



DEINSTITUTIONALISATION PRACTICE MODEL

A Guide for Residential Homes for Children

GHANA 2020

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Acronyms

BCN	Better Care Network
CRI	Care Reform Initiative
DI	Deinstitutionalisation
DSW	Department of Social Welfare
MoGCSP	Ministry of Gender, Children and Social Protection
NPA	National Plan of Action
OVC	Orphans and Vulnerable Children
RHC	Residential Homes for Children
SER	Social Enquiry Report
SOP	Standard Operating Procedure(s)
SWO	Social Welfare Officer(s)
UNCRC	United Nations Conventions on the Rights of Children
UNICEF	United Nations Children Emergency Fund

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NB: This DI practice model has been developed by Bethany Christian Services for RHC. It is recommended that you contact Bethany for further trainings suggested in this document for effective sustainable DI implementation.

Preamble

The development of Ghana has not been without social challenges. The country has experienced a change in the traditional communal life and social organisation that support Orphans and Vulnerable Children (OVC) through the extended family system. Apart from that, economic hardship has contributed to child neglect and family separation. As a result, institutionalisation of children has risen significantly. To resolve the situation, the Department of Social Welfare (DSW) introduced the Care Reform Initiative (CRI) in 2007. The goal of the CRI is to ensure that family-based care becomes the main alternative for children in need of care and protection. The care reform led to the closing of several Residential Homes for Children (RHC) in Ghana by the DSW.

Further, many RHC have been earmarked for closure. However, resistance to closure among RHC persist due to the lack of political will to enforce closure (Hickmann et al, 2018). Meanwhile, RHC are significant stakeholders in the success of the CRI. They can be supported to transition to community and family-based options for children through the process of deinstitutionalisation (DI). For this change to occur, the concept of DI should be understood at the level of RHC and made practical in terms of its implementation.

Bethany Ghana, in recognition of the above situation and role of RHC in care reform, has developed a practical model for deinstitutionalisation in Ghana. The model was developed in consultation with Bethany, experienced grassroots implementers from RHC, DSW, and other local professionals. The model is based on the Ghanaian context of care reform. It draws on existing policies, laws, research, child welfare practice in other countries, and Ghanaian operational manuals on alternative childcare to highlight and guide the user through a clear process of DI.

What is Deinstitutionalisation (DI)?

DI is generally understood as “the process of moving away from a childcare system based on institutions towards a range of integrated family and community-based services” (OrphanCare, 2017). Mostly, the term DI has been used interchangeably with closure, though they have different meanings. Whereas closure shuts down (ends) the operations of RHC, DI transforms the operations of RHC into family and community-based services for children. Hence, DI cannot be limited to moving children out of institutions. It is an integrated system made up of preventive mechanisms, reunification of children into families, and the provision of family and community-based services (OrphanCare, 2017; Milligan et al, 2016).

To date, most DI efforts in Ghana have been spearheaded by DSW (Milligan et al, 2016). This DI Practice Model, on the contrary, identifies RHC as initiators and implementers of DI and the DSW as the mandated supervisor and collaborator. Subsequently, this model defines DI as:

The process in which RHC willingly moves children into family-based care options and transforms into an organisation that can support family-based care options in the community and prevents the dissolution of families.

Aim and Intentions of this Practice Model

DI is essential for care reform for any country. The process of DI is implied in Ghana’s laws, policies, and guidelines on childcare. The absence of a DI practice model in Ghana contributes partly to the barriers to implementing the CRI. It is recorded in the mapping of RHC in Ghana (2018), conducted by the Department of Social Welfare and UNICEF, that several closed homes reopen and operate because Social Welfare Officers (SWO) are unable to force closure without access to or knowledge of alternative care provisions. The aim of this DI model is to give guidance and a clear, practical approach for deinstitutionalisation for RHC. This practice model intends to be:

- A guide to organisational change for RHC
- A guide to the process of placing children into family-based care
- A source of implementation tools to ensure quality assessment and provision of alternative childcare

PART I:

UNDERSTANDING DEINSTITUTIONALISATION IN THE GHANAIAN CONTEXT

History of Child Welfare in Ghana

In every society and culture, the welfare of children is paramount for the transfer of culture from one generation to the other. Child welfare in Ghana can be traced back to the pre-colonial period, where traditional mechanisms were used to ensure the welfare of children. The upbringing and care of children was held as a collective community responsibility. It was believed that those who refused to care for children of their dead relatives would be punished by the spirit of the departed relative (Frimpong-Manso, 2014). This socio-cultural organisation could not be sustained in the era of development and civilisation. As a result, the traditional family type of child welfare began fading.

As people migrated from their traditional communities to work, the loss of the communal bond weakened the existing communal and family child welfare system. In response, European missionaries began providing care for vulnerable children in schools and Infant Welfare Centres (Frimpong-Manso, 2014). The Osu Children's Home was the first residential home established in Ghana by an organisation called Child Care Society in 1949 to care for orphaned and vulnerable children (OVC) (Frimpong-Manso, 2014). In 1990, the United Nations Convention on the Rights of Children (UNCRC) was ratified by the

Government of Ghana. However, institutional care continued in the colonial and post-independence era. As of 1998, two children's homes had been established by the government and 6 private institutions had entered into agreement with the government to care for children (Frimpong-Manso, 2014). By 2006, the government had established three children's homes—Accra, Kumasi, and Tamale—and made special arrangements with SOS Children's Village to operate two residential homes in Ghana (Department of Social Welfare, 2008). The government also supported the St. Joseph's Orphanage and Mampong Babies Home with subventions (Department of Social Welfare, 2008). In order to adhere to the UNCRC and subsequent legislation, the Care Reform Initiative (CRI) was introduced in 2007 to promote family-based care and DI (BCN and UNICEF, 2015; Hickmann et al, 2018).

Current Situation: The Care Reform Initiative

The introduction of the CRI led to the closure of 47 private children's homes in 2012 and reintegration of about 1,577 children in 2013 (Better Care Network (BCN) and UNICEF, 2015). Eighty-five (85) residential homes operating below standards were earmarked for closure, and those with good standards were licensed (Hickmann et al, 2018).

In 2013, Bethany Ghana (BCSG) and OrphanAid Africa (now OAfrica) piloted foster care programmes in Ghana (BCN and UNICEF, 2015). In addition, a moratorium was issued on 20th May, 2013, to suspend domestic and intercountry adoptions, and the Hague Convention was ratified by Ghana in 2016 (Hickmann, Adams and Ghana Country Core Team, 2018). In 2018, a Foster Services Unit and a Residential Care Unit was established by DSW to regulate the operation of foster care and residential care in Ghana. These are to facilitate the promotion and implementation of family-based care in Ghana.

Laws, Policies, and Guidelines

The care of children and protection of their rights have been enshrined in the 1992 constitution of Ghana (Article 28). Pursuance to these constitutional provisions, the Government of Ghana has formulated several legislations to safeguard the protection and care of children. These include the Children’s Act, 1998 (560) and The Children’s Amendment Act 2016, (937). The Children’s Act was amended in 2016 to make further provisions for matters relating to foster care and adoption. The Children’s Amendment Act, 2016 (937) outlines the various procedures for fostering and adoption in sections 62, 66, 79, and 81. The provisions on foster care and adoptions have been translated into legal instruments: Foster Care Regulation (L. I. 2361) and Adoptions Regulations (L. I. 2360).

Aside the legislations, The Child and Family Welfare Policy (2014) provides guidance for the prevention of unnecessary institutionalisation of children and protection of children in families. The policy stipulates removal of the child from the family—under a Care Order—should be a last resort, and the next option to the child’s family should be within the child’s community. In the best interests of the child, exceptions can be made where the community poses a threat to the child.

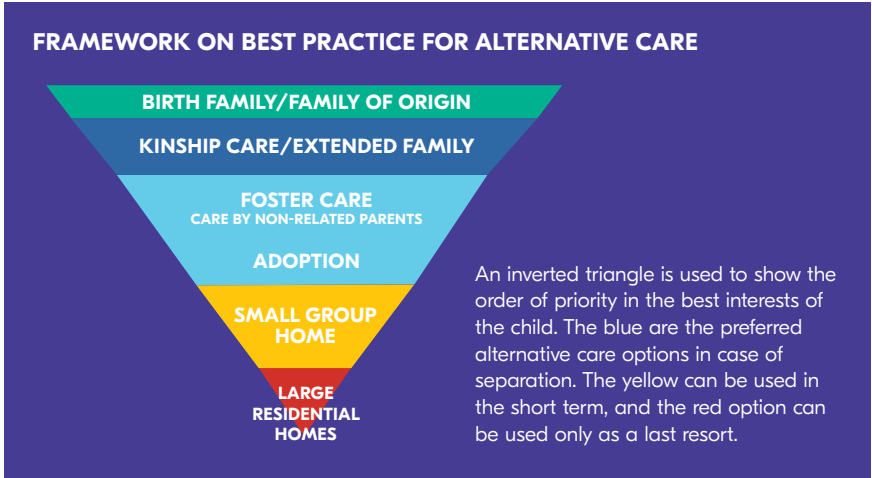
Further, several guidelines to the implementation of CRI have been published by the Department of Social Welfare with its development partners. These include:

- Foster Care Operational Manual, 2018
- Foster Parent Training Manual, 2018
- Case Management Standard Operating Procedures for Children in Need of Care and Protection, 2018
- Manual for Routine Monitoring of Alternative Care Systems in Ghana, 2019

Collectively, these laws, policies, and guidelines are expected to strengthen existing systems and guide practice. It is also expected to help deinstitutionalise children and make family-based care the main alternative care option in Ghana.

Framework on Best Practice for Alternative Care

Figure 1: Continuum of Care (Faith to Action Initiative, 2015)



We seek to incorporate the continuum of care in the determination of children’s best interests. This helps to ensure children are provided with a nurturing environment to thrive with love, care, and protection.

A continuum of care depicts care options made available for children who have been separated from their families due to loss of love, care, and protection. An inverted triangle is used to show the order of priority for permanency and the best interests of the child, with remaining with birth family when it is safe at the top (in green). Adoption and foster care (alternative family options) are placed in the same row because, during DI, children from the RHC may be placed in either adoption or foster care, based on their best interests. Foster care is a temporary home for children where decisions about their long-term permanence is being made, be that reunification with birth or extended family or adoption. The blue shows the care solution that is in the best interests of a child, should there be separation. The yellow shows short-term residential small group homes,

which should be considered with caution when the former is unavailable. The red shows large-scale institutional care, which should be a last option as it cannot provide an environment conducive for children to thrive.

Empowerment and strengthening of families of origin to care for their children is the best way to serve vulnerable children in any community. This is because attachment connections should be maintained to prevent children from suffering the trauma of separation. Several factors, including economic and social issues, account for the separation of families globally. Thus, strengthening the capacities of families through livelihood support programmes, such as small-scale businesses and income-generating activities alongside education, can help families in need to provide the care and love needed by their children. This will help in reunifying children with birth families or extended family members. Reunifying separated children and ensuring families have the capacity to provide care is essential to prevent the return to an institution. There is a need to prioritise reconnecting children who have been separated from their birth families to live with them once again. Living too long outside the family is counterproductive to their social and psychological health and development. This can be made feasible when factors bringing about the separation are dealt with.

Why Family-Based Care?

