trust in whom they may confide in total confidentiality. This person should be designated by the competent authority with the agreement of the child concerned. The child should be informed that legal or ethical standards may require breaching confidentiality under certain circumstances.

99. Children in care should have access to a known, effective and impartial mechanism whereby they can notify complaints or concerns regarding their treatment or conditions of placement. Such mechanisms should include initial consultation, feedback, implementation and further consultation. Young people with previous care experience should be involved in this process, due weight being given to their opinions. This process should be conducted by competent persons trained to work with children and young people.

100. To promote the child's sense of self-identity, a life story book comprising appropriate information, pictures, personal objects and mementoes regarding each step of the child's life should be maintained with the child's participation and made available to the child throughout his/her life.

B. Legal responsibility for the child

101. In situations where the child's parents are absent or are incapable of making day-to-day decisions in the best interests of the child, and the child's placement in alternative care has been ordered or authorized by a competent administrative body or judicial authority, a designated individual or competent entity should be vested with the legal right and responsibility to make such decisions in the place of parents, in full consultation with the child. States should ensure that a mechanism is in place for designating such an individual or entity.

102. Such legal responsibility should be attributed by the competent authorities and be supervised directly by them or through formally accredited entities, including non-governmental organizations. Accountability for the actions of the individual or entity concerned should lie with the designating body.

103. Persons exercising such legal responsibility should be reputable individuals with relevant knowledge of children's issues, an ability to work directly with children and an understanding of any special and cultural needs of the children to be entrusted to them. They should receive appropriate training and professional support in this regard. They should be in a position to make independent and impartial decisions that are in the best interests of the children concerned and that promote and safeguard each child's welfare.

104. The role and specific responsibilities of the designated person or entity should include:

(a) Ensuring that the rights of the child are protected and, in particular, that the child has appropriate care, accommodation, health-care provision, developmental opportunities, psychosocial support, education and language support;

(b) Ensuring that the child has access to legal and other representation where necessary, consulting with the child so that the child's views are taken into account by decision-making authorities, and advising and keeping the child informed of his/her rights;

(c) Contributing to the identification of a stable solution in the best interests of the child;

(d) Providing a link between the child and various organizations that may provide services to the child;

(e) Assisting the child in family tracing;

(f) Ensuring that, if repatriation or family reunification is carried out, it is done in the best interests of the child;

(g) Helping the child to keep in touch with his/her family, when appropriate.

1. Agencies and facilities responsible for formal care

105. Legislation should stipulate that all agencies and facilities must be registered and authorized to operate by social welfare services or another competent authority, and that failure to comply with such legislation constitutes an offence punishable by law. Authorization should be granted and be regularly reviewed by the competent authorities on the basis of standard criteria covering, at a minimum, the agency's or facility's objectives, functioning, staff recruitment and qualifications, conditions of care and financial resources and management.

106. All agencies and facilities should have written policy and practice statements, consistent with the present Guidelines, setting out clearly their aims, policies, methods and the standards applied for the recruitment, monitoring, supervision and evaluation of qualified and suitable carers to ensure that those aims are met.

107. All agencies and facilities should develop a staff code of conduct, consistent with the present Guidelines, that defines the role of each professional and of the carers in particular and includes clear reporting procedures on allegations of misconduct by any team member.

108. The forms of financing care provision should never be such as to encourage a child's unnecessary placement or prolonged stay in care arrangements organized or provided by an agency or facility.

109. Comprehensive and up-to-date records should be maintained regarding the administration of alternative care services, including detailed files on all children in their care, staff employed and financial transactions.

110. The records on children in care should be complete, up to date, confidential and secure, and should include information on their admission and departure and the form, content and details of the care placement of each child, together with any appropriate identity documents and other personal information. Information on the child's family should be included in the child's file as well as in the reports based on regular evaluations. This record should follow the child throughout the alternative care period and be consulted by duly authorized professionals responsible for his/her current care.

111. The above-mentioned records could be made available to the child, as well as to the parents or guardians, within the limits of the child's right to privacy and confidentiality, as appropriate. Appropriate counselling should be provided before, during and after consultation of the record.

112. All alternative care services should have a clear policy on maintaining the confidentiality of information pertaining to each child, which all carers are aware of and adhere to.

