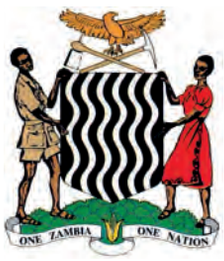

Ministry of Community Development and Social Services

Nationwide Assessment Report on Child Care Facilities

Department of Social Welfare
Community House, Sadzu Road
P.O. Box 31958
Lusaka

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Acknowledgement

The Nationwide Assessment of Child Care Facilities in Zambia provides important baseline information on the situation of children in residential care. It will be a useful tool for informing future plans and interventions aimed at improving the wellbeing of children in need of care including those at risk of being separated from their families.

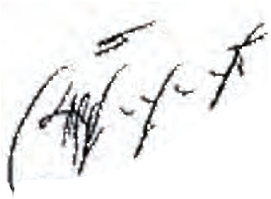
The Ministry of Community Development and Social Services wishes to convey special thanks to Triple M Impact Consulting Limited and the entire Assessment Team for undertaking this important assignment and visiting each and every child care facility in Zambia to collect firsthand information on the wellbeing of the children in these facilities. The commitment of the team from throughout the data collection and reporting process of this assignment is highly appreciated.

Special thanks also go to the Managers of the Child Care Facilities and members of staff in these facilities; without whose collaboration this survey would not have been possible. I also wish to thank all the Community Leaders that provided useful additional information to the situation of children and families in their communities.

A special thank you to all the children that participated through interviews and Focus Group Discussions representing all the children in formal care to inform the Ministry of Community Development and Social Services about their wellbeing and the situation of their families.

I would like to take this opportunity to especially thank our fair weather partner, UNICEF for providing technical and financial support for the undertaking of this important assignment. Their commitment in supporting the Ministry towards continued evidence generation for a strengthened child and family welfare system has been unwavering .

Finally, I wish to thank senior officers in the Department of Social Welfare for their commitment in providing technical guidance and advice throughout the data collection and reporting process. I also wish to thank the District Officers from Livingstone, Chilanga, Chongwe, Lusaka, Chisamba, Kitwe, Mazabuka, Mpika and Ndola Districts for representing the Ministry of Community Development as part of the Assessment Team.



Rev. Dr. Howard J. Sikwela
Permanent Secretary
MINISTRY OF COMMUNITY DEVELOPMENT AND SOCIAL SERVICES

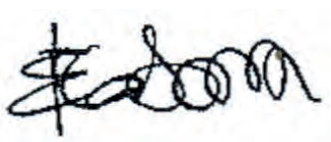
Foreword

The Nationwide Assessment of Child Care Facilities in Zambia is an important milestone for the Ministry of Community Development and Social Services. It has provided useful insight and enlightened all of us on the plight of children living in Child Care Facilities. The Assessment has set into motion the wheels of change for how the Ministry of Community Development and Social Services as well as all concerned stakeholders respond to the varied situations of children in need of care. The findings of the Assessment have resounded a clear call on all us to begin moving away from unnecessary placement of children into Child Care Facilities and work towards promoting and supporting family based care.

It is evident from findings reflected in the Nationwide Assessment Report that over 6000 children have for one reason or the other been separated from their family. It is unfortunate that most of these children have according to the findings, been placed into Child Care Facilities by their parents or guardians with poverty being sighted as the main reason for placement into care. Lack of safety nets for families to cushion economic shocks have contributed to the increase in the number of parents choosing to place their children into care in the hope that the children will be able to access education, health services, nutritious food and clothing among others. There is therefore urgent need for concerted efforts between the Ministry of Community Development and Social Services, relevant government line ministries and cooperating and implementing partners as well as Community Leaders and members of the public to work towards promoting family preservation and reintegration.

The Nationwide Assessment Report makes important recommendations for the Ministry of Community Development and Social Services to regularly monitor the standards of care being provided. The report further recommends that Social Protection interventions targeting children and families at risk of separation as well as those already separated be put in place.

My Ministry believes that every child should belong to a family and must be given the opportunity to remain with his or her family and where this is not possible, other family based care options such as kinship care, foster care or adoption should be available. Placement of children in child care facilities should be a measure of last resort to respond to emergency cases and for very short periods of time.



Hon. Emerine Kabanshi, MP
MINISTER OF COMMUNITY DEVELOPMENT AND SOCIAL SERVICES

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List of Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
CoR	of Recognition
CPP	Child Protection Policy
DHS	Demographic and Health Survey
DSWO	District Social Welfare Office
DSW	Department of Social Welfare
FBO	Faith Based Organisation
FGD	Focus Group Discussion FM Facility Manager
GRZ	Government of the Republic of Zambia
IGA	Income Generating Activity
MCDSS	Ministry of Community Development and Social Services
MSC	Minimum Standards of Care for Child Care Facilities
NGO	Non-Governmental Organisation
CCF	Child Care Facility
RoNGO	Registrar of NGOs UN United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund

Executive Summary

Background

In December 2015, the Government of the Republic of Zambia (GRZ) through the Ministry of Community Development and Social Services (MCDSS), in partnership with United Nations Children's Fund (UNICEF), commissioned the Nationwide Assessment of all Child Care Facilities (CCFs). The Assessment was undertaken between April and July 2016 as a collaborative effort between the Ministry of Community Development and Social Services (MCDSS) and UNICEF. This report is based on findings the Nationwide Assessment

The aim of the Assessment was to gather evidence for the purpose of updating baseline information pertaining to the condition of all Child Care Facilities (CCFs) in Zambia; in line with the Minimum Standards of Care for Child Care Facilities (MSC), United Nations Conventions on the Rights of the Child (UNCRC) as well as the UN Guidelines for the Alternative Care of Children. The generated evidence will inform efforts by the GRZ through the MCDSW and partners to strengthen the alternative care system in the Country. Specifically the exercise included physical inspections, assessment of processes of gatekeeping, admission, care, family tracing and reintegration as well as the identification of clear benchmarks for strengthening the capacity of each CCF in the provision of residential child care services.

Methodology

The Assessment targeted all 189[1] Child Care Facilities (CCFs) in all the 10 provinces of Zambia. Although 173 Facilities were visited, for different reasons including the facilities being closed or not being accessible, data could only be collected from 164 Facilities, representing a 94.80 percent output.
The Assessment used both qualitative and quantitative methods. Two survey questionnaires one for Facility Managers and another for children aged between 10 and 18 years were administered. Structured interviews were conducted with caregivers and focus group discussions were held with boys and girls not included in the face to face interviews. Physical observations were also carried out at facilities with specific attention to living conditions, play and sleeping areas, food stocks and meals, recreation as well as water and sanitation facilities.

Key Findings

Characteristics of Children

There were 6,413 children in residential care; 49.35 percent males and 48.23 percent females, 2 percent of children were not disaggregated by gender by 4 facilities. The 13-15 years category comprised the highest number of children in residential care (23 percent) whilst the 0-3 years' category presented the lowest at 6 percent. However individual ages for 6 percent of children were not provided by 7 facilities. The average number of children per facility was 37.72 with a median of 24 and mode of 13. The maximum number of children at a facility was found to be 689 and the minimum was 1. 52 percent of CCFs indicated that they could admit a child aged below one year.

Facilities and the Minimum Standards of Care for Child Care Facility

The Assessment found that CCFs did not meet the MSC in a number of categories including issues relating to registration of CCFs, existence of a Constitution, Certificate of Recognition (CoR), internal policies, record keeping and child participation and family contact. However, CCFs prioritised access to education and access to health care for the children. 90 percent of children of school going age attended school and only 3.5 percent of children, 317 children, reported not having received any medical attention for their sickness the last time they were ill.

[1]Ministry of Community Development and Social Welfare List of Child Care Facilities

Registration Status of Child Care Facilities

The adherence of CCFs to the legal and policy framework was below par, whereas current legislation and policy guidelines require that CCFs are registered with the Registrar of Non-Governmental Organisations (RoNGO), only 24.06 percent had a certificate of registration from the NGO board. Registration with the Registrar of Societies remains prevalent; with 60.9 percent having a certificate of registration from the Registrar of Societies. A further 15 percent were registered with the Registrar of Companies.

In relation to CCFs that had Constitutions, 85.9 percent reported having a Constitution however, only half of these provided evidence of the existence of this document. The category that did not have a Constitution in place was found to be mainly Faith Based Organisations (FBOs). It was established that CCFs operated by FBOs were often not registered as independent entities but operated under the legal registration of the mother body. Findings showed that 70.5 percent of 78 CCFs covered in Phase II of the survey, were independently registered, whilst 29.5 percent operated under the registration of their founding organisations.

Certificate of Recognition

A Certificate of Recognition is issued to CCF by the Department of Social Welfare in the Ministry of Community Development and Social Services. The Assessment established that only 38.5 percent of CCFs had a Certificate of Recognition, while 44.9 percent did not have and the remaining 16.7 percent did not know whether their organisation had one or not.

Governance

The findings show that 82 percent of CCFs had a governing body in place, 13.5 percent did not have and 4.5 percent were not sure. However, of the 82 percent that had a governing body, only 39.8 percent indicated that their board met quarterly, 8.6 percent met annually, 20.3 percent bi-annually 11.7 percent met on a monthly basis and a further 10.9 percent met as and when need arose without a set time interval.

Child Protection

The MSC emphasises the protection of children and requires CCFs to develop Child Protection Policies which should be signed by all staff and volunteers. Findings from interviews held with 156 Facility Managers/ proxies show that 45.5 percent reported having a Child Protection Policy in place, 46.2 percent did not have one and 8.3 percent of respondents were not sure.

Some questions in the survey on child protection issues were included only in the second phase of the Assessment which covered 78 CCFs. Only 13 out of 78 CCFs[2] reported having the Child Protection Policy signed by members of staff. 63 CCFs in Phase Two that had volunteers but only at 31 percent of these CCFs had volunteers signed a Child Protection Policy. Training in child protection was provided by 25.6 percent of CCFs whereas 66.7 percent did not provide training and 7.8 percent did not know whether or not training was offered. A code of conduct was signed by 46 percent of the 78 CCFs covered in Phase Two. Of the 156 Facility Managers/ proxies interviewed; 38.5 percent reported having a complaints reporting procedure while 60.9 percent did not have and 0.6 percent did not know.

Staff working in CCFs

There were 2,411 full time members of staff in all CCFs, caregivers comprised 41 percent of staff, social workers 5.4 percent and Teachers 23 percent of all staff. Children to caregiver ratio was 6:1, while there were 49 children to each Social Worker. Although caregivers were required to have Grade 12 level of education, findings showed that this was not the case as reported by 80 percent of Facility Managers/proxies interviewed. Related findings also showed that CCFs employed more Caregivers than

Social Workers. At the time of the Assessment, there were 992 Caregivers to 130 Social Workers; a ratio of 8:1, nationally.

Only 22.7 percent of Facility Managers indicated that caregivers at their facilities had completed vocational training related to child care. 53.8 percent of CCFs provided in-service training for caregivers in those facilities.[3]

Police Clearance

Only 11.5 percent of all CCFs reported having members of staff that had police clearance while 84.6 percent did not have. However, in some cases, there were Facility Managers that had obtained police clearance while other staff members at the same facility had not. The Assessment found that 47.4 percent of Facility Managers had Police Clearance Certificates while 52.6 percent did not have.

Admission Procedures and Case Management

The Assessment found that the key reasons for placement of children were; poverty, child abandonment, death of a parent, abuse and maltreatment, disability of primary caregivers within the family and sometime disability of the child. Imprisonment of parent as well as mental illness of the mother were also significant contributors.

Children are as likely to be admitted through direct reference from the District Social Welfare Office as they are admitted by reference from outreach programmes validated by the District Social Welfare (DSW) Offices. 84.6 percent of all CCFs reported having no Committal Orders for the children in their care. It was further reported by 67.9 percent of CCFs that an admission form was signed by a parent or guardian whenever possible.

87.2 percent of all CCFs had children's files with 51.8 percent of CCFs having files that contained relevant documents. The Assessment findings show that 14.7 percent of CCF had children's birth certificates on file, 65.7 percent of CCFs had children's school reports on file, 65 percent had case reports on file but these were incomplete in most cases. 41.7 percent of CCFs had care plans for each child.

Health and Education Services for Children

Children had access to health and education services. 79.5 percent of all CCFs had First Aid Kits, 37.8 percent had a sick bay out of which 50.8 percent sick bays were run by a qualified medical staff. There were 871 children that had experienced ill health during their stay at CCFs, 97 percent of these had received medical attention for their condition. Only 3.5 percent had not received treatment.

13 out of 78 Facilities in Phase Two had a clinic at the premises. Children received annual or bi-annual routine medical check-up at 51.3 percent of CCFs.

Of the 959 children interviewed, 90.6 percent attended school. 46.2 percent of CCFs had a school on their premises. There were 579 young adults (aged above 18 years) in residential care that were attending college/university and vocational training, out of which 41.4 percent were female.

Water and Sanitation

Children had access to clean water, with 62 percent of CCF obtaining their water from a borehole and 33.6 percent had access the public water supply. Availability of flush toilets was reported by 94.8 percent of

[2]Question asked only in Phase Two of the Assessment, this was because the ToRs allowed for modification of tools with approval from the MCDSW. But because Phae I and Phase II were in distinct parts of the country findings could not be generalised.
[3]n=78, Phase Two Question

CCFs, among these were some that had both flush (water borne) toilets and pit latrines, 24.4 percent of CCF reported also having pit latrines. Of the children, 317 interviewed in Phase two, 65.3 percent reported that they always had soap to wash their hands after using the toilet.

Clothing and Beddings

Children were happy with their clothing as reported by 71.1 percent of the total number interviewed (959), with 55.8 reporting that their clothes were adequate. Only 8.9 percent of children did not have a pair of shoes. 95.9 percent of children slept on a bed and mattress, 2.5 percent on a mattress on the floor. Sharing of a bed or sleeping space was reported by 21.1 percent of children.

Food and Nutrition

The nutritional aspect was characterised by a high starch diet and meals were not balanced.

Discipline and Child Participation in Decision Making

Common forms of discipline included carrying out house chores, slashing, gardening and verbal correction. However children also mentioned being subject to verbal abuse, being grounded and being beaten. Children reported that beating was not severe only at two facilities were beatings reported to be severe.

76.03 percent of children reported that they did not take part in decisions affecting them.

Family Based Care

In relation to reintegration, the Assessment found that 73 percent of CCFs had reintegrated children in the three years prior to the study. Fostering and adoptions were rare. In 2015, 46 children were fostered, 8children were adopted and 13.5 percent of CCFs had children declared free for adoption.

The Role of the Department of Social Welfare

The Assessment noted constraints relating to the Department of Social Welfare's (DSW) ability to discharge its roles, especially those relating to conducting regular monitoring visits to CCFs as well as conducting assessments of new ones. Constraints included, inadequate finances, non-availability of transport and sometimes stationery. Some District Social Welfare Officers indicated that the last monitoring they had conducted was a year before this Assessment. Other limitations were inadequate knowledge and application of the MSC by District Social Welfare Officers. In addition, there was a lack of structured capacity building and awareness raising on the MSC for CCFs.

Conclusion

The Assessment concluded that Facility Managers were aware of the Minimum Standards of Care but were not sufficiently knowledgeable about the provisions therein, this contributed to their limited capacity to comply. Management capacity was weak in the majority of Facilities as seen by the poor record keeping, failure to develop child care plans and low capacity to raise funds. There were very few CCFs that had exceptional management capacities and were well resourced. The majority of CCF did not have adequate funds with funding from the Government being the least likely source.

The Department of Social Welfare was inadequately resourced, thereby being unable to conduct timely monitoring of CCFs. Staff from the Department of Social Welfare were also not well versed with the MSC.

Limitations of the Study

The three limitations of the study related to:

i. Non-availability of age and gender disaggregated data of children in care limited the determination of the sample size prior to commencement of field work.
ii. Views from community leaders were not adequately included in the study due to limited time in the field, however, this did not have a significant impact as community leaders have minimal to no impact on the operations of the CCFs.
iii. Some children could not be reached as they were either in school or on school holidays.

The Assessment has two categories of recommendations summarised as follows:

1. Recommendations to the Ministry of Community Development and Social Services

a. The Department of Social Welfare requires adequate funds to enable it effectively conduct its functions such as consistent scheduled monitoring of Child Care Facilities
b. The Department of Social Welfare needs to conduct training for its Social Welfare Officers on the Minimum Standards of Care to improve their capacity to implement its provisions.
c. There is need to improve collaboration between the Department of NGO Registration as well as other Ministries and the Judiciary so as to streamline services required by CCFs.

2. To the Department of Social Welfare in relation to Child Care Facilities

a. Build the capacity of CCFs in relation to the Minimum Standards of Care and thereby encourage compliance.
b. Provide documentation required by CCFs in a timely manner in order to support the placement of children.
c. Conduct robust monitoring of CCFs which includes obtaining information from children and caregivers.

1.0 Introduction

1.1 Background

Zambia had a population of 13 million people in 2010. With a population growth rate of 2.8 percent, the country poses as one of the fastest growing populations in the world. The 2010 Census indicates that children below the age of 18 constituted 55 percent of the population[4], with just about half of these living in rural areas. The Living Conditions Monitoring Survey (LCMS) of 2015 estimated the population of Zambia to be at 15.5 million[5]. The population was concentrated in rural areas at 58.2 percent compared to 41.4 percent in urban areas[6]. Certain development challenges pose particular risks to children's wellbeing in Zambia, key among these are the impact of HIV and AIDS coupled with high poverty levels. The 2013-2014 Demographic and Health Survey (DHS) indicates that 11 percent of children below the age of 18 were orphaned, with one or both parents dead[7]. The proportions of orphans was higher in urban areas, 13 percent, than in rural areas, 10 percent. Orphanhood increased with age, with 31.8 percent of children losing both parents by the time they were 18. By the time they were 20 years old, a third of young adults, 33.6 percent, would have lost both parent[8]. The DHS found that 60 percent of children younger than age 18 lived with both parents.

Poverty and resultant economic hardships can have a detrimental effect on children's development, Zambia is a country that grapples with these challenges. With a population of 15.5 million people[9], Zambia has a high proportion of its population aged below 15 years. The 2013-2014 Demographic and Health Survey (DHS) states that 50 percent of the population was below 15 years of age whilst 9.5 percent were aged between 15 -19 years[10]. The DHS notes that these proportions remained the same over the past six years.

Zambia grapples with developmental challenges of high poverty levels and HIV prevalence. The 2013-2014 HIV prevalence was 13 percent of men and women aged between 15 -49. Prevalence decreased from 16 percent in 2001 -2002. The 2015 Living Conditions Monitoring Survey estimated that 54.4 percent of people in the country lived below the poverty line, however poverty in Zambia remains a rural phenomenon. In 2015, 76.6 percent of rural dwellers lived in poverty compared to 23.4 percent of urban dwellers. It is in this context that the Assessment was undertaken.

Whilst the country has experienced positive economic growth averaging 6 percent for over a decade now, the impact of growth on poverty has been negligible. For example, between 2006 and 2010, the country recorded a reduction in poverty levels of only 2.3 percent. Over 60 percent of the population lived in poverty with nearly half were extremely poor, 42.3 percent[11]. With some changes in the methods used to measure poverty applied for the 2015 survey, results show that poverty fell from 60.5 percent in 2010 to 54.4 percent in 2015 and extreme poverty affected 40.8 percent of Zambians. Rural poverty fell from 77.9 in 2010 to 76.6 percent in 2015 and urban poverty which was 27.5 percent in 2010 decreased to 2.4 percent in 2015. Therefore, poverty is predominantly a rural phenomenon[12].

The inability to meet the daily food requirements, education and health care, shelter and clothing needs assigns the majority of people to lives of marginalisation and exclusion with children being significantly affected. In such a development context, orphaned and other vulnerable children are often looked after by their relatives but some enter CCF run by Faith Based Organisations (FBOs), Non-Governmental Organisations (NGOs) and individuals.

[4]Central Statistical Office (CSO) Zambia, 2012. 2010 Census of Population and Housing, National Descriptive Tables Volume 11, Central Statistical Office, Lusaka
[5]Central Statistical office, Zambia, 2015 Living Conditions Monitoring Survey Key Findings, 2016, Central Statistical Office, Lusaka
[6]Ibid
[7]Central Statistical Office (CSO), Ministry of Health (MoH) Zambia, ICF International, 2014. Zambia Demographic and Health Survey 2013-2014. Rockville Maryland, USA, CSO, MoH and ICF International
[8]Central Statistical Office, 2012, Living Conditions Monitoring Survey Report 2016 & 2010, Central Statistical office, Lusaka,
[9]Central Statistical office, Zambia, 2015 Living Conditions Monitoring Survey Key Findings, 2016, Central Statistical Office, Lusaka
[10]Central Statistical Office (CSO), Ministry of Health (MoH) Zambia, ICF International, 2014. Zambia Demographic and Health Survey 2013-2014. Rockville Maryland, USA, CSO, MoH and ICF International
[11]Ibid

Residential Care is provided in a non-family based group setting and may include transit centres in emergency situations, places of safety for emergency care and long-term residential care facilities.[13] It is estimated that there around 8 million children in residential care across the globe.[14] However, these numbers are estimates as it has been observed that there is poor monitoring of Child Care Facilities by Governments. The reasons advanced for children being in residential care include poverty, armed conflict, natural disasters, disease burden and death of primary caregivers.[15]

Data from the MCDSW (2016) indicates that there were 8,335 children in residential care16 in 189 known homes. The provision of residential care is regulated by the MCDSW drawing its mandate from national laws on the protection of children in need of care.

The United Nations Convention on the Rights of the Child (UNCRC), to which Zambia is a State Party, provides for the protection children, including those in residential care. Specifically, the general principles of the UNCRC include: the best interest of the child (Article 3), Non-discrimination (Article 2), Survival and development (Article 6) and Children's participation and influence (Article 12). Article 20 further provides that a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. Furthermore, States Parties shall in accordance with their national laws ensure alternative care for such a child. In addition, the development of the UN Guidelines for the Alternative Care of Children in 2009 marked a milestone regarding the protection of children in need of care. The UN guidelines are aimed at enhancing the implementation of the CRC. Zambia is also a State Party to the African Charter on the Rights and Welfare of the Child (ACRWC), which also provides under Article 25 that any child who is permanently or temporarily deprived of his family environment for any reason shall be entitled to special protection and assistance. The Convention obligates States Parties to ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include, among others, foster placement, or placement in suitable institutions for the care of children. The ACRWC further provides States Parties should take necessary measures to trace and re-unite children with parents or relatives whenever separation occurs.

The UN Guidelines for the Alternative Care of Children emphasise residential child care as a measure of last resort, with the preference that children should grow up within their family setting. However due to various circumstances this is not always tenable. The UN Guidelines therefore provide that alternative care must be provided based on two key principles; the necessity principle and the suitability principle. These two highlight the need to ensure that alternative care is genuinely needed and that it is appropriate17. The Guidelines encourage States to put in place rigorous screening procedures to ensure that only appropriate admissions to Facilities are made18. The Guidelines further call on States to ensure policy and regulatory measures. Whilst not binding in nature, the Guidelines provide a more comprehensive approach to ensure that the rights of children in need of care are upheld.

The national legal and policy framework includes; the Juveniles Act Chapter 53 of the Laws of Zambia; the Adoption Act Chapter 54 of the Laws of Zambia, Societies Act, the NGO Act, the National Child Policy of 2006, 2014 National Social Protection Policy and the MSC. The MSC which were launched in 2014 by the MCDSW are a benchmark for the quality of care that CCFs should provide for children under their care.

In 2016, the MCDSW in partnership with UNICEF commissioned a Nationwide Assessment of CCFs to establish a baseline on the prevailing situation of children in CCFs in relation to the facilities adherence to the MSC against which progress can be measured.

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[12]Central Statistical Office (CSO), Zambia, 2015 Living Conditions Monitoring Survey key Findings, Central Statistical Office, Lusaka

[13]UN General Assembly; Guidelines on the Alternative Care for Children 2009; Res/64/1142; Resolution Adopted on the Report of the 3rd Committee; A/64/634

[14]Mann, G; Long, S; Delap, E; & Connell, L. (2012), Children Living with and Affected by HIV in Residential Care; UNICEF, New York.

[15]Williamson, J & Greenberg, A. (2010) *Families, Not Orphanages*. Better Care Network, New York

[16]Ministry of Community Development and Social Welfare, March 2016, Children's Homes Providing Support and Institutional Care to Orphans and Vulnerable Children,

The Nationwide Assessment of Child Facilities was conducted in two stages, April and in July 2016, reaching all CCFs and assessing the situation of children in care.

1.2 Objectives of the assessment

The overall objective of the Assessment was to collect comprehensive information on the condition of all CCFs in line with the MSC as well as the UN Guidelines for the Alternative Care of Children. The Assessment aimed to provide critical analysis and recommendations necessary to inform the care reforms in Zambia. It also aimed to provide baseline information against which future progress could be measured.

1.2.1 Specific Objectives

1. To develop a comprehensive and standardised tool that can be adopted by the MCDSW for routine assessment of CCFs.
2. To build capacity of provincial and district social welfare officers to use the developed tools for routine assessment and oversight.
3. To assess the gatekeeping, admission, care and reintegration processes employed in each Child Care Facility.
4. To carry out physical inspections of all residential child care institutions.
5. To identify clear benchmarks (indicators) for strengthening the capacity of each home in the provision of residential child care services.

1.3 Structure of the report

This Report begins with an Executive Summary which is followed by the Introduction which highlights the background and context of the Assessment. Prior to discussion of the methodological approach adopted, both the overall and specific objectives of the Assessment are presented. The Section that follows present the findings of the Assessment. Since the Assessment is of a baseline nature, as required by the Terms of Reference, the report refrains from discussing and interpreting findings. The report ends with a conclusion and recommendations.

1.4 Assessment methodology

The study utilised a mixed methods approach with several tools developed and applied across all CCFs to different categories of respondents. The Assessment employed seven principal data collection tools namely: i) a questionnaire for Facility Manager; ii) a questionnaire for children; iii) structured interviews with caregivers; iv) Focus Group Discussion with children; v) an observation checklist; vi) semi structured interview with District Social Welfare Officer and vii) document verification. Children aged between 10-18 years were included in the study however about 2 percent of respondents were above 18 years of age. A total of 156 Facility Managers were interviewed, in addition interviews were conducted at 8 other Child Care Facilities (CCFs) targeting caregivers and children where Facility Managers were not available but had given permission for data collection. The Assessment conducted individual interviews with 959 children, excluding those that participated in Focus Group Discussions. The data presented in this report is derived from interviews with Facility Managers and children. It is triangulated by information from caregivers and focus group discussions. Data from the caregivers and the Focus Group Discussions was primarily used to compile a report containing findings and recommendations for each CCF.