Family-based care is essential to holistic child development. Children have the right to a family, survival, and development. These can be hindered when a child is in an institutional setting. Children need the attachment to a consistent adult caregiver to thrive. Though institutions can provide temporary care for children at risk or in need, long-term institutionalised care is not considered conducive to or in the best interests of children for the following reasons:

- In an institutional setting where caregivers are usually responsible for many children at one time, one-on-one personal, connected care may be hindered (UNICEF Ghana and DSW, 2018). The workload on the caregivers does not permit them to provide the needed care for the children. When children do not have one-on-one care from a primary caregiver, they do not develop secure attachment, and they lack the ability to develop trust, self-esteem, and healthy relationships (Purvis, Cross and Sunshine, 2007). This leads to challenges in relationships throughout their lives, mental illness, and behavioural challenges.
- Children's developing brains need connection with a primary caregiver constantly to grow and develop normally (Purvis, Cross and Sunshine, 2007). This caregiver provides the environment and connection for children's physical, emotional, cognitive, and social development. When children are in an institution, they develop delays in all areas of development due to the lack of a one-on-one caregiver.
- Limited resources lead to basic facilities often being below acceptable standards.
- Institutional facilities are mostly isolated from the community, limiting children's community participation opportunities. Some children in an institution therefore grieve over the loss of their biological family, social norms, culture, community, etc., which can lead to identity challenges.
- Children in an institution could be at higher risk of emotional, physical, and sexual abuse, as they may not have a one-on-one caregiver who can protect them from harm.
- Some children face stigma from the community due to their status as orphans, which can be a barrier to social connections as an adult.
- The role of institutions is to provide temporal support for children in times of emergency. It is an interim measure to be used in the shortest possible time.

There is still hope for these children. If we cannot prevent children from entering an institution by preserving their biological family, we can reunify these children with their birth families and support them to provide for the needs of the children. Also, we can place them in an alternative family that is trained to support their needs following the loss they have experienced. Children can thrive with the right care.

PART II:

PROCESS OF TRANSITION TO FAMILY-BASED CARE

Introduction to Change

Organisational change can be implemented either from the planned change approach or emergent change approach. Planned change is a gradual and incremental approach, which applies to a more stable organisational environment (Burnes, 2004). Here, change is well thought out and organised before implemented. On the other hand, the emergent change approach is flexible, quick, and suitable for unstable organisational environments (Burnes, 2014). For the purpose of DI, a planned change approach would be recommended.

The process for DI change can be classified into 4 major steps:

STEP 1: Sensitisation and change communication

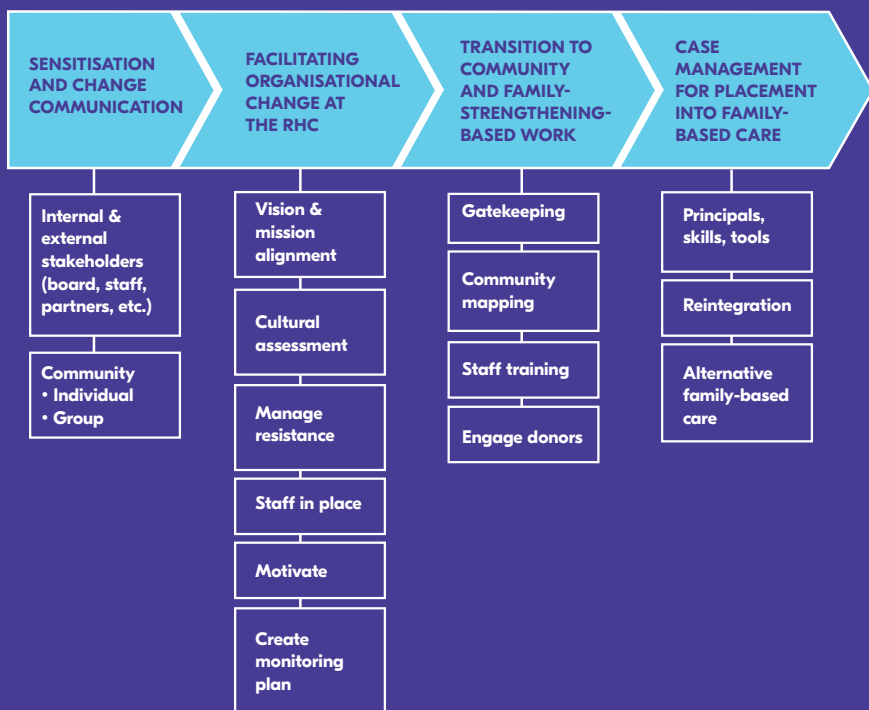
STEP 2: Facilitating organisational change at the RHC

STEP 3: Transition to community and family-strengthening-based work

STEP 4: Case management for placement into family-based care

Figure 2: Steps in the Process of DI

These steps are illustrated in detail throughout this model.



Consider assessing your thoughts and emotions on DI with this activity.

Activity 1: Growth Zones

Purpose: To identify your areas of growth in relation to DI

ITEMS NEEDED: Pen/pencil and a plain sheet of paper

INSTRUCTIONS: Draw three concentric circles on a sheet of paper as shown in Figure 3 (page 17) to represent three zones. Your circles should be spacious enough to allow writing within.

IDENTIFYING YOUR COMFORT ZONE

Ask yourself, What am I comfortable doing in the way I care for children?

Now write your answers in the innermost circle (Zone 1). This is called your Comfort Zone.

IDENTIFYING YOUR PANIC ZONE

Ask yourself, What am I afraid of when considering changing to family-based care?

Now write your answers in the second inner circle (Zone 2). This is called your Panic Zone.

IDENTIFY YOUR GROWTH OR STRETCH ZONE

Ask yourself these questions:

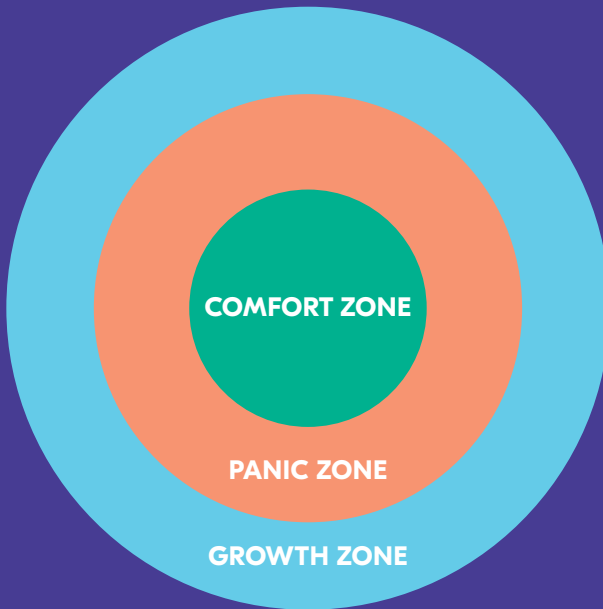
What am I ready to let go?

What am I interested in seeing?

What do I like about family-based care?

Now write your answers in the outer circle (Zone 3). This is called your Growth or Stretch Zone.

Figure 3: Three Growth Zones



NARRATION: You are to recognise that, as you attempt the process of DI, you may be coming from a place of comfort in your service provision—in your values and methods of caring for children. You should commit to approaching DI from a place of growth and learning, while acknowledging when a step could take you too far into panic. You should also acknowledge that your growth area and pace of change may not be the same as the person next to you or the teams you will be working with. To successfully change, you should be open to helping your team through growth not through panic. When you are in panic, you cannot grow. Your mind will not learn, and change will meet resistance.

REFLECTION QUESTION: How can I take the step towards change without panicking or creating panic for others?

Now that you are aware of your growth zone, you can begin to walk through the process of change. You are free to pause and speak to others for support if anything ignites your fears.

STEP 1: SENSITISATION AND CHANGE COMMUNICATION

Since actors in your RHC and community may not understand DI, sensitisation and change communication is essential to the process of DI. Your first step is to engage your community and stakeholders like staff, board members, future collaborative partners in community-based services (e.g., schools and hospitals), donors, etc., in DI.

Communicating Change to Stakeholders

For DI to be successful in any organisation that currently provides residential care, internal and external stakeholders must embrace a new and more in-depth understanding of the best interests of children and recommended provision of care. This will enable an understanding of the importance of DI.

Your internal stakeholders are those working directly in the RHC, like the organisation's board, management, and all staff. Your external stakeholders are those working indirectly with the RHC, such as donors, Social Welfare Officers (SWO), police, and future collaborative partners in community-based services.

STEPS TO COMMUNICATING CHANGE IN THE INSTITUTIONS:

1. Identify and provide training to and share DI concept with key influential persons in the institution (see annex 1a on page 52 for how to identify an influential person).
2. Identify internal and external stakeholders of the institution with the help of the key influential persons.
3. Organise a DI concept meeting (spearheaded by your RHC's management) with internal stakeholders of the institution (see annex 6 on page 63 for outline of internal DI concept meeting).
4. Organise a DI concept meeting (spearheaded by your RHC's management) with external stakeholders of the institution (see annex 8 on page 65 for outline of external stakeholders' DI concept meeting).

Communicating Change in the RHC's Community

Your RHC's community perception and values should be aligned with DI. The chief community elders and opinion leaders must be engaged and should fully support the rationale behind family-based care. Groups within the community and faith-based organisations must accept DI. Certain cultural beliefs and practices should be addressed or reaffirmed and encouraged. For example, there should be efforts aimed at encouraging and supporting the extended family members to readily accept children from their deceased members to take care of them as their own. Misconceptions such as a child is better off in RHC than at home with the family should be changed. Change must be facilitated at the individual or group level in the community.

ADDRESSING CHANGE AT THE INDIVIDUAL LEVEL

1. Identify and share DI concept with key influential community members (see annex 1b on page 53 for how to identify an influential person).
2. Identify key influential stakeholders with the help of key influential persons.
3. Organise a DI concept meeting with stakeholders within the community. This could be individual-level meetings or group meetings (see annex 2 on page 54 for outline of individual-level presentation).

ADDRESSING CHANGE AT THE GROUP LEVEL

1. Identify resources and channels for community-level sensitisation with the help of key stakeholders in the community (see annex 3 on page 55 for list of resources and channels).
2. Empower community stakeholders to organise community group sensitisation meetings (recommended approach). However, you should be sensitive to what works for your community (see annex 4 on page 56 for outline for community-level presentation).

STEP 2: FACILITATING ORGANISATIONAL CHANGE AT THE RHC

Kurt Lewin's change model can be applied in facilitating organisational change at the RHC. According to Burnes (2004), Kurt Lewin's model involves three progressive stages. First is the unfreezing stage where people do things based on their beliefs and norms and do not accept change easily. Unfreezing requires changing existing beliefs and norms. The second stage is the changing stage, which involves the implementation of new ideas. Finally, there is a freezing stage where you would have incorporated the new ideas into your values. You may return to your initial beliefs and values only if the first two stages are not done properly. Based on this model, the following is recommended for organisational change at the RHC.

UNFREEZING STAGE

Vision and Mission Realignment:

Beyond a doubt, as an established RHC you have a vision and mission that you have worked diligently to materialise. Therefore, at the unfreezing stage, the outcome of the DI model and its advantages over the existing model should be understood and communicated clearly to the understanding of your team in the RHC. The outcomes of DI should be feasible and attainable. It is then that you and your team will be willing to realign your vision and mission with that of the DI model.

THINGS TO DO AT THE UNFREEZING STAGE:

1. Explore the vision and mission that your establishment has been working with over the years.
2. Identify and isolate the key action points of the vision and mission.
3. Help the stakeholders in your RHC to explore how the DI process/project will affect the current vision and mission.