113. As a matter of good practice, all agencies and facilities should systematically ensure that, prior to employment, carers and other staff in direct contact with children undergo an appropriate and comprehensive assessment of their suitability to work with children.

114. Conditions of work, including remuneration, for carers employed by agencies and facilities should be such as to maximize motivation, job satisfaction and continuity, and hence their disposition to fulfil their role in the most appropriate and effective manner.

115. Training should be provided to all carers on the rights of children without parental care and on the specific vulnerability of children, in particularly difficult situations, such as emergency placements or placements outside their area of habitual residence. Cultural, social, gender and religious sensitization should also be assured. States should also provide adequate resources and channels for the recognition of these professionals in order to favour the implementation of these provisions.

116. Training in dealing appropriately with challenging behaviour, including conflict resolution techniques and means to prevent acts of harm or self-harm, should be provided to all care staff employed by agencies and facilities.

117. Agencies and facilities should ensure that, wherever appropriate, carers are prepared to respond to children with special needs, notably those living with HIV/AIDS or other chronic physical or mental illnesses, and children with physical or mental disabilities.

2. Foster care

118. The competent authority or agency should devise a system, and should train concerned staff accordingly, to assess and match the needs of the child with the abilities and resources of potential foster carers and to prepare all concerned for the placement.

119. A pool of accredited foster carers should be identified in each locality who can provide children with care and protection while maintaining ties to family, community and cultural group.

120. Special preparation, support and counselling services for foster carers should be developed and made available to carers at regular intervals, before, during and after the placement.

121. Carers should have, within fostering agencies and other systems involved with children without parental care, the opportunity to make their voice heard and to influence policy.

122. Encouragement should be given to the establishment of associations of foster carers that can provide important mutual support and contribute to practice and policy development.

C. Residential care

123. Facilities providing residential care should be small and be organized around the rights and needs of the child, in a setting as close as possible to a family or small group situation. Their objective should generally be to provide temporary care and to contribute actively to the child's family reintegration or, if this is not possible, to secure his/her stable care in an alternative family setting, including through adoption or *kafala* of Islamic law, where appropriate.

124. Measures should be taken so that, where necessary and appropriate, a child solely in need of protection and alternative care may be accommodated separately from children who are subject to the criminal justice system.

125. The competent national or local authority should establish rigorous screening procedures to ensure that only appropriate admissions to such facilities are made.

126. States should ensure that there are sufficient carers in residential care settings to allow individualized attention and to give the child, where appropriate, the opportunity to bond with a specific carer. Carers should also be deployed within the care setting in such a way as to implement effectively its aims and objectives and ensure child protection.

127. Laws, policies and regulations should prohibit the recruitment and solicitation of children for placement in residential care by agencies, facilities or individuals.

D. Inspection and monitoring

128. Agencies, facilities and professionals involved in care provision should be accountable to a specific public authority, which should ensure, inter alia, frequent inspections comprising both scheduled and unannounced visits, involving discussion with and observation of the staff and the children.

129. To the extent possible and appropriate, inspection functions should include a component of training and capacity-building for care providers.

130. States should be encouraged to ensure that an independent monitoring mechanism is in place, with due consideration for the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris

Principles).⁸ The monitoring mechanism should be easily accessible to children, parents and those responsible for children without parental care. The functions of the monitoring mechanism should include:

(a) Consulting in conditions of privacy with children in all forms of alternative care, visiting the care settings in which they live and undertaking investigations into any alleged situation of violation of children's rights in those settings, on complaint or on its own initiative;

(b) Recommending relevant policies to appropriate authorities with the aim of improving the treatment of children deprived of parental care and ensuring that it is in keeping with the preponderance of research findings on child protection, health, development and care;

(c) Submitting proposals and observations concerning draft legislation;

(d) Contributing independently to the reporting process under the Convention on the Rights of the Child,² including to periodic State party reports to the Committee on the Rights of the Child with regard to the implementation of the present Guidelines.

E. Support for aftercare

131. Agencies and facilities should have a clear policy and should carry out agreed procedures relating to the planned and unplanned conclusion of their work with children to ensure appropriate aftercare and/or follow-up. Throughout the period of care, they should systematically aim at preparing children to assume self-reliance and to integrate fully in the community, notably through the acquisition of social and life skills, which are fostered by participation in the life of the local community.