The Assessment was conducted in two phases of data collection. The first phase, targeted the whole of the Copperbelt Province and parts of Lusaka and Central provinces. The second phase included all the other seven provinces and the Facilities in Lusaka and Central provinces that were not covered in phase one.

[17]Cantwell, N., Davidson, J., Elsley, S., Milligan, I., Quinn, N. 2012, Moving Forward,; Implementing the Guidelines for Alternative Care of Children UK: Centre for Excellence for Looked After Children, Scotland

[18]United Nations, 2010, Resolutions Adopted by the General Assembly, 64/142, Guidelines for the Alternative Care of Children

The Assessment was split in this manner at the request of the Clients, Ministry of Community Development and Social Services (MCDSS) and UNICEF. The reasons for the two phased approach were; (i) a desire to obtain results from the Copperbelt in the shortest possible time to inform programming efforts by the Ministry and other partners such as Save the Children and the Catholic Medical Missions Board (CMMB) and (ii) to obtain lessons that could be applied in the second phase.

There was some lesson learning from phase one of the Assessment which informed the second phase of data collection. In a few cases some questions in the Facility Manager and Child questionnaires were improved, dropped or new questions added. Where this was the case, data from Phase one and Phase two could not be aggregated, it is reported on in the context of the total sample size of the respective phases. Generalisation of findings of the few questions that did not appear in both phases has been avoided since each phase of data collection was in a specific geographical area and therefore not randomly selected and not representative of the whole country.

1.4.1 Quantitative component

Questionnaires

Two types of questionnaires were developed and administered to the Facility Managers/Directors and to children aged between 10 and 18 years respectively. The questionnaires were administered through face to face interviews and data was captured electronically. One hundred and fifty six (156) Facility Managers were interviewed on their CCFs adherence to the Minimum Standards of Care, number of children in care and the personal information of the Facility Managers. Nine hundred and fifty nine (959) children were interviewed in relation to their living standards, attendance of school, contact with their families among other issues.

1.4.2 Qualitative component

The qualitative component included the use of Focus Group Discussions (FGDs), Structured Individual Interviews, Key Informant Interviews and Observations. The category of respondents is provided in each section below.

a. Focus Group Discussions with children

FGDs were held with children between the ages 10 to 18. These were held in nearly all the 78 Facilities in Phase One. In Phase Two, the number of children found at Facilities could not meet the minimum required number of 6 to hold a FGD. Focus group discussions were held separately with boy and girl groups. In some cases where time allowed a combination of girls and boys FGD was also held.

b. Individual Interviews

Structured individual interviews were held with caregivers at each facility. The information from the caregivers was used for triangulation purposes. One care giver was interviewed at each CCFs, however, for facilities with more than 200 children, two caregivers were interviewed. There were five such facilities were more than one care giver was interviewed. The face to face interview with the Care giver obtained information on their educational background, their role in the facility, the provisions for children and available amenities.

c. Key Informant Interviews

i. District Social Welfare Officers

District Social Welfare Officers were included in the study as key informants. A semi structured interview guide was used to collect data from the Social Welfare Officers.

ii. Community leaders

Another category of Key Informants was community leaders. Only two community leaders were interviewed. Limitation on time resulted in low inclusion of community leaders.

d. Direct Observation

Observations were conducted for each CCF using a checklist. The main areas of observation included; notice boards, sleeping, eating and play areas, bathrooms and toilets, fire equipment and store rooms/pantry and wardrobes as well as the general surroundings.

e. Document Verification

Key documents were requested on site for verification during the Assessment. These included organisation's Constitutions, institutional policies and children's' files.

1.4.3 Coverage

As per terms of reference, all 189 known and registered CCFs were included in the study. In some cases this information was not up to date as facilities were found to have closed down or not operational. The details of Facilities visited are provided in Annex III.

1.4.4 Sampling technique for children's survey

Due to the non-availability of age and sex disaggregated data on children at the sampling stage, a predetermined sample size could not be set. To overcome this challenge, working on a scenario estimating that 60 percent of children would be aged 10 – 18 years old from the given population of 8335 children in residential care as provided by the Ministry of Community Development and Social Services, the survey required to attain a sample size of 357 based on 95 percent confidence level and 5 percent margin of error. The actual number of children interviewed superseded the scenario case, 959 children were interviewed from an actual population of 6,413 children in care. Less the 25 young adults aged 19 years and above, the number of children interviewed who were aged 10 – 18 years was 934. The actual number of children in residential care aged 10 -18 was 3899. Therefore the survey attained 99 percent Confidence Level and 3.7 percent margin of error.

1.4.5 Data Quality Assurance and Accuracy

The Study team applied various data quality assurance and accuracy measures for the survey. These measures included:

a. Pre-Assessment Measures

Pre-survey measures included an intensive training of 17 data enumerators (7 research assistants and 10 social workers from the Department of Social Welfare). The training consisted of a theoretical and a practical module designed to familiarise enumerators with the Survey and Survey instruments. Since the survey employed a digital data collection approach, all team members were adequately trained in using tablets for data collection.

Additionally, the training also aimed at informing enumerators of specific field research procedures in relation to logistics, ethical research behaviour, and ethical issues when collecting data from children and instructions on how to proceed in cases where Survey respondents sampled for the Survey are not available.

The training further included a pre-test of the Survey instruments in the field. Pre-testing of Survey instruments ensured that terminologies and phrases used in the instruments were well-understood, both by the interviewers and respondents. This was of particular importance because the Survey instruments

in some cases had to be translated into local languages where sampled respondents were not proficient in English.

b. On-Assessment Measures

To ensure high quality data collection, three measures were put in place. First, each team had a team leader or deputy team leader who provided guidance on response selection in cases where this was unclear. Secondly, the electronically programmed questionnaires had in-built quality measures that prevent enumerators from accidentally asking unnecessary questions (in-built skip-logic) or skipping an entire question. And thirdly, completed questionnaires were sent to the consulting firm´s server at the end of each day. This allowed the data quality Manager to assess completed questionnaires regarding data accuracy and consistency and to guide the teams on how to improve overall data quality.

c. Post-Assessment Measures

Data was cleaned before it was imported to SPSS and erroneous questionnaires were removed. After importing the data into SPSS, frequencies were generated for the entire data set. A syntax and error lists was produced that informed the data quality enhancement strategy.

d. Data Analysis

Quantitative data analysis was done both for the children's as well as to the Facility Manager's questionnaire. Frequencies on key variables were generated for both categories of respondents.
Analysis of qualitative data from FGDs was analysed by examining the content, themes and frequency of issues. The information from FGD discussions, observations and interviews with caregivers was used immediately by incorporating key issues in a summary facility report. The qualitative data was also used to complement and triangulate information from Facility Managers, the children and caregivers.

1.4.6 Assessment Ethics

The Assessment adhered to ethics in relation to informed consent and assent, confidentiality, referral in cases of serious matters affecting children and the right for children to opting out of an interview. The purpose of the Assessment was fully explained to children and adults before commencing on data collection.

The research proposal was submitted to an academic ethics committee for approval, which was granted. During research, permission to interview children was obtained from Facility Managers, research protocols were explained to children and consent and assent forms were signed both by Facility Managers and individual children. No photographs were taken of children. Children were assured of confidentiality and in cases where verbal and physical abuse were reported by children, such issues, were followed up with Facility Managers.

1.4.7 Limitations of the Assessment

Planning of the Assessment and literature review was constrained by the non-availability of comprehensive data on children in residential care. No authoritative studies on children in residential care in Zambia have been conducted. As a result, there was inadequate disaggregation of the population of children in care and lack of aggregated data on their social backgrounds. CCFs submit the numbers of children in their care to the Department of Social Welfare, however in most cases, such information proved to be inaccurate. Because CCFs are themselves the primary source of records to the Ministry, it was not possible to independently verify such data through any form of triangulation. CCF's data adequacy, accuracy and comprehensiveness on children, their admission, social conditions/background and exiting of Facilities tends to be poorly maintained by the facilities.

Another limitation of the Assessment was the difficulty faced in reaching community leaders. This was mainly as a result of time factor. However, there was no compromise in the data as community leaders have minimal or no influence on CCFs in issues of admission, care and reintegration.

A third limitation was in relation to the availability of children in CCFs. The Assessment commenced during the month of April which is the month when schools are on recess. Facilities reported having sent some of their children back to their families on holiday. While in the month of July, children were in school and would often return to the Facilities late in the afternoon. In a few cases, children were followed to school, especially where the school was run by the facility and where the facility had a good relationship with the school. Other mitigation measures included making arrangements to meet with children at a later time or day and also interviewing some of the children aged above 18 years (the 25 young adults), who were found at Facilities at the time of the Assessment.

2.0 Assessment Findings

2.1 Profile of Facilities, Facility Managers and Children

2.1.1 Facilities

The complete list of CCF was 189, this was according to MCDSW records. However, 173 were visited out of which data was collected from 164 Facilities, representing a 94.80 percent data output. Three Facilities that were initially on the complete list of 189 were found to be closed, three others were non-residential, one could not be located and two were not operational whilst one had no children at the time of Assessment. Although data was collected from 164 Facilities, interviews were held with 156 Facility Managers, as indicated in Table 2. Some Facility Managers had travelled at the time of the Assessment, others did not cooperate and were elusive. Further, it was found that three Facility Managers were responsible for two or three facilities each, therefore only one Facility Manager Interview was held in such a case. Two CCFs were repeated on the MCDSW list, thereby further reducing the number of eligible CCFs that could be included in the Assessment from the original 189 listed by the Ministry.

2.1.2 Profile of Facility Managers

A total of 156 Facility Managers and their representatives participated in the Assessment. Facility Managers from 18 CCFs could not be interviewed because of several reasons as indicated above. Annex II provides the specific details. Table 1 below shows that of those who were interviewed, 39.1 percent were males and 60.9 percent were females, an indication that Facility Managers were more likely to be females than males. The average age of Facility Managers was 48.8 years old, males were younger than female

Table 1: Number of Facility Managers interviewed by province, sex and average age (n=156)

Province	№ of Males	№ of Females	Province	Average age Male	Average age Female	Total (average age)
Central	7	12	**Central**	38.4	44.6	41.5
Copperbelt	12	30	**Copperbelt**	41.7	46.9	44.3
Eastern	1	4	**Eastern**	50	48.8	49.4
Luapula	1	3	**Luapula**	53	47.3	50.2
Lusaka	16	27	**Lusaka**	46	42,1	44.1
Muchinga	2	1	**Muchinga**	39.5	61	50.3
Northern	2	1	**Northern**	58	53.3	55.7
North western	3	3	**North western**	44	57	50.5
Southern	12	10	**Southern**	47.2	54.1	50.7
Western	5	3	**Western**	43.8	59.7	51.8
Total	61	95	**Average age**	46.2	51.5	48.8
	39.1 %	60.9 %				

Source: Field Data

Table 2 shows that Lusaka Province had the highest number of Facility Managers interviewed (44), followed by Copperbelt (42), Southern (22) and Central Province (19). The number of Facility Mangers interviewed in the rest of the Provinces ranged between three and eight, with the least being in Muchinga and Northern Provinces. The urban provinces have a higher number of CCFs than the rural provinces.

Table 2: Number and percent of Facility Managers interviewed by province

Province	№of CCF on finalised list	№ and % of Facility Managers interviewed by Province		Province % out of the total number of facilities (156)
		№	%	
Central	20	19	95.00	12.18
Copperbelt	50	42	84.00	26.92
Eastern	5	5	100.00	3.21
Luapula	5	4	80.00	2.56
Muchinga	4	3	75.00	1.92
Lusaka	48	44	91.67	28.21
Northern	4	3	75.00	1.92
N-Western	11	6	54.55	3.85
Southern	24	22	91.67	14.10
Western	8	8	100.00	5.13
Total	**179**	**156**	**87.15**	**100.00**

Source: Field data

2.1.3 Profile of Children

2.1.3.1 Numbers of Children in residential child care

Table 3 below highlights the age distribution of children as provided by 179 CCFs. The total number of children in these Facilities was 6,413, (49.35 percent) males and (48.23 percent) females, 2 percent of children were not disaggregated by gender by four facilities. Individual ages for 6 percent of children were not provided by seven facilities.

The total number of children living with disability was 305, accounting for 4.8 percent of all children in care. Out of the total number of children living with disability, 28 percent were classified as living with mental/intellectual disabilities. Chronic conditions affected 168 of children out of which 100 were living with HIV. Epilepsy was reported more frequently than the rest of the chronic conditions of sickle cell anaemia, cerebral palsy and albinism.

The average number of children per facility was 37.72 with a median of 24 and mode of 13. However, these measures of central tendency mask the disparities in the distribution of children in facilities. The maximum number of children at a facility was found to be 689 and the minimum was one child.

Findings further indicated that 52 percent of Facilities admit children younger than one year old. There were some disparities in responses between the age range of children in the facility and the preferred minimum age of admission. For example, in Phase one[19] of the study (n=78), where the specific question was posed, 88.5 percent of CCF stated the age range of children included 0-3 year olds but only 46.1 percent of the total indicated 1 -3 years as a minimum age of admission. There were children in Facilities that were younger than the preferred/ policy position of the facility.

[19]Phase One included Facilities in parts of Lusaka, all of Copperbelt, Kabwe and Kapiri Mposhi. Because the ToRs allowed revision to the tools after Phase One, some questions posed in Phase One were not included in Phase two and vise versa, findings on specific questions which were only applicable in one phase were not generalised because rural and urban areas are not representative of each other. See details in methodology.

Table 3: Percentage Age range of children in Child Care Facility

Age group and Number of children	Total no. of Children in CCFs - 6413
0-3 years	6%
4 -6 years	8%
7 -9 years	13 %
10 - 12 years	21%
13 -15 years	23%
16 - 18 years	17%
19+	6%
TOTAL	94%
N.B Individual ages of the missing 6% were not provided by seven facilities	

Source: Field Data

The total number of children in CCFs was 6413; 3164 boys and 3249 girls. Despite the maximum age being stipulated as 18 years, there were 403 (6. percent) children aged 19 years and above in 39 Facilities. These came to the Facilities when they were younger. The section on reintegration provides more details on reasons youth over eighteen years were still in residential care. 23 percent of children were aged between 13 – 15 years, the largest category. This was followed by children aged between 10 – 12 years, 21 percent. Children between 16 -18 years old accounted for 17 percent of all children. As children's ages lowered and so did the proportion. There were 13 percent children aged 7 – 9 years, 8 percent were aged between 4-6 years and lastly 6 percent were aged 0-3years.

2.1.3.2 Profile of interviewed children

Nine hundred and fifty nine, (959) children participated in individual interviews. Table 4 provides the age and sex disaggregation of the interviewed children. Children interviewed were aged between 10 -18 years apart from 2.6 percent who were over 18 years of age. The composition of the sex disaggregation was 49.1 percent males and 50.9 percent females.

Table 4: Profile of interviewed children by province, Number, age range and sex

Province	10 - 12 years		13 - 15 years		16 - 18 years		>18 years		Total	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Central	19	11	21	17	24	13	2	1	66	42
Copperbelt	30	51	44	61	64	52	1	10	139	174
Eastern	2	4	1	0	1	5	0	0	4	9
Luapula	2	2	1	3	1	0	0	0	4	5
Lusaka	45	41	61	75	57	40	2	6	165	162
Muchinga	2	6	5	5	0	1	0	0	7	12
Northern	4	2	8	4	6	2	0	0	18	8
North-Western	4	10	3	8	10	4	0	0	17	22
Southern	21	17	8	10	9	13	0	3	38	43
Western	1	5	4	2	8	4	0	0	13	11
Total	**№ 130**	**149**	**156**	**185**	**180**	**134**	**5**	**20**	**471**	**488**
	%	**13.6**	**15,5**	**16.3**	**19.3**	**18.8**	**14.0**	**0.5**	**2.1**	**49.1**	**50.9**

Source: Field data

There were 25 (2.6 percent) young people who were over 18 years old that were included in the Assessment because some CCFs had sent children back to their families on holiday in the month of April and because other children could not be reached since they were in school in the month of July)

Therefore, the 25 above 18 years old, found at the Facilities at the time of the Assessment were interviewed. However, this number (25) of young adult does not affect the margin of error as it is not included in calculating the actual margin of error for the desired age of the sample size.

Some children had to be followed to nearby schools as was the case for two Facilities located in Choma and Kaoma. The phenomenon of children going back to their homes during school holiday was a key finding indicating that some children in care still have families to return to. This point will be detailed later in the report under the section that discusses *home visits*.

2.2 Governance - Procedures and Administration -

2.2.1. Facility Constitutions

According to Zambian legislation, registration of an entity requires formulation of a Constitution, which among other things, details the purpose of the organisation. A total of 149 Facility Managers or their representatives responded to this question. Table 5 shows that 85.9 percent of CCF had a Constitution. Twenty one CCF did not have a Constitution. Some of these were statutory bodies and others were Faith Based Organisations. Evidence of a Constitution was seen in only half (51.0 percent) of CCFs that reported having a Constitution. Some representatives of Facility Managers were not able to produce evidence of the Constitution as they did not have access to documents. Government run CCF being statutory bodies are not required to formulate a Constitution.

The MSC[20] stipulate that a CCF's Constitution should contain information on the categories of children to be offered care. To the contrary, Constitutions did not have comprehensive information. Constitutions stipulated neither the age range of children to be offered care nor the numbers of children to be admitted. Only a few Constitutions stipulated the category of children to be served e.g. "orphaned, ill or abandoned children"[21] in the case of one facility. Facility Managers were not aware that these details were outlined in their Constitution. Constitutions were generally formulated and not according to the specifications of the MSC.

Table 5: Availability and evidence of a Constitution (n = 149)

Province	No. of facilities that had a Constitution	%	No. of facilities that were able to provide evidence of their Constitution	% of 149 that reported having a Constitution
Central	15	10.1	9	6.0
Copperbelt	35	23.5	19	12.8
Eastern	4	2.7	2	1.3
Luapula	3	2.0	2	1.3
Lusaka	38	25.5	25	16.8
Muchinga	2	1.3	1	0.7
Northern	3	2.0	3	2.0
North Western	4	2.7	1	0.7
Southern	16	10.7	10	6.7
Western	8	5.4	4	2.7
Total	128	85.9	76	51.0

Source: Field data

[20]Ministry of Community Development Mother and Child Health, Minimum Standards of Care for Child Care Facilities, 2014, p6, Department of Social Welfare, Lusaka
[21]Kasisi Children's Home, Lusaka

2.2.2 Types of Registration for Child Care Facilities

Zambian legislation provides for three types of registration; with the Registrar of Societies, Registrar of Companies, and through the Registrar of NGOs. Government institutions are exempt from registration. The Government of Zambia legislated the NGO Act in 2009. The Act compels all NGOs to register with the Registrar of NGOs. By obtaining re-registration under the NGO Act, NGOs would lose their recognition under the Societies Act. Only one form of registration is allowed. However the transition from Registrar of Societies to Registrar of NGOs has not been without heated debate and resistance among Civil Society Organisations (CSOs). The MSC requires CCFs to register with the Registrar of NGOs[22].

Data in Tables 6 shows that registration with the Registrar of Societies was the most common with 62 percent (82/133) CCFs**.** The second category was CCFs registered under the NGO Act, 24 percent. Registration with Registrar of Companies (PACRA) was reported by 14 percent, 19/133. Facilities had not transitioned from Registrar of Societies to Registrar of NGOs as required by the MSC. Therefore compliance with both the legislation and the MSC was low.

Table 6: Type of registration

Province	Registrar of Societies	Registrar of NGOS	PACRA	Total responses
Central	9	6	3	18
Copperbelt	32	9	2	43
Eastern	1	1	0	2
Luapula	3	0	0	3
Lusaka	26	12	3	41
Muchinga	0	0	2	2
North Western	3	0	1	4
Northern	0	0	2	2
Southern	3	4	6	13
Western	5	0	0	5
Total	**82**	**32**	**19**	**133**
Percent	**62**	**24**	**14**	**100**

Source: Field data

Three CCFs had commenced the process of registration with the Registrar of NGOs and were able to show the receipts of their submission. However, at the time of the Assessment, these Facilities had not yet obtained their registration certificates despite having submitted documentation for re-registration with the Registrar of NGOs 2 months prior to the Assessment.

2.2.3 Non registration of CCF operated by faith based organisations

The 21 CCF that had no Constitutions also included CCFs that were neither registered through Registrar of Societies, Registrar of NGOs nor Registrar of Companies. Three of these were government institutions that did not require such a registration. For the rest of the 18 some respondents could not provide answers on the type of registration their CCF held. However, CCFs managed by religious groups/ Faith Based Organisations (FBOs) were often not registered as individual entities. The Assessment found 12 of such CCF of Faith based organisations that operated under the umbrella of their mother body' registration status. Further, six CCFs managed by NGOs did not also have their own independent registration as Child Care Facilities. Both the FBO and NGO CCFs were treated as programmes of the main mother body/organisation.

[22]Ministry of Community Development Mother and Child Health, Minimum Standards of Care for Child Care Facilities, 2014, p5, Department of Social Welfare, Lusaka

2.2.4 Certificate of Recognition

All CCFs are supposed to obtain a Certificate of Recognition (CoR) from the Department of Social Welfare once they have been assessed and approved to operate as such. Table 7 shows that only 38.5 percent of CCFs had a CoR, 44.9 percent did not have a CoR while 16.7 percent of respondents were not aware whether their facility had a CoR or not. Managers of Facilities that did not have a CoR reported being unaware of the requirement to obtain a CoR.

Table 7: Facilities possessing Certificate of Recognition

Number and % of Facilities that had a Certificate of Recognition (CoR) from the Department of Social Welfare (n=156)								
Province	**Facility has a CoR**		**Facility does not have a CoR**		**Respondent does not know**		**Total**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Central	9	5.8	9	5.7	1	0.6	19	12.1
Copperbelt	15	9.6	18	11.5	9	5.8	42	2.9
Eastern	1	0.6	4	2.6	0	0.0	5	3.2
Luapula	0	0.0	5	3.2	0	0.0	5	3.2
Lusaka	20	12.8	13	8.3	10	6.4	43	27.6
Muchinga	1	0.6	2	1.3	0	0.0	3	1.9
Northern	1	0.6	1	0.6	1	0.6	3	1.9
North Western	3	1.9	2	1.3	1	0.6	6	3.8
Southern	8	51	10	6.4	4	2.6	22	14.1
Western	2	1.3	6	3.8	0	0.0	8	5.1
Total	**60**	**38.5**	**70**	**44.9**	**26**	**16.7**	**156**	**100**

Source: Field Data

2.2.5 Ownership of Facilities

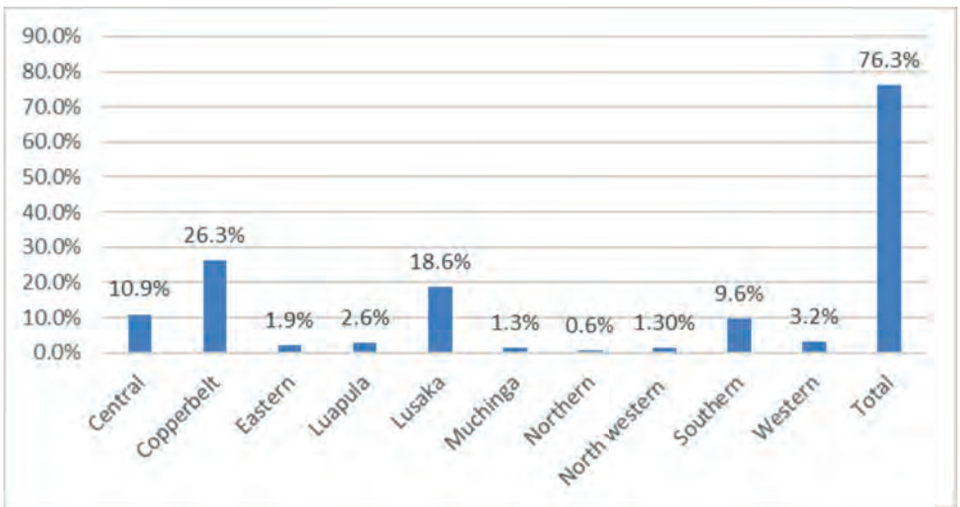
Ownership of Facilities varied with 35.9 percent (56) of the Facilities owning the buildings from which they operated. FBOs owned 22.44 percent (35) of CCFs, while 14.74 percent were owned by Facility Managers or their spouses and 12.18 percent were owned by a local authority/ the Ministry of Community Development and Social Services or individuals providing the premises on gratis but not connected to the founders. Private landlords owned 10.26 percent of the Facilities.

The least likely ownership was by women's group representing 1.28 percent (2) while community groups owned 3.20 percent (5). Findings showed that 10 percent (16) of CCFs were privately owned.

2.2.6 Funding

The Assessment found that 76.3 percent of Facilities received funding from local and international sources as Figure 1 indicates. CCFs from the Copperbelt had the largest proportion of those that received funding at 26.3 percent followed by Lusaka based CCFs at 18.6 percent as shown in Figure 3. Northern, Muchinga and North-western provinces were the least likely to receive funding.

Figure 1: Percent of facilities that received regular funding (n=156)



Source: Field data

2.2.7 Source of Funding

Table 8 shows, the most common sources of funds for the 119 CCFs that received funds. Individuals, mainly living outside Zambia were the highest contributors to CCFs at 43.7 percent. This was followed by Church groups at 39.5 percent, international NGOs accounted for 26.1, and other sources accounted for 18.5 percent. 'Other' sources of funding included organisation's Income Generating Activities (IGA) which included selling hydra foam interlocking blocks and broiler chickens. Other forms of IGAs included the running of community schools that charged a minimal amount on fees and were open to the public. It was noted that for most CCFs, funding from own resources was inadequate to meet the running costs.