4. Explain to your stakeholders the concept of force-field analysis (see annex 10 on page 67 for force-field analysis tool).
5. Help them to do appreciative inquiry (see annex 11) and community resource mapping (see annex 12 on page 69 for community mapping tools).
6. Start the process of building a new vision and mission based on the resources they have identified and the DI paradigm.
7. Develop new objectives and action points, with timelines, from your new vision and mission.
8. Explore ways of communicating the new vision and mission with all stakeholders.

Organisational Cultural Assessment:

A cultural assessment will help you understand what is workable versus unrealistic for DI in your organisation. It will help you know the internal forces to be changed and those to be sustained for a successful DI implementation. According to Reh (2019), in understanding the culture of an organization, some specific questions must be asked, and the following questions have been developed from his ideas:

1. How are tasks assigned in my organisation?
2. What are the values of my organisation?
3. What is the greatest achievement of my organisation?
4. What are my organisation's areas of failure?
5. How is the work environment in my organisation?
6. How are activities carried out in my organisation?
7. Does my organisation believe in teamwork?

Having answered all the above questions, develop a strategy with your stakeholders for changing/modifying your current organisational culture to suit the new direction. Moving forward, you can start implementing your new vision and mission (change) gradually.

CHANGING STAGE

At this stage, your RHC is transitioning, and resistance is likely to arise. Step 3 details the transitions process, so the focus shall be on managing resistance and involving the right staff to make DI successful.

How to Work with Resistance to Change:

People naturally resist change. They do so because change brings uncertainty (the fear of the unknown) and loss (love for what already seems to be working) (Kotter and Schlesinger, 1989). So, in principle, if there is no fear of the unknown, and DI is seen as tried and true—proven to be sustainable—change can be made easier. The changing stage can be made possible if the unfreezing stage is done successfully.

THE FOLLOWING CAN SERVE AS A GUIDE TO MANAGING RESISTANCE TO DI:

- Identify who and what will resist the DI project.
- Identify how and why they will resist it.
- Meet with those “powerful power brokers” and understand their fears. (These are those who are directly benefiting from the old models of your RHC and whose pride and livelihood will be affected by the new model DI).
- Paint a positive and evidence-based picture of life after DI implementation.
- Explore their potential and how it will be rewarded by the new model.
- Categorise the rewards of DI into immediate, short term, medium term, and long term, as illustrated in Table 1 (page 23).
- Help them to see and begin to benefit from the positive results immediately.
- Develop an open-door policy (so those who cannot take the change can exit).

NB: For better understanding on how to manage change, watch Kotter & Schlesinger - Six Methods of Overcoming Resistance to Change on YouTube via this link <https://youtu.be/q9FbCsVe5So>.

Table 1: Goals of DI

Immediate Reward (within six months)	Short-Term Rewards (within a year)	Medium-Term Rewards (within 2–5 years)	Long-Term Rewards (5+ years)
Reduction in cost of maintenance and utility	Manageable caseloads and improvement in service delivery and provision of care Improvement in child growth and development	RHC-community bond growing stronger as essential community services are delivered	More children retained in families Reduction in the effects of institutionalisation (example: children learn and retain their lost culture)

Staffing Needed in Place (Hire a Social Worker):

Professionals in their respective areas must be engaged to improve services in your RHC as you implement DI. Most importantly, there should be at least a qualified social worker who functions as case manager in your RHC (UNICEF and DSW, 2017). If your RHC cannot afford professional services, it is recommended that able caregivers undergo basic training to support part-time professional staff. For example, Hickmann et al (2018) suggest basic physiotherapy and psychosocial training for caregivers to improve standards in RHC where professionals cannot be employed. Such trainings may be comprised of child development, attachment, caregiving, nutrition, and behaviour management (Bethany Christian Services can be contacted for staff trainings). Part-time professional staff may include a psychologist, physiotherapist, and social worker (refer to Staff Training in Step 3 and Children’s Case Management in Step 4 for details).

FREEZING STAGE

At this stage you may have implemented the change successfully and a new childcare model (which is family- or community-based) is being operated. There is a tendency for your RHC to resort to its old organisational culture if the motivation that was given at the initial stage of change is ceased. Hence, your change mechanisms should be reinforced (thus freezing). Motivation, monitoring, evaluation, and learning are recommended at this stage.

Motivation:

In order not to drift, you may need motivation for staff to cope and adapt to the new childcare model. However, you should be informed of the possible challenges that may come with the DI plan. It might not work 100%.

THE FOLLOWING ARE SOME OF THE WAYS TO MOTIVATE YOUR TEAM:

- Have a flexible DI plan.
- Make known the benefits of your new childcare model.
- Involve key stakeholders from your RHC in planning the DI and new childcare model.
- Align the objectives of your RHC with that of the new childcare model.

Monitoring and Evaluation:

The progress of DI and your new childcare program should be monitored to ensure your RHC has really stuck to the implemented change. The outcomes of your activities should be monitored monthly. To effectively monitor and evaluate DI, you need to be taking records of your outputs as demonstrated in Table 2 (page 25).

The data you have recorded can be evaluated to know the extent to which DI has been implemented. Kindly refer to the Manual for Routine Monitoring of the Alternative Care System in Ghana (Measure Evaluation, 2019) for further details on monitoring (see annex 13 on page 72 for report tools).

When your new values and mission have been embraced and organisational structures have been configured for DI, your transition can begin.

Table 2: Example of Simple Plan for Monitoring DI

Outputs	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of child assessments completed												
# of families successfully traced												
# of family assessments completed												
# of families prepared for reunification												
# of children prepared for reunification												
# of children reunified with their parent												
# of children recommended for foster care												
# of children placed in foster care												
# of children recommended for adoption												
# of children adopted												
# of children receiving services in families												
# of donations for family-based care												

NB: # means number

STEP 3: TRANSITIONING TO COMMUNITY- AND FAMILY-STRENGTHENING-BASED WORK

This is the gradual shift towards a new childcare model. This step is where DI is being implemented on the ground. You may have to cease or lower child intake to the barest minimum as you organise and shift your resources to family- and community-based services. This is known as gatekeeping.

Gatekeeping

While your RHC is working to transition service provision and focus on reunification or moving children into alternative families, they cannot continue to take in children. New admission may lead to service provision and staff being overstretched. It is important that once the decision is made to transition services, your RHC carefully places measures to manage services well. Gatekeeping means establishing mechanisms and systems in your RHC to prevent unnecessary institutionalisation of children.

Per the principles of necessity and suitability, grounded on laws and policies locally and internationally, institutionalisation should be a last resort. Necessity means verifying if institutionalisation or any form of alternative care is needed by considering first the possibility of supporting birth families to look after children themselves (Family for Every Child, 2015). Suitability is to ensure that, should a child enter alternative care, an appropriate option is chosen in the best interests of the child (Family for Every Child, 2015). Thus:

Firstly, a child should not be separated from the family except if there is a critical condition that poses a significant threat to the child's life or survival and development.

Institutionalisation should only be a last (and temporal) resort after all family-based care options have failed.

TO IMPLEMENT THESE PRINCIPLES, THE FOLLOWING ARE RECOMMENDED:

- Local agreement between police, DSW, and private care providers should be established to guide the process for referral and placement of a child in times of crisis.
- Temporary placement in an alternative, family-based care setting (e.g., kinship or foster care) should be the identified first option.
- There should be proof of failed attempts to place a child in temporary, family-based care before a child is admitted into your RHC.
- Unless in emergency, children without police extract should not be admitted. Emergencies are crisis or life-threatening situations such as accidents, natural disasters, and an attempt to murder or harm a child, which offer little or no time to follow the formal processes of placing a child.
- Unless in emergency, children without a Social Investigation Report should not be admitted. A police officer or SWO should sign an undertaking to provide a care order, as required by law, during emergency admissions.
- During admission, the child should be accompanied by a relative or a guardian who can prove his identity (if applicable). In an emergency where last resort admittance is accepted, an agreement on the length of the stay should be required. An established timeframe for care planning for transfer to temporary, family-based alternative care placement should also be established. This should not exceed 6 months (refer to National Standard for Residential Homes for Children, 2017).
- Clear delineation of responsibility should be established between DSW, care provider, and police authorities to ensure progress toward approved temporary, family-based placement or reunification.

The internal culture of your RHC should be adjusted to make reunification easier. The level of care and type of care (e.g., sweet treats, expensive gifts, pampering) should be aligned with normal community standards, and the incorporation of cultures more reflective of the local community should be considered—for example, considering moving towards a traditional home care model by eating traditional meals, speaking traditional language, teaching children to perform household chores, etc. Thus, not lowering the standard but changing the type of provision.

Realignment of Your Services to be Community Based

Internal RHC Assessment

Realigning your services to be community based begins with an understanding of your RHC. A self-assessment will give you an understanding of your RHC's status and the possibilities for DI. It is essential to know the status of: the children in your RHC and their families; your infrastructure and physical environment; your staff; the community and government regulations; etc. (See annex 21 on page 88 for RHC self-assessment questionnaire.)

Community Mapping

As part of the process of change, it is necessary to go through a process of community mapping. Understanding the community in your surroundings, identifying the key causes that historically bring children to your RHC, and identifying community assets will allow you to realign your service provision. Since the goal is to DI, then services in the community must align to ensure families are supported to care for their children in the community. The process of community mapping will give your organisation full information on services that are already in place and the gaps which lead to children coming to your RHC. You can determine from this exercise a few things:

1. What are the gaps that lead children to come into my organisation? What services can my organisation provide to strengthen and support families in the community?
2. Who are the partners in the community that I should engage with to ensure service provision is well integrated? (See annex 12 on page 69 for community mapping tool.)

What About the Physical Infrastructure?

Realigning RHC services will be determined by the gaps identified in the community. As you better understand what causes children to come to your RHC and the current preventive services, you will be determining the new direction for your service provision. There are several services you could provide with existing facilities in your RHC based on the needs of your community.

YOUR NEW COMMUNITY-BASED PROGRAMME COULD BE:

A Daycare Centre: Daycare centres provide services to children whose parents may not be available during the day. Thus, the facility will provide care for children during the day only. The children go home when their parents return.

A Community Day School: Community schools can provide quality education to children in the community. Day schools are recommended for DI because children can go back to their families every day, making it less expensive than boarding schools.

Child Recreational Centres/Playgrounds: Children can learn other skills and get entertained at child recreational centres. Skills like music, arts and crafts, acrobatics, swimming, karate, and other sports can improve the welfare of children and community experience.

Community Child Healthcare Centres: This can provide for the basic health care needs of children in communities without health facilities.

Family and Child Support Centres: These can provide different therapeutic and counselling support (e.g., parental coaching, marital counselling) for families and children in the community.

Community Event Centre: Provides venue for events within the community.

Children's Library: Can provide access to educational materials, including computer and internet. Children can be assisted with extra tuition and homework at the library.

Staff Training/Capacity Building

DI does not mean caregivers and other staff are no longer needed. The services of staff will be needed during and after DI. For example, caregivers can be trained to foster children or coach parents in communities. For your staff to embrace the concept of DI, understand your decision to change, and be motivated to care differently, it is advised that you provide training in the following areas:

- Children's rights
- Children's developmental needs
- Parenting and attachment
- Grief, loss, and trauma
- Training on case management in social work
- Best practice care in an institutional setting
 - Nutrition and health care
 - Developmental needs throughout childhood
 - Psychosocial needs and support to the children
 - Discipline
 - Identifying abuse and appropriate reporting mechanisms
 - The importance of keeping written confidential case records
 - How to assess children's needs

This training will ensure staff understand what children need and how care provision should be aligned to meet children's needs. Staff should be fully engaged and should support your service realignment with the right information, training, and consultation.