132. The process of transition from care to aftercare should take into consideration children's gender, age, maturity and particular circumstances and include counselling and support, notably to avoid exploitation. Children leaving care should be encouraged to take part in the planning of aftercare life. Children with special needs, such as disabilities, should benefit from an appropriate support system, ensuring, inter alia, avoidance of unnecessary institutionalization. Both the public and the private sectors should be encouraged, including through incentives, to employ children from different care services, particularly children with special needs.

133. Special efforts should be made to allocate to each child, whenever possible, a specialized person who can facilitate his/her independence when leaving care.

134. Aftercare should be prepared as early as possible in the placement and, in any case, well before the child leaves the care setting.

135. Ongoing educational and vocational training opportunities should be imparted as part of life skills education to young people leaving care in order to help them to become financially independent and generate their own income.

136. Access to social, legal and health services, together with appropriate financial support, should also be provided to young people leaving care and during aftercare.

⁸ Resolution 48/134, annex.

VIII. Care provision for children outside their country of habitual residence

A. Placement of a child for care abroad

137. The present Guidelines should apply to all public and private entities and all persons involved in arrangements for a child to be sent for care to a country other than his/her country of habitual residence, whether for medical treatment, temporary hosting, respite care or any other reason.

138. States concerned should ensure that a designated body has responsibility for determining specific standards to be met regarding, in particular, the criteria for selecting carers in the host country and the quality of care and follow-up, as well as for supervising and monitoring the operation of such schemes.

139. To ensure appropriate international cooperation and child protection in such situations, States are encouraged to ratify or accede to the Hague Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Cooperation in respect of Parental Responsibility and Measures for the Protection of Children, of 19 October 1996.⁹

B. Provision of care for a child already abroad

140. The present Guidelines, as well as other relevant international provisions, should apply to all public and private entities and all persons involved in arrangements for a child needing care while in a country other than his/her country of habitual residence, for whatever reason.

141. Unaccompanied or separated children already abroad should, in principle, enjoy the same level of protection and care as national children in the country concerned.

142. In determining appropriate care provision, the diversity and disparity of unaccompanied or separated children (such as ethnic and migratory background or cultural and religious diversity) should be taken into consideration on a case-by-case basis.

143. Unaccompanied or separated children, including those who arrive irregularly in a country, should not, in principle, be deprived of their liberty solely for having breached any law governing access to and stay within the territory.

144. Child victims of trafficking should neither be detained in police custody nor subjected to penalties for their involvement under compulsion in unlawful activities.

145. As soon as an unaccompanied child is identified, States are strongly encouraged to appoint a guardian or, where necessary, representation by an organization responsible for his/her care and well-being to accompany the child throughout the status determination and decision-making process.

146. As soon as an unaccompanied or separated child is taken into care, all reasonable efforts should be made to trace his/her family and re-establish family ties, when this is in the best interests of the child and would not endanger those involved.

147. In order to assist in planning the future of an unaccompanied or separated child in a manner that best protects his/her rights, relevant State and social service authorities should make all reasonable efforts to procure documentation and information in order to conduct an assessment of the child's risk and social and family conditions in his/her country of habitual residence.

⁹ United Nations, *Treaty Series*, vol. 2204, No. 39130.

148. Unaccompanied or separated children must not be returned to their country of habitual residence:

(a) If, following the risk and security assessment, there are reasons to believe that the child's safety and security are in danger;

(b) Unless, prior to the return, a suitable caregiver, such as a parent, other relative, other adult caretaker, a Government agency or an authorized agency or facility in the country of origin, has agreed and is able to take responsibility for the child and provide him or her with appropriate care and protection;

(c) If, for other reasons, it is not in the best interests of the child, according to the assessment of the competent authorities.

149. With the above aims in mind, cooperation among States, regions, local authorities and civil society associations should be promoted, strengthened and enhanced.

150. The effective involvement of consular services or, failing that, legal representatives of the country of origin should be foreseen, when this is in the best interests of the child and would not endanger the child or his/her family.

151. Those responsible for the welfare of an unaccompanied or separated child should facilitate regular communication between the child and his/her family, except where this is against the child's wishes or is demonstrably not in his/her best interests.

152. Placement with a view to adoption or *kafala* of Islamic law should not be considered a suitable initial option for an unaccompanied or separated child. States are encouraged to consider this option only after efforts to determine the location of his/her parents, extended family or habitual carers have been exhausted.