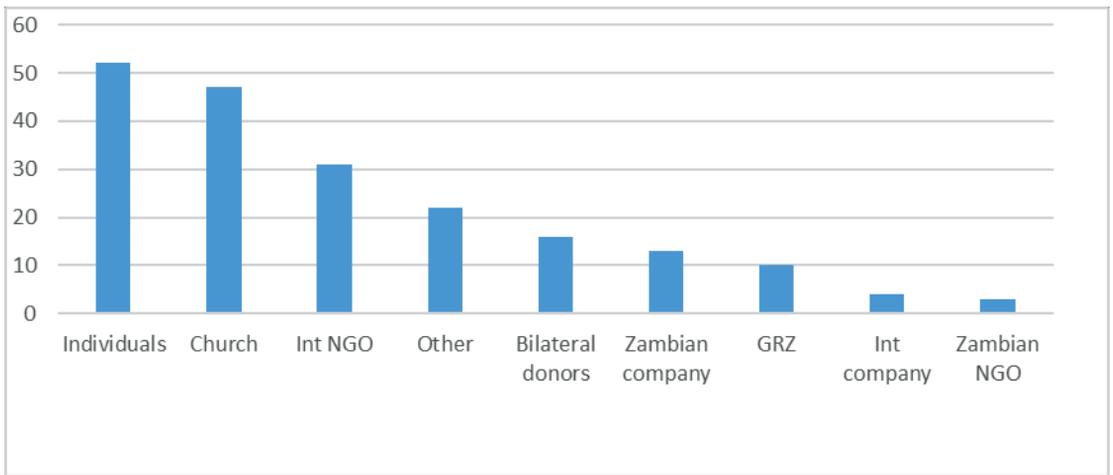
Table 8: Common sources of funding

№ & percent of funded Facilities by source of funding (n=119)									
	GRZ	Church	Bilateral Donor	Intl. NGO	Zambian NGO	Zambian Company	Intl. company	Individuals	Other
Central	3	7	4	3	0	3	1	7	1
Copperbelt	2	15	7	6	1	4	1	14	6
Eastern	1	0	0	2	0	0	0	1	1
Luapula	0	1	1	0	0	1	0	2	1
Lusaka	2	9	3	12	1	4	1	17	5
Muchinga	0	1	0	1	0	0	0	0	0
Northern	0	0	0	0	0	0	0	0	1
North Western	0	1	0	1	0	0	0	0	1
Southern	2	11	1	3	1	1	0	10	4
Western	0	2	0	3	0	0	1	1	2
Total percent	**10**	**47**	**16**	**31**	**3**	**13**	**4**	**52**	**22**
	8.4	**39.5**	**13.4**	**26.1**	**2.5**	**10.9**	**3.4**	**43.7**	**18.5**

Source: Field data

Only 8.4 percent (10) of responses denoted receipt of funds from the Government of the Republic Zambia (GRZ). CCFs raised concern over the "lack" of Government funding to support operational costs. Facility Managers were of the view that since they had assumed the responsibility of looking after needy children, their CCFs needed to be supplemented with GRZ funding.

Figure 2: Commonly mentioned source of funds



Source: Field data

Obtaining responses to questions about funding was a challenge in that some CCFs were reluctant to provide detailed information on their financial status. Another challenge faced was poor record keeping which resulted in information not being provided when required during the Assessment. Only 45.5 percent provided figures of their expenditure in 2014 and 2015. Funding levels varied with some CCFs spending over K2,500,000 per annum while others spent in the range of K300,000 or much less.

2.2.8 Board of Directors

Table 9 shows that 82.1 percent (128) of CCFs had a Board of Directors in place, 13 percent (21) did not have and 4.5 percent (7) of respondents did not know whether or not they had a Board. CCFs that did not have Board of Directors included the three Government owned and managed Facilities and some of the Faith Based CCFs, such as, those operated by catholic religious sisters' congregations.

Table 9: Existence of a Board of Directors at CCF

№ & percent of Facilities by existence of aboard of directors (n=156)								
Province	Facility had a board	%	Facility did not have a board	%	Respondent did not know	%	Total	%
Central	17	10.9	1	0.6	1	0.6	19	12.2
Copperbelt	37	23.7	4	2.6	1	0.6	42	26.9
Eastern	2	1.3	3	1.9	0	0.0	5	3.2
Luapula	4	2.6	1	0.6	0	0.0	5	3.2
Lusaka	34	21.8	6	3.8	3	1.9	43	27.6
Muchinga	2	1.3	1	0.6	0	0.0	3	1.9
Northern	3	1.9	0	0.0	0	0.0	3	1.9
N-Western	4	2.6	2	1.3	0	0.0	6	3.8
Southern	18	11.5	2	1.3	2	1.3	22	14.1
Western	7	4.5	1	0.6	0	0.0	8	5.1
Total	**128**	**82.1**	**21**	**13.5**	**7**	**4.5**	**156**	**100**

CCFs guidance indicated that Board Meetings were supposed to be held quarterly, bi-annually and annually. From the CCFs that reported having a Board, 39.8 percent (50) indicated that their Boards met quarterly, 20.3 percent (29) met biannually, 11.7 percent (14) met monthly, 8.6 percent (11) met annually and 10.9 percent (13) met as need arose while 8.6 percent (11) did not know how often their CCFs board members met. Those that did not know were representatives of Facility Managers. In the absence of board minutes these claims could not be verified. Minutes of meetings were not available for a myriad of reasons.

[23]Op. cit 19, p6

2.2.9 Separation between Board and Management

The MSC states that there should be a separation of roles between a Governing Board and Management23. This separation between Board Members and Management was quite blurred with most Facility Managers also being executive Board Members and/or Chairpersons of the Board. This showed that principles of good governance and levels of accountability were compromised in Facilities where this was the case.

2.3 Policies of Child Care Facilities

2.3.1 Child Protection Policy

CCFs are required to develop policies relating to the protection of children and a code of conduct for staff working in these facilities[24]. The Child Protection Policy (CPP) should link into the national child protection procedures approved by the Department of Social Welfare. Such a written statement must be based on national and social welfare policies and procedures, clearly stating employee responsibilities with regard to the reporting of suspected child abuse and neglect. The statement must include contact names and telephone numbers for making reports and should include procedures to be followed in the event of an allegation being made against a facility employee or volunteer.[25] Further, "all staff, volunteers and interns working with and looking after children should put the policy into practice."[26]

Table 10: Availability of a Child Protection Policy and Facilities providing evidence of a CPP

№and % of Facilities by status of Child Protection Policy (CPP) (n=156)					№ and %percent of Facilities by providing evidence on Child Protection Policy (CPP), (n=71)		
	Facility had CPP	Facility did not have CPP	Respondent did not know	Total	CPP seen (whether hard or soft copy)	CPP not seen (neither hard nor soft copy)	Total
Central	9	9	1	19	6	3	9
%	5.8	5.8	0.6	12.2	8.5	4.2	12.7
Copperbelt	22	14	6	42	12	10	22
%	14,1	9.0	3.8	26.9	16.9	14.1	31.0
Eastern	2	3	0	5	2	0	2
%	1.3	1.9	0.0	3.2	2.8	0.0	2.8
Luapula	1	4	0	5	0	1	1
%	0.6	2.6	0.0	3.2	0.0	1.4	1.4
Lusaka	20	20	3	43	12	8	20
%p	12.8	12.8	1.9	27.6	16.9	11.3	28.2
Muchinga	0	3	0	3	n/a	n/a	n/a
%	0.0	1.9	0.0	1.9			
Northern	0	2	1	3	n/a	n/a	n/a
%	0.0	1.3	0.6	1.9			
North Western	2	4	0	6	1	1	2
%	1.3	2.6	0.0	3.8	1.4	1.4	2.8
Southern	8	12	2	22	3	5	8
%	5.1	7.7	1.3	14.1	4.2	7.0	11.3
Western	7	1	0	8	2	5	7
%	4.5	0.6	0.0	5.1	2.8	7.0	9.9
Total	**71**	**72**	**13**	**156**	**38**	**33**	**71**
%	**45.5**	**46.2**	**8.3**	**100.**	**53.5**	**46.5**	**100.**

Source: Field data

[24]Minimum Standards p11
[25] Minimum Standards p12

The Assessment as shown in Table 10 found that less than half of CCF had Child Protection Policies, 45.5 percent, while 46.2 percent did not have these policies and 8.3 percent of respondents did not know if such a policy was in place or not. Copperbelt and Lusaka Provinces reported the largest proportion of Facilities that had child protection policies. In Muchinga and Northern provinces, CCFs did not have child protection policies at all. Of the 71 CCFs that reported having a child protection policy, only 53.5 percent (38) were able to provide evidence of the policy, through a hard or soft copy. Since only 38 out of 156 CCFs could provide evidence, the Assessment concluded that only 24.3 percent had a verifiable child protection policy in place.

The content and degree of compliance of child protection policies to MSC varied with some not having the necessary information stipulated in the MSC. Missing information included names and contact numbers of individuals to whom reports could be made. In some cases for example, SOS Children's Villages had the children identify and select a Person of Trust. The Person of Trust's names and a pictures were posted on a notice Board and children were informed that they could report issues of concern to such a person.
Implementation of child protection policies could not be fully ascertained during interviews with Facility Managers. However the Assessment established cases where children did not report cases of verbal abuse, cases of denial of food by caregivers or cases of being sent off to beg/look for food despite child protection policies being available at some the Facilities.

The MSC lists the categories of staff, volunteers and interns eligible to work at a CCF. These are, Director, child care workers, general staff, interns (local and international), volunteers, (local and international) and other employees. All these categories of staff are required to sign the institutional child protection policy. Table 11 shows that 27 Facilities required members of staff to sign the child protection policy. The Assessment found that of these 27, only at 13 Facilities (48.1 percent) had staff signed the policy. These findings show a significant level of non-compliance with MSC regarding policies for the protection of children.

Table 11: Number and percent of Facilities by Province where staff sign a Child Protection Policy [27]

Number and % of Facility by staff signing the CPP (n=27)						
Province	**Staff sign CPP**		**Staff does not sign CPP**		**Total**	
	№	**%**	**№**	**%**	**№**	**%**
Central	0	0.00	1	3.70	1	3.70
Eastern	2	7.40	0	0.00	2	7.40
Luapula	0	0.00	1	3.70	1	3.70
Lusaka	3	11.10	3	11.10	6	22.20
North Western	0	0.00	2	7.40	2	7.40
Southern	7	25.90	1	3.70	8	29.60
Western	1	3.70	6	22.20	7	25.90
Total	**13**	**48.10**	**14**	**51.90**	**27**	**100.00**

Source: Field data

2.3.2 Signing of child protection policy by volunteers

The MSC stipulates that all members of staff, volunteers and Interns are required to sign the Institutional Child Protection Policy28. Data from Phase One29 in Table 12 shows that of the 42 CCF that had volunteers, only at 13 Facilities (31 percent) did all volunteers sign a Child Protection Policy. Lusaka Province was in the lead with a higher proportion of volunteers in CCFs having signed a child protection policy. The Central Province had a third of CCF at which volunteers had signed the policy.

[27] These finding apply to findings of Phase Two. There was no data on this in Phase One of the Survey.

Table 12: No. of Facilities with volunteers signing child protection policy (Phase One Question only, n=42)

Province	No. of facilities that had local volunteers		No. of Facilities that had international volunteers		Facilities where volunteers had signed the CPP	
	№	%	№	%	№	%
Central	6	7.7	3	50.0	2	33.3
Copperbelt		30.8	9	37.5	6	25.0
Lusaka	12	15.4	9	75.0	5	41.7
Total	**42**	**53.8**	**21**	**50.0**	**13**	**31.0**

Source: Field data

2.3.3 Training of employees in child protection

The MSC stipulates that "child care facility Directors must ensure that: every member of staff has attended child protection training." In Phase Two,31 Facility Managers were asked whether staff had attended training in child protection. Results in Table 13 shows that only 25.6 percent of CCFs reported having provided training to their staff on child protection while 66.7 percent did not facilitate child protection training for their staff.

Table 13: Facilities providing training in child protection (Phase Two question only)

No. (percent) of Facilities by providing training in child protection to employees (n=78)								
Province	Provided training		Did not provide training		Respondent did not know		Total	
	№		№		№		№	percent
Central	0		6		0		6	7.7
Eastern	2		3		0		5	6.4
Luapula	1		4		0		5	6.4
Lusaka	6		11		3		20	25.6
Muchinga	0		3		0		3	3,8
Northern	0		3		0		3	3.8
North Western	0		6		0		6	7.7
Southern	7		15		0		22	28.2
Western	4		1		3		8	10.3
Total	**20**	**25.6%**	**52**	**66.7%**	**6**	**7.7%**	**78**	**100**

Source: Field data

2.3.4 Code of conduct

Facility Managers must ensure that "all employees sign the code of conduct for CCFs"32. Table 14 shows data from Phase One33, 46 percent (36) of Facility Managers reported that all their staff members had signed a code of conduct. This was less than half of the Facilities assessed. Evidence of a signed code of conduct was provided by 69.4 percent (25) of those that had signed.

28 Minimum Standards of Care p13 -14
29 No data available from Phase Two of the Assessment as the question was not included.
30 Ibid
31 No data available from Phase One

Table 14: Facilities where staff signed code of conduct and Facilities able to provide signed copied

Province	No. of facilities where all staff members had signed the Code of Conduct		No. of facilities able to provide signed Code of Conduct	
Central	6	7.7%	4	66.7%
Copperbelt	16	20.5%	12	75.0%
Lusaka	14	60.9%	9	64.3%
Total	**36**	**46.2%**	**25**	**69.4%**

2.3.5 Complaints reporting procedure

Table 15 shows that 38.5 percent of CCFs assessed had a complaints reporting procedure. However for 60.9 percent of the Facilities, the procedure was not written down. Caregivers and children affirmed that children knew they could report complaints to their caregivers, or to the care giver's supervisor if a complaint was of a serious nature. In only very few places, about 5 CCFs, was the complaints procedure displayed. Copperbelt and Lusaka had the highest proportions of CCFs with written complaints procedure. In Muchinga, Northern and North-western CCFs did not have complaints reporting procedures.

Table 15: Facilities that had/ did not have written complaints procedure

No (%) of facilities that did/did not have a written out complaints procedure (n=156)								
Province	**Facility had a complaints procedure**		**Facility did not have a complaints procedure**		**Respondent did not know**		**Total**	
	№	%	№	%	№	%	№	%
Central	7	4.5	12	7.7	0	0.0	19	12.2
Copperbelt	27	17.3	15	9.6	0	0.0	42	26.9
Eastern	1	0.6	4	2.6	0	0.0	5	3.2
Luapula	1	0.6	4	2.6	0	0.0	5	3.2
Lusaka	16	10.3	27	17.3	0	0.0	43	27.6
Muchinga	0	0.0	3	1.9	0	0.0	3	1.9
Northern	0	0.0	3	1.9	0	0.0	3	1.9
North Western	0	0.0	6	3.8	0	0.0	6	3.8
Southern	4	2.6	17	10.9	1	0.6	22	14.1
Western	4	2.6	4	2.6	0	0.0	8	5.1
Total	**60**	**38.5**	**95**	**60.9**	**1**	**0.6**	**156**	**100**

Source: Field Data

2.4 Child Care Facility Employees

2.4.1 Gender and Age

There were 40.1 percent male and 59.9 percent female CCF Managers of the 156 interviewed. The average age of Facility Managers was 46.2 years for males and 51.5 years for females.

2.4.2 Qualifications of Facility Managers

A total of 143 Facility Managers responded to a question on their educational attainment. The Assessment found that nearly a quarter of Facility Managers (24.5 percent) had a first degree, a third had a diploma (37.8 percent), 12.6 percent had attained secondary school certificate while 17.5 percent had a general professional certificate. Facility Managers with only primary school level of education comprised 3.5 percent. The MSC require Facility Managers to have a minimum of a Grade 12 school certificate. The MSC

[32] Minimum Standards of Care
[33] No data available or phase Two

also require Facility Managers to possess a recognised diploma in Child Care or in a related field. Findings showed that this was not the case. The majority did not have any professional background in Child Care. In Phase Two34 Facility Managers were asked whether they had received any training in management or Child Care, of the 78 that responded, 21.8 percent had no training, 7.7 percent had training in Management, 32.1 percent had training in Child Care and 38.5 percent had training in both Management and child care.

2.4.3 Qualifications of Caregivers

The MSC stipulate that Child Care Workers should have of Grade 12 as a minimum qualification and must have "completed a career certificate or vocational training programme in provision of Child Care" services.35 Data from Phase Two36, which comprised half of the CCFs included in the Assessment showed that Facility Managers at 80 percent (60) of the Facilities reported that caregivers at their Facilities had not attained Grade 12 level of education. Only at 14.7 percent (11) of the Facilities had caregivers attained the Grade 12 level of education. At 5.3 percent (4) of Facilities, Facility Managers or their representatives did not know the educational level of care givers. Although these precise statistics on educational level of caregivers were not collected in Phase One, responses from structured individual interviews with caregivers indicted that they did not have Grade 12 level of education as required by the MSC.

In addition, at 22.7percent (17) of CCF in Phase Two, caregivers had a professional qualification, whilst at 76 (57) percent of Facilities, caregivers did not have a professional qualification. Facility Managers or their representatives at 1.3 percent (1) of Facilities did not know if caregivers at their respective facilities had any professional qualifications.

The Assessment found that child care workers caregivers were engaged at two levels. The first category included caregivers that had professional qualifications, specifically at certificate levels and in a few cases diploma levels. These were often employed as Social Workers, Coordinators or Supervisors. The second category of Child Care Workers had no Grade 12 certificate but had Grade 9 level of education or lower. This category was employed as caregivers responsible for day to day duties such as cooking, cleaning, caring for and living with the children.

Caregivers at Government Facilities had a first degree or diploma in social work or community development studies and were directly responsible for the care of children but not for the tasks of cooking and cleaning. These tasks were performed by general workers employed specifically for cooking and cleaning.

An individual should have satisfactorily completed a career certificate or vocational training in child care programme in the provision of child care.37 Data from Phase two shows that 22.7 percent of Facility Managers indicated that some caregivers had obtained such qualifications while at 76 percent of facilities, caregivers had not obtained any professional certificates. These findings indicate that the regulations contained in the MSC were not being met by the majority of CCFs.

2.4.4 Type of staff categories

Table 16 indicates that caregivers are the largest of the staff categories comprising 41 percent of all members of staff in CCFs, with teachers being the next largest category at 22.9 percent. Social workers comprised 5.39 percent of all staff. The children to staff category ratio shows that per capita, caregivers were the category with the smallest number of children.

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34 No data available for Phase One

35 Minimum Standards of Care p13

36 No data available for Phase one, please see mehodology for detailed expalnation. The question on "qualifications of Caregivers" was included in Phase Two after review of tools used in Phase One (Copperbelt, parts of Lusaka and Parts of Central

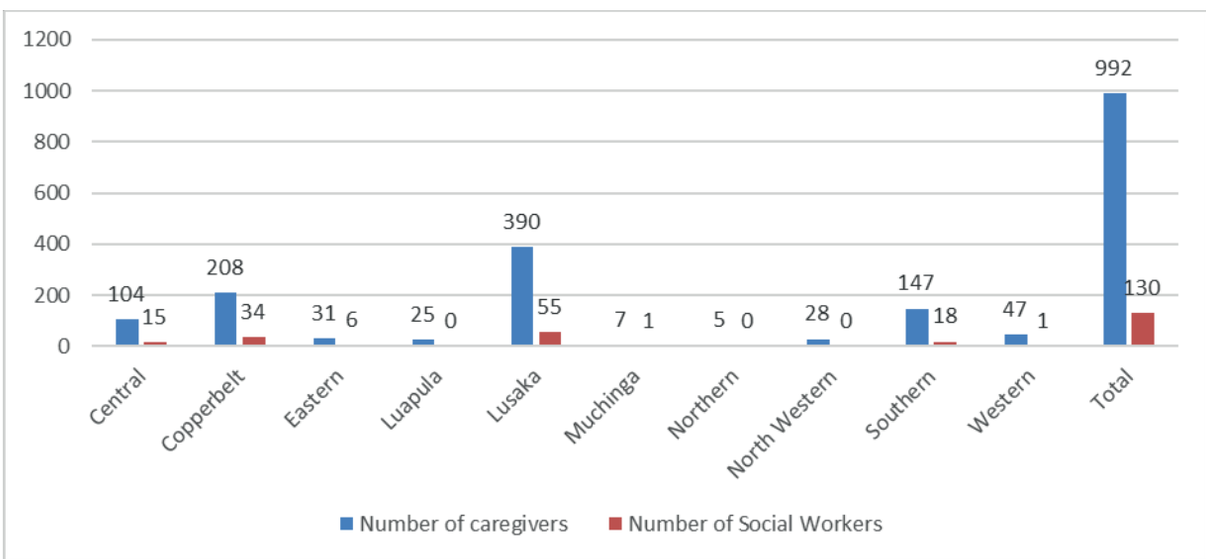
Table 16: Staff categories at Child Care Facilities and Child to Staff Ratio

Total No. of children	**6413**	**% of staff category to total staff**	**Children to staff ratio**
Total No. of full time staff	**2411**		
Staff Category	**No. of staff**		
Caregivers	992	41.14	6:1
Social Workers	130	5.39	49:1
Teachers	552	22.90	12:1
Special Needs Expert	23	0.95	13:1 - Ratio of disabled children to staff
Nutritionists	24	1.00	267:1
Nurses	62	2.57	103:1
Medical Doctors	4	0.17	1603:1
Physiotherapists	9	0.37	24:1 - Ratio of disabled children to staff
Accountants	85	3.53	
Human resource Officers	21	0.87	
IT specialists	30	1.24	
Cooks	166	6.89	39:1
Janitors/Cleaners	209	8.67	31:1
Guards	208	8.63	31:1
Drivers	43	1.78	

Source: Field data

The Assessment revealed a disproportionate representation of caregivers among staff compared to social workers. Caregivers did not have appropriate vocational training, however they spent more time with children. At the national level, the social worker to care giver ratio was 1:7. Figure 3 shows this disparity by province. The numbers show that in Lusaka for example, there was one social worker to seven (7) caregivers, on the Copperbelt, the ratio was 1:6 and in Southern it was 1:8. The non- availability of professional personnel such as, social workers in CCFs could explain the failure to produce care plans and other necessary documentation on children in residential care. Additionally, the low educational attainment of caregivers could have a negative impact on the development of the children, since the former would be limited in the manner they mentally engage or stimulate learning in the children.

Figure 3: Number of Caregivers and social workers by province



Source: Field data

[37] MSC p13

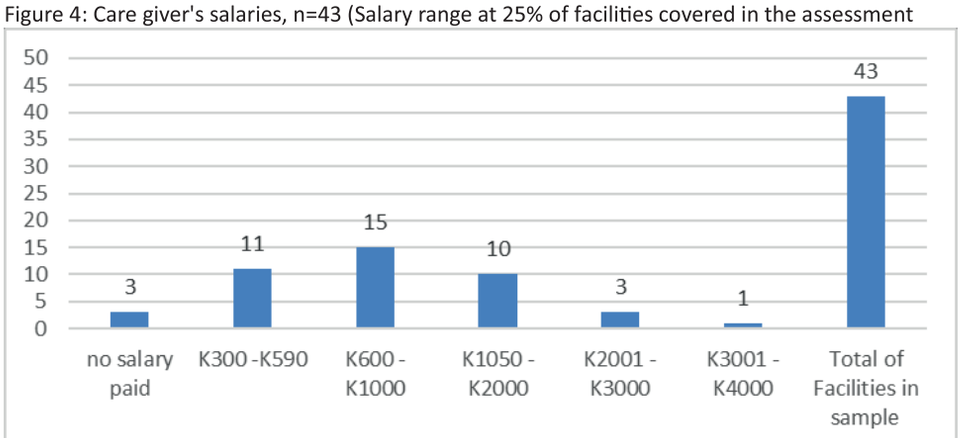
2.4.5 Remuneration for Caregivers

Section 113 of the United Nations Guidelines for the Alternative Care of Children provides that "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". 85.5 percent of CCFS paid salaries monthly while 11.5 percent indicated failing to pay monthly. The amounts paid out in salaries was analysed from responses obtained from interviews with caregivers.

Analysis was done of a random sample of 43 care giver interviews, constituting 25 percent of caregivers interviewed during the Assessment. The sample was drawn from Copperbelt, Lusaka, Western, North-western, and Southern provinces. The ranges of salaries paid were as follows; 7 percent of caregivers earned within the range ZMW 2,001.00 – ZMW 3,000.00, 34.9 percent earned between ZMW 600.00 and ZMW 1,000.00, followed by the ZMW300.00 – ZMW 590.00 bracket which accounted for 25.6 percent of caregivers. The findings show that another 7 percent of caregivers reported not receiving a salary at all, as depicted in Figure 4.

Salaries below ZMW550 fall below the national minimum salary for domestic staff. Financial constraints, as a result of dwindling resources and the failure by CCF to generate adequate funds resulted in their inability to meet the minimum wage requirement as well as the non-payment of salaries.
Facilities with external support tended to pay better, from ZMW 2,000.00 and above to caregivers and other supervisory positions. A salary of ZMW 300.00 – ZMW 590.00 was common in smaller towns in the provinces away from provincial capitals. However, there were also Facilities that paid ZMW 500.00 within provincial capitals.

Figure 4: Care giver's salaries, n=43 (Salary range at 25% of facilities covered in the assessment



Source: Field data

2.4.6 Engagement of former Residents of Child Care Facility

The practice of engaging young people that formerly lived in the facility as children was not common. The Assessment findings show only 10.14 percent of CCFs reported having former residents employed as caregivers. Of the 156 Facility Managers interviewed, 148 Facility Managers provided responses.

2.4.7 Periodic in-service training for staff

CCFs should provide employee pre-service and in-service training in a number of listed topics as provided in the MSC. Table 17 lists these topics. Over half of Facility Managers, 53.8 percent (Phase Two n=75)38, reported that caregivers underwent in-house training. Table 17 shows the most frequently mentioned topics of training.

38 The question on in service training was included in Phase two of the Assessment. This was done after discussion with the MCDSW and review of tools to include issues not specifically captured in Phase One.