HOW TO ORGANISE INTERNAL STAFF TRAINING

- Mobilisation for training: Invite the trainers (bringing in experts) to train staff in your RHC, or find a central point for a couple of RHC within a close distance for joint training (**Bethany can be consulted for staff trainings**). Logistics needed for training must be provided on time (see annex 14 on page 72 for list of logistics).
- You may organise staff training on weekdays when the children are in school.
- Post-training issues: Have a follow-up plan to ensure staff engagement with new knowledge acquired.
- Provide support, including work logistics for best practices. Provide a forum for discussion and practice implementation review.
- Monitor and evaluate the implementation of best practice.

Engaging Donors for Community Services and Family Strengthening

For a successful transition, you need funds for the new activities, services, and case management. This is why you have to sensitise your donors on DI. To get funding and support from your donors, the following is recommended:

Segment and map donors with empathy for DI: From your list of donors, identify who you can talk to for funding to deinstitutionalise and operate a family-based care programme. You have to know what your donors want—their interests, motivation, and desires are important.

Identify and share your most potent stories of family reunification or family-based care.

Build your donor communication plan. You must know:

- Who you are approaching for donations.
- What message you are going to give them. Donors must have trust in your RHC or community, based on accountability and transparency. Inform them about accountability measures you have put in place. This includes receipt books and feedback from beneficiaries, timely programme reports, and external audit reports. This can also motivate them on their giving.
- Where you will be delivering the message (online, phone, physical meetings/events, email).
- How you will deliver the message (letters, flyers, videos, etc.). (See annex 7 on page 64 for donor sensitisation.)
- When you will deliver the message (monthly, quarterly, weekly, etc.).

Change your fundraising ask and calls-to-action: To transition donors for DI, have a call to action or ask phrase. This should make donors know that financial support can be given at the community level. For example, clothing, footwear, medical supplies, etc. can be made available in the community to be forwarded to the needy families and children in the community. Hence, it is important to have a call to action that reminds donors of their role in making DI possible. Community donation centres can be established (this could be online or physical). The community donation centres should be managed by a team. The total membership of the team should be an odd number that does not exceed 7. Community members, traditional leaders (e.g., chiefs), and political leaders (e.g., assemblymen) should be duly represented in the donation centre management team. Other members could be representatives from religious leaders, community health workers, and the Civil Society Organisation (CSO).

Source: <https://resources.cafo.org/resource/transitioning-donors-5-steps-to-bring-your-supporters-on-the-journey-to-a-new-model/>



OAFRICA was founded by Lisa Lovatt-Smith in October 2002 due to her experiences of children in institutions. As part of several initiatives to help children, a shelter was established to care for children and babies with mental and physical disabilities and HIV/AIDS. The shelter was praised and hailed as a model for West Africa. Stories about the shelter were even captured in documentaries and reports of UNICEF.

However, there was a shift in this focus in 2006 as an attempt to adopt a new policy in line with the guidelines of UNICEF, the UN, and the Government of Ghana. The new policy was basically to do away with institutional care, which left children with several negative impacts, and to provide children with family-based care or have them placed with foster families. The new policy's motto was, "Every child deserves a family."

To make this a reality, OAFRICA collaborated with DSW in 2007 to implement the care reform initiative. Leading by example, OAFRICA reintegrated almost all the children living in their shelter into their biological families, except those with special needs who were placed in foster families. OAFRICA supported the government to pursue family preservation programmes. A lot more children were reached by OAFRICA. In 2008, they were able to feed about 700 children in communities each month, and 75 new children received better care from their parents who received cash transfers, counselling, and health education from OAFRICA. By 2012, about 5,000 children had benefitted from OAFRICA's programme.

STEP 4: CASE MANAGEMENT FOR PLACEMENT INTO FAMILY-BASED CARE

The final step in DI is where children will be prepared and placed in families. Placement decisions for children in RHC and reunification or alternative family-based care requires a trained and skilled workforce to ensure safe practice through supporting and empowering caregivers, while monitoring, providing supervision, and keeping to mandated reporting requirements. Regulation requirements are specific, and RHC should be aware of laws, policies, and practice manuals they are required to reference and utilise. Social workers are always required to make decisions in the best interests of the child, prioritising safety, security, wellbeing, and the child's right to participate in the decision making.

Case Management and Assessment

The Ghana, Case Management Standard Operating Procedures for Children in Need of Care and Protection (Case Management SOP) (UNICEF Ghana and DSW, 2018) outlines the principles of case management as follows:

Best interests of the child

Preference for the child to be kept with parent, guardian, or relative

Non-discrimination

Collaboration and partnership

Respect for diversity, culture, and tradition

Confidentiality

Quality assurance in case management

The Ghana Case Management SOP specifies the processes of managing cases of children in need of care and protection as:

Identification: First contact with a child in need of care and protection.

Assessment: Comprising of initial screening and comprehensive assessment of the child.

Planning: Making decisions to meet child's needs. This includes a care plan for the needs of the child whilst in care and a case plan for the overall case.

Implementation of case plan: Providing planned support and services to meet a child's needs.

Follow up and review: To confirm the extent to which the plan has been achieved and make amendments if necessary.

Closure: Termination plan after all goals have been achieved.

For the purpose of DI, the above process is recommended for all children entering (in case of emergency, since new admissions are being discouraged under DI), living in, or exiting your RHC. Refer to the National Standards for Residential Homes for Children in Ghana, section 2 (UNICEF Ghana and DSW, 2017, p. 17) for case management of children in RHC. Based on the national standards cited above, it is recommended that any RHC implementing DI in collaboration with their District SWO should:

- Limit admission of new children as much as possible. However, assuming there is a new admission, the care and case plans should be developed within 4 weeks. A care plan focuses on interventions for the child whilst in care, and the case plan is a holistic plan to resolve the case.
- Review all child cases to ensure proper care plans and case plans, with steps for reunification in place. This review should be repeated every 6 months.
- Provide support services to the child and family as planned.
- Refer children who cannot be reunified immediately to their district SWO for foster care placement or adoption to prevent long-term institutionalisation.

Case Management Tools

The Ghanaian Case Management SOP provides tools for each of the steps in the case management process. The tools have been outlined in Table 3 below.

Table 3: Case Management Tools

No.	Case Management Process		Tools
1.	Identification		Case Registration Form [SOP Form #1]
2.	Assessment	Initial Screening	Initial Screening (Safety Assessment) [SOP Form #2] Social Enquiry Report [SOP Form #4]
		Comprehensive Assessment	Comprehensive Assessment Form [SOP Form #3] Child Background Assessment [annex 16,17] * Health Assessment Tool [annex 19] * Bio Psychosocial Assessment Tool [annex 18] *
3.	Planning	Case Plan	Case Plan [SOP Form #5]
		Care Plan	Care Plan Template—Alternative Care [SOP Form #6]
4.	Implementation		Case Management Notes [SOP Form #8] Case Conference Form [SOP Form #9] Search Process Evidence [annex 15] * Reunification Certificate [SOP Form #13] Case Files Checklist [SOP Form #14]
5.	Follow up and Review		Care Plan Review Template [SOP Form #7] Case Conference Form [SOP Form #9] Referral Form [SOP Form #10] Case Files Checklist [SOP Form #14]
6.	Closure		Case Closure Form [SOP Form #12] Case Files Checklist [SOP Form #14]
7.	Other forms		Welcome of the Child to The Family Form Confidentiality Agreement Form

NB * additional DI model recommended tools for assessment

NB: For access and details on how to use these tools, kindly refer to the Case Management Standard Operating Procedures for Children in Need of Care and Protection (UNICEF Ghana and DSW, 2018), or visit: <https://bettercarenetwork.org/sites/default/files/Child%20Protection%20Case%20Management%20SOPs%20e-copy.pdf>

In order to effectively work toward a child's best interests, social workers in RHC must be adequately trained on the above case management process, principles, and skills. Essential training for DI includes skills in interview with children, caregivers, and birth family, and skills in conducting assessment. You can identify a government or private agency within your jurisdiction for this training.

Case Management Process for Reintegration

FAMILY

I. FAMILY TRACING: Information gathering → Exploration → Family contact

Tracing is the process of searching for family members—primary legal or customary caregivers of the child. The primary aspiration of tracing is to achieve a long-term solution for the child's protection and care. Tracing attends to opportunities that can help towards reestablishing contact or reuniting the separated child with their families in the child's best interests. Tracing can also be used when referring to a child being searched for by their parents—a missing child (Save the Children International -FTR, 2017, p. 20).

TRACING INVOLVES THE FOLLOWING ACTIVITIES:

Information gathering on the child: Basic among all, information can be obtained from the SER on the child in the RHC. Additionally, the social worker should interview the child and caregiver to revise information in the SER (see annex 16 and 17 on pages 74-78). Supplementary information on the child can be obtained from essential agencies like police, hospitals, schools, and other NGOs in the case of referral and radio stations.

Exploration: It is not assured or certain that a family can be located after the first search. It is therefore advised that subsequent quests are organised until family is found.

Family contact: Observe the community's cultural dispositions as a guide in order to be accepted and welcomed by the family. Social workers need to be tactical in making their mission known to the family with professional practice and ethics in deliberation. The search ends with confirmation of the child's family.

2. FAMILY ASSESSMENT: Home visit/interview family →

Determine suitable caregiver

When the family tracing is successful, there is the need to pay a number of visits to the family to assess them. We recommend a comprehensive assessment for the purpose of reunification. This will help determine who is willing and has the capacity within the extended family to be the primary caregiver of the child.

FAMILY ASSESSMENT INCLUDES THE FOLLOWING ACTIVITIES:

Home visit: Families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system (Kerr, 2000). Home visits can be done to meet family members. This is an opportunity to learn about the family systems. It will give detailed information about the background of the child from the family's perspective, as well as inform on who among the family is the ideal or appropriate caregiver for the child. Three to four visits to the family are recommended to gather enough information to make a comprehensive assessment to inform decision making (BCSG or DSW can be consulted for a standard home study guide).

Interview family: Home visits and interviews are intertwined. Interviewing family members will help the social worker understand family relations in order to get an appropriate plan for the child. Social workers are to use interviewing skills to understand and assess family motivation, dynamics, and ability to care.

Determine suitable caregiver: To avoid incidence of a child wanting to be removed from the family after reunification, certain key factors need to be considered. According to Save The Children International-FTR (2017, p. 23), the following questions can be useful in determining the suitable caregiver for the child:

- Is the primary caregiver willing to be reunified with the child?
- How accurate is the information provided by the child compared with that of the adult primary caregiver?
- Would additional verification actions be required?
- Can the socio-economic circumstances of the family support successful reunification?
- Are there child protection concerns for the child in the family?
- Are there (CP) concerns for any other children in the family that may affect the reunified child?
- What needs to be done to strengthen family circumstances to accommodate the child?

- Is the family fully prepared to reintegrate the child as she/he is now (e.g., a child separated at eight years old but is now a teenager)?
- Does the family, or certain family members, need mediation or additional psychosocial support (or professional mental health support) in preparation for physical reunification?
- Are there likely to be any adverse effects on the child, family, and other children as a result of reunification?
- What can we do to mitigate these adverse effects?
- Are these so severe that reunification should not go ahead, and have alternative options have been explored?