IX. Care in emergency situations

A. Application of the Guidelines

153. The present Guidelines should continue to apply in situations of emergency arising from natural and man-made disasters, including international and non-international armed conflicts, as well as foreign occupation. Individuals and organizations wishing to work on behalf of children without parental care in emergency situations are strongly encouraged to operate in accordance with the Guidelines.

154. In such circumstances, the State or de facto authorities in the region concerned, the international community and all local, national, foreign and international agencies providing or intending to provide child-focused services should pay special attention:

(a) To ensure that all entities and persons involved in responding to unaccompanied or separated children are sufficiently experienced, trained, resourceful and equipped to do so in an appropriate manner;

(b) To develop, as necessary, temporary and long-term family-based care;

(c) To use residential care only as a temporary measure until family-based care can be developed;

(d) To prohibit the establishment of new residential facilities structured to provide simultaneous care to large groups of children on a permanent or long-term basis;

(e) To prevent the cross-border displacement of children, except under the circumstances described in paragraph 160 below;

(f) To make cooperation with family tracing and reintegration efforts mandatory.

Preventing separation

155. Organizations and authorities should make every effort to prevent the separation of children from their parents or primary caregivers, unless the best interests of the child so require, and ensure that their actions do not inadvertently encourage family separation by providing services and benefits to children alone rather than to families.

156. Separation initiated by the child's parents or other primary caregivers should be prevented by:

(a) Ensuring that all households have access to basic food and medical supplies and other services, including education;

(b) Limiting the development of residential care options and restricting their use to those situations where it is absolutely necessary.

B. Care arrangements

157. Communities should be assisted in playing an active role in monitoring and responding to care and protection issues facing children in their local context.

158. Care within a child's own community, including fostering, should be encouraged, as it provides continuity in socialization and development.

159. As unaccompanied or separated children may be at heightened risk of abuse and exploitation, monitoring and specific support to carers should be foreseen to ensure their protection.

160. Children in emergency situations should not be moved to a country other than that of their habitual residence for alternative care except temporarily for compelling health, medical or safety reasons. In that case, this should be as close as possible to their home, they should be accompanied by a parent or caregiver known to them, and a clear return plan should be established.

161. Should family reintegration prove impossible within an appropriate period or be deemed contrary to the best interests of the child, stable and definitive solutions, such as adoption or *kafala* of Islamic law, should be envisaged; failing this, other long-term options should be considered, such as foster care or appropriate residential care, including group homes and other supervised living arrangements.

C. Tracing and family reintegration

162. Identifying, registering and documenting unaccompanied or separated children are priorities in any emergency and should be carried out as quickly as possible.

163. Registration activities should be conducted by or under the direct supervision of State authorities and explicitly mandated entities with responsibility for and experience in this task.

164. The confidential nature of the information collected should be respected and systems put in place for safe forwarding and storage of information. Information should only be shared among duly mandated agencies for the purpose of tracing, family reintegration and care.

165. All those engaged in tracing family members or primary legal or customary caregivers should operate within a coordinated system, using standardized forms and mutually compatible procedures, wherever possible. They should ensure that the child and others concerned would not be endangered by their actions.

166. The validity of relationships and the confirmation of the willingness of the child and family members to be reunited must be verified for every child. No action should be taken that may hinder eventual family reintegration, such as adoption, change of name or movement to places far from the family's likely location, until all tracing efforts have been exhausted.

167. Appropriate records of any placement of a child should be made and kept in a safe and secure manner so that reunification can be facilitated in the future.