Table 17: MSC Stipulated content of pre and in-service training and ranking of topics offered by CCF

	Areas To Be Covered During In-Service Training	Ranking of training topics mentioned by Facility Managers
a.	Child development	**1**
b.	Care of children with special needs	**8**
c.	Adult and child health	**5 (child health)**
d.	Nutrition	**2**
e.	Safety and risk management	**6**
f.	Curriculum planning	**10**
g.	Identification and care of ill children	**3**
h.	Recognition of child abuse, neglect and sexual abuse and reporting responsibilities	**4**
i.	Cultural diversity and gender awareness	**9**
j.	Professional development such as communication, time management and stress management	**7**

Source: Ministry of Community Development Mother and Child Health, Minimum Standards of Care for CCFs, 2014, p17
Ranking based on field data

50 percent of Facility Managers reported offering in-house trainings for all staff, while the other 50 percent did not offer any training at all. Apart from SOS Children's Villages that had a structured pre and in-service training, the other CCFs did not have a structured approach. This was noted from the long intervals of time between trainings offered. Some of the topics offered include the ethos and principles of the organisation, budgeting, health and first aid, positive parenting, child rights safeguarding and youth programme skills. No other CCF indicated having a programme as detailed and structured as the one offered by SOS.

Apart from "child development" the ranking of topics in Table 17 shows that the preferences of CCFs did not coincide with those provided in the MSC. Pre-service training was not offered as a two weeks long programme as prescribed in the minimum standards (two weeks training). Facilities indicated that they gave talks to new staff.

2.4.8. Police Clearance Certificate

The MSC stipulate that all categories of staff, volunteers and interns are required to have police clearance certificates. Findings in Table 18 show that less than half, 47.4 percent of Facility Managers had police clearance certificates, 52.6 percent did not have. Facility Managers in Muchinga, Northern and North-western did not have police clearance certificates at all. 11.5 percent of Facility Managers indicated that staff at their Facilities had police clearance certificates whilst 84.6 percent of Facility Managers reported that their staff had no police clearance certificates. Facility Managers were more likely to possess police clearance certificates than their members of staff. The reasons given for not having police clearance certificates were lack of awareness about the requirement as well as the cost associated with obtaining certificates for all staff.

Table 18: Facilities where staff had/ did not have police clearance

No. of facilities where all staff members had / did not have a police clearance (n=156)								
Province	**Staff members had police clearance**		**Staff members did not have police clearance**		**Respondent did not know**		**Total**	
	№		№		№		№	percent
Central	0		19		0		19	12.2
Copperbelt	9		33		0		42	26.9
Eastern	1		4		0		5	3.2
Luapula	0		5		0		5	3.2
Lusaka	4		36		3		43	27.6
Muchinga	0		3		0		3	1.9
Northern	0		3		0		3	1.9
North Western	0		6		0		6	3.8
Southern	2		20		0		22	14.1
Western	2		3		3		8	5.1
Total	**18**	**11.5%**	**132**	**84.6%**	**6**	**3.8%**	**156**	**100**

Source: Field data

2.4.9. Medical Clearance

The MSC state that "prior to employment, personnel must submit medical information to establish their physical and emotional ability to provide the necessary supervision and guidance to children". Table 19 shows that over two thirds, 68.6 percent of CCFs did not obtain medical clearance certificates for staff. Periodic medical check-ups for certain categories of staff, such as, food handlers, is compulsory in the MSC. The Assessment found that this requirement was not adhered to by CCF. 26 percent of CCF reported that staff at their facility had medical clearance certificates. Staff at 68.6 percent of CCF did not have any medical clearance certificates. Respondents at eight CCF did not know whether staff there had medical clearance certificates or not.

Table 19: Facilities where staff had/ did not have medical clearance certificate

№ of facilities where staff members had / did not have medical clearance (n=156)								
Province	**Staff members had medical clearance**		**Staff members did not have medical clearance**		**Respondent did not know**		**Total**	
	№	%percent	№	%percent	№	%	№	%
Central	3	1.9	16	10.3	0	0.0	19	12.2
Copperbelt	13	8.3	29	18.6		0.0	42	26.9
Eastern	2	1.3	2	1.3	1	0.6	5	3.2
Luapula	0	0.0	5	3.2	0	0.0	5	3.2
Lusaka	14	9.0	26	16.7	3	1.9	43	27.6
Muchinga	1	0.6	2	1.3	0	0.0	3	1.9
Northern	0	0.0	3	1.9	0	0.0	3	1.9
North Western	0	0.0	6	3.8	0	0.0	6	3.8
Southern	8	5.1	13	8.3	1	0.6	22	14.1
Western	0	0.0	5	3.2	3	1.9	8	5.1
Total	**41**	**26.3**	**107**	**68.6**	**8**	**5.1**	**156**	**100**

Source: Field data

2.5 Admission, Documentation and Care of Children

2.5.1 Admission Documents

The Ministry of Community Development and Social Services (MCDSS) is responsible for ensuring that an effective and appropriate gate keeping system is in place to ensure children are not taken into residential care without due consideration of the principles of necessity and suitability. The UN Guidelines for the Alternative Care of Children stipulate that States should ensure the availability of a range of alternative care options[39]. The MSC provide a set of conditions that must be met when admitting a child in residential care. Some of these include securing the Social Welfare Report, Committal Order, admission letter and a police report (where applicable) as well as a Birth Certificate and Under Five Card. Table 20 provides data from Phase One and shows that 488 children did not have letters of admission from the Department of Social welfare. The accuracy of figures is in doubt in view of the weak data/information storage and retrieval mechanisms in many Facilities. However, the figures were indicative of the incompleteness of required documentation.

Table 20: Number of children without written referrals from MCDSS

Province	No. of children at facilities without written referrals from DSW
Copperbelt	261
Central	130
Lusaka	97
Total	**488**

Source: Field data

Whilst Admission letters from the Department of Social Welfare were often in place, the situation was different with regard to Committal Orders. Table 21 shows that 84.6 percent of CCFs did not have committal orders for children and 10.55 percent did not know whether these were available or not for children in their care. CCFs reported that Social Welfare Officers did not often follow up on obtaining Committal Orders from the Courts. District Social Welfare Officers on the other hand attributed the delay in obtaining Committal Orders to red tape within the Judiciary. It was reported that processing of Committal Orders once lodged at Court could take a duration of four months. This was the case in some districts. Some Facilities however indicated that application forms they had completed had been misplaced at the District Social Welfare Office. This finding was indicative of weak information management systems within the CCFs and at the Department of Social Welfare.

Table 21: Availability of Committal Orders

Province	No. (%) of facilities that did not have Committal Orders for children (n=148)	%	Respondent did not know	%
Central	9	5.8	1	0.6
Copperbelt	28	17.9	4	2.6
Eastern	2	1.3	1	0.6
Luapula	2	1.3	0	0.0
Lusaka	23	14.7	2	1.3
Muchinga	2	1.3	0	0.0
Northern	1	0.6	0	0.0
North Western	5	3.2	1	0.6
Southern	6	3.8	1	0.6
Western	4	2.6	0	0.0
TOTAL	**132**	**84.6**	**16**	**10.5**

Source: Field data

In some districts the challenge in obtaining Committal Orders arose because CCFs were required to pay a court fee for each application. This had proved costly especially for CCFs that were not well resourced. However in some districts, the courts waived the charge for processing Committal Orders.

Over two thirds of CCFs (67.9 percent), indicated that parents/guardians, if available signed a document when their children were admitted while 30.1 percent of CCFs reported that guardians did not have to sign an admission document; Table 22. This situation is indicative that some children in residential care had surviving parents/guardians, thereby increasing the possibility of reintegration. The MSC require that CCFs should obtain an admission letter from the District Social Welfare Office, no stipulation is provided in the MSC for signing by parents or guardians.

Table 22: Parent/guardian signs an admission document

No. (%) of facilities by parents/guardians (if available) sign an admission document (n=156)								
Province	**Parents/guardians have to sign an admission document**	**%**	**Parents/guardians do not have to sign an admission document**	**%**	**Don't know**	**%**	**Total**	**%**
Central	16	10.3	3	1,9	0	0.0	19	12.2
Copperbelt	30	19.2	12	7.7	0	0.0	42	26.9
Eastern	3	1.9	2	1.3	0	0.0	5	3.2
Luapula	3	1.9	2	1.3	0	0.0	5	3.2
Lusaka	26	16.7	15	9.6	2	1.3	43	27.6
Muchinga	0	0.0	3	1.9	0	0.0	3	1.9
Northern	0	0.0	3	1.9	0	0.0	3	1.9
North Western	4	2.6	2	1.3	0	0.0	6	3.8
Southern	20	12.8	1	0.6	1	0.6	22	14.1
Western	4	2.6	4	2.6	0	0.0	8	5.1
Total	**106**	**67.9**	**47**	**30.1**	**3**	**1.9**	**156**	**100.**

Source: Field data

2.5.2 Reasons for admission

The Assessment found that the most cited key reasons for placement of children were; poverty (lack of income, assets), child being abandoned, death of a parent, abuse and maltreatment of child and disability of primary care giver or the child. Imprisonment of parent as well as mental illness of mother were also significant contributors.

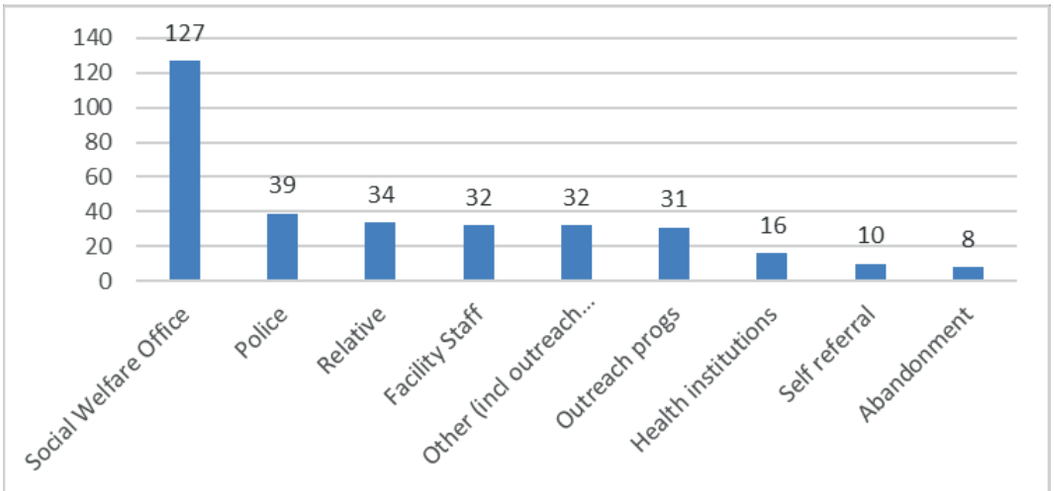
2.5.3 Admission channels

Figure 5 depicts the different ways in which children were brought to CCFs. The District Social Welfare Office ranked highest as the primary channel. The next channel was the police followed by relatives, and lastly through facility staff and 'Other'. These last two categories included children that were identified through outreach programmes carried out by Facilities. For example, outreach to vulnerable children living in elderly grandparent headed households or those headed by low income females/widows. 'Other' also included referrals from community and traditional leaders and church groups. Another mode of outreach was to children living on the streets. Children identified through outreach programmes would be assessed by the District Social Welfare Office and if found in need of care would be recommended for residential care. It was further reported that children were sometimes admitted before the assessment by District Social Welfare Officers was conducted. CCFs were well aware that children needed to be referred for care by the District Social Welfare Office. Admission by way of Relative, Outreach programmes and 'Other' were quite prevalent, indicating some weaknesses in gate keeping mechanisms within the country.

[39] Art. 53 of the UN Guidelines for the Alternative Care of Children; (2009)

The Assessment found that 1,537 children had been admitted to residential care since January 2015, i.e. one and half years before the Assessment was conducted.

Figure 5: Frequently stated ways that children were brought to Facilities



Source: Field data

Table 23 shows the distribution among provinces of ways through which children come into residential care. In Central, Eastern, Luapula, Muchinga and Southern Provinces the aspect of a health institution bringing children to a facility was not a practice. Children being abandoned was indicated in Central, Copperbelt, Lusaka and North-western provinces.

Table 23: Frequently stated ways children are brought to Facilities by Province

№ and (%) of facilities by usual way in which children are brought/referred to facility (n=156)[40]									
	Police	SWO	Health-related institution	Relatives	Abando-nment	Self-referral	Facility staff member	Commun-ity outreach program	Other
Central	5	14	0	5	1	3	3	3	3
Copperbelt	10	34	5	8	4	1	15	n/a	11
Eastern	2	3	0	2	0	0	1	2	0
Luapula	0	5	0	1	0	1	1	1	1
Lusaka	16	36	4	8	2	4	11	9	12
Muchinga	0	2	0	1	0	0	0	1	0
North Western	0	4	4	2	1	1	0	4	0
Northern	1	2	0	0	0	0	0	1	1
Southern	4	20	1	5	0	0	1	7	2
Western	1	7	2	2	0	0	0	3	2
Total	**39**	**127**	**16**	**34**	**8**	**10**	**32**	**31**	**32**
%	**25.0**	**81.4**	**10.3**	**21.8**	**5.1**	**6.4**	**20.5**	**19.9**	**20.5**

Source: Field data

2.5.4 Record keeping

All CCFs are required to maintain individual children's files and records. The MSC specifies the kind of documents to be included in each child's individual file.41 Table 24 shows that 87.2 percent of Facility Managers kept personal files for each child in care, 3.2 percent of Facility Managers indicated that only some children had personal files and 8.3 percent of Facility Managers stated that children at their CCF had no personal files. A further 1.3 percent of respondents did not know anything about children's personal

41 MSC 2014, p10

files. Overall, findings indicate a high level of compliance with the MSC's requirement of maintaining children's personal files.

Whereas personal files were available at 87.2 percent of CCFs as indicated in Table 24, the information kept therein was incomplete. The manner in which files were kept and the information they held was neither comprehensive nor consistent. A scan of the files indicated that files did not contain all necessary documents as seen from Tables 25 and 26.

Table 24: Number and percent of CCF by record keeping of children's files

№ and (percent) of Facilities by record keeping for children (n=156)						
Province		**All children had personal files**	**Only some children had personal files**	**None of the children had personal files**	**Respondent did not know**	**Total**
Central		17	1	1	0	19
Copperbelt		37	1	3	1	42
Eastern		4	0	1	0	5
Luapula		3	0	2	0	5
Lusaka		38	2	2	1	43
Muchinga		3	0	0	0	3
Northern		3	0	0	0	3
North Western		6	0	0	0	6
Southern		19	1	2	0	22
Western		6	0	2	0	8
Total	**No.**	**136**	**5**	**13**	**2**	**156**
	%	**87.2**	**3.2**	**8.3**	**1.3**	**100.**

Source: Field data

In a few cases, such as, at Kasisi Children's' Home, all documents about a child were on file for all the children and these included among others; birth certificate, care plan, medical report, photograph, under-five clinic card for children below the age of five, letter of admission, committal order as well as referral letter and consent forms from guardians where applicable. However, for most CCFs this was not the case.

Table 25: Types of documents contained in files

№ and (%) of facilities by type of documents contained in children´s files (n=143)						
Province	**Birth Certificate**	**Medical reports**	**School reports**	**Personal photographs**	**Case reports**	**Information about parents/guardians**
Central	3	8	12	4	8	9
Copperbelt	8	26	33	22	32	25
Eastern	0	3	3	1	3	3
Luapula	0	1	1	2	2	2
Lusaka	8	33	29	31	27	28
Muchinga	0	0	1	0	1	0
North Western	0	1	1	1	1	2
Northern	0	0	0	0	1	0
Southern	1	8	13	9	13	11
Western	1	4	1	3	5	3
Total	**21**	**84**	**94**	**73**	**93**	**83**
%	**14.7**	**58.7**	**65.7**	**51.0**	**65.0**	**58.0**

Source: Field data

41 MSC 2014, p10

Table 25 also shows that birth certificates are among most unlikely document on file, only 14.7 percent had these on file. The most likely documents to be on file were school reports 65.7 percent and case reports 65 percent. Case reports were often not complete, however some of the information therein included the child's names, age and where/with whom the child had previously lived. Facility Managers indicated that it was difficult to obtain birth certificates especially for children whose parents were not known and background information about the child was lacking. However, it was established that in most cases, CCFs made no effort towards obtaining such essential documents for children in their care even in situations where close relatives were available and hospital records could be found. Medical records of children were available at 58.7 percent of CCFs. Those that did not have medical records explained that records were kept at the clinics/hospitals that children attended when they were in need of medical attention.

Table 26 shows that 51.8 percent of CCFs had files that contained the relevant information, slightly over a quarter of the CCFs, 26.2 percent had files that contained only some of the information and 6.4 percent had no relevant information on the files. The Assessment team could not access files at 15.6 percent of CCFs because Facility Managers were away and did not give access to their subordinates to release the files. The relevant information outlined by the MSC includes; birth certificate, admission record, a document signed by parent or guardian and contact details of parent or guardian as well as medical records and school reports.

Table 26: Facilities with relevant documents on children's files

№ and (%) of facilities by content of children´s files (n=141)					
Province	**№ (%) of facilities that had files containing relevant documents**	**№ (%) of facilities that had files containing only some of the relevant documents**	**№ (%) of facilities that had files not containing any relevant documents**	**No (%) of facilities where files were not accessible**	**Total**
Central	9	5	1	3	18
%	6.4	3.5	0.7	2.1	12.8
Copperbelt	21	8	4	6	39
%	14.9	5.7	2.8	4.3	27.7
Eastern	2	0	1	1	4
%	1,4	0.0	0.7	0.7	2.8
Luapula	0	2	1	0	3
%	0.0	1.4	0,7	0.0	2,1
Lusaka	20	11	1	5	37
%	14.2	7.8	0.7	3.5	26.2
Muchinga	2	1	0	0	3
%	1.4	0.7	0.0	0.0	2.1
Northern	2	0	0	1	3
%	1.4	0.0	0.0	0.7	2.1
North Western	3	2	0	1	6
%	2.1	1.4	0.0	0.7	4.3
Southern	10	7	0	3	20
%	7.1	5.0	0.0	2.1	14.2
Western	4	1	1	2	8
%	2.8	0.7	0.7	1.4	5.7
Total	**73**	**37**	**9**	**22**	**141**
%	**51.8**	**26.2**	**6.4**	**15.6**	**100.**

Source: Field data

2.5.5 Child Care Plans

The MSC stipulate that a system must be in place for reporting the progress of each child to the Department of Social Welfare, the child's family and other relevant stakeholders. Every CCF is required to develop a Child Care Plan for each child in care. The Assessment found that Child Care Plans were available in less than half (41.7 percent) of the Facilities as shown in Figure 6.

Figure 6: % of Facilities with individual child care plans

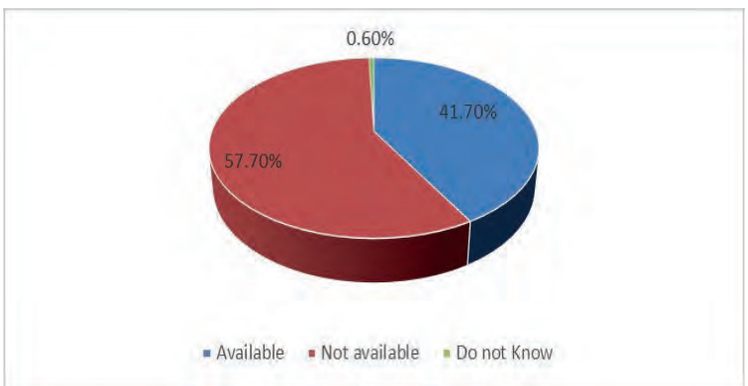


Table 27: Existence of Child Care Plans in Facilities

№ and (%) of facilities by individual child care plan existence (n=156)								
	Facility had child care plans		Facility did not have child care plans		Respondent did not know		Total	
	№	%	№	%	№	%	№	%
Central	7	4,5	12	7,7	0	0,0	19	12,2
Copperbelt	18	11,5	24	15,4	0	0,0	42	26,9
Eastern	1	0,6	4	2,6	0	0,0	5	3,2
Luapula	1	0,6	3	1,9	0	0,0	4	2,6
Lusaka	21	13,5	23	14,7	0	0,0	44	28,2
Muchinga	0	0,0	3	1,9	0	0,0	3	1,9
Northern	0	0,0	3	1,9	0	0,0	3	1,9
North Western	2	1,3	4	2,6	0	0,0	6	3,8
Southern	10	6,4	11	7,1	1	0,6	22	14,1
Western	5	3,2	3	1,9	0	0,0	8	5,1
Total	**65**	**41,7**	**90**	**57,7**	**1**	**0,6**	**156**	**100**

Source: Field data

However, there were some exceptions, such as, SOS Children's Village and Abba's House where Child Care Plans were thorough, well thought out and included input and a reflection of the child in terms of his/her personal development goals and plans. A contributory factor to poor and/or non-development of Child Care Plans could be due to lack of professional staff, such as, Social Workers and inadequate orientation of Facility Managers on the importance of such documents. Further, Facility Managers indicated that they received no guidance from District Social Welfare Officers on the need for Child Care Plans.

2.6 Services available to children in care

2.6.1 Health

Access to adequate health care is a right that must be enjoyed by all children including children in residential care. The MSC state that all children in care must have access to and receive adequate health care. This includes receiving medical check-ups at admission, access to medical treatment, up-to-date medical records, and carers must have relevant training in the care, treatment and use of medication for a child with a disability, disease or infection. General health services at CCFs included presence of a sick bay or a dispensary at the facility. 871 of the sampled children reported having experienced ill health during their stay at CCFs, (with periods of stay ranging from one year to seven or eight years), 97 percent of these children had received medical attention for their condition. Only 3 percent had not received treatment. This was a demonstration of the importance that Facilities attached to providing children with medical care when in need of it. This also showed the importance placed on children's right to health care.

Table 28 shows that 42.3 percent of CCFs did not offer any health services, 19.9 percent offered general health services to children at the facility for example having a sick bay or providing health talks, 14.7 percent had a dispensary/medicines and 30.1 percent offered general child counselling to children. Total responses of more than 156 Facilities show that at some Facilities more than one type of service was available.

Table 28: Health services offered by CCFS

№ and (%) of facilities offering medical services to children in care at the facility (n=156)							
	No services offered	**General health**	**Dental clinic**	**Pharmacy/ Medicine**	**Mental health / Counselling**	**Wheelchairs, glasses, hearing aids**	**Other**
Central	8	4	1	3	9	2	2
%	5.1	2.6	0.6	1.9	5.8	1.3	1.3
Copperbelt	14	9	0	8	18	1	4
%	9.0	5.8	0.0	5.1	11.5	0.6	2.6
Eastern	4	1	0	1	0	0	1
%	2.6	0.6	0.0	0.6	0.0	0.0	0.6
Luapula	2	2	1	1	1	1	0
%	1.3	1.3	0.6	0.6	0.6	0.6	0.0
Lusaka	14	5	1	5	5	2	1
%	9.0	3.2	0.6	3.2	3.2	1.3	0.6
Muchinga	3	0	0	0	0	0	0
%	1.9	0.0	0.0	0.0	0.0	0.0	0.0
Northern	4	0	0	0	1	0	0
%	2.6	0.0	0.0	0.0	0.6	0.0	0.0
North Western	2	2	0	2	2	0	0
%	1.3	1.3	0.0	1.3	1.3	0.0	0.0
Southern	11	5	2	2	9	0	1
%	7.1	3.2	1.3	1.3	5.8	0.0	0.6
Western	4	3	0	1	2	1	0
%	2.6	1.9	0.0	0.6	1.3	0.6	0.0
Total	**66**	**31**	**5**	**23**	**47**	**7**	**9**
%	**42.3**	**19.9**	**3.2**	**14.7**	**30.1**	**4.5**	**5.8**

Source: Field Data

Table 29 shows that out of the 73 responses in Phase Two42, 17.8 percent of CCFs had a Clinic on their premises and 82.2 percent did not. In Phase One, the question only asked about type of health services and not whether there was a Clinic at the Facility. CCFs that had health related infrastructure such as a clinic within their premises were able to carry out regular screening, deworming and other medical check-ups. CCFs without a clinic on their premises hired medical personnel to conduct medical check- ups, however, this was verified in few cases.

Table 29: CCFs that had a clinic at premises

№ and (%percent) of facilities by having a clinic on their premise (n=73)						
Province	**Facility had a clinic**	**%**	**Facility did not have a clinic**	**%**	**Total**	**%**
Central	0	0.0	6	8.2	6	8.2
Eastern	1	1,4	4	5,5	5	6,8
Luapula	1	1,4	3	4,1	4	5,5
Lusaka	2	2,7	19	26,0	21	28,8
Muchinga	1	1,4	2	2,7	3	4,1
Northern	2	2,7	1	1,4	3	4,1
North Western	0	0,0	6	8,2	6	8,2
Southern	6	8,2	16	21,9	22	30,1
Western	0	0,0	6	8,2	6	8,2
Total	**13**	**17,8**	**60**	**82,2**	**73**	**100**

Source: Field data

The findings in Table 30 show that 79.5 percent of CCFs had First Aid Kits and over a third (37.8 percent) had Sick Bays. Of the 59 Facilities that had sick bays, 30 (50.8 percent) were managed by a qualified medical personnel hired full time or periodically by the CCF. There was one CCF at which the Sick Bay was managed by a school health worker.

Focus Group Discussions with children revealed some concerns regarding caregivers' adherence to medication schedules for children on treatment. For example, at one facility, there was a report that a caregiver had fallen asleep and did not wake up at night to administer the next dose of malaria treatment despite being woken up by the child.

Table 30: Facilities with First Aid Kits and Sick Bay

Province	№ and (%percent) of facilities with		No. (% percent) sick bays run by medical personnel (n=59)	Qualification of medical personnel in charge of sick bay (n=30)					
	First Aid Kits (n=156)	Sick Bays (n=156)		Registered Nurse	Nurse Assista-nt	Enrolled Nurse	Clinical Officer	Medical doctor	Other [43]
Central	17	9	2	0	1	0	0	1	0
%	10.9	5.8	3.4	0.0	3.3	0.0	0.0	3.3	0.0
Copperbelt	36	11	8	7	0	0	0	1	0
%	23.1	7.1	13.6	23.3	0.0	0.0	0.0	3.3	0.0
Eastern	4	1	1	0	0	0	1	0	0
%	2.6	0.6	1.7	0.0	0.0	0.0	3.3	0.0	0.0
Luapula	3	2	0	**n/a**					
	1.9	1.3	0.0						
Lusaka	35	25	13	8	0	0	0	4	1
%	22.4	16.0	22.0	26.7	0.0	0.0	0.0	13.3	3.3
Muchinga	2	1	1	0	0	1	0	0	0
%	1.3	0.6	1.7	0.0	0.0	3.3	0.0	0.0	0.0
Northern	0	0	0	**n/a**					
%	0.0	0.0	0.0						
North Western	4	1	1	1	0	0	0	0	0
%	2.6	0.6	1.7	3.3	0.0	0.0	0.0	0.0	0.0
Southern	17	7	2	1	0	0	0	1	0
%	10.9	4.5	3.4	3.3	0.0	0.0	0.0	3.3	0.0
Western	6	2	2	1	0	0	0	1	0
%	3.8	1.3	3.4	3.3	0.0	0.0	0.0	3.3	0.0
Total	**124**	**59**	**30**	**18**	**1**	**1**	**1**	**8**	**1**
%	**79.5**	**37.8**	**50.8**	**60.0**	**3.3**	**3.3**	**3.3**	**26.7**	**3.3**

Source: Field data

Taking sick children to a Government Clinic or Hospital was the most common practice for CCFs that did not have a health facility at their premises. Table 31 shows that 75.6 percent of CCFs took children to a Government Clinic or Hospital. The choice depended on whichever was in close proximity and 16.5 percent took children to a Private Clinic or Hospital. The CCFs incurred costs charged by both government health facilities and privately owned clinics or hospitals.