3. FAMILY PREPARATION: Training → Economic support → Reunification therapy

To have a successful reunification, the family would have to be prepared to be able to receive the child coming into care. Usually when there has been a break in care, coming back is challenging for both child and family. To make it possible, reunification should be systematic. The process is challenging due to the expectations and willingness of both child and family to change.

FAMILY PREPARATION INCLUDES THE FOLLOWING ACTIVITIES:

Training: Parents need to know about the concept of attachment (the significance of their relationship to their child's wellbeing), how trauma affects the child's brain development, and discipline. They should be educated about the impact of separation from birth family and exposure to the traditions and formalities of RHC, which can cause trauma—placing children into a place of fear and insecurity. The family will need to prepare for all the things that have gone wrong in the child's life, which will translate into his behaviour, and learn how to parent differently to meet their child's needs moving forward.

Economic support: In some family situations, the assessment process will identify that in order to reunify successfully, some short-term support is needed for the family to have access to food, education, and appropriate health care. The other thing to consider could be vocational training so that caregivers are empowered to provide sustainable, appropriate care to the returning children. Economic support is ideal when the separation was due to lack of basic needs.

Reunification therapy: Where more complex reasons other than the lack of finances (such as abuse, mental health challenges, and neglect) are reasons for separation, reunification therapy is considered to support the family in receiving the child. Children, when they are reunited from

RHC, find everything wrong with their birth families by coming up with stories and scenarios that justify why they cannot fit in their new environment. Using therapy will help change the family dynamics, establish a bond between the child and family, and create a new parenting relationship. Where reunification therapy is required, referral should be made to a clinical psychologist.

It is important to have a case plan that outlines the activities and interventions for the family as required by professional standards and Ghanaian Case Management SOP.

CHILD

1. CHILD ASSESSMENT: Identify child's needs, interests, and abilities

To get a better understanding of child's needs, social workers must refer to the comprehensive assessment report. This will focus on the diverse needs of the child as well as match him to the right caregiver within the family.

2. CHILD PREPARATION: Provide counselling → Arrange initial meeting of child with family → Arrange family visits

Preparing children is to give them the professional support and empowerment to cope with issues that will arise as a spillover of the reunification process.

PREPARING A CHILD INCLUDES THE FOLLOWING ACTIVITIES:

Provide counselling: Children in care may have traumatic experiences and behavioural or psychosocial problems which need to be worked on during reunification. The idea of reunification can worsen and trigger trauma or negative emotions. Hence, it is important to provide pre-reunification individual counselling to the child to address anger, confusion, and any lurking trauma that may manifest in a challenging behaviour as he/she moves to the family. Help the child understand and appreciate the change.

Initial meeting of child with the family: Children may have anxieties about going back home after a separation. To help alleviate feelings of anxieties, social workers are to ensure all members of the household are aware and supportive of the reunification. It is recommended that key

persons are available at the initial meeting to prevent the child from being overwhelmed with the situation. Social workers can accompany the child to the family—specifically to the caregiver for the first time, as an introduction to other family members can take place subsequently to ensure a gradual reunification. The process should not be in a rush, as that can help make bonding natural. Initial meeting can be held on a neutral ground.

Arrange family visits for the child for the beginning of attachment and bonding: At this stage, the child is already familiar with members of the family. We can start with weekend visits for the child and move to vacation/school holiday visits, which takes longer than the former. All these will help enhance the learning process of the child and of course increase affection and trust, which will in turn facilitate attachment and bonding. Averagely, three visits are recommended for a successful reintegration. However, social workers should be sensitive to the pace of the child and family.

Finalise Reunification

The decision to permanently reunify a child must be in the best interests of the child. The child's interests and views must be respected. At this stage, it is important to review all reports to ensure the needs of the child can be met in the family after reunification (see annex 20 on page 86 on what to consider for best interests determination). During family visits, social workers should note the three things that help parents/kinsmen to make reunification successful:

- The parent/kin understanding the child's needs and other behavioural problems
- Testing and identification of parenting capability and how to handle challenges at the time of visits
- Parents/kin involvement of social worker to support and connect family to available resources when needed

When both child and family have come to the point where they want to live together permanently, reunification can be finalised. At this stage, the child and family should be given final preparation.

Reintegration—Post-Reunification Monitoring

While reunification is complete at placement, reintegration is just beginning. Following the critical period of bonding and preparing to transition, the initial placement phase will be one that needs case management support.

Honeymoon: The “honeymoon” is the period after reunification where the child exhibits good behaviour in order to gain the trust of his caregiver. Mostly, children can express themselves better when they have trusted caregivers.

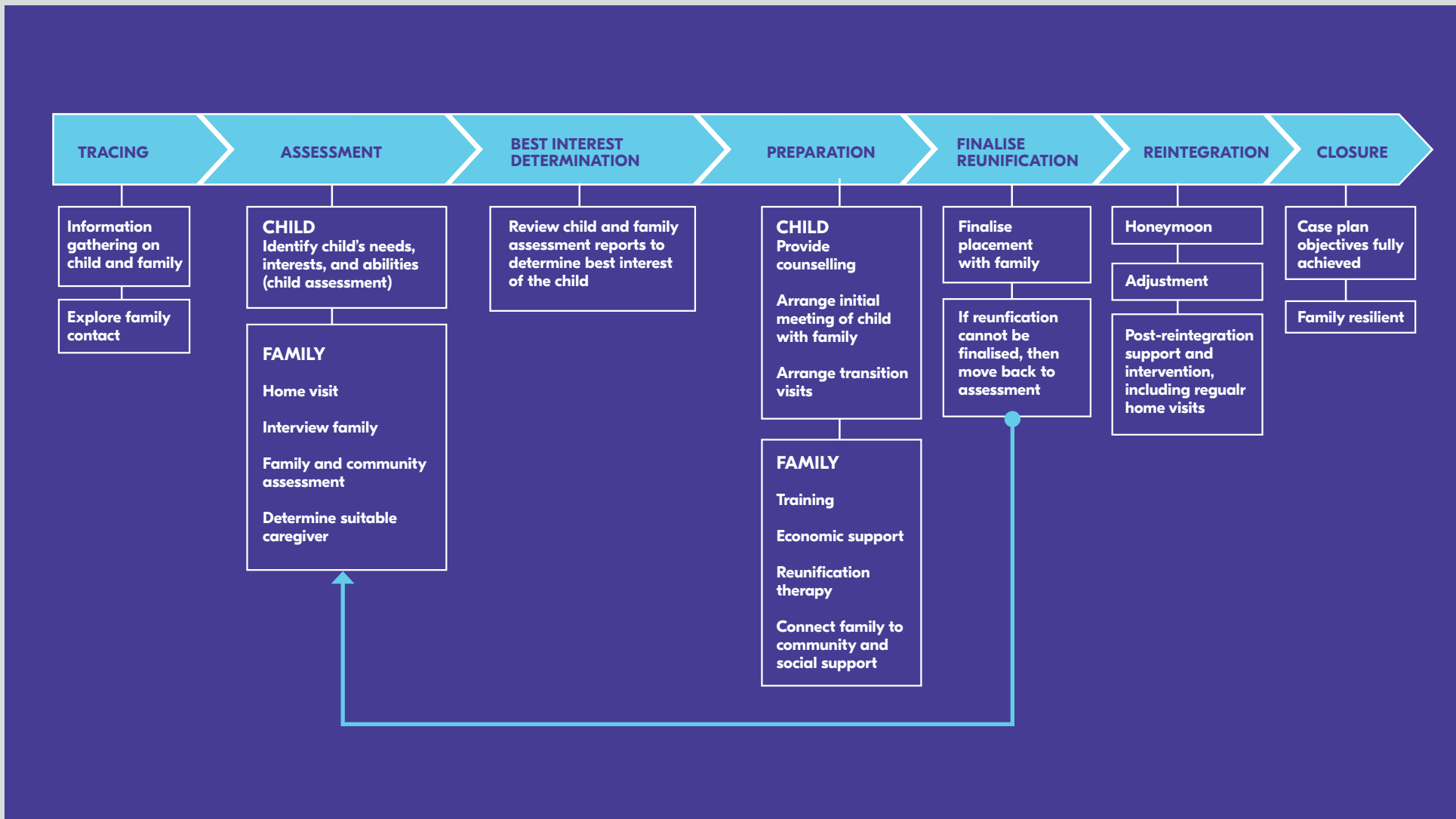
Adjustment: Though some familiarity has been established during the family visits and honeymoon, this is where reality crops up. Adjustment for both family and child after reunification can be challenging. There will therefore be the need for professional support after the “honeymoon” period to help maintain the family in equilibrium.

Post-reunification support and intervention: As the family walks through the adjustment period together, best practice recommendations would include regular visits to the home. This is a process for the social worker—who has built a professional relationship based upon trust with the child and family—to intervene and support as challenges arise. It is recommended after placement that social workers visit once every week for the first month and once every month for the next five months. This is intended to help the family manage issues that arise and eventually connect them to community resources for support in the absence of a social worker. When the family has adjusted very well after the first six months, the follow-up visits can be once each quarter. Reunification therapy, training, and economic empowerment must continue until the case plan’s objectives have been achieved.

Case Closure

Case closure begins when reintegration has succeeded, and case plan objectives have been fully achieved. If the family is resilient enough to be on their own, the social worker can close the case. At this stage, bonding has taken place and both the family and child are able to cope with any challenges that may arise. The family should be properly involved in the decision to close the case. The social worker must discuss coping strategies with the family and help them to alleviate any fears. See Figure 4 (pages 42-43) illustrating the process of reintegration.

Figure 4: Process of Reintegration



Alternative Family-Based Care (What if we cannot reunify?)

Where a child cannot be reunified with their family of origin, foster care or adoption is recommended in their best interests and for their wellbeing (refer to the continuum of care).

FOSTER CARE: “The full-time substitute and temporary care of children outside their own home by people other than their biological or adoptive parents or legal guardians” (UNICEF and DSW, 2018a p. 9).

ADOPTION: Legally placing a child in a family permanently. Thus, the parental right to the child is transferred from the biological parents to an adoptive parent by law.

Foster care and adoption should be done in collaboration with DSW and/or a Foster Care Agency. For example, Bethany can be a useful collaborator to RHC seeking to transition children into family-based care. Bethany has the resources, capacity, and experience to work with DSW to transition children in RHC into foster care or adoption successfully.

What is involved in foster care?

Trained and prepared foster parents: Willing adults who have a desire to provide for orphaned and vulnerable children are trained, assessed, and supported to provide trauma-informed parenting. Foster parents are assessed, are motivated to care, and provide safe and effective parenting.

Matching of appropriate foster parent to meet the child’s (assessed) needs: The DSW officer in your district will make recommendations for matching and forward to the regional office. Matching is solely the responsibility of the regional DSW matching committee.

Prepared transitions for the child and family: Children and families need to be adequately prepared before they can live together successfully. They should know each other and establish a bond before placement.

Appropriate support from community: This includes the understanding of community members and available and accessible community facilities like school, a hospital, and church.

Supervision of placement and support to foster child in placement: Bethany’s model includes weekly visits for the first month following placement, monthly supervision for 6 months, and quarterly visits complimented with

monthly calls afterward. The DSW Foster Care Operations Manual 2018 requires monthly visits for the first 3 months, followed by quarterly visits.

Care planning for children in care: Review of the child's needs in placement and the long-term care plan for the child through reunification or permanency planning for adoption.

(Refer to DSW Foster Care Operational Manual 2018 for more details.)

Foster care is a more temporary family placement designed to provide a temporary healing environment. Where possible, permanency for a child should be sought. Children who cannot be reunited should be considered for adoption if an assessment determines it is in their best interests.

What is involved in adoption?

Adoption provides children identity, a sense of belonging, and acceptance into a family. Since adoption is permanent, children have a life-long security in the relationship with parents and other family relatives. This gives children the foundation for life and hope for a better future. Also, it helps children to develop faster and overcome the effects of institutionalisation.

The Children's Amendment Act 937 (2016) stipulates adoption involves the following:

Child study: Social workers conduct a study to determine the adoptability of the child.

Home study: Social workers conduct a study to determine the eligibility of an applicant.

Matching: An authorised technical committee will match the child with a suitable applicant.

Pre-adoption placement: After matching, a child will be placed with the adoptive family for at least 6 months under the supervision of DSW.

Adoption: The court grants adoption, considering the pre-adoption placement report from DSW.

Post-adoption: DSW continues to monitor the family and provide necessary support for a period of 5 years.

(Refer to Adoption Regulation L.I. 2360 for more details.)

CONCLUSION

Ghana has made strides in moving towards family-based care under the Care Reform Initiative (CRI) to ensure better care for children in need of care and protection. There are new laws, policies, and procedures in place, paving the way for the implementation of change. We are at the point where change needs to occur through RHC and communities. There may be fears that RHC are being closed or collapsed by the state and other partners and that children will continue to be at risk if there is a reduction in the number of RHC available. However, this Deinstitutionalisation Practice Model has demonstrated that if realigned, the operations, facilities, and resources of RHC can be reinvested in the community, indicating that RHC can remain significantly impactful to communities by strongly supporting family-based care. This model gives a new life and hope to those with genuine investment in child welfare, with knowledge to make a change that will bring positive impact through best practice. The Deinstitutionalisation Practice Model outlines conscious efforts to be made to transition from RHC to a community service provider. DI implies organisational and behavioural change, which will ensure children's best interests through family-based care are satisfied by building stronger communities in which children will thrive.

Change may be difficult, but as a responsible party raising the next generation, you have a duty to provide care which gives children the opportunity to reach their full potential. Change is possible, with knowledge and investment in genuine collaboration with others in the community. Change requires a deep and sincere reflection, which leads to passion and energy for a new approach.

Are you ready for change? What are your thoughts and resolutions for next actions?

Bethany envisions a world where every child has a loving family.

THE STORY OF NANA*

AN EXAMPLE OF DEINSTITUTIONALISATION AND FAMILY REUNIFICATION

Nana was born to a mother with a mental health issue. When Nana was 4 years old, his mother was admitted to a psychiatric hospital for treatment and, with family members either unwilling or unable to take care of him, he was placed in an orphanage, where he lived for 2 years. During this time, his mother would sometimes escape from the psychiatric hospital and go to the orphanage to see her son. There were fears that she may abduct or harm him. The DSW made the determination in his best interests that he be placed into foster care. This is how Nana, aged 6 years old, found himself in the care of Madam Yaa, an approved foster parent under Bethany.

Yaa is a kind and caring woman. Her empathy for children who have experienced physical or emotional neglect comes from her own personal experience of this growing up. She was the first-born child to a teenage mother and was left in the care of her grandmother so her mother could return to school. Yaa had a happy and exciting childhood with her grandparents but struggled with being fatherless. Her father abandoned her while she was growing up. Nana also struggled to come to terms with being separated from his mentally ill mother at a young age, and Yaa was able to listen to and support him to come to terms with this.

*Alias names used for confidentiality.

Begin your next step towards change.
How ready are you?

Activity 2: The 17 Questions Challenge

Before you continue with the next stage, it is important you know how ready you are for DI. To do that, try responding to the following statements. You may be surprised at the result. This will also help you know where to start your DI process.

INSTRUCTIONS: Please score each statement from 1 to 5 based on your response. Add all scores together.

NO = [1] MAYBE = [3] YES = [5]

EXAMPLE QUESTION: I like to eat eggs.

You would score [1] if, no, you do not like to eat eggs, [3] you maybe likely to eat eggs, or [5] yes, you like to eat eggs.

YOUR TOTAL SCORE

Total score numbers between 17 and 45 tell you that your organisation is beginning to think about change.

Total score numbers 46 to 63 suggest you are in the middle of and getting ready for change. Therefore, your organisation needs to still communicate but has some allies that think about DI and are ready to work together with you.

Total score numbers between 64 and 85 mean you are ready to start the change.

	Statement	Score
1	I believe children develop best in a family.	
2	I believe RHC cannot fully support the development of children.	
3	I believe foster families can be found for children who do not have parents.	
4	I believe it is possible to change our model of care.	
5	I believe my organisation has the experience to improve the way we care for children.	
6	We have the leadership skills in our organisation to lead the change.	
7	I can identify in my mind one, two, or three people in my organisation that can lead the change.	
8	In my organization, we have the knowledge to assess the needs of children; we know how to do the assessments of children.	
9	We know how to assess the needs of parents and families.	
10	We know how to recruit and train foster families.	
11	We have strong experience working with young children.	
12	We have strong experience working with biological parents.	
13	We have strong experience engaging our community.	
14	We belong to a network of organisations that think like us and support us.	
15	My donors that give us funding for our program are supportive of the work we are doing now.	
16	We think our donors will support us if we make this change.	
17	We know how to find new donors if our donors do not support our change.	
	Total Score	

ANNEX

ANNEX 1: HOW TO IDENTIFY INFLUENTIAL PERSONS

A: Identifying Influential Persons in an RHC

Identify and rank your staff against the following parameter.

1 = High 2 = Moderate 3 = Low

No.	Name of Staff	Level of Authority (position)	Interpersonal Relationship	Expertise Level	Information Level on RHC	Seniority/Length of Stay	Total
1.							
2.							
3.							
4.							
5.							
6.							
7.							

B: Identifying Influential Persons in a Community

Identify and rank influential community members against the following parameter.

1 = High 2 = Moderate 3 = Low

No.	Name	Interpersonal Relationship & Public Appeal	Information Level on Community	Popularity	Audience & Reach	Total
1.						
2.						
3.						
4.						
5.						
6.						
7.						

ANNEX 2:

OUTLINE FOR INDIVIDUAL-LEVEL PRESENTATION

Introduction: Briefly introduce yourself/your organization.
(3 minutes)

Briefly explain DI concept: Begin by explaining the existing childcare practices in the community. Then explain the limitations of institutional care and the importance of transitioning into family-based care. (See appendix for sample presentation.)
(8 minutes)

Getting the buy-in of the community: Explain the role of the community to giving better care to children and the process of DI.
(4 minutes)

Ask for questions and provide answers.
(20 minutes)

ANNEX 3:

LIST OF RESOURCES AND CHANNELS FOR COMMUNITY-LEVEL SENSITISATION

Examples of Community Channels

- Durbar (for the chiefs and people)
- District assembly workshop
- Talk show by social workers
- Drama
- Jingles designed to send direct messages to the people
- Film shows
- Information vans
- Town Hall meetings
- Stakeholder group meetings (e.g., Residents Association meetings)

Examples of Community Resources

- Local languages (short sayings, proverbs, and terms) supporting DI. For example, sE agya bi wu a agya bi te ase—in Akan, meaning when a father dies another father is alive.
- Chief and elders
- Assembly members
- Religious leaders
- Identifiable (youth groups, etc.)
- Local GPRTU associations, hairdressers, dressmaker associations
- Farmers groups
- Donors in the communities
- Community health workers
- The media, including local information centers and social media platforms (e.g., WhatsApp and Facebook)
- Civil Society Organisation playing intermediary

ANNEX 4:

OUTLINE FOR COMMUNITY-LEVEL PRESENTATION

Introduction: The lead stakeholder briefly introduces himself and other key personalities present and the organisation working on the DI.
(10 minutes)

Briefly explain DI concept: Begin by explaining the existing childcare practices in the community. Then explain the limitations of institutional care and the importance of transitioning into family-based care. (See annex 5 for sample presentation.)
(15 minutes)

Getting the buy-in of the community: Invite key stakeholders to explain the role of the community in providing better care to children and the process of DI.
(10 minutes)

Ask for questions and provide answers.
(30 minutes)

ANNEX 5:

SAMPLE PRESENTATION

Community Sensitisation on Family-Based Care

Why Family?

Family is more than just sharing the same genes, genealogy, ancestry, and bloodlines. There are many definitions of family, including traditional definitions which portray a family as a two-parent, child-centred, nuclear, stage-based group of people living in the same household. There are other emerging definitions of family that are looser than the traditional definitions.

- An intimate environment “consisting of two or more people who have made a commitment to share living space, have developed close emotional ties, and share a variety of family roles and functions” (Schriver, 2001).
- From a general developmental perspective, this “intimate environment” plays a critical role in the growth of most living organisms, including human beings.

Two-Way Interaction

The effects of the interaction with caregivers profoundly affect children at multiple levels, including physical satisfaction, emotional regulations, learning to trust and forge healthy relationships, and gaining a sense of grounding and permanency.

Nature/Nurture

- The interaction of genetics (nature)
- Environmental influences (nurture)
- Professionals generally agree that the interaction of nature and nurture determines who a child will become.
- This means that a child’s development is not necessarily ensnared by genetics. The intimate environment of a family may provide the counteractive influences in the development of a child.

- We come into existence with a pre-packaged set of potentials, collected over multitudes of generations, and inherit our basic set of potentials from our parents with genes that carry the codes and blueprints that direct how we develop.
- It is estimated that 50 percent of who we are is inherited and the other half is formed through experience (Callahan, 2009).
- That second half is largely influenced through our family experience. Callahan (2009) suggests that early attachment within family experiences have the most impact because the infant brain is malleable and impressionable.

Common Functions of Families

- Families provide for the proper upbringing and socialisation of children. This includes protection from abuse, neglect, trafficking, and other problems that pose a threat to children's wellbeing. Families also provide children with stimulation, physical care, emotional care, access to health care and education, and preparation for adulthood.
- Families provide what children need to know in order to function within a culture in society by teaching and modelling basic values, morals, and social skills, such as honesty, responsibility, cooperation, compassion, trust, sharing, communication, and self-acceptance.
- Families protect, assist, and care for those members that are vulnerable or cannot care for themselves, such as children.
- Families serve as an advocate for family members in need of community resources. Through this function, parents can identify when a child is ill and can seek medical care.
- Families provide its members with legal and social identity. The family provides an identity and location for the purposes of legal transaction, especially those related to parental rights and responsibilities.
- Families provide their members with sense of intimacy and belonging including acceptance and love.
- Families provide their members with a place of privacy and respite.

A Child Has a Fundamental Right to a Family

The preamble of the United Nations Convention on the Rights of the Child (UNCRC) clearly states, "Every child has a right to a family of her/his own." This is the basis of the UNCRC. Children without a family are at risk of

neglect and abuse. As much as we strive to create “family-like” care with orphanages and large group homes, nothing can constitute a family except a family itself. Family allows children the optimal opportunity to learn and to grow. When a child does not have a strong attachment, the child is left unprotected and vulnerable.

This fundamental right of a child to a family is foundational to the child’s ability to leverage all that makes us fully human, which includes social and interpersonal intelligence, emotional fortitude, cognitive aptitude, spiritual development and formation, and even survival itself.

In the words of Goodman, the long-lasting impact of family comes out with a striking resonance: “Parents remain our touchstones, fellow travellers, even after death. They are both missing and present. So, when I succeed, I glance sideways and see a snapshot of how my father handled successes: with wry pleasure and a strong sense of the capriciousness of life. When I fail, I would glance sideways and remember how he handled failure: with grit and perspective. He got up, put on his tie, and went back to work” (Ellen Goodman, *Boston Globe*, June 20, 1999).

The Need

In today’s world, there are multiple factors that are threatening to disintegrate families and cause children to be out of parental care. Poverty, chronic illness, displacement, natural disasters, etc., are a few among the causes that are presenting a challenge to parents, forcing them to abandon their parental roles and responsibilities.

When children are out of parental care, it is often the case that they get admitted in residential childcare facilities, including orphanages, group homes, children’s homes, etc., where there is a lack of close and personal relationship with one adult. The lack of nurturing and protection threatens a child’s normal developmental process. Institutions do not offer the care and nurturing family environments offer and therefore deprive children of the basic elements that contribute to their character development. The risk of abuse and neglect is also more prevalent in such settings where children’s needs are

not consistently met by responsive and available adults. Children who have spent a considerable amount of their childhood time in institutions and age-out of the system are at a higher risk of developing mental health problems, including suicidal ideations. Many grow up to become isolated, broken, and even a threat to the society that failed them in one way or another. Different studies show that children who grew up in institutions face difficulties coping with life outside of institutions. Without having the social cues and skills that one naturally develops while growing up in a supportive environment, they find it hard to reintegrate back into the community as an adult and are often stigmatised by society.

The Solution

What is commonly practised by community members in terms of assisting children in residential care facilities is that members usually bring in different goods and supplies to be used by the children and staff, participate in painting walls and renovating houses, build playgrounds, etc. As part of church outreach programs, different groups around the globe also travel across the world to spend time with children in residential care facilities. A lot of resources are invested in organising these programmes. While these actions are well intended and serve a noble cause, they are not always in the best interests of the children they are meant to serve. Most importantly, the same resources can be redirected to help many children and families while they are in the community.

There are multiple ways individuals, groups, and communities can come together to wrap around these families and assist them during their times of need, helping them get back on their feet to prevent them from having to make the difficult decision to relinquish their child to an institution. These supports can be provided at an individual, group, and community level.

“Success is knowing that one’s contribution is what helps the collective.” —ADRIAN GRENIER

Individual Level

Thinking of all the problems that exist in one's community can be too overwhelming to individuals, leading them to despair, believing there is nothing they can do that would solve the community's problem or that whatever they do would be too insignificant in light of the weight of the problem that exists.

However, as the story goes of the boy who was throwing starfishes back into the sea, believing it mattered to every single one he managed to throw back, whatever an individual can do to help out a struggling family or two in their community, it matters to those families. And the collective act of individuals can go a long way in addressing the needs of families in the community.

SOME PRACTICAL WAYS AN INDIVIDUAL CAN HELP A FAMILY IN NEED IN THEIR COMMUNITY INCLUDE:

- Offering to pay school fees and related expenses to one child or more in a family
- Offering after school tutorial services to children
- Offering to buy a day's, week's, or month's worth of groceries
- Cooking meals for a family to bring to them, or welcome them to your home
- Providing the means where an individual in the family can receive a skills training that would later translate into income generation
- Drop-in centre (day care or babysitting): A stay-at-home mother with time and space can offer to look after some children of single mothers so the women can work during the day and generate income.
- Mentoring a child
- Donating old, gently used clothes or household belongings
- Offering to help clean or make repairs to a family's home
- Offering to transport a family to a doctor's appointment or other needed appointments
- Offering to listen to a family that needs someone to talk to about their struggles
- Developing a relationship to provide encouragement and education on why family is the best place for the children, so they do not feel alone
- Considering becoming a foster parent or supporting a foster parent (meals, babysitting)

Small Groups

In many communities, there are small groups that are established to serve varying purposes. These include home cell groups, artisan groups, farmers' association, drivers' unions, youth groups, etc. These are resources that can be tapped and used for the good of families in the community that would benefit from a helping hand.

SOME PRACTICAL WAYS SMALL GROUPS CAN HELP A FAMILY IN NEED IN THEIR COMMUNITY INCLUDE:

- Identifying families in the community that have needs and the type of need they have. These families could be channelled through the church.
- Gathering materials (furniture, utensils, school supplies, and other household items) from their homes and those they know that they can provide to needy families
- Organising a garage sale in the community and using the proceeds to support an identified family(ies)
- Beginning a small monthly financial contribution that can be used to send a child to school or a youngster to a skills training facility or help a single mother start a small business/support an existing one etc.

Communities

SOME PRACTICAL WAYS COMMUNITY MEMBERS CAN HELP FAMILIES IN THEIR COMMUNITY INCLUDE:

- Engaging in house renovation projects
- Building community drop-in centres
- Joining the movement to educate the community about why family is best. Example: Offer to speak at your church or partner with Bethany to do so. Offer to speak at a community building/event.

ANNEX 6:

OUTLINE FOR INTERNAL DI CONCEPT MEETING

Welcome internal stakeholders (staff, board, management, etc.) to the meeting.

(5 minutes)

Briefly explain DI concept: Begin by explaining the existing childcare practices in the institution and the need for DI training. Then explain the limitations of institutional care and the importance of transitioning into family-based care.

(20 minutes)

Get the buy-in of internal stakeholders: Explain the role of the institution in providing better care to children and the process of DI.

(5 minutes)

Ask for questions and provide answers.

(30 minutes)

ANNEX Z:

FLYER FOR DONOR SENSITISATION

How can I get involved?

Be an educated donor, and make sure your money is actually doing good.

* Assist the community to move their focus to family and community-based care for children, share the message that funds are better spent on sustainable services which prevent separation and keep children in families.

* Redirect donations to family and community-based care service providers which will encourage a gradual transition from orphanage to family care while minimizing risks to a child's health and wellbeing.

* Support foster families in your community who can provide a valued service to orphaned and vulnerable children in need of a loving home.

* Work together with local authorities and consider forming coalitions with other organizations to ensure a coordinated, joint approach to the provision of services for children and families.

* Invest in young adults leaving the care system who are in need of employment and life skills opportunities.



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Supporting Family Based Care



Are we helping children the right way?

There is powerful evidence of the negative impact of orphanage care and that family is what is best for children. Children growing in institutions may show signs of poor physical growth, indiscriminate social behaviours and, low intellect and emotional instabilities. Research demonstrates they can develop better when moved into families. And the truth is there are only a few real orphans—4 in 5 children living in residential homes have at least one living parent.¹ However, poverty drives them to send their children to these homes in the false hope they will have better lives there.

Keeping children in orphanage limits their fundamental right to family as provided by the Children's Act 560 (1998), the Children's Amendment Act 937 (2016), the UN Convention on the Rights of the Child 1990 (UNCRC) and the UN Guidelines for the Protection and Alternative Care of Children without Parental Care. In 2007, the government of Ghana launched the Care Reform Initiative (CRI) towards integrated care services for vulnerable children and families in Ghana.² The main objective is to transform Ghana's care system which is over reliant on orphanages into foster care enterprise; to use institutional care as a last resort.

4000 Children still live in institutions

Private support for orphaned and vulnerable children in Ghana has generally focused on supporting orphanages.³ Don't make a practice of donating to orphanages. Instead, direct your giving to alternatives that keep families together or provide alternative families where essential. The fact is that raising children in family-based care is 10x less expensive than in a residential home.⁴

This orphanage business—where orphanages are established and recruit children to raise donations from foreigners — is increasingly recognized globally as a form of trafficking.

— LUMOS FOUNDATION

"Like a family" isn't a family. An actual family is objectively better for kids.

— KRISTI GLEASON, BETHANY GLOBAL

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ANNEX 8:

OUTLINE OF EXTERNAL STAKEHOLDERS' DI CONCEPT MEETING

Introduction: The lead external stakeholder briefly introduces himself/herself and other key personalities present and the organisation working on the DI.
(10 minutes)

Briefly make your DI presentation to external stakeholders
(annex 9 for presentation guide).
(20 minutes)

Get the buy-in of external stakeholders: Invite external stakeholders to explain the role of the stakeholders in providing better care to children in families and the process of DI.
(10 minutes)

Ask for questions and provide answers.
(30 minutes)

ANNEX 9:

PRESENTATION GUIDE

- Share your “why” story (select one story you developed earlier in Step 3).
 - When you share, include data as part of the story.
- What made you want to consider changing your model? Why now?
- Tell the donor what you are doing and why you are doing it.
 - Identify that care decisions need to be made based on the best interests of a child.
 - Share research that children need to live in a loving family whenever possible for healthy development into adulthood (visit <https://www.kinnected.org.au/resources> or <https://www.kinnected.org.au/faq-1>).
 - Children want to be with their families.
 - Not all children in orphanages are orphans (do family retracing and share why kids are in care).
 - Many struggling families can care well for their children with some support (even if it looks different from our culture/context).
- Share about other organisations in your context that have adopted a family-based care approach.
- Message donors on a business case to answer, How do we reach more children?
- Get comfortable with saying, “I don’t know how exactly this is going to work yet.”
- Talk about the changes you are making and updates on your progress.
- Share how much financial support you will need. What will you ask your donor to do or pray about?



DOWNLOAD

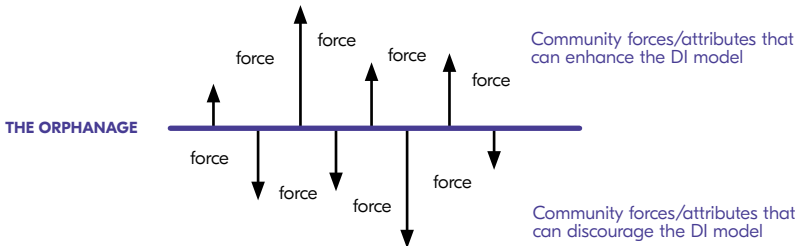
Source: <https://resources.cafo.org/resource/transitioning-donors-5-steps-to-bring-your-supporters-on-the-journey-to-a-new-model/>

ANNEX 10:

FORCE FIELD ANALYSIS WITHIN THE ORPHANAGE IN THE COMMUNITY

Imagine two magnets, one labelled positive and another labelled negative, placed in opposite directions with a metal object in the middle. Both magnets would try to draw the metal in their direction. But you need the metal to be drawn to the positive magnet. What can you do to make this happen?

Think of this in the context of enhancing DI in your RHC as follows:

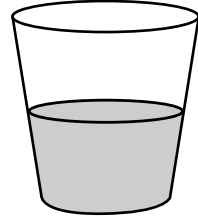


- Identify forces that can enhance DI
- Identify forces that can discourage DI
- Strengthen the role and involvement of the forces enhancing DI
- Work towards diminishing the impact of the forces working against DI

ANNEX II:

ORPHANAGE APPRECIATIVE INQUIRY

1. Fill a glass half-way with water and ask team members to tell you what they see. Record their answers.
2. Using the glass of water as an illustration, help team members identify and appreciate resources as you explore the following questions:



Questions

- What is going well in this RHC that could improve the implementing of DI?
- What skills or potentials do I have that will work seamlessly with the DI model?
- What do I see in my colleagues that will enhance DI?
- How will the community we live in help make DI a success?

These questions will help shift the focus from a half-empty perspective to the half-full perspective.

ANNEX 12:

COMMUNITY MAPPING TOOL



What are existing assests in my community?

Associations

Physical space

Institutions

Individuals

Local economy

What are the assests of my organization at present?

Personal

Space and facilities

Expertise

Materials and equipment

Constituents

Network of connections

Economic power

**Which organizations do we currently have partnership with?
What partnerships would we like to move toward in the future?**

Existing

My organization

Potential



DOWNLOAD

Source: <https://resources.depaul.edu/abcd-institute/resources/Documents/D.%20Duncan%20Asset%20Mapping%20Toolkit%20Eight%20Steps%20to%20Increase%20Residential%20Engagement.pdf>
(pp. 14–17)

ANNEX 13:

REPORTING TOOLS

A Manual for Routine Monitoring of the Alternative Care System in Ghana:

Monitoring Tool #1: Status of RHC

Monitoring Tool #2: Children in RHC

Monitoring Tool #5: Family re-unification/re-integration

Monitoring Tool #7: Adoptable children

Monitoring Tool #8: Child adopted



DOWNLOAD

Source: https://www.measureevaluation.org/resources/publications/ms-19-169/at_download/document

ANNEX 14:

LOGISTICS CHECKLIST FOR TRAINING

Announcements: Memo, flyers, invitation letters, community information centre adverts, etc.

Venue: Chairs, tables, ventilation, restroom/washroom, dustbin, etc.

Facilitation: Projector and screen, white board/flip chart, white board marker, presentation tool kits, etc.

Participation: Pens and notepads, handouts, etc.

Refreshments: Snacks, lunch, and water

ANNEX 15:

SEARCH PROCESS EVIDENCE

Name of child: _____

Date _____ Time: _____

Location/community visited: _____

No.	Name	Physical Address	Meeting Location	Contact

Findings and Observation

Name of social worker: _____

Signature: _____

ANNEX 16:

GUIDE FOR INTERVIEWING CHILDREN— CHILD BACKGROUND ASSESSMENT

Questions to start with to help get the child comfortable:

- Who is your best friend? What do you do together?
- Do you have a favourite sport? Tell me about your favourite sport and who you like to play with. What position do you play?
- If you could be an animal, what animal would you like to be? Why?
- Who is a hero to you? Why?
- What is the best food you have ever eaten?
- If you could be a superhero, what would you wish your power to be?

Engagement strategies:

- Encourage eye contact, but do not force eye contact.
- Try to sit on the same level as the child to help them build trust.
- Be aware of your tone of voice. If the child is being playful, then use a more playful tone. If the child is telling a difficult story, be sure to use a soft and slower voice.
- Be aware of your facial or body expressions and what those may be conveying to the child.

CHILD BACKGROUND ASSESSMENT

Name of institution: _____

Child's name: _____

Child's age and date of birth: _____

Background	Response
When did you come to live here?	
How did you arrive?	
Who did you come with?	
What do you remember about the day you arrived?	
Do you remember how far you travelled?	
Where were you last living before you arrived?	
Who were you living with?	
Do you remember anything about your home or the area? (Name of the village; What did you see when you left home each day? Name of church or school)	

Background	Response
What do you remember about your parents?	
Do you remember anything about other people in your family?	
Have you ever been unwell? Tell me about that.	
Have you ever been to a hospital?	
Were you ever given medicine?	
Did you ever go to school? What was that like?	
Have you ever been in trouble with the police?	
Have you ever been hurt by someone?	

NB: Follow-up questions such as Why? When? Where? etc. may be useful to obtaining details.

This form was completed in my presence/with my assistance.

Name: _____

Role/position: _____

Signature: _____

Date: _____

ANNEX 17:

GUIDE FOR INTERVIEWING CAREGIVERS— CHILD BACKGROUND ASSESSMENT

The purpose of this report is to share full information on the child in my care. I am aware that what I share will be kept confidential and that it will be used in the best interests of the child. The information is true to the best of my knowledge and given with understanding.

Name of institution: _____

Name of caregiver: _____

Role/position: _____

Signed: _____

Contact details (for follow up, as needed): _____

Child's name: _____

Child's age and date of birth: _____

Question	Response
Do you remember the day the child arrived in your care? What can you tell me about that moment? How long has he/she been in your care?	
Do you remember who brought the child into your care? (name, position, contact details, if known) What information did they share? What were you told about why the child was brought to your care? Do you know where the child came from?	
How did the child appear when you first met him/her? Please comment on demeanour, physical presentation, observations you had.	

<p>What has the child shared with you about his/her past?</p> <p>Has he/she talked about memories they have?</p>	
<p>Has anyone ever visited the child? (who and when)</p> <p>Do you know anything about the child's family? Has he/she mentioned family members, siblings, parents, significant people to you?</p>	
<p>If someone else was to care for this child, what would you want them to know about the child so they can understand the child? For example, likes and dislikes, how they engage with other children, what their routines are, child's behaviour.</p> <p>What do you know about the child's education? (past and present)</p>	
<p>What has the child shared with you about his/her past?</p> <p>Has he/she talked about memories they have?</p>	
<p>What do you know about the child's health? (past and present)</p>	
<p>Do you have any specific memories of the child while he/she has been in your care? (dreams/nightmares the child has had, times he/she has shared something important to you)</p>	
<p>What else do you feel is important for me to know about this child?</p>	

This form was completed in my presence/with my assistance.

Name: _____

Role/position: _____

Signature: _____

Date: _____

ANNEX 18:

QUESTIONNAIRE TO AID CAREGIVERS IN DOING BIOTHEOPSYCHOSOCIAL ASSESSMENT

ASSESSMENT AND REFERRAL OF CHILDREN

About the questionnaire:

For a questionnaire to be acceptable as useful in psychometrics, it must have a high level of reliability and validity and must be culturally sensitive. The questionnaire chosen for the assessment of children in an institution like an orphanage must also be one that can be used by the caregivers to determine the health of the child across multimodal dimensions. It must also be age appropriate. The Y-OQ[®]-2.01 (Wells, Burlingame & Lambert, 1996) has been adapted for this purpose. Although it is an outcome questionnaire, it is being used here as a quick assessment of a child to determine if they are in need of a further assessment by a licensed psychologist. This tool can help suggest problems in six dimensions of the child's health. These are:

- Intrapersonal distress (emotional distress)
- Somatic distress (distress presenting physically)
- Interpersonal relations (relationship with parents, other adults, and peers)
- Critical items (flags the need for those requiring immediate intervention beyond standard outpatient treatment)
- Social problems (socially related problematic behaviours)
- Behavioural dysfunction (unhealthy behaviours)
- It is also adapted to include items 37 and 45 that explore the spiritual dimension of the child's health.

How to use this tool:

The original tool has clinical cut-off points. However, this one is supposed to be a simple tool to help the caregiver in determining "cursorily" if a child needs further exploration with a professional; thus a simple "no," "yes, to some extent," or "to a large extent" scoring will be used.

QUICK BIOTHEOPSYCHOSOCIAL ASSESSMENT AND REFERRAL OF CHILDREN

Does the child want to be alone more than other children of the same age?

No [] Yes, to some extent [] To a large extent []

Does the child have headaches or feel dizzy?

No [] Yes, to some extent [] To a large extent []

Does the child participate in activities that used to be fun to him or her?

No [] Yes, to some extent [] To a large extent []

Does the child argue with or speak rudely to others?

No [] Yes, to some extent [] To a large extent []

Does the child seem to have more fears than others of his/her age group?

No [] Yes, to some extent [] To a large extent []

Does he absent himself/herself from school or avoid school altogether?

No [] Yes, to some extent [] To a large extent []

Does the child cooperate with the rules and expectations of adults?

No [] Yes, to some extent [] To a large extent []

Does he or she have a hard time finishing assignments or do them carelessly?

No [] Yes, to some extent [] To a large extent []

Does the child avoid complaining about things that are unfair?

No [] Yes, to some extent [] To a large extent []

**Does the child have problems with constipation (not attending to toilet)
or diarrhoea (frequently visiting the toilet)?**

No [] Yes, to some extent [] To a large extent []

Does the child have physical fights (hitting, kicking, or scratching others)?

No [] Yes, to some extent [] To a large extent []

Does he or she seem to be worrying and can't overcome it?

No [] Yes, to some extent [] To a large extent []

Does he or she steal or lie?

No [] Yes, to some extent [] To a large extent []

Does he or she have a hard time sitting still (or have too much energy)?

No [] Yes, to some extent [] To a large extent []

Does he or she feel anxious or nervous?

No [] Yes, to some extent [] To a large extent []

Does the child find it difficult to be friendly?

No [] Yes, to some extent [] To a large extent []

Is the child easily startled or tensed?

No [] Yes, to some extent [] To a large extent []

Does the child wet his/ her bed or mess his or her pants?

No [] Yes, to some extent [] To a large extent []

Does the child physically fight with adults?

No [] Yes, to some extent [] To a large extent []

Does the child see, hear, or believe in things that are not real?

No [] Yes, to some extent [] To a large extent []

Has he or she ever cut or scratched him/herself on purpose or attempted suicide?

No [] Yes, to some extent [] To a large extent []

Does the child use alcohol?

No [] Yes, to some extent [] To a large extent []

Is the child disorganised?

No [] Yes, to some extent [] To a large extent []

Is the child enjoying his/her relationship with caregivers or family?

No [] Yes, to some extent [] To a large extent []

Is the child sad or unhappy?

No [] Yes, to some extent [] To a large extent []

Does the child have pain or weakness in the muscles or joints?

No [] Yes, to some extent [] To a large extent []

Does the child have a hard time trusting friends, family, caregivers, and adults?

No [] Yes, to some extent [] To a large extent []

Does the child feel others are trying to hurt him or her even when they are not?

No [] Yes, to some extent [] To a large extent []

Has he or she threatened to or has run away from home?

No [] Yes, to some extent [] To a large extent []

Are the child's emotions strong and change quickly?

No [] Yes, to some extent [] To a large extent []

Does the child break rules or laws and does not meet others' expectations on purpose?

No [] Yes, to some extent [] To a large extent []

Is the child happy with himself or herself?

No [] Yes, to some extent [] To a large extent []

Does the child pout, cry, or feel sorry for himself or herself more than others of his or her age?

No [] Yes, to some extent [] To a large extent []

Does he or she withdraw from caregivers, family, and friends?

No [] Yes, to some extent [] To a large extent []

Does the child's stomach hurt or does he or she feel sick more than others of his or her age?

No [] Yes, to some extent [] To a large extent []

Does the child not have friends or does not keep friends for long?

No [] Yes, to some extent [] To a large extent []

Does the child avoid attending church services or prayer meetings?

No [] Yes, to some extent [] To a large extent []

Does the child think he or she can hear other people's thoughts or that they can hear his or hers?

No [] Yes, to some extent [] To a large extent []

Is he or she involved in sexual behaviour the family would not approve of?

No [] Yes, to some extent [] To a large extent []

Does the child have a hard time waiting for his or her turn in activities or conversations?

No [] Yes, to some extent [] To a large extent []

Does he or she contemplate or feel that he or she will be better off dead?

No [] Yes, to some extent [] To a large extent []

Does the child have nightmares, trouble getting to sleep, problems oversleeping, or problems waking up from sleep too early?

No [] Yes, to some extent [] To a large extent []

Does he or she question rules, expectations, or responsibilities?

No [] Yes, to some extent [] To a large extent []

Does he or she have times of unusual happiness or excessive energy?

No [] Yes, to some extent [] To a large extent []

Does he or she enter into periods of excessive fasting without any real reason?

No [] Yes, to some extent [] To a large extent []

Is the child afraid he or she is going crazy?

No [] Yes, to some extent [] To a large extent []

Does he or she feel very guilty when he or she does something wrong