APPENDIX 2: CARE FOR ME! COUNTRY REPORT METHODOLOGIES TABLE

Country	Research methods
Benin	<ul style="list-style-type: none"> • Desk review of existing literature: government reports and reports by international organisations and NGOs. • Interviews with key stakeholders in the area of alternative care, including government and NGOs.
Gambia	<ul style="list-style-type: none"> • Desk review of existing literature: legal documents, surveys, research reports, and reports by international organisations and NGOs. • Unstructured interviews. • Visits to care homes and other institutions providing alternative care.
Kenya	<ul style="list-style-type: none"> • Desk review of existing literature: legal and policy documents, and research reports. • Survey with various stakeholders, including government officers, based on the assessment tool. • Interviews with stakeholders in 19 counties (of 47) with senior government officers, social workers, heads of children's homes, district officers, sectional officers at the directorate of children's services and NGOs. • Focus group discussions with children in various institutions. • Analysis: employed quantitative data analysis.
Malawi	<ul style="list-style-type: none"> • Based on a desk review of existing literature: legal documents, government and NGO reports. • 27 key informant interviews (both structured and semi-structured) with senior officers and academics. • Focus group discussions with 10 children (five girls and five boys) not receiving parental care from nine orphanages, and a focus group in one safety home with five girls and five boys. • Analysis: employed qualitative data analysis.
Tanzania	<ul style="list-style-type: none"> • Based on a desk review of existing literature: legal documents, academic papers, and reports. • Focus group discussions and consultative meetings involving decision-makers and NGOs working with children.
Togo	<ul style="list-style-type: none"> • No methodology provided.
Zambia	<ul style="list-style-type: none"> • Desk review of existing literature: studies, policy and legal documents obtained from the government. • Key informant interviews with individuals in organisations, institutions and government departments responsible for child care in five of the 10 provinces. • Analysis: thematic analysis.

Country	Research methods
Zimbabwe	<ul style="list-style-type: none"> • Desk review of existing literature: research by both government and non-state actors, international organisations and academics. • Semi-structured interviews based on the assessment tool with government officials, UNICEF child protection specialists, children’s rights advisors and experts within NGOs and care providers. • Two focus group sessions with children: one based in a residential centre and another in a rural community. • Systematic participatory observation to understand community values. • Analysis: mostly qualitative, with quantitative material coming from secondary sources.

Note: See the full methodologies in each of the reports at: www.care-for-me.org

APPENDIX 3: LEGAL TABLES

Table 1

Country	UNCRC ratification Date	UNCRC last report date ¹	Hague Convention on Intercountry Adoption ratification status ²	Due date for 1st Period Report - ACRC ³
Benin	3 August 1990	U.N. Doc. CRC/C/BEN/CO/2 (2006).	Non signatory	29/11/2004
Gambia	8 August 1990	CRC/C/15/Add.165. (2001).	Non signatory	14/12/2005
Kenya	30 July 1990	U.N. Doc. CRC/C/15/Add.160 (2001).	Entry into force 1-VI-2007	25/07/2005
Malawi	2 January 1991 (a)	U.N. Doc. CRC/C/15/Add.174 (2002).	Non signatory	29/11/2004
Tanzania	10 June 1991	U.N. Doc. CRC/C/TZA/CO/2 (2006).	Non signatory	16/03/2008
Togo	1 August 1990	U.N. Doc. CRC/C/TGO/CO/3-4 (2012).	Entry into force 1-II-2010	29/11/2004
Zambia	6 December 1991	U.N. Doc. CRC/C/15/Add.206 (2003).	Non signatory	02/12/2013
Zimbabwe	11 September 1990	U.N. Doc. CRC/C/15/Add.55 (1996).	Non signatory	29/11/2004

Table 2

Country	Concerns raised in the concluding observations of the UNCRC Committee/ ACRC	Meeting the challenge	
		Constitutional provisions	Recent legislation and policy
Benin	<ul style="list-style-type: none"> • High numbers in alternative care • Prevention of separation data collection • Training • Complaints • Inter-country Adoption • Regulation 	<i>Information not available</i>	Code de l'enfant du Bénin, 2007 Act No. 2006/04 sets out conditions for the displacement of minors and the suppression of trafficking

¹ See: http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/SessionsList.aspx?Treaty=CRC