Table 31: Where children are taken for medical treatment

№ and (%) facilities by type of clinic/hospital children are taken for medical services (n=127) [44]								
Province	**Government clinic/hospital**	**%**	**Private clinic/hospital**	**%**	**Other**	**%**	**Total**	**%**
Central	13	10.2	0	0.0	0	0,0	13	10.2
Copperbelt	19	15.0	7	5.5	5	3.9	31	24.4
Eastern	3	2.4	1	0.8	1	0.8	5	3.9
Luapula	4	3.1	0	0.0	0	0.0	4	3.1
Lusaka	26	20.5	7	5.5	1	0.8	34	26.8
Muchinga	3	2.4	0	0.0	0	0.0	3	2.4
Northern	3	2.4	0	0.0	0	0.0	3	2.4
North Western	5	3.9	1	0.8 .	0	0.0	6	4.7
Southern	16	12.6	4	3.1	2	1.6	22	17.3
Western	4	3.1	1	0.8	1	0.8	6	4.7
Total	**96**	**75.6**	**21**	**16.5**	**10**	**7.9**	**127**	**100.**

Source: Field data

[42] No data available for Phase One. This is because the question was not included.

Table 32 presents findings on routine medical check-ups. The question was only included in Phase Two of the Assessment.45 Findings were that 51.3 percent of CCFs provided routine medical check-ups for children. The intervals of check-ups were annually; undertaken by 25 percent of CCFs and another 25 percent of CCFs conducted routine medical check-ups bi-annually. An additional 22.5 percent of CCFs reported conducting monthly check-ups while quarterly check-ups were reported by 20 percent of CCFs. In Northern Province none of the CCFs provided any routine medical check-up. The MSC only requires children to under-go a medical check-up at admission.

Table 32: provision of routine medical check-up

Province	№ and (%) of facilities that provided routine medical check-up to children (n=78)		No. (%) of facilities by frequency of routine medical service provision (n=40)									
			Monthly		Quarterly		Bi-annually		Annually		Other[46]	
	№	%	№	%	№	%	№	%	№	%	№	%
Central	2	2.6	0	0.0	0	0.0	1	2.5	1	2.5	0	0.0
Eastern	4	5.1	0	0.0	2	5.0	1	2.5	0	0.0	1	2.5
Luapula	4	5.1	1	2.5	0	0.0	2	5.0	1	2.5	0	0.0
Lusaka	11	14.1	3	7.5	0	0.0	4	10.0	3	7.5	1	2.5
Muchinga	2	2.6	2	5.0	0	0.0	0	0.0	0	0.0	0	0.0
Northern	0	0.0	n/a									
North Western	2	2.6	0	0.0	1	2.5	0	00	1	2.5	0	0.0
Southern	12	15.4	3	7.5	2	5.0	2	5.0	4	10.0	1	2.5
Western	3	3.8	0	0.0	3	7.5	0	0.0	0	0.0	0	0.0
Total	**40**	**51.3**	**9**	**22.5**	**8**	**20.0**	**10**	**25.0**	**10**	**25.0**	**3**	**7.5**

Source: Field data

2.6.2 Education

The MSC provides that every child in a CCF must be provided unconditionally, with appropriate and relevant educational services that respond to their capacity, circumstances and developmental needs and given assistance to make effective use of the education provided.

Findings in Table 33 show that 90.6 percent of children in CCFs attended school, out of which 39.1 percent attended school within the CCFs premises while 60.9 percent attended school outside the premises CCFs. This finding underscores the value that CCFs place on children's access to education.
Out of the 959 children that were interviewed, 9.4 percent reported not being in school because they had completed their secondary education.

Facility Managers emphasised the importance of access to education for children under their care. There were a few CCFs where children did not attend school including one Government-run facility where it was reported that despite it being a transit home, children would live at the facility for up to two years and during this time, the children would not be enrolled into a school.

[43] School Health Worker

Table 33: Interviewed children that attended school, within facility premises and outside

Province	№ and (%) of children that attend school (n=959)	%	№ and (%) of children that attend school within the Facility´s premise (n=869)	%	№ and (%) of children that attend school outside the facility´s premise (n=869)	%
Central	102	10.6	48	5.5	54	6.2
Copperbelt	287	29.9	89	10.2	198	22.8
Eastern	12	1.3	8	0.9	4	0.5
Luapula	9	0.9	3	0.3	6	0.7
Lusaka	287	29.9	133	15.3	154	17.7
Muchinga	19	2.0	11	1.3	8	0.9
Northern	25	2.6	9	1.0	16	1.8
North-Western	34	3.5	17	2.0	17	2.0
Southern	76	7.9	21	2.4	55	6.3
Western	18	1.9	1	0.1	17	2.0
Total	**869**	**90.6**	**340**	**39,1**	**529**	**60.9**

Source: Field data

The Assessment findings as indicated in Table 34, show that overall, 46.2 percent of CCFs had a school located on their premises. The schools were all primary schools, with a few running Early Childhood Education Centres. Such schools were usually community schools except in the case of SOS Children's village that had ordinary fee paying schools open to the community but with children living in care being exempt from fees. Out of the 72 schools operating within CCFs premises, 70.8 percent reported having approval from the Ministry of Education but no evidence was shown to this effect. Some CCFs conducted home schooling programmes for categories of children, such as, those formerly living on the streets or physically challenged children. Children formerly living on the streets could not easily be placed in an ordinary schooling system because of their low numeracy and literacy skills in relation to their ages. Children living with disability often started school late and would be unable to attend school in their communities due to their disability, in addition, the long periods they had to stay in a CCF for corrective surgery necessitated home schooling to ensure they did not lose out on the education opportunity. Four CCFs provided such in-house schooling and two other facilities reported running early childhood classes prior to obtaining approval from the Ministry of General Education.

Table 34: Facilities with school on premises and whether approved by the Ministry of Education

Province	No (%) of facilities that had a school on the premise (n=156)	%	No (%) of facility schools that are approved by Ministry of Education (n=72)[47]	%
Central	9	5.8	9	12.5
Copperbelt	18	11.5	15	20.8
Eastern	4	2.6	1	1.4
Luapula	1	0.6	0	0.0
Lusaka	24	15.4	17	23.6
Muchinga	1	0.6	1	1.4
Northern	0	0.0	1	1.4
North Western	1	0.6	1	1.4
Southern	11	7.1	4	5.6
Western	3	1.9	2	2.8
Total	**72**	**46.2**	**51**	**70.8**

Source: Field Data

[44] Not applicable in Phase One to CCF that had their own sick bay
[45] The question was made more precise after review of experience from Phase One.
[46] 2 responses refer to weekly, 1 response "I don't know"

While primary and secondary level education were the most attended by children in CCFs, some facilities had children and/or young people that were pursuing college or university and vocational training. There were 48 CCFs with young people at college or university and 38 Facilities with young people at vocational training centres, 30.8 percent and 24.4 percent respectively as shown in Table 34.

At the time of the Assessment, from the total population of children and young people in care (6,413), there were 140 males and 88 females at college/university. There were 199 males and 152 females at vocational training institutions. Central Province accounted for the largest number of young people at vocational training centres with 206 students followed by Copperbelt with 99 students. Lusaka had more young people at college/university, 83, followed by Copperbelt which had 69 students, see Table 35. There were some Facilities that could not afford to send school leavers for tertiary education due to financial constraints. Obtaining bursaries for tertiary education support was reported to be a challenge.

Table 35: CCFs that had students at tertiary learning institutions and number of students at tertiary institutions

Province	№ and (%) of facilities with youths in college/university education (n=156)		№and of residents in college / university education		№ and (%) of facilities with residents attending vocational training (n=156)		№ attending vocational training	
	№	%	Male	Female	№	%	Male	Female
Central	4	2.6	12	4	6	3.8	112	94
Copperbelt	12	7.7	42	27	9	5.8	51	48
Eastern	2	1.3	2	2	1	0.6	unknown	Unknown
Luapula	2	1.3	1	3	1	0.6	1	0
Lusaka	14	9.0	54	29	12	7.7	19	8
Muchinga	1	0.6	1	0	0	0.0	0	0
Northern	0	0.0	0	0	0	0.0	0	0
Western	3	1.9	2	4	2	1.3	4	0
Southern	7	4.5	20	10	5	3.2	12	2
Western	3	1.9	6	9	2	1.3	0	0
Total	**48**	**30.8**	**140**	**88**	**38**	**24.4**	**199**	**152**

Source: Field data

Table 36 indicates that 28.2 percent of CCFs had children of school-going age that did not attend school. The total number of children of school-going age not in school was 217. Reasons for not attending school included; long distances to pre-schools, children being new at the facility, inability or not being ready to attend school due to mental disability or being slow learners. The 217 not in school was obtained from the total population of children in care 6,413.

The Assessment found that children with special needs that were admitted to CCFs that were not specialised to care for them, often missed out on their education. This was because CCFs had no access to specialised personnel and services. Children with special learning needs and other type of challenges, such as, motor skills comprised this category. Cheshire Home Society run children's facilities that admitted children specifically for corrective surgery and rehabilitation provided using the home schooling concept or boarding school arrangement. . The lack of specialised care for children with special needs in CCFs that were not equipped to cater for such children was neither in accordance with UN Guidelines for the Alternative Care of Children nor the MSC.

[47] No evidence

Table 36: Number of CCFS with children not attending school

Province	№ and (%) of facilities with children of school-going age not attending school (n=156)	%	№ of children of school going age not attending school (n=156)
Central	4	2.6	29
Copperbelt	7	4.5	56
Eastern	1	0.6	1
Luapula	0	0.0	0
Lusaka	18	11.5	68
Muchinga	1	0.6	1
Northern	2	1.3	8
North Western	2	1.3	15
Southern	5	3.2	18
Western	4	2.6	21
Total	**44**	**28.2**	**217**

Source: Field data

Table 37 shows the means by which children got to school. Walking to school was reported by 72.7 percent of the children that participated in the Assessment as the most common means of getting to school. Another 12.8 percent of the children reported that transport to school was provided by the CCFs while 4.8 percent reported that they used public transport (bus) to get to school and 5 percent reported cycling to school. 5 percent of the children were of the view that it was not safe to get school. The common reason given was the long distances to school especially that some children had to walk through the bush or hills

Table 37: No. of children by means of getting to school and opinion on safety

№ and (%) of children by how they got to school (n=954)							№ and % of children that thought it is not safe to get to school (n=959)
Province	**Walking**	**Public bus**	**Transport provided by facility**	**Bicycle**	**Other[48]**	**Total**	
Central	86	7	8	1	0	102	7
Copperbelt	211	18	58	0	26	313	21
Eastern	9	1	2	0	1	13	0
Luapula	9	0	0	0	0	9	3
Lusaka	218	18	44	0	48	328	3
Muchinga	17	1	1	0	0	19	1
Northern	25	0	0	0	1	26	5
N-Western	30	0	4	0	5	39	2
Southern	71	1	4	1	4	81	4
Western	18	0	1	0	5	24	2
Total	**694**	**46**	**122**	**2**	**90**	**954**	**48**
%	**72.7**	**4.8**	**12.8**	**0.2**	**9.4**	**100**	**5.0**

Source: Field data

Payment of school fees was an issue that some CCFs grappled with, although no specific question was posed about the ability to pay fees, Facility Managers raised this as an issue especially as it related to children at secondary school level. Some facilities were not able to meet the school fees demanded by secondary schools and sometimes children were sent away from school. Payment of college fees was also cited as a challenge. CCFs that faced these problems indicated that they were unsuccessful in obtaining bursaries from the Ministry of Community Development and Social Services.[49]

[48] Others mostly refers to „not going to school"

2.6.3 Water and Sanitation

Water

The Assessment found that 62.5 percent of CCFs obtained their water from a borehole or connection to the local water service provider. Water sources, such as, a spring or stream were reported by 33.6 percent while 3.9 percent obtained their water supply from nearby public facility, such as a clinic or a school. CCFs in the last two categories had no water supply of their own due to broken down infrastructure and inability to install water reticulation.

Bathrooms

In-door showers were the prevalent type of bathroom but there were also outdoor bathrooms in very few cases. Table 38 shows that 20.2 percent of children reported that they shared a bathroom with children of the opposite sex and 39.9 percent reported that they shared their bathroom with adults. The MSC do not contain any specific provisions disallowing sharing of bathrooms. Nearly half of the children interviewed 47.4 percent felt that the number of bathrooms at their CCF were inadequate. Observations carried out during the Assessment indicated that the adequacy of stand-alone outside "bathrooms" in rural settings were a matter of concern. The issues raised by children were; the lack of privacy, when using a bathing area with thatched walls or pan bricks but had no door and no roof.

Table 38: number and % of children that share bathrooms, adequacy and availability of soap

Province	No (%) of children that share bathrooms with adults (n=950)		No (%) of children that share bathrooms with the opposite sex (n=950)		No (%) of children who feel that there are not enough bathrooms at the facility (n=959)		No (%) of children who always have soap for bathing (n=950)	
	№	%	№	%	№	%	№	%
Central	41	4.3	19	2.0	72	7.5	95	10.0
Copperbelt	116	12.2	71	7.5	202	21.1	297	31.3
Eastern	4	0.4	6	0.6	9	0.9	13	1.4
Luapula	4	0.4	1	0.1	5	0.5	8	0.8
Lusaka	143	15.1	43	4.5	242	25.2	278	29.3
Muchinga	7	0.7	6	0.6	19	2.0	17	1.8
Northern	9	0.9	6	0.6	18	1.9	20	2.1
North-Western	17	1.8	7	0.7	31	3.2	29	3.1
Southern	32	3.4	28	2.9	47	4.9	49	5.2
Western	6	0.6	5	0.5	12	1.3	14	1.5
Total	**379**	**39.9**	**192**	**20.2**	**455**	**47.4**	**523**	**55.1**

Source: Field data

Soap is an important item to ensure hygiene, 55.1 %percent of children reported that, they always had soap for bathing. Conversely 44.9 percent did not always have soap for bathing. At one CCF children indicated they sometimes had no soap for a week.

Toilets

Nearly all the CCFs, 94.8 percent had flush toilets (water-borne) with running water. 24.4 percent of CCFs had pit latrines as well. 6 facilities only had pit latrines.

[49] Living Hope Foundation spoke about the challenge of paying school fees and of children being sent back. Namumu in Siavonga supported children only to Grade 12 and then sent them back to their villages because the Orphanage could not take on provision of fees for tertiary education.

There were 20.4 percent of the children that were interviewed reported, that they shared toilets with children of the opposite sex while 38 percent shared toilets with adults. This is similar to the proportion that shared bathrooms. The findings show that children were 2 percent more likely to share a bathroom with adults than to share a toilet.

When asked about whether children always had soap to wash their hands after using the toilet, 65.3 percent indicated that they always had soap to wash their hands after using the toilet. The remaining 34.7 percent did not always have soap for hand washing as Table 39 indicates. This question was only included in Phase Two of the Assessment.

Table 39: Sharing of toilets and availability of soap to wash hands

Province	№ and (%) of children that share toilets with adults (n=959)		№ and (%) of children that share toilets with the opposite sex (n=959)		№ and (%) of children that always have soap to wash their hands after using the toilet (n=317)[50]	
	№	%	№	%	№	%
Central	30	3.1	18	1.9	27	8.5
Copperbelt	106	11.1	67	7.0		0.0
Eastern	5	0.5	6	0.6	13	4.1
Luapula	4	0.4	2	0.2	6	1.9
Lusaka	133	13.9	44	4.6	51	16.1
Muchinga	6	0.6	4	0.4	14	4.4
Northern	14	1.5	6	0.6	12	3.8
North-Western	17	1.8	9	0.9	29	9,1
Southern	43	4.5	35	3.6	43	13.6
Western	6	0.6	5	0.5	12	3.8
Total	**364**	**38.0**	**196**	**20.4**	**207**	**65.3**

Source: Field data

2.6.4 Recreation

The findings show that recreation for children was a much neglected area; games such as, football, were the most common. Mental games and other mental stimulating engagements, such as, reading materials or board games were not available in most CCFs.

However, some CCFs provided a few special treats once in a while such as, taking children to the theatre, biking and bringing in drama groups to perform at the facility, while in other facilities children complained of not ever having been taken for an outing. In a few facilities, each children's house had a bookshelf for children to read during their leisure time.

2.6.5 Clothing and shoes

The findings show that clothing was provided to varying degrees, well-resourced CCFs provided a set of clothes considered adequate by the child which the child did not have to share. At one facility, (with only seven children), children were taken out for shopping and given the opportunity to select their own clothes. Table 40 shows that 55.8 percent of children felt that they had enough clothing and 44.2 percent felt that their clothes were not adequate in number. The proportion of children that felt happy with their clothes was 71.1 percent, which was 21.3 percent more than those that considered their clothing inadequate. This indicated that whilst some children felt their clothing was not enough they were still happy with what they had. Adequacy of clothing is an important aspect of wellbeing and contributes to a sense of social inclusion. This was confirmed by some children during Focus Group Discussions who stated

[50] Only administered during Phase 2

that they did not have good clothes and shoes to wear when attending church services. Table 40 further shows that 91.1 percent of children owned a pair of shoes, while 8.9 percent did not own a pair of shoes.

Table 40: No. of children who felt they had enough clothes by №happy with clothes and № that owned a pair of shoes

	No. (%) of children who felt they had enough clothes (n=959)		No. (%) of children that were happy with their clothes (n=959)		No. (%) of children that owned a pair of shoes (n=959)	
	№	%	№	%	№	%
Central	64	6.67	74	7.7	98	10.2
Copperbelt	163	17.08	223	23.2	289	30.1
Eastern	10	1.08	11	1.2	13	1.4
Luapula	7	0.78	7	0.7	8	0.83
Lusaka	199	20.8	240	25.0	304	31.70
Muchinga	9	0.9	17	1.8	15	1.6
Northern	10	1.0	14	1.5	21	2.9
North-Western	20	2.1	25	2.6	37	3.9
Southern	46	4.8	56	5.8	67	7.0
Western	7	0.7	15	1.6	22	2.3
Total	**535**	**55.8**	**682**	**71.1**	**874**	**91.1**

Source: Field data

2.6.6 Beddings

The Assessment established that; 95.9 percent of children slept on a bed with a mattress, 2.5 percent slept on a mattress on the floor, 0.1 percent slept on a mat on the bed and 0.3 percent slept on a mat on the floor. The remaining 1.1 percent had no permanent sleeping arrangement as they alternated. In some cases, children slept on a floor bed as punishment for bed wetting.

The incidence of sharing a bed/mat/mattress was reported by 21.1 percent of interviewed children as shown in Table 41. It was established during the Assessment that facilities that had inadequate number of beds or mattresses tend to make children share bed space. The findings further showed that chances of children sharing a sleeping area were more likely during school holidays when other children returned from boarding school.

Table 41: Number of children by sleeping arrangement

Province	№ and (% of children by sleeping arrangement (n=959)					No. of children that shared beds/ mats/mattre sses with others (n=959)	No. of children that shared beds/mats/mat tresses with other children that were at least 5 years younger/older (n=136)[51]
	Bed with mattress	Mattress on the floor	Mat on the bed	Mat on the floor	Other [52]		
Central	107	0	1	0	0	16	1
Copperbelt	312	1	0	0	0	40	
Eastern	13	0	0	0	0	4	1
Luapula	9	0	0	0	0	2	1
Lusaka	317	6	0	2	2	98	7
Muchinga	17	1	0	0	1	2	2
Northern	22	3	0	0	1	8	3
North-Western	36	2	0	0	1	3	3
Southern	63	11	0	1	6	27	18
Western	24	0	0	0	0	2	1
Total	**920**	**24**	**1**	**3**	**11**	**202**	**37**
%	**95.9**	**2.5**	**0.1**	**0.3**	**1.1**	**21.1**	**27.2**

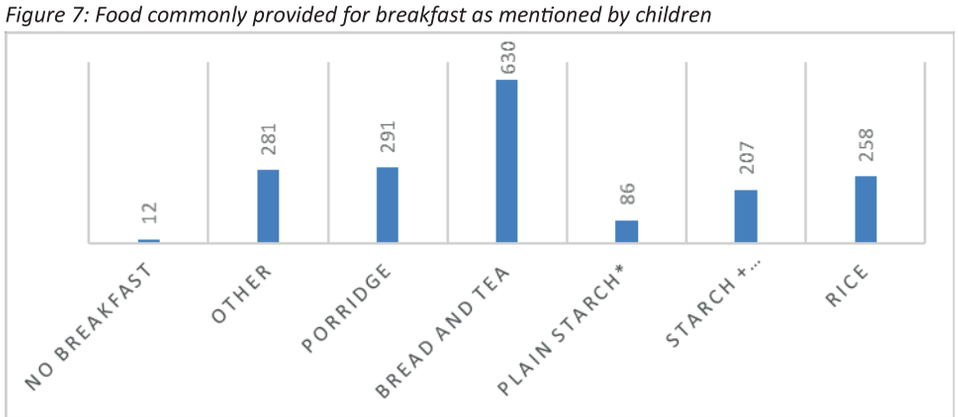
Source: Field data

2.6.7 Nutrition and Food

The UN Guidelines for the Alternative Care of Children stipulate that "carers should ensure that children, receive adequate amounts of wholesome and nutritious food in accordance with the local dietary habits and relevant dietary standards, as well as with the children's' religious beliefs". The MSC require that; a menu should be displayed on a notice board. It is further required, that children in full time care have snacks twice daily and meals three times daily.

The Assessment established that the displaying of the weekly menu and adhering to it was often not the case. Facility Managers and Caregivers confirmed that meals were provided not according to the menu plan but based on the food that was available on a particular day. However, there were some CCFs that displayed the menu and followed it to provide food for the children. The foods listed in the MSC were usually provided, with the exception of honey, potatoes, fruit, fruit juices and noodles.

Figure 7: Food commonly provided for breakfast as mentioned by children



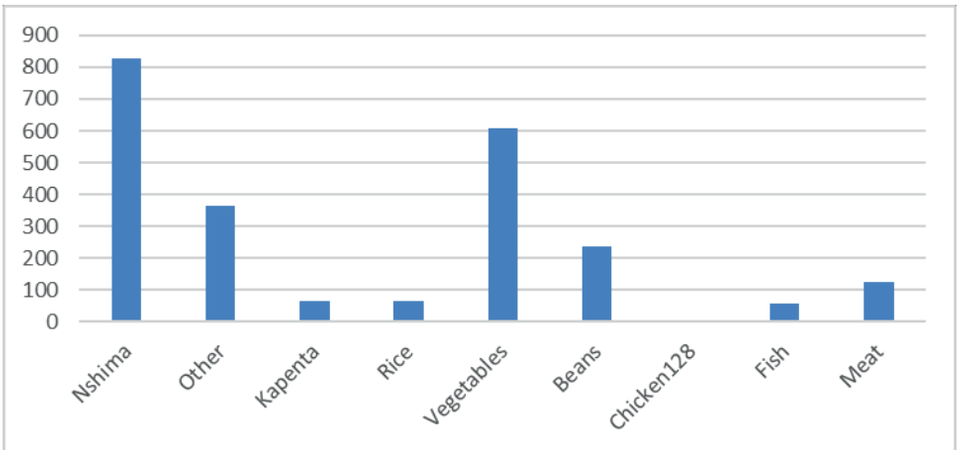
Source: Field data ('Others' includes: buns, milk, eggs and sweet potatoes, * Starch was Samp, rice or mealie meal porridge)

Figure 7 shows the most frequently mentioned types of food provided for breakfast. Tea and bread were most frequently mentioned by children at 630 times, followed by porridge mentioned 291 times, buns, eggs, milk and sweet potatoes in the "Other" category followed in frequency indicated 281 times. Rice at 258 was the fourth type of food, followed by Samp/ rice and porridge with ground nuts, plain Samp and porridge were indicated 86 times. Breakfast comprised mainly of starch/carbohydrate foods and was not nutritionally balanced. Some children indicated not having breakfast at all. This was mentioned 12 times. At facilities that did not serve breakfast, there was no exception made for young children.

Figure 8 shows foods commonly provided for lunch. These included; Nshima with vegetable, Nshima with soya chunks, in third place was Nshima with beans and lastly Nshima served with eggs. At one facility, children in the Focused Group Discussion stated that the one thing they would like to change the most was having soya chunks for nearly every meal. Information from observations, interviews with Caregivers and Focus Group Discussions with children indicated that in most facilities, meals were not balanced. Provision of meat, chicken and fish was not common. Findings show that at 2 facilities, children received all types of foods i.e. carbohydrates, protein and vitamins at each meal time.

[51] Was only asked during phase 2 and only to children that confirmed sharing their bed with others (who are 136 out of 317)
[52] Others refer to "no fixed sleeping arrangements" as children alternate

Figure 8: Foods commonly provided for Lunch as mentioned by children



Source: Field data ('Others' refers to: 1. Soya chunks, eggs, sour milk (usually in combination with Nshima)

The MSC provide guidance in the form of caloric intake but provide no guidance on the amount of food to give a child. Adhering to the caloric guidance would be difficult for most CCF members of staff to follow. This is compounded by the fact that most of the Caregivers responsible for preparation of meals had low educational attainment.

During Focus Group Discussions, children pointed to the need for an improvement in the portion of food served. This was reiterated by caregivers during individual interviews. The findings also showed that contrary to the provisions of the MSC, food was used as a form of punishment.

2.7 Discipline and Child Participation

2.7.1 Discipline

The Assessment found that the most common form of punishment were assignment of chores such as cleaning, picking papers, slashing or gardening, this was indicated by a frequency of 461 responses from the children. The second category of punishment was being "shouted at" (scolded, spoken to in a high tone of voice, and verbal abuse) with a frequency of 166 responses from the children. Being beaten and being grounded were equally likely to occur and denial of meals was least likely to occur. The forms of punishment were the same for boys and girls. Children indicated that even though beating was mentioned, it was not severe, in instances where this happened, children were beaten using a stick or bare hands.

However in some cases, punishments were severe and included denial of food, pinching, whipping, beating and denial of visitation rights. All these were contrary to the provisions of the MSC. Table 42 provides the different forms of discipline or punishment that children were subjected to. During a Focus Group Discussion at a rural based facility, a child reported having ran away due to an incident of verbal abuse from a caregiver. The child walked a long distance to return to his grandmother's home.

Table 42: Common forms of Discipline as mentioned by children

	Shouted at	Grounded/ playing	No	Beaten	No meals	Others
Central	22	17	14	10	52	
Copperbelt	54	36	38	23	149	
Eastern	2	1	7	2	6	
Luapula	1	2	2	2	4	
Lusaka	45	52	24	17	168	
Muchinga	1	3	3	0	8	
Northern	3	1	4	5	11	
North-Western	13	7	7	5	19	
Southern	20	8	26	13	30	
Western	5	2	5	3	14	
Total	**166**	**129**	**130**	**80**	**461**	

Source: Field data ('Others' refers to "house chores, slashing, picking papers, cleaning surrounding" and "verbal correction")

2.7.2 Child Participation and Channels of Participation

One of the rights of a child is participation in decisions that affect the child, taking into account the maturity and age of the child. In Phase two, a question on participation was included, Table 43 indicates that 76 percent of children did not participate in decisions relating to placement in the facility, family reintegration and leaving care. Some Facility Mangers indicated that children participated in budgeting for household items, however Focus Group Discussions with children indicated that this was not the case. Caregivers decided on the items that were to be purchased without including the older children in such decisions.

Table 43: Child participation, Phase Two question

Child participation in decisions making affecting the child (e.g. regarding placement in the facility, family reintegration matters, leaving care) (n=317)* Asked only in Phase Two						
Name of Province	Yes		No		Total	
	№	%	№	%	№	%
Luapula	2	0.63	7	2.21	9	2.84
Muchinga	3	0.95	16	5.05	19	5.99
Eastern	6	1.89	7	2.21	13	4.10
Southern	11	3.47	70	22.08	81	25.55
Central	9	2.84	26	8.20	35	11.04
Lusaka	17	5.36	54	17.03	71	22.40
Western	9	2.84	15	4.73	24	7.57
North-Western	13	4.10	26	8.20	39	12.30
Total	**76**	**23.97**	**241**	**76.03**	**317**	**100**

Source: Field data

2.7.3 Channels of participation

Facility Managers reported the channels of inclusion of children in decision making as; regular meetings, 48.05 percent, 'Other'; mainly individual face to face meetings, 31.77 percent and lastly children's panels as shown in Table 44.

Table 44: Channels of child participation in decision making

Channels of participation in decisions (n=77)[53]								
Name of Province	**Children`s panel**		**Regular meetings**		**Other[54]**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Northern	0	0.00	6	7.79	0	0.00	6	7.79
Luapula	0	0.00	1	1.30	1	1.30	2	2.60
Muchinga	0	0.00	1	1.30	2	2.60	3	3.90
Eastern	1	1.30	3	3.90	2	2.60	6	7.79
Southern	2	2.60	8	10.39	2	2.60	12	15.58
Central	1	1.30	4	5.19	4	5.19	9	11.69
Lusaka	3	3.90	4	5.19	10	12.99	17	22.08
Western	5	6.49	1	1.30	3	3.90	9	11.69
North-Western	4	5.19	9	11.69	0	0.00	13	16.88
Total	**16**	**20.78**	**37**	**48.05**	**24**	**31.17**	**77**	**100.00**

Source: Field data

2.7.4 Participation in development of child care plans

Development of a Care Plan is one of the significant processes in which a child could participate in decision making. However, interviews with Facility Managers showed that children were not often included in decision-making in formulation of Care Plans, where these were available. Children were the least consulted. Table 45 shows that at 65 CCFs, where care plans were available, 'Child' ranked fifth in line as someone to be consulted. The key players reported in drawing up Care Plans were; the Facility Manager 75.4 percent, the Caregiver 60 percent, others included social workers 35 percent, Board members 27. 7 percent, the child 26.2 percent and the relatives 10.8 percent.

Table 45: Involvement in formulation of child care plans

Categories of people involved in developing child care plans; responses by Facility Managers (N=65)												
Province	**Facility Manager**		**Care giver**		**Child**		**Relatives**		**Board members**		**Others**	
	№	**%**	**№**	**%**	**№**	**%**	**№**	**%**	**№**	**%**	**№**	**%**
Central	6	9.23	4	6.15	0	0.00	0	0.00	3	4.62	2	3.08
Copperbelt	13	20.00	11	16.92	6	9.23	2	3.08	7	10.77	6	9.23
Eastern	1	1.54	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Luapula	1	1.54	1	1.54	1	1.54	0	0.00	1	1.54	0	0
Lusaka	14	21.54	12	18.46	6	9.23	2	3.08	4	6.15	8	12.31
North-Western	2	3.08	1	1.54	0	0.00	0	0.00	1	1.54	0	0
Southern	8	12.31	6	9.23	3	4.62	2	3.08	0	0.00	5	7.69
Western	4	6.15	4	6.15	1	1.54	1	1.54	2	3.08	2	3.08
Total	**49**	**75.38**	**39**	**60.00**	**17**	**26.15**	**7**	**10.77**	**18**	**27.69**	**23**	**35.38**

Source: Field data

[53] Only included in Phase Two
[54] Other included individual face to face meetings

2.7.5 Participation through a complaints procedure

A complaints procedure is one way that children could express themselves. There were only 46/78 Facilities that had a complaints procedure (Phase One question) through which children could express their concerns as shown in Table 46. The majority of the facilities did not have a written down complaints procedure. However children indicated that they knew whom to complain to when they had an issue. In one of the big facilities, children did not report cases of verbal abuse that they were subjected to by their Caregiver. This was despite the facility having had appointed "Persons of Trust" as part of the complaints procedure.

Table 46: Availability of a complaints procedure

Province	No. of facilities that had a complaints procedure (n=78)	Total
Central		13
%	9.0%	16.7%
Copperbelt	27	42
%	34.6%	53.8%
Lusaka	12	23
%	15.4%	29.5%
Total	**46**	**78**
%	**59.0%**	**100.0%**

Source: Field data

2.8 Leaving care and after care support

2.8.1 Contact with family and visits

Maintaining contact with family where possible is a right of every child. Although many CCFs allowed families (parents or guardians) to visit the children in their care, only a few children received such visitors. Table 47 shows that of the 146 Facility Managers that provided responses, 63 percent reported that only a few children were visited by their family members in the three months prior to the Assessment. 17.1 percent of Facility Managers reported that most of the children had been visited and 11.6 percent of Facility Managers reported that none of the children received visits from their family members.

Table 47: Children visited by parents, guardians in last three months - Facility Manager

Distribution of children visited by parents/guardians or family in the last three months? (n=146)							
Province		**None**	**A few**	**About half of them**	**Most of them**	**All of them**	**Total**
Central		0	12	1	5	1	19
Copperbelt		4	24	3	6	2	39
Eastern		1	1	0	1	1	4
Luapula		0	4	0	0	0	4
Lusaka		6	25	1	6	1	39
Muchinga		0	2	0	1	0	3
Northern		0	2	0	0	0	2
North Western		1	5	0	0	0	6
Southern		1	14	1	6	0	22
Western		4	3	0	0	1	8
Total	**№**	**17**	**92**	**6**	**25**	**6**	**146**
	%	**11.6**	**63.0**	**4.1**	**17.1**	**4.1**	**100**

Source: Field data

Children were asked if they were allowed to receive visitors and the intervals at which visitors could visit them. The Assessment found that 33.1 percent of children did not know whether they could receive visitors. In relation to the intervals of the visits, 7 percent reported that the facility allowed children to be visited anytime, 12.61 percent reported that they were allowed to be visited once a month while 10 percent of the children reported being allowed visitation rights once a week, 14 percent reported that they were allowed to be visited every day and 4.5 percent reported quarterly visitations. The findings of the Assessment show that 50.67 percent of the children in care received visitors (family members) in the six months prior to the Assessment. It was reported that parents/ guardians did not visit their children for fear that the responsibility of caring for the children would be handed back to them. Consequently parents/guardians kept away to minimise their appearances at CCFs. Furthermore, the inability of parents to visit their children was attributed to long distances and the associated cost of travel.

The findings further show that 11 percent of the children reported that they were not allowed to visit their families. In Phase Two (n=317) 48 percent of children indicted that they had visited their families. Focus Group Discussions revealed that the frequency of visits was low. Some children were allowed to go on holiday once a year for a duration of one to two weeks. In some cases children were not allowed to go on holiday at all. In some cases children were not allowed to leave the facility once they 'entered'. The tendency to keep children with minimal or no contact with families seemed to be on the increase; children at some facilities indicated that in previous years they were allowed to visit their families twice a year but this had changed to once a year.

In a few cases, children became emotional during Focus Group Discussions when narrating how they were not allowed to go and visit their relatives, see Box 1.

Box 1: Children's feelings about not seeing their family

"My grandmother came to see me here at the facility but she was not allowed to come in and was turned away at the gate"
Another child said "I was not allowed to go to my mother's funeral when she died"
"My grandmother is very old now and I am not allowed to go and visit her"

Reduced number of times that children could go on holiday, the short duration of hours in a day that a parent/guardian could visit a child and the confinement of children by not allowing them to visit family creates a loss of attachment and could make reintegration difficult. The situation emerging in many facilities is a violation of the right to maintain contact with one's family. Facilities claimed that children became unruly whenever they returned to the facilities from home visits.

2.8.2 Family Tracing

Family tracing is an initial step towards the reunification and re-integration of children with their families. Table 48 shows that only 40.4 percent of all Facilities reported having conducted family tracing. Some of the challenges faced included lack of information on some children's family background as well as lack of funds to carry out this extensive exercise.

Some Facilities stated that the Department of Social Welfare was the entity responsible for family tracing, especially for the children that the Department referred to facilities. However, the Department did not carry out this exercise due to lack of funds. There seemed to be lack of clarity on the roles of the Department of Social Welfare and the facilities with regard to family tracing.

Table 48: Distribution of Facilities conduct family tracing

№ (percent) of facilities that did family tracing (n=156)		
Province	**№**	**Percent**
Central	11	7.1
Copperbelt	40	25.6
Eastern	4	2.6
Luapula	2	1.3
Lusaka	38	24.4
Muchinga	3	1.9
Northern	2	1.3
North Western	5	3.2
Southern	19	12.2
Western	7	4.5
Total	**63**	**40.4**

Source: Field data

2.8.3 Children's knowledge about the whereabouts of their families

The Assessment found that 86 percent of children knew where their families were but 14 percent did not know. Some of those that did not know included children that had been admitted due to being stranded, lost or abandoned.

The Assessment did not ask whether children were from within the same district or from out of the district in which the facility was located. However, through interviews with children, it emerged that whilst the majority of children were from the same district in which the CCF was located, there were children from other districts of the same province. For example, at SOS in Livingstone, some children were from Siavonga, Gweembe and Mazabuka. In Ndola, there was a facility that had a couple of children from Mpika and Northern Province, their parents were imprisoned. It however seems that the practice of bringing children from other districts and provinces was not very prevalent.

2.8.4 Reintegration

Reintegration with family or community must be undertaken in a step by step process. The MSC provide that, children must be included in the decision making process and be given ample time to decide whether they are ready to go ahead with the process. Some of the necessary steps include facilitating reintroductions, visits to family and community, identifying the needs of the child and the family, identifying the appropriate family strengthening and support intervention to prevent future separation as well as pre and post monitoring of the process.

Table 49 provides the number of facilities that reported having had some children reintegrated. The findings show that 73 percent of CCFs reported reintegrating children in the three years prior to the Assessment. Facilities that had not reintegrated children during the same period were 22.4 percent. The total number of children reintegrated in the three years prior to the study was 2,016.

Facility Managers and caregivers indicated that reintegration was made difficult by the non-improvement of the living conditions of families. In other cases some children had no family to be reintegrated with, as a result they stayed in care until they completed their education and found employment.

Reintegration was not entirely welcomed by some children in care. Some children expressed concern about being taken back to their families. In Focus Group Discussions, one of the worst fears expressed by children was the possibility of being reintegrated with their families. Children were concerned about the ability of their parent/guardian to provide adequately for them and meet all school requirements.

Table 49: Distribution of Facilities reintegrating children in three years prior to the Assessment

Facilities that had reintegrated children 3 years prior to the Assessment, n=156								
Province	**Have any children been reintegrated in the past 3 years?**							
	Yes		No		I don't know		Total	
	№	%	№	%	№	%	№	%
Central	12	7.69	5	3.21	2	1.28	19	12.18
Copperbelt	33	21.15	7	4.49	2	1.28	42	26.92
Eastern	4	2.56	0	0.00	1	0.64	5	3.21
Luapula	2	1.28	2	1.28	0	0.00	4	2.56
Lusaka	37	23.72	7	4.49	0	0.00	44	28.21
Muchinga	2	1.28	1	0.64	0	0.00	3	1.92
Northern	1	0.64	2	1.28	0	0.00	3	1.92
North Western	4	2.56	2	1.28	0	0.00	6	3.85
Southern	15	9.62	5	3.21	2	1.28	22	14.10
Western	4	2.56	4	2.56	0	0.00	8	5.13
Total	**114**	**73.08**	**35**	**22.44**	**7**	**4.49**	**156**	**100.00**

Source: Field Data

Taking these challenges into account, CCFs included as part of their overall strategy, supporting the education of children up to college or university level. This was seen as a way of increasing the chances of employment and eventually independent living. This resulted in children being in care for long periods of time, some over ten years. However, there were some facilities that only supported children to complete secondary school education and stated that they could not afford to meet costs associated with tertiary education. The institutionalisation of children for longer periods resulted in them becoming disconnected from their biological families. While tertiary education increased chances of employment, the lack of family bonds could have implications on these children later in their lives. This was especially the case in social related matters such as various cultural rites required for marriage for example. Such stages required the families of the young people involved these rites of passage. Two CCFs reported having stood-in as representatives of the young people under their care when it was time for them to be married. The Assessment further found that children maintained bonds with other children that they grew up with in residential care. In one case, a young man that grew up in residential care was keeping other younger males from the facility he grew up in who had completed school and had helped to secure employment for some of them.

2.8.5 Children return to facility after reintegration

Reintegration was not always successful, there were 31 CCFs that reported children returning to the facility after reintegration. A total of 141 children returned to their former CCFs after reintegration. The figure represent 7 percent of those reintegrated in the three years prior to the Assessment. The reasons for their return included lack of care from their guardians, death of guardian and failing to fit in with the family

2.8.6 Fostering and Adoption

The practice of fostering and adoption was not prevalent, the Assessment found that 23 boys and 23 girls were fostered, whilst eight boys were adopted in 2015.

The Assessment found that in some cases, children were 'fostered' without the involvement of the Department of Social Welfare. At two Facilities, the Assessment found that during school holidays one of the Facilities sent some children to live with families, unrelated to the children without the involvement of the District of Social Welfare Office or the court. The intention was to provide children with a 'family experience'. At another CCF, a few children were sent to some families during school term so as to attend school whilst living with another family and the children would return to the facility during school holidays.

Table 50 shows that only 13.5 percent (21) of CCFs had children that were declared free for adoption and there were only 8 CCFs where children were adopted in 2015.

Table 50: CCFs with children free for adoption and facilities with children adopted in 2015

Province	№ and (%) of facilities that had children who were declared free for adoption (n=156)		№ and (%) of facilities where children were adopted in 2015 (n=156)	
	№	%	№	%
Central	3	1.9	0	0.0
Copperbelt	6	3.8	3	1.9
Eastern	0	0.0	0	0.0
Luapula	0	0.0	0	0.0
Lusaka	10	6.4	4	2.6
Muchinga	0	0.0	0	0.0
Northern	0	0.0	0	0.0
North Western	1	0.6	0	0.0
Southern	1	0.6	0	0.0
Western	0	0.0	1	0.6
Total	**21**	**13.5**	**8**	**5.1**

Source: Field data

2.9 Ability of the Government to discharge its oversight role

The Assessment found that the ability of the Department of Social Welfare to discharge its duty in relation to ensuring that CCFs implemented the MSC was constrained by a number of factors which are outlined below.

1. Inadequate resources

a. Lack of systematic monitoring of Facilities

Nearly all District Social Welfare Officers interviewed as well as the Officers from the National Office who were part of the Assessment team indicated that they were not able to carry out monitoring of CCFs due to the lack of funds. In some cases District DSWOs last carried out monitoring a year before this Assessment.

Due to this inability to monitor at regular intervals, some facilities have continued to offer residential care even when children's living conditions were deplorable. Because there was no close supervision, no periodic inspections and no sanctions for non-adherence, some facilities had continued to offer sub-standard care to children.

b. Lack of transport at district level

Failure to regularly monitor the conditions of CCFs was compounded by the limited number of vehicles at district level. The Assessment findings showed that District Social Welfare Offices relied on availability of vehicles from other Government agencies in order to reach some Facilities. A few others used their own personal vehicles and resources to monitor CCFs under their jurisdiction especially those within close vicinity to the District Social Welfare Offices.

c. Lack of funding for District Offices

It was reported that some of the newly established districts had not received funding for program implementation since 2015, however this situation did not only affect new districts but older ones as well. This included funding for monitoring of CCFs by the Department of Social Welfare.

2. Lack of application of a "minimum level of care" below which no facility should be allowed to operate.

Some Districts were aware that CCFs offered poor standards of care. District Social Welfare Officers seemed unwilling to take strong measures in the event that CCFs were consistently failing to meet the MSC. For instance in one facility it was reported that children had to fend for themselves to get food.

3. Differing standards of quality of care at Government managed institutions.

This relates specifically to Chikumbi Children's Centre, Nakambala Approved School and Insakwe Approved School for girls. Chikumbi was until few years ago managed by the MCDSS, but was transferred to another Government Ministry. Nakambala and Insakwe at the time of the Assessment were still under the MCDSS. The standards at the three facilities varied considerably with Insakwe being the best managed in terms of clean living areas and surrounding, good food and school opportunities. Nakambala and Chikumbi seemed poorly resourced; not well maintained; with poor living conditions. Children at Nakambala were sent out to work to earn income for their personal necessities. Some workers at Nakambala were also reported to be often reporting for duty under the influence of alcohol. In the case of Chikumbi children in care were not in school.

4. Awareness and Knowledge of the provisions of the MSC among DSWO

DSWOs interviewed and those on the Assessment team did not have adequate awareness and knowledge of the MSC in order to provide sufficient guidance to CCFs.

5. Capacity building on MSC

Capacity building by the MCDSS on the MSC is neither provided for Social welfare officers nor for staff in CCFs. District Social Welfare Offices and some CCFs had copies of the MSC but were not aware of the provisions therein. The Department of Social Welfare occasionally provided guidance by explaining the provisions of the MSC to representatives of RCCF on a case by case basis.

6. "Temporary" placement of children in need of shelter with children in conflict with the law compromises care

Children in need of shelter were sometimes placed in CCFs intended for children in conflict with the law as in the case of Insakwe. The non-offenders in Facilities complained about their negative experiences as a result of this practice.

7. Placement of children with mental or physical challenges in CCFs without specialised care

Due to the lack of specialised CCFs for children with special needs, DSWOs placed children with disabilities in Facilities that lacked specialised staff and linkages to or support from institutions that had such specialised services.

8. Delays in obtaining Committal Orders and in some cases lack of awareness about the need for Committal Orders

The Department of Social Welfare faced challenges in working with the Judiciary, in some districts, obtaining signed Committal Orders took several months. While in some districts, the court charged a fee for processing Committal Orders. Many facilities were unable to meet the fee of K108 per application in order to obtain Committal Orders for all the children under their care. This meant that children were placed in CCFs without any legal document that authenticated the placements.

In a few districts, DSWOs were not aware of the need to ensure that Committal Orders were obtained for every child placed in a CCF and therefore they did not give any support in this regard to CCFs. Some CCFs reported that DSWOs misplaced documents submitted by CCFs and therefore protracted the process of obtaining Committal Orders.

3.0 Conclusion

The Assessment concluded that Facility Managers were aware of the MSC but were not sufficiently conversant with the provisions therein. Consequently in a number of categories CCFs did not meet the requirements stipulated in the MSC. It was the conclusion of the Assessment too, that District Social Welfare Officers were insufficiently knowledgeable about the provisions and procedures to follow in the effective enforcement of the MSC.

The Assessment further established that most CCFs were registered with the Registrar of Societies with only a few being registered with the Registrar of NGOs. The non-registration of facilities as residential child care providers separate from the legal registration of some Faith Based Organisations was also a key finding.

Additionally, poverty and economic hardships were the main drivers that forced children to be in residential care and not a lack of family or orphanhood.

Management capacity in most facilities was weak. The findings shows that most Facility Managers lacked the required prior training in child care and management. This, coupled with the general lack of professional staff resulted in inadequacies and a total lack of organisational Constitutions and policies, poor oversight and poor record keeping. Despite the availability of the MSC, they did not seem to provide an impetus for improvement of practice. However, there were a few facilities that were exceptional in these areas. Governance systems in CCF were weak with Board meetings infrequently held and inadequate separation of roles between the Board and management.

Linked to the failure by CCFs to generally adhere to the provisions of the MSC, was the insufficient oversight role played by the Department of Social Welfare. The levels of awareness on the provisions of the MSC were low among members of staff in CCFs coupled with low qualification of caregivers also contributed to the failure by CCFs to adhere to the MSC. The Assessment established that District Social Welfare Officers were equally not adequately knowledgeable about the provisions of the MSC as well as their role in promoting compliance among CCFs. This was evident from the failure by District Social Welfare Officers to; secure committal Orders for the children placed in institutional care, provide guidance to the CCFs on the Minimum Standards that needed to be adhered to; facilitate family tracing and reintegration for children as well as the failure to conduct regular monitoring of CCFs.

The Assessment further established that majority of children in institutional care knew where their family members were and had contact with them at least once a year.

Conditions in CCFs varied greatly with some on the top range offering nutritionally balanced meals, mental stimulation, clean environment, recreation and opportunities for advancement for the children. Most others however, were on the other end of the continuum. Nonetheless, the opportunities and the better standard of living received in CCFs compared to what children would have experienced within their families is a fact not to be overlooked. Children had access to clean water, education, and healthcare and for the majority three meals a day. The nutritional value and the sufficiency of the amounts of food served could be improved upon. Children appreciated these provisions but decried the restrictions on the number of times they could visit their families. Whilst the Assessment recognises the role that CCFs played in enhancing access to education and life opportunities, it was however difficult to draw a definitive conclusion about whether children with families would have been better off within their families or not. This would require the Department of Social Welfare to undertake thorough assessments and investigations into all individual cases of children admitted to CCFs to ascertain the conditions of their family environments and develop case by case response plans as well as identify relevant family strengthening services.

Children were disciplined in different ways with some citing physical punishment, however this was not severe.

The right of children to participate in matters that concerned them was superficially upheld.

Recreation facilities were not adequate in most cases.

Although some of the CCFs reported having reintegrated some children the year prior to the assessment, it was not clear what steps had been taken to ensure successful reintegration processes. It seemed the facilities reintegrated children without the knowledge of the Department of Social Welfare. In addition, the provision of other options of care such as adoption and foster care were not so prominent. Some Facility Managers exhibited a negative attitude towards adoption and family reintegration. CCFs in most cases planned to provide long term care for children in most cases until the children completed their secondary or tertiary education.

Funding of CCF was often very inadequate resulting in nutritionally unbalanced meals, limited number of meals and difficulties in meeting education fees required for secondary education. Low wages of caregivers and inability of CCFs to hire professional staff such as social workers were also off shoots of an inadequate funding base.

The Government of Zambia did not provide funding for small grants to private CCF; where this was done, it was on an ad hoc basis with no government funding for more than 3 years.

4.0 Recommendations

In view of the key findings being lack of adequate knowledge about the MSC among DSWOs and staff in CCFs, inadequate professional and managerial capacity among management and staff of CCFs, as well as limited capacity of the DSWO to monitor CCF, the Assessment recommends the following measures:

4. 1 At the political level

1. Build a case for increased funding to the Ministry and the Department. This would need to be both at the political level specifically Cabinet and at technical level through the Ministry of Finance level. Financial assistance can also be sought from multilateral and bi-lateral partners.
2. Allocate sufficient resources to enable the Department Social Welfare to enable the Department undertake quality routine monitoring of CCFs.

4.2 Inter-ministerial Level

3. Liaise with the judiciary to waive fees for Committal Orders in districts where these are applicable.
4. Explore partnerships with the Ministry of General Education, Ministry of Higher Education and Ministry of Health for secondment of specialised staff to CCFs.
5. Promote the development of a national curriculum and qualification on child care through TEVETA and/or through the Staff Development College under the Ministry Of Community Development and Social Services. Lessons can be learned from the SOS in-service training manual and approach. During fieldwork the Assessment found that there was a distance learning programme supported by REPSSI offered at the Mindolo Ecumenical Foundation, lessons could be drawn from there.

4.3 Intra ministerial Level

1. Develop an electronic database that should be updated on a regular basis and that should form the foundation of a case management and monitoring system for all children in formal care.
2. Ensure that legal and policy provisions regarding the recognition and registration of CCFs are adhered. The Department of Social Welfare in collaboration with the Registrar of NGOs should give a deadline for CCFs to register with the Registrar of NGOs. This should be accompanied by penalties if timelines are not adhered to.
3. Work with the Registrar of NGOs to ensure adequacy of Constitutions so that governance mechanisms within CCF assure accountability and transparency.
4. Liaise with the Registrar of NGOs to shorten the period of time between submission of documents and provision of NGO registration certificate for already existing entities.
5. Ensure all children taken into care have documentation such as referral letters, admission letter and Committal Orders as well as other relevant documents as provided in the MSC.
6. Provide Certificates of Recognition to CCFs in a timely manner and ensure that these are renewed as required.
7. Provide orientation and training for all DSWOs regarding the provisions of the MSC.
8. Provide training to staff in new districts to ensure they attain proficiency in relation to the roles they are supposed to perform at district level in relation to CCFs and children in need of care.
9. Include observations and interviews with children as part of the routine monitoring of CCFs.
10. Adopt a simple but strict system for flagging and responding to CCFs that fail to comply with MSC.
11. Have clear and stronger guidelines between a child care facility and a boarding school for vulnerable children. In several cases some facilities discharged children on account of failing the national examinations in school.
12. Provide adequate resources (e.g. transport and funds) to District Social Welfare Offices to enable them conduct their duties such as assessment of new facilities, monitoring of conditions at CCFs, Family Tracing, family assessments, reintegration and follow-ups.

4.4 To ensure policy adherence by CCFs

1. The MCDSS should provide training to CCFs management on the provisions of the MSC. This could be on a cost sharing basis but facilities should be compelled to participate in the training. Some of the key areas to include in the training would include: a. Role of the governing board

   a. Preparation of care plans
   b. Record keeping
   c. Forms of discipline and behaviour management
   d. Maintain family links for the children in residential care
   e. Gate keeping and admission procedures
   f. Obtaining certificate of recognition
   g. Reintegration and social protection support
   h. Nutrition – food preparation and amounts
   i. Effects of institutionalisation on children, based on scientific research.

2. The Ministry should support cross learning among CCFs.
3. MCDSS should provide timeframes in which CCFs can obtain police clearance for Facility Managers and other staff. The high level of non-compliance on this aspect is of grave concern. The protection of children is essential, CCFs should ensure that they comply with all measures to uphold the security of children in care.
4. Give specific timeframe to CCFs to improve all records on children under their care. These would be best implemented after training has been conducted for CCFs. There is need for the Department of Social Welfare to obligate CCF to obtain birth certificates for all children under their care. Other documents that CCFs should be requested to prepare are;

   a. Care plans
   b. Reintegration plans
   c. Up to date list of children in care, their ages and contact addresses of their families
   d. Proper admission record.

5. Provide a timeframe and technical support to CCFs for the preparation of organisational policies including;

   a. Child Protection Policy that should be signed by all staff, volunteers and interns
   b. Code of Conduct, which should be signed by all staff
   c. Complaint procedures

6. Ensure that CCFs have proper financial reports and account for donations received.
7. Obligate CCFs to develop and implement visitation schedules that will enhance the children's contact with members of their families and ease the process of family reintegration.
8. Guide CCFs to prioritise engagement of professional staff such as social workers/ childcare and youth work diploma holders and behavioural science specialists.
9. Ensure CCFs implement the requirements for medical clearance of staff as well as medical check-ups for children.
10. Emphasise the need for adequate oversight by Facility Managers to ensure cleanliness of sleeping and living areas, bathrooms and toilets as well as cleanliness of clothes and beddings. Facility Managers should ensure that sleeping areas are not crowded and have good ventilation.
11. Promote the provision of alternatives to institutional care for children in need (support within the family setting), implementing poverty-reducing measures such as savings groups, cash transfers within communities)
12. Promote programmes on family building.
13. Encourage CCFs to diversify income sources but without exploiting children.

4.5 Review of the Minimum Standards of Care

Revise some aspects in the MSC for example;

a. The MSC document should include guidance on the amount of starch, protein and vegetables and fruit to be served to children based on age. This should be in additional to current guidance on caloric intake, which many caregivers were not able to calculate.
b. Review the requirement for Grade 12 level of education for caregivers and give CCFs a timeframe in which to move towards this target.
c. Differentiate between caregivers that are largely support staff (doing the cooking and cleaning) and those that are more professional, such as, social workers or trained child care workers.

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Annex I: Examples of good practice

Record Keeping

Kasisi Orphanage maintained up to date records on each child, with files containing birth certificates, school records, photographs and admission letters. The facility also had manuals demonstrating the type of exercises each physically challenged child was supposed to practice. It was the only non-special needs facility that provided some specialised care for children with special needs.

St Lawrence maintained an electronic record on the 'cloud', of all children with photographs. This enabled the Manager to confirm on the spot whether a new child was a returnee or not. This system was also useful for family tracing.

Cheshire Home Society Mongu Branch, despite the facility being primarily a centre for the surgical correction of disabilities for children, the Manager maintained accurate records on children in care as well as management plans for each child's post-surgery care.

Care Plans

Abba's House had care plans for each child, including the child's own development goal and reflection on his performance or interaction with his family. These were discussed with the child and new targets for improvements were mutually set.

SOS Children' Villages Social workers at SOS Children's Villages kept up to date records on children's assessments including strengths and weaknesses and the developmental goals to be attaine

Capacity Building of Caregivers

SOS Children's Village runs a comprehensive two year pre-service and in-service training for cCaregivers. The training includes topics on child development, positive parenting, child protection procedures and ethical and legal framework among others. SOS was in the process of obtaining certification from TEVET for the training.

Abba's House the facility has a volunteer caregiver with professional expertise in behavioural sciences. The volunteer provides in service training to cCaregivers on managing difficult behaviour of the children in care who were formerly living on the street.

Family Tracing

Palabana Children's Home, the Facility Manager makes an effort to not only trace the children's family but also draws a Family tree for the child thus making it possible for the child to trace as many relatives as possible once they leave the facility.

Learning and Sharing

In Luapula province, the management of Kazembe orphanage and Musuma visited each other for purposes of learning from each other.

Sanitation

Nkhwazi Youth Project had displayed instructions on the proper way of washing of hands on walls and other places where children could easily see them.

Julie Anne had pictorial display on walls showing the proper way of hand washing.

Recreation

Ipusukilo Children's Trust had a bicycle for each child and children go out biking together in the surrounding farm land.

Ipusukilo Children's Trust had books readily accessible in each house for children to read.

Chishawasha maintained a small library of books in each house which children had access to and could read during their leisure time

Kasisi Orphanage had a garden for outdoor play as well as a variety of toys for the children.

Age appropriate amenities

Natwange had age appropriate wash laundry lines for children to hang personal items.

Cheshire Home Society Mongu Branch had age appropriate dining tables and chairs. Children's beds were also adapted to suit each child's specific challenge.

Resource mobilisation / moving towards self-sustainability

Cheshire Home Society Mongu Branch runs a lodge that offers reasonable high standard of accommodation. The facility also produces and sells hydra-form interlocking blocks.

Kaoma Cheshire Community Care owns a few guest rooms that are reasonably priced.

Namumu Orphanage with contributions from local business owners the facility managed to build fishing rigs and operated them during the Kapenta season

Promoting hygiene among the Children

Nkwazi youth project had instructors everywhere on washing hands

At Julie Anne, management has pictures showing step by step procedure for washing hand placed around the facility.

Annex II: Pictures of Good Practice

Provision of adequate space for children to sit indoors

Photo: ©Triple M Impact Consulting/2016

At Mutende, each of the children's houses has been built to have an area where children can sit and watch TV or sit and play indoor games.

Provision of age appropriate toilets

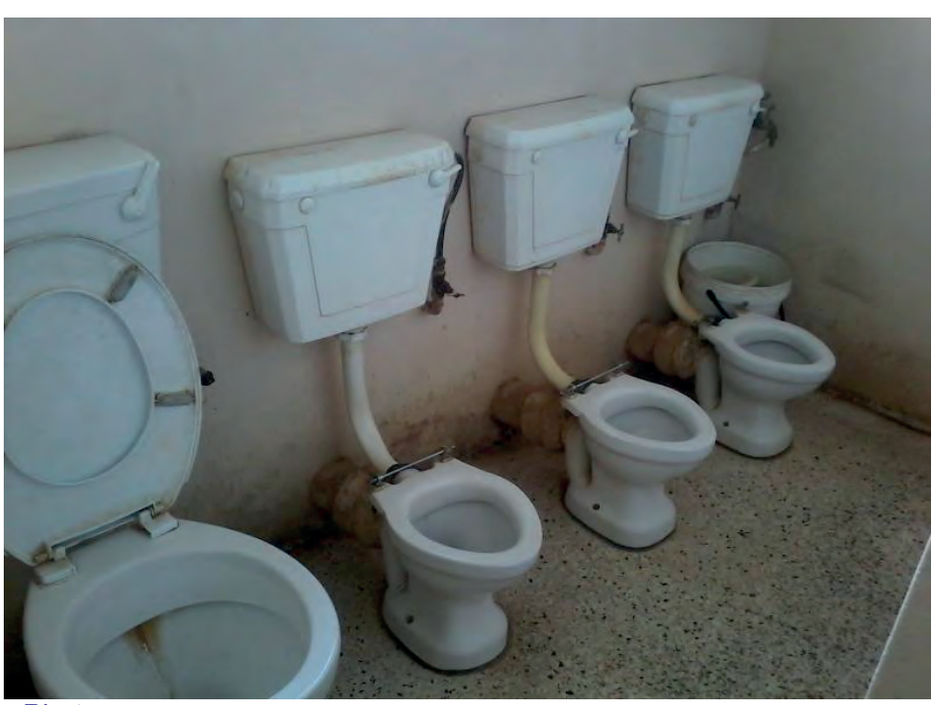


Photo: ©Triple M Impact Consulting/2016

At Mother Theresa Home of Joy, there are appropriate toilets.

Ensuring safety of the children by securing cooking area

Photo: ©Triple M Impact Consulting/2016

Mother Theresa Home of Joy, has two kitchens, one indoors and the other outdoors. For the safety of the children, this outdoor kitchen is built within an enclosure and in such a way that children cannot get too close to the fire.

Ensuring children have vegetables and fruits as part of their diet ,

Photo:©Triple M Impact Consulting/2016

At Tikondane, the Manager has been growing vegetables and fruits to supplement children's diet. Vegetables in full maturity and seedling stage, there is never a time when there are no vegetables in the garden.

Provision of support to children's education - Library

Photo: ©Triple M Impact Consulting/2016

At Chishawasha, each of the children's houses has a mini library well stocked with reading materials for the children. Children interviewed confirmed that they had access to the books in the library.

Documentation of data on the children

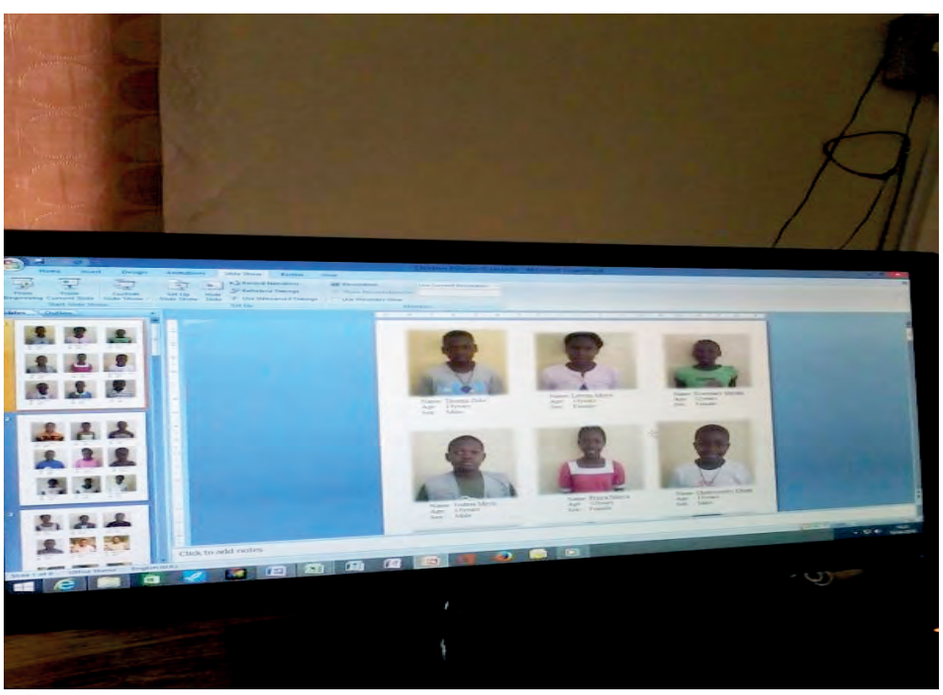


Photo: ©Triple M Impact Consulting/2016

1. At Chishawasha, the children's files are kept both electronically and in hard copy. Pictures of the children are all kept electronically.
2. At St Lawrence, all the documentation is stored in the cloud and is easily accessible

Annex III: Facilities contacted for inclusion (9 not included in Assessment)

	District	Name of Childcare Facility
Lusaka District		
1.		Living Hope Foundation
2.		Kabwata Orphanage
3.		City of Hope
4.		Chilenje Transit Centre
5.		Zambia Children New Life Centre
6.		Chisomo Chidren's home
7.		Vision of Hope
8.		Fountain of Hope
9.		Matthew 25
10.		Action for Children
11.		Jesus Cares Ministries
12.		Kids Alive
13.		Mother Theresa Home of Hope
14.		St Lawrence Home of Hope
15.		Home of David and Faith
16.		Open Arms Family Home
17.		Star Ministries
18.		Arise Ministries
19.		My Fathers House
20.		Cheshire Homes
21.		Inevitable rescue
22.		Old McDonalds
23.		St. Cecilia
24.		House of Moses
25.		Daughters of Zion
26.		Bill and Bette
27.		Vinebranch
28.		Bethel Home
29.		Zoe's Hope
Kafue District		
30.		Tache
31.		Energy of Hope
32.		New Beginnings Children's Home
33.		Emmanuels Home
34.		Mwana Maria Children's Home Village
Chilanga District		
35.		Mthunzi Children's Home
36.		Care for Kids Orphanage
37.		Blessed Emmel Children's Home

38.		Mothers without Borders
Chibombo District		
39.		Chikumbi Children's Centre
40.		Chikawasha
41.		All Kids can Learn Village of Hope
42.		DAPP Children's Town
43.		Project Samuel
44.		Anchor orphanage
Chongwe		
45.		Kasisi
46.		Well Spring of life
47.		Rafiki
48.		Tree of Life
49.		Village of Hope
50.		Fountain Gate
51.		Home of Joy
52.		Palabana Children's Village Trust
53.		
Rufunsa		
54.		My Fathers House
55.		Kulanga Bana
Chisamba		
56.		Sunflower Family Centre
Kabwe		
57.		Arteco Childrens Home
58.		Mother Theresa Home of Joy
59.		Tikondane
60.		Sables Drop in Centre
61.		Children of Promise
62.		Julie Ann Children's Home
63.		Eva Chabala Foundation
Kapiri Mposhi		
64.		Nsungeni
Ndola		
65.		Insakwe Approved School
66.		Child Life Touch
67.		Nkwaxi Chichetekelo Youth Project
68.		Jabulani Children's Home
69.		Natwange Youth Centre
70.		Holy Family Home for Children
71.		St Anthony Children's Village
72.		Twapia Transit Home
73.		Arise

74.		Cheshire Homes
75.		Grace Academy Seeds of Hope
76.		Mercy Touch (Oil of joy/garments of praise)
77.		Lubuto Father's Love
78.		Isubilo Resource Centre
79.		Face of a Child
80.		Child Care and Adoption Centre
81.		Living Hope International
Lufwanyama		
82.		Hand on Africa Orphanage
83.		FUSCO'S Orphanage
Kalulushi		
84.		New Hope Chidren's Village
Kitwe		
85.		Friends of the Street Children
86.		Abbas heart
87.		Chande Orphange
88.		SOS Children's Village
89.		Young Women Christian Association
90.		Renewed Hope
91.		Children of Destiny
92.		Ben Doree
93.		Day Spring Street Life Project
94.		Bush Fire Ministries
95.		Sara Rose Children's Home
96.		Nehemiah Boys ranch
97.		Village of Hope – Kitwe
98.		Sara Rose Maternity Home
99.		Somone Orphanage
100.		Faith Children's Village
Luanshya		
101.		Loves Door for All Nations
102.		Chichetekelo Childrens home (Luanshya)
103.		VM Lupwa Home Orphanage
104.		Kafubu Block Mission Orphanage
Mufulira		
105.		Green Forest School and Orphanage
106.		Emmas Kids Ministries
107.		Robins nest Orphanage
108.		Mufulira Childrens Centre
Chingola		
109.		Ipusukilo Childrens Trust
110.		Luwi Community Orphanage
111.		Edens Farm Childrens Village

112.		Mutendes Childrens Village
113.		Lusungus Orphanage
Chililabombwe		
114.		One Way Childrens Home
Mazabuka		
115.		Nakambala Approved school
116.		Oz Kids
117.		Ark House
118.		Family in Christ mission - Mbaya Musuma Rural Health Centre and Orphanage
Choma		
119.		New Day
120.		Children's Nest
121.		Children of the Most High
Kalomo		
122.		Namianga Orphanage
Kazungula		
123.		World Orphan Relief
124.		Mission of Love
125.		Global Samaritan Childre's Home
Livingstone		
126.		Lushomo Trust Dani's Home
127.		Ebenezer *(Founder passed on)*
128.		Lubasi Trust Home
129.		Love's Door
130.		Calvary Church – PAOGZ
131.		House of Hope
132.		City of Joy
133.		Kwathu Children's Home
134.		Heartspring Orphanage
135.		Cheshire Home Livingstone
136.		SOS Children's Village
Siavonga		
137.		Namumu Orphanage
Itezhi tezhi		
138.		Kidz4him
Mkushi		
139.		Maranatha Children's Centre
Serenje		
140.		Help Ministries Orphanage
141.		Serenje Orphans Children's home
Chitambo		
142.		Agape Village Foundation
Mpika		
143.		Mpika Village Hope Orphanage

Chinsali		
144.		Antonella Transient Home for baby orphans
145.		Mary Milimo Orphanage
Nakonde		
146.		Reedeemers House Orphanage
Kasama		
147.		Brothers Keeper Orphanage
148.		YWCA
149.		Chikuku
Luwingu		
150.		Compassionate Orphanage
Mansa		
151.		Mansa orphanage
152.		Fatima Home
Mwansabombwe		
153.		Kazembe Orphanage
Kawambwa		
154.		Kachema Musuma
Mwense		
155.		Mpaso Orphanage
Livingstone		
156.		
157.		
158.		
159.		
160.		
161.		
162.		
Petauke		
163.		Kachele Transit Home
Chipata		
164.		Smiling Kids Zambia
165.		Cheshire Home Chipata
166.		SOS Children's Village Chipata
Mambwe		
167.		Hanada Orphanage
Chirundu		
168.		Munzi Wa Moyo
Kazungula		
169.		One Day Zambia
Kaoma		
170.		Kaoma Cheshire Community Care Centre
Mongu		
171.		Little Noah Children's Home

172.		Emmanuel Mission Centre
173.		Nehemiah House of Favour
174.		Cheshire Home Society Mongu Branch
175.		Village of Hope
176.		Kids Alive Zambia
177.		Liyoyelo Community Trust Orphanage
Solwezi		
178.		Kilela balanda
179.		Gilgal Orphanage
180.		Cheshire Home Solwezi
Mwinilunga		
181.		Mama Faridha islamic Orphanage
182.		Chisanyi Chidren's Home
Ikelenge		
183.		Ikelenge Orphanage
184.		Hill wood Children's Home
185.		Sacred heart Deaf Unit
Kabompo		
186.		The Falconer's Home
Zambezi		
187.		The Lord's Mountain Orphanage
Kasempa		
188.		Mulunda Miaka

Annex IV: Facilities at which no data was collected from Facility Manager and reason

	Facility	District	Reason
1.	Kabwata Orphanage	Lusaka	Unwilling to be interviewed
2.	Ishuzui Noish	Chongwe	Unwilling to be interviewed
3.	Well Spring of Faith	Chongwe	Closed
4.	Zoe' Hope	Chilanga	Could not be located
5.	Family Legacy		Same management, only one FM interview conducted
6.	Tree of Life		
7.	Energy of Hope	Kafue	Manager based in UK, managed by children themselves
8.	Emmanuel House	Kafue	FM not available
9.	Nehemiah Boy's Ranch	Kitwe	Managed by one person but unwilling to be interviewed
10.	Sara Rose Children's Home	Kitwe	
11.	Sara Rose Maternity Home	Kitwe	
12.	Zambia New life Centre	Lusaka	Double counted, same facility different name. Interview conducted
13.	Kavwumbu Home for girls	Lusaka	
14.	Katombora Reformatory School	Kazungula	Permission denied due to absence of letter from Ministry of Home Affairs.
15.	Mufulira Children's Home	Mufulira	Facility not operational
16.	Ikelenge Child	Ikelenge	Facility Manager in Lusaka at time of interview, no representative
17.	Sepo Drop in Centre	Kaoma	No longer a children's Home but a feeding centre
18.	Mpika Village Hope	Mpika	Day care and feeding centre
19.	Antonella Transit Home	Chinsali	FM was in Lusaka at time of interview, no representative
20.	Household in Distress	Mbala	Day care
21.	Luse Orphanage	Mbala	Facility closed
22.	Sunsuntila Day Care Centre	Mbala	Day care centre

Annex V: Table of Facilities by capacity

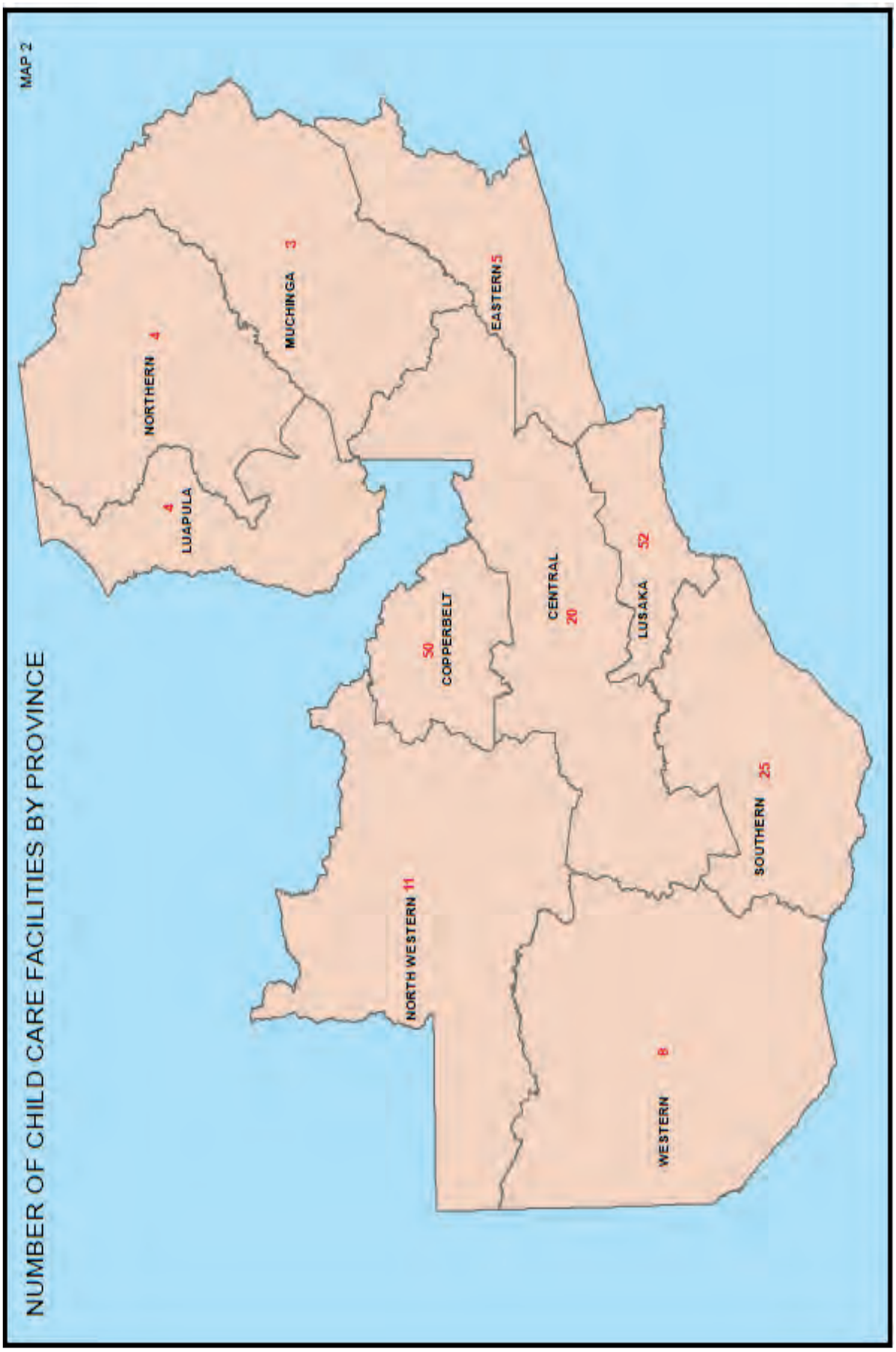
Name of Facility	Capacity
Abba's Vineyard	14
Action For Children Zambia	24
All Kids Can Learn/Village Of Hope	69
Arteco Orphanage	60
Ben Doree	15
Bushfire Ministries	100
Care For Kids	40
Chande Baptist Orphanage	100
Cheshire Homes	30
Chichetekelo Childrens Home	20
Chikumbi Children' Centre	60
Child Care And Adoption	24
Child Life Touch	30
Children Of Promise	30
Children Of Destiny Project	12
Chilenje Transit Home	15
Chishawasha Childrens Home	90
City of Hope	60
Dapp Children's Town	450
Dayspring Street Life Project	50
Eden Farm Childrens Village	18
Emma's Kids Ministries	35
Eva Chabala Foundation	25
Face Of A Child	30
Faith Children's Village	100
Fountain Gate	160
Fountain Of Hope	60
Friends Of The Street Children	45
Fuscos	18
Grace Academy And Village	150
Green Forest School And Orphanage	12
Hands On Africa	50
Holy Family Home	12
Home Of David And Faith	27
Home Of Joy	45
Insakwe Approved School	48
Ipusukilo Children' Trust	48
Isubilo Resource Centre	30
Jabulani Children's Village	48
Jesus Cares Ministries	23
Julie Annie Children's Home	90
Kasisi Orphanage	240

Name of Facility	Capacity
Kavbu Shelter	20
Kids Alive	28
Kulanga Bana	27
Living Hope Foundation	25
Living Hope International	31
Lubuto Father' Love,	16
Lusungu Orphage	35
Luwi Community Orphane Scheme	30
Mathew 25	20
Misundu Youth Center Nkwazi	75
Mother Theresa Home Of Hope	70
Mother Theresas Home Of Joy	30
Mthunzi centre	60
Mutende Childrens Village	30
Natwangale Home, Chipulukusu,	60
New Hope Children Village	12
Nsungeni Children's Home	18
Oil Of Joy	8
One Way Children's Home	35
Rafiki Children's Home	80
Renewed Hope Childrens Village	12
Robins Nest	24
Sample Nua Drop in Centre	20
Sara Rose Childrens Home	40
Someone Home	9
Sos Children's Village	196
St Lawrence Transit Home	55
Sunflower Children' Centre	100
Tache Home	12
Tikondane Orphanage	30
Tree Of Life	688
Village Of Hope	120
Village Of Hope	64
Vision of Hope	20
VM Lupwa Orphanage	8
Ywca	18

Name of Facility	Capacity
Anchor Orphanage	40
Project Samuel	24
Help Ministries Orphanage	75
Agape village foundation	96
Kidz4him, Kaingu Palace, Itumpi village	4
Serenje orphans children's home	44
Smiling Kids	10
SOS Chipata	130
Hanada Orphanage	5
Cheshire Home Chipata	40
Kachele House	10
Fatima Home	6
Mansa Orphange	6
Kacema Musuma Children's Home home	35
Kazembe orphanage	36
Inevitable Rescue Centre	Unknown
Cheshire Home -Kabulonga	50
Arise africa home	16
My Fathers house	Unknown
Bill and Bette	35
Star Ministries	17
Macdonald Children Home	20
Mwana Maria Children' Home Village,	40
SOS Children' Villages Zambia - Lusaka	275
Daughters of Zion International	25
Palabana childrens village trust	97
Munzi Wa Moyo	80
Emmanuel Children Home	8
Bethel Home	15
Vinebranch Ministries	40
St Cecilia	20
Open arms	40
House of Moses	25
Mothers Without boarders	35
Blessed Emmel Childrens home	Unknown
New beggining	26
Mpika Village Hope Orphanage	21
Redeemer house orphanage	15
Mary Milimo orphanage	20
Kidz Alive Mongu	60
Liyoyelo community Orphanage	23

Name of Facility	Capacity
Brothers keeper orphanage	17
Chikuku Orphanage	Unknown
Ywca	15
Mama Faridah Islamic Orphanage	15
Kilelabalanda Orphan and Widow Care	80
Hillwood Children's Home	Unknown
The Falconer Home	150
Lord's Mountain, United Methodist Church	50
Mulunda Miaka Orphanage	Unknown
Ark House	40
Namianga orphanage	Unknown
World Orphan Relief	72
Mission of Love	Unknown
Ebenezer child care trust	48
Nakambala approved school	75
City of Joy	53
House of Hope	12
Heartspring Orphanage	44
Kwathu Childrens Home	19
Love' s Door for all nations	Unknown
Calvary Church Home	11
SOS Children's Village - Livingstone	165
Global Samaritan Children's Home	64
Family in Christ Mission Rural Health Centre and Orphanage	Unknown
Oz Kids International	Unknown
Children of the Most High	30
Namumu Orphanage	Unknown
New day orphanage	30
Lushomo trust Dani's home	15
Lubasi home	60
Children' Nest Orphanage	65
Kaoma Cheshire Community Care Centre	120
Little Noah Children's Home	12
Emmanuel Mission Centre Place of Safety	Unknown
Nehemiah House of Favour	21
Cheshire Home Society Mongu Branch	85
Village of Hope -Mongu	48

Annex VI: MAP – Number of Facilities by Province



Annex VII: Proposed Assessment Form (Facility Manager, Caregiver and Children's Focus Group Discussion Guide)

CONFIDENTIAL (additions in red font)

MINISTRY OF COMMUNITY DEVELOPMENT AND SOCIAL SERVICES

DEPARTMENT OF SOCIAL SERVICES

STATUTORY UNIT

CHILD CARE FACILITY ASSESSMENT FORM

A. Information about the Interviewing team and the interviewee

1.	Who are members of the assessment team?	**Name**	**Designation**	**Organization**
2.	Date of interview			
3.	Name of Interviewee			
4.	Position in the Home			
5.	Gender			
6.	How long has the interviewee worked in the home?			

B. General Information About the Home

1.	**Name of the Home:**	
2.	**Run by:**	
3	**E-mail Address:**	
4.	**Physical Address:**	
5.	**Town/City:**	
6.	**District:**	
7.	**Province:**	
8.	**Telephone Number:**	
9.	**Mobile Number:**	
10.	**Fax Number:**	

11.	**Email Address:**	

C. Legal Status of the Home

1.	Is the Home registered with the Registrar of Societies?	**A.** ☐ **Yes**	**B.** ☐ **No**	**C.** ☐ **No Idea**
2.	Year of Registration with Registrar of Societies	**MM/DD/YY**		
3.	What is the Certificate Number?			
4.	Has the home renewed its registration since its registration?	**A.** ☐ **Yes**	**B.** ☐ **No**	**C.** ☐ **No Idea**
5.	When was registration renewed?	**MM/DD/YY**		
6.	Is the Home registered with the Registrar of NGOs?	**A.** ☐ **Yes**	**B.** ☐ **No**	**C.** ☐ **No Idea**
7.	Year of Registration with the Registrar of NGOs:	**MM/DD/YY**		
8.	What is the Certificate Number?			
9.	In which year was the Home officially opened?	**MM/DD/YY**		
10.	How is the home registered?	**A.** ☐ **NGO**	**B.** ☐ **CBO**	**C.** ☐ **Children's Home**
11.	Is the Home registered with the Registrar of Companies	**Yes**	**No**	**No Idea**
12.	Year of registration with the Registrar of Companies	**MM/DD/YY**		
13.	What is the Mission Statement /Motto of the Home?			

D. Management of Home

1.	Name of the person in charge of the home			
2.	Designation of the person			
3.	What is the phone number of this person?			
4.	Is there a management board? **Note:** *If the response on*	A. ☐ Yes	B. ☐ No	C. ☐ No Idea

	this question is ***No/No Idea****, kindly* ***proceed to Section E***			
5.	What are the names and contact numbers of the chairperson/ vice of the Board?			
	Names of Board Members	**Position on the Board**		**Contact Number**
i.				
ii.				
6.	Do Board Members visit the Home?	**A.** ☐ **Yes**	**B.** ☐ **No**	**C.** ☐ **No Idea**
7.	If yes who among the Board Members visit the home and how often?			

	Name/position of Board member	**Frequency**			
		M[55]	**Q**[56]	**BA**[57]	**A**[58]
i.					
ii.					
iii.					
iv.					

Management Policies

		YES	**NO**
1.	Does this Facility have a Constitution?		
2.	Does this facility have a Child Protection Policy		
3.	If yes, is the child protection policy signed by all staff members		
4.	Does this Facility have a Code of Conduct?		
5.	If Yes, is the Code of Conduct signed by each staff		

E. Information about Staff working in the Home

1. Information about professional staff employed at the Home:

Name of Profession (list each individually)	**Field and Qualifications – Degree, Diploma, Certificate, High School**	**Length of Service at the Home**	**Current Position Held**
Social worker			

[55] Monthly
[56] Quarterly
[57] Biannually
[58] Annually

Child Care giver			
Nurse			
Teacher			
Physiotherapist			
Nutritionist			
Counsellor			
Comments if any:			

2. Information about support staff employed at the Home: janitors

Staff Category	**Number currently Employed**	**Level of Education**
Cooks that are not Caregivers		
Guards		
Caretakers		
Cleaners that are not Caregivers		
Other Staff - gardeners		
Comments:		

	A. ☐ **Organization** **B.** ☐ **Head of Organization** **C.** ☐ **Government /Local Govt-(Council)** **D.** ☐ **Community**		**E.** ☐ **Catholic Sisters** **F.** ☐ **Catholic Brothers** **G.** ☐ **Protestant Church** **H.** ☐ **Mosque**		
2.	**Type of Building**	**A.** ☐ **Concrete**		**B.** ☐ **Mud**	
Comments:					

F. In-service and pre- service training offered to staff

1.	Do you offer In-service training at least once a year? **A.** ☐ **Yes** **B.** ☐ **No** **C.** ☐ **No Idea**
2.	If Yes, when was the last time you conducted in-service training?
3. **3.** 4.	Please name the topics covered in the training?

Which staff members attended the training Number of Male staff	**Number of Female staff**	**Topics**

4. Do you offer pre-service training to new staff? **A.** ☐ **Yes** **B.** ☐ **No** **C.** ☐ **No**
5. If Yes, when was the last time you conducted pre-service training?
6. Which members of staff attended the training?
7. Please name the topics covered in the training?

G. Ownership and Type of Structure

1	Who owns the premises

H. Source of Funds

1.	Does the home receive regular funding?	**A.** ☐ **Yes**	**B.** ☐ **No**

If yes, what are the sources of funding for this institution?

Source of Fund	Tick	Amount (Per Year)
Government		
Fees		
Zambia Church groups		
Church group outside Zambia		
International NGO Funding		
Individual/Private Donations from within Zambia		
Individual/ Private outside Zambia		
Income Generating Activity		
Other (Specify)		

2.	If No how is the home funded?
3.	What is the home's Annual Budget?
4.	What was the expenditure for the last year?
5.	**Comments:**

I. Status of Facilities

SUITABILITY OF INFRASTRUCTURE		Excellent	Good	Fair	Poor
1	Cooking and dining facilities				
2	Ventilation				
3	Home security				
4	Fire Safety				

5	Recreation facilities				

RECREATION FACILITIES/ACTIVITIES

		Present	State Type (E.g., football netball etc, chess)	Absent
1	Mental games			
2	Physical games			
3	Indoor games			
4	Outdoor games			
5	Are the games and toys age appropriate?	A. Yes	B. No	C. No Idea

Comments

SLEEPING QUARTERS

1	How many bedrooms are there in the home?	# of bedrooms for boys:	# of bedrooms for girls:
2	How many children sleep in a room?	Number of Boys:	Number of Girls:
3	Do children sleep on a bed?	A. Yes	B. No
4	How many children per bed	Number of Boys:	Number of Girls:
5	If No, how many children sleep on a bed?	Number of Boys:	Number of Girls:
6	How many children sleep on the floor on mats?	Number of Boys:	Number of Girls:
7	Are there separate sleeping quarters for boys and girls?	A. Yes	B. No
8	Are there mosquito nets in the children's bedroo ms?	A. Yes	B. No

Comment

J. Health

1	Is there a first aid box?	**A.** **Yes**	**B.** **No**
2	If yes what is contained in the first aid box?		
3	Is there a sick bay? Note: if the response to this Question is **No; kindly proceed to Question 7**	**A.** **Yes**	**B.** **No**
4	If the response in Question 3 is Yes; what is the condition of the sick bay?	**A.** **Excellent**	**B.** **Fair** **C.** **Poor**
5	Is there trained medical personnel running the sick bay?	**A.** **Yes**	**B.** **No**
6	If the response in **Question 5 is No** ; where are the children taken when in need of medical treatment?		
7	How far is the nearest health center?	**A.** **< 100 meters** **B.** **200 - 100 meters**	**I.** **200 -300 meters** **D** **300 - 400 meters**
8.	How are the children transported to the health facility?		
9.	How often are medical check-up carried out?	**A.** Every 3 to 4 months **B.** every six months **C.** Once a year	

K. Food and Nutritional Intake

	Present	Absent
Dietary chart		
Do children always eat vegetables at lunch and supper time?	YES	NO
Do you supplement the diet with vegetables, meat, chickens or fish that you produce yourselves?		
Nutritional supplement: Gardening/poultry etc		
Under five cards for children aged 5 & below		

N.Water and Sanitation

Water			
1.	Is there running water in the home?	**A. Yes**	**B. No**
2.	If yes what is the source: **J. Local Authority (Piped water)** **K. Borehole** **Other (specify)**		
3.	Does the water source service the Home on a daily basis?	**A. Yes**	**B. No**
4.	If No, what is the alternative source of water?	1. 2.	
5.	How far is the alternative source water from the Home?	**A. < 100 meters** **B. 100 - 200 meters**	**L. 200 -300** **M. 300 - 400**
Sanitation - Toilets			
6	Do boys and girls use the same toilets?	**A. Yes**	**B. No**
7	If yes how many toilets are there in the Home?		
8	If No, how many toilets are used by the boys?		
9	How many toilets are used by the girls?		
10	How many flush toilets are working currently?		
11	What type of toilets are used in the home?	A. Flush	B. Pit Latrine	Other (Specify)
12	What is the Hygiene standard of the Home	A. Very Clean	B. Clean	B. Not Clean
Comments			
Sanitation – Bathrooms			
13	Do boys and girls use the same bathrooms?	A. Yes	B. No
14	If yes how many bathrooms are there in the Home?		
	If No, how many bathrooms are used by the boys?		
	How many bathrooms are used by the girls?		
	What type of bathrooms are used in the home?	A. Bath tab	B. Shower	C. Outdoor
	What is the Hygiene standard of the Home	A. Very Clean	B. Clean	B. Not Clean
Comments			

How many meals are provided daily	A. ☐ 3 Meals	B. ☐ 2 Meals	B. ☐ 1 Meal
How many times do children snack between meals per day	A. ☐ Once	B. ☐ Twice	C. ☐ None

L. Educational and Skills Training Programmes

How many children attend formal school?		**Number of Boys:**	**Number of Girls:**
Where is the school located?	A. ☐ In the Home	B. ☐ In the community	B. ☐ Other
If the school is within the Home is it approved by MESVTEE?		A. ☐ Yes	B. ☐ No
How many children of school going age do not attend school?		Number of Boys:	Number of girls:
Why do children of school going age not attend school?		1. 2. 3.	

How many children attend vocational/skills training?	**Number of Boys:**	**Number of Girls:**
University		
College		
Vocational Training e.g.		
Carpentry		
Tailoring		
Driving		
Agriculture /gardening		
Poultry		
Bricklaying tertiary		
Electronics		
Plumbing		
Specify others:		

M. Information on Children

1.	What is the Capacity of this Home?			
2.	What is the total number of children currently in the Home?	**Boys:**		**Girls:**
3.	Specify the number of children currently in the home by age		**Boys**	**Girls**
		Below 12 Months		

		1 Year Old		
		2 Years Old		
		3 Years Old		
		4 Years Old		
		5 Years Old		
		6 Years Old		
		7 Years Old		
		8 Years Old		
		9 Years Old		
		10 Years Old		
		11 Years Old		
		12 Years Old		
		13 Years Old		
		14 Year Old		
		15 Years Old		
		16 Years Old		
		17 Years Old		
		18 Years Old		
4	Number of children seen in the home			
		Boys	**Girls**	
5	What is the age range of children in this Home?	0 - 5yrs 6 – 11yrs 12 – 17yrs 18yrs and above	0 - 5yrs 6 – 11yrs 12 – 17yrs 18yrs and above	

6	Type of Children Admitted to this Home	**Boys**	**Girls**
a.	Dumped babies		
b.	Orphans		
c.	Special needs/physically disabled		
d.	Special needs / mentally disabled		
e.	Children in need of care (Street children)		
f.	Children in need of care (abused children)		
g.	Children in need of care (neglected children)		
h.	Children in need of care (abandoned children)		
i.	Children in need of care (mother mentally ill)		
j.	Children in need of care (parent/s in prison)		
k.	How many children are single orphans?		
l.	How many are double orphans?		
m.	How many are non-orphans		
n.	Children that are HIV positive		
7	How do you address issues of stigma against children that are HIV positive?		

8	What is the number of Children currently being served that are resident?		
9	What is the number of Children currently being served that are non- resident?		
10	Has the home recorded any death in the last 12 months?	A. Yes	B. No
11	If yes, how many children died in the last 12 months?		
12	What were the causes of death?		

O. Admission of Children

1.	Indicate the minimum and maximum age of Admission?	Minimum Age:	Maximum Age
2.	Is there a document that parents/guardians sign when their children are admitted into this home?	A. Yes	B. No
		Boys	**Girls**
3.	How many children have this document on file?		
4.	How many children were referred by the MCDSS?		
5.	How many children were initially identified through outreach programmes and thereafter referred to MCDSS		
6.	How many children were referred by other NGOs?		
7.	How many children were admitted directly by the Home?		
8.	How many children have Court Orders?		
9.	How many children were referred by MCDSS but do not have written referrals?		
10.	How many children were referred by Community members?		
11.	How many children are self-referrals?		
12.	How many children have files?		
13.	How many children have birth certificates on their files?		
14.	How many children have medical reports on their files?		
15.	How many children have school report cards on their file?		

16.	How many children have personal photographs on their file?		
17.	How many children have photographs of their parents on their file?		
18.	How many children have case report note on their file?		
19.	How many children have records of care reviews on their file?		
20.	How many children have information about their parents on their file?		
21.	For how many children has family tracing been done?		
22.	For how children is family reunification planned?		
23.	How many children have been reunified before and have settled well in their family environment?		
24.	Was District Social Welfare Office involved in the re-unification process?	YES	No
25.	How many children who have been reunified before but are now back in the Home?		
26.	Why are these children re-admitted?		

P. Contact with Family and Community Members

1.	Are parents/guardians/other family members allowed to visit?	A. ☐ Yes	B. ☐ No
2.	If yes, how often are these visits allowed?		
3.	How frequently do parents actually visit?		
4.	How often are children allowed to go on holiday to their families?		
5.	Did any children go to visit their family in the last school holiday?		
6.	If No, how does the Home ensure that children maintain contact with their families?		
7.	Do community member visit the home?	A. ☐ Yes	B. ☐ No
8.	Who in the community visits the Home?		
9.	Why do they visit?		
10.	Do children participate in religious activities?	A. ☐ Yes	B. ☐ No
11.	Are religious activities available for all religions?	A. ☐ Yes	B. ☐ No
12.	Do children in the home visit the community?	A. ☐ Yes	B. ☐ No

13.	If yes, what activities do they take part in when they visit the community?		
Comments			

Q. Recommendations to the Home

Staff related (child staff ratio; type of staff; gender of staff; training required)	1.
	2.
	3.
	4.
	5.
Structural (improvements to the facility- toilets, bathrooms, beds, dining area, kitchen)	1.
	2.
	3.
	4.
	5.
Management related (internal policies, case file management, admission issues, issues around exceeding the capacity of the facility)	1.
	2.
	3.
Care of children (nutrition, corporal punishment, family contact)	1.
	2.
	3.
Security Related (Guards, visitors book, vetting visitors)	1.
	2.
	3.
	4.
	5.

Annex VIII: Interview Guide for Care Giver

EXPERIENCE AS A CHILD CARE GIVER

1. How old are you
2. How long have you been a care giver at this Home?
3. Were you a Care giver at another home before?
4. In total how long have you worked as a care giver?
5. What is your marital status?

EMPLOYMENT AND QUALIFICATIONS

6. Do you have a contract for your job?
7. Did you receive a job description and a letter of employment when you started working here?
8. Do you receive a salary? If yes, how much?
9. Up to what Grade have you attained education?
10. What qualifications do you have? (Certificate, diploma, degree etc.)
11. Did you obtain the qualification before you started work at this Home?
12. Did you obtain qualification whilst working at this home?
13. Have you received training through this Home on HIV AIDS, Counselling, child care, child protection or any other areas relevant to your job?
    (When I talk about training I mean even short courses such as for a duration of two weeks?)
14. Do you perform other duties / other jobs apart from Care giving in this facility?
    a. If Yes, which kind of other duties do you perform (e.g. cooking, laundry
    b. Do you have other jobs outside this Facility?
15. From your work experience as care giver, what would you say are some of the reasons that children end up being brought to this Facility?

WORKING AS A CHILD CARE GIVER

16. How many children are under your care?
17. What is the age range for these children, and how many children in each age group:
    How old is the youngest and how old is the oldest?

Age range	№ of children	Age range	№ of children
0 – 3 years		14 – 18 years	
4- 5 years			
6 – 10			
11 - 13 years			

18. What is the longest number of years a child has lived at this Facility?
19. What are some of the things you like about working here?
20. What are some of the things you think could be improved?

PROVISIONS FOR THE CHILDREN IN THE FACILITY

21. Is the clothing for the children enough? :
    a. Do children share clothing?
    b. Does each child have appropriate size of clothing?
    c. How many blankets are there per bed?

d. How many bed sheets are on each bed?
e. Are blankets enough for cold season,

22. What type of recreation do children have; at the Facility? (E.g. games and relaxation activities and activities related to their hobbies)
    a. In-doors (e.g. Puzzles, building blocks, dolls, toys)
    b. Outdoors
    c. Do they go outside the Facility premises for recreation activities, what type, how often?

FOOD

23. What food did children have for meals today – breakfast, lunch supper,
    - Breakfast:
    - Lunch:
    - Supper:

    a. What food did they have the day before yesterday; breakfast, Lunch and supper
        - Breakfast:
        - Lunch:
        - Supper:

    b. Do you think the meals are adequate / filling for the children?
    c. Are meals well cooked
    d. Where do the children eat the meals from?
    e. Does each child have his or her own plate, cup, spoon and forks?
    f. Do any children miss meals?
        - If 'Yes', please explain why.

CARE PLANS FOR CHILDREN) Can Also Be Obtained From The Social Worker/Coordinator Or Deputy if available)

24. Do you know if the social workers or the managers have developed plans for each child under your care? By this I mean the a plan that shows how each child will spend their days, what school they will attend, the recreation they will participate in, how they will be reunited with their family/ relatives and how the facility will be help the child to settle outside the Facility.
    a. Are you involved in discussions about the children's care plans?
    b. If 'No' why
    c. Are care plans followed?

COMPLAINTS

25. What type of complaints do children normally have?
26. If children have serious complaints how do they channel these?
27. Is there a complaint reporting mechanism? Please explain
28. Have any of the children under your care for used the complaint reporting mechanism?
    a. Does it work
    b. Please give an example of the last time a child reported an issue through the complaints mechanism and how it was handled?

VISITORS

29. Do the children in your care receive visitors from their family members ?
    a. What are the rules about receiving visitors in this Home?
    b. Who visits them

c. Tell me about each child's visitors and how often they come?

CHILDREN / YOUNG PEOPLE LEAVING THE FACILITY

30. In the past, have children in your care left this Facility (TO LIVE ELSEWHERE)?
    a. If 'Yes' where did they go and what role did you play? Also describe how the process of taking the child was done and the role you played. *(This should be described under each of the sections below appropriately*)
    b. Have any of the children left the facility to be reunited with their families? – How many?
    c. What kind of challenges did these children face in the reunification process?
    d. What support did the Facility provide to these children and to the families?
    e. Have any of the children you have been responsible for been assessed to be ready to move out to live alone or with a family? – how many
    f. Have any of the children gone to live with a family with whom they are not related on a temporary arrangement)– how many in in the past year (Forster care)
    g. Have any of the children been taken to live with a family with whom they are not related on a permanent arrangement – how many in the past year? (Adoption)?
        - What role did you play?

31. Do you know of any child from this Facility who has successfully moved out of the Facility to live on their own?
    a. If 'Yes', who do they live with?
    b. If no, why do you think there are no children that are old enough that move out to live in the community?
    c. What do you think are the biggest challenges that a young person can face when returning to the community to live independently after living in a residential care?
        - What help does the young person get from the facility in order to help them start a new life outside the Facility?
        - What other help would be required to prepare youth to live on their own?

32. Does this Facility follow-up to monitor how the children or young people are settling after they have left the Facility?
33. Does this Facility provide any support for children /young people that have left the Facility? If yes, what kind of support

Is there any other information you would like to share with us/me or are there any comments you that would like to make?

Inform the respondent that the interview is now competed and thank the person for their participation

Annex IX: Focus Group Discussion Guide with Children

Introduction

Interviewer introduces herself or himself.

A. Explain the purpose of the group discussion
B. Explain that the children are free to withdraw from the discussion whenever they felt uncomfortable to continue.
C. Inform the children that if at any time during the discussion any one of them feels he or she would like to talk to someone away from the other children regarding something unrelated to the Study, they are free to do so and assure the children that you will make arrangements for someone on your team who is specialised in such cases.
D. If the respondents agree to continue ask them to sign the written assent form

Breaking the ice

Start the FGD with an icebreaker, e.g. a song, energiser or a game or a dance

1. Do you all go to school? How many of you go to school?
2. Are there some children that do not attend school at this Facility?
   a. If Yes, why do they not attend school
3. What are your favourite subjects at school?
4. What games do you like to play at school and here at the Facility?
5. Apart from playing games, what else do you do in your free time when you are not at school?
6. What would you like to become when you grow up?

Let us now talk about your life here at this Facility

7. How many years has it been since you came here? - (Obtain individual responses)
8. Who is your favourite Care giver?
9. Why is she/he the favourite Care giver?
10. Tell me about some of your best experiences of living here and why these were your best experiences?
11. Tell me about some of the experiences that have not been so good when living here?
    a. What makes you say so?
12. Who takes care of you here?
13. How do they take care of you?
14. What do they do for you?
15. What would you say about these things in this home:
    a. Your clothes (Does each child have their own or you have to share?
    b. Are they in good condition?
    c. Do you have enough warm clothes?
    d. Do you always have soap?
16. Sleeping arrangements (probe on number of children per bed,

a) How many sleep on the floor but on a mattress? Why?
b) How many sleep on the floor but on a blanket, why do they sleep on the floor?
c) How many blankets each, availability of bed sheet/linen,
d) Are there mosquito nets in the rooms?
e) Are the boys and girls separated
f) Do older children sleep separately from younger ones?

17. Is the food enough? Is the food well cooked? (Say for lunch what do you usually eat? Is there a menu? Is the menu always followed, how many meals a day do you have?
    a. What did you have today for; Breakfast, Lunch
    b. What did you have yesterday for breakfast, Lunch and Supper
    c. What did you have the day before yesterday for breakfast, Lunch and Supper

18. Do you get snacks in the morning and afternoon? Who is given snacks and what type?
19. Play time and leisure (probe does the facility provide toys? leisure time?) What type of games are played. Who is in charge?
20. Do children go outside the Facility for recreation activities?
    a. What type, how often?
    b. Who is in charge when you go out?
21. If someone does something wrong, what type of punishment is given?
22. How many of you have been punished for doing something wrong since you came to this Facility?

Notify group that the discussion is about to end but would like to discuss a few other points

23. Do you receive any visitors? (probe: relatives, when, who received visitors)
24. When did each of you last receive visitors (family members)
25. Do you go on holidays to your family?
26. When did any of you last go for a holiday to his / her family?
27. Do you look forward to being reunited with your families?
28. What things would you like to be improved at this Facility?
29. Is there anything else you would like to say?

Announce end of discussion and thank participants.