² See: http://www.hcch.net/index_en.php?act=conventions.status&cid=69#nonmem

³ See: <http://acerwc.org/member-states/state-reporting-calendar/>

Country	Concerns raised in the concluding observations of the UNCRC Committee/ ACERWC	Meeting the challenge	
		Constitutional provisions	Recent legislation and policy
Benin (cntd)	<ul style="list-style-type: none"> Inadequate enforcement of anti-discrimination laws 	<i>Information not available</i>	Act No. 2006/31 on Prevention, Care and Support related to HIV /AIDS
Gambia	<ul style="list-style-type: none"> Domestic legislation including customary law does not fully respect the rights of the child Lack of complaints mechanisms Financial resources Training Lack of Facilities Adoption Act, 1992 in need of review 	1997 Constitution contains the right of children to know and be cared for by their parents	Children's Act No 38, 2005 Guidelines on Quality Care for Children in Alternative Care, 2012
Kenya	<ul style="list-style-type: none"> National legislation in need of further harmonisation and strengthening Children Act 2001 not fully compliant, with international law Inadequate resources for the implementation of the Act Inadequate implementation of anti-discrimination laws Coverage of birth registration not wide Inadequate family support Lack of data 	<ul style="list-style-type: none"> Best Interests of the child provision in the 2010 constitution The Constitution provides for: children's rights and freedoms 	In 2010, the state embarked on a review of the 2001 Children Act to harmonise it with the Constitution The Children Act No 8, 2001 domesticates the UNCRC
Malawi	<ul style="list-style-type: none"> Inadequate legislation / slow progress towards reforming child related laws Best interests of the child principle not fully integrated into legislation Inadequate finance Adoption Law needs revision Child labour insufficiently addressed 	<ul style="list-style-type: none"> The 1994 Constitution amended in 2010 to include, inter alia, the best interests of the child provision Protects the family and provides for children's rights 	The Child Care, Protection and Justice Act, 2010 Prevention of Domestic Violence Act, 2006 National Registration Act, 2009 (Act No.13 of 2010) The Deceased Estates (Wills, Inheritance and Protection) Act The Disability Act, 2012 National Plan of Action on Orphan and Vulnerable Children, 2005-2009 National Early Childhood Development Policy, 2004

Country	Concerns raised in the concluding observations of the UNCRC Committee/ ACERWC	Meeting the challenge	
		Constitutional provisions	Recent legislation and policy
Tanzania	<ul style="list-style-type: none"> • Badly implemented Policy Violence against children with disabilities (Albinos) • Slow progress towards enacting the Children's Act • Tanzania not a party to the Hague Convention • Lack of commitment to honour obligations under the ACRWC (lack of specific child trafficking laws) • No categorical laws to ensure enforcement against child abuse/trafficking • Limited data • Birth legislation not compulsory /difficult • Inadequate implementation of anti-discrimination provisions 	<i>Information not available</i>	<p>Law of the Child Act, 2009 (Tanzanian Mainland)</p> <p>Children Act, 2011 (Zanzibar)</p> <p>Child Development Policy, 1996 revised in 2008</p> <p>Provisions of the Optional Protocol to the UNCRC on the Sale of Children, Child Prostitution and Pornography – domesticated</p> <p>The Policy for Child Survival, Protection and Development, 2001 (Zanzibar)</p> <p>The National Disability Policy, 2004</p>
Togo	<ul style="list-style-type: none"> • Inadequate legal framework • Children not fully recognised as right-holders • Weak enforcement of child-related laws • Inadequate implementation of anti-discrimination laws • Slow legislative reform process 	<ul style="list-style-type: none"> • Constitution with amendments through 2007 • Guarantees the right of children to familial and social protection 	<p>Act No. 2007-017 (2007) on the Children's Code</p> <p>Act No. 2005-009 (2005) on the suppression of child trafficking in Togo</p> <p>National Child Protection Policy, 2009</p>
Zambia	<ul style="list-style-type: none"> • Domestic legislation not in full harmony with the UNCRC • Some customary laws antagonistic to the UNCRC • Inadequate enforcement of anti-discrimination provisions in favour of vulnerable children • Narrow coverage of birth registration 	<ul style="list-style-type: none"> • Children's rights are being considered for inclusion into the Constitution • The draft constitution includes best interests of the child and a right to appropriate alternative care 	<p>Anti-Gender Based Violence Act, 2011</p> <p>National Child Policy, 2006</p>

Country	Concerns raised in the concluding observations of the UNCRC Committee/ ACERWC	Meeting the challenge	
		Constitutional provisions	Recent legislation and policy
Zimbabwe		<ul style="list-style-type: none"> • Best interests of the child included in the 2013 Constitution • Protects rights of people with disabilities • Protects the family and calls for the adoption of measures for the provision of care and support for families with children • Obliges the State to facilitate the provision of appropriate alternative care for children removed from the family environment 	



Change will demand action from us all - action based on understanding that is constructive and, most importantly, reflects innovative approaches.

There is no one pathway for change. In each context, we will be drumming with different rhythms but together these rhythms, in all their syncopation, must be heard and felt as a collective call for positive, real change in the lives of the most vulnerable members of our societies.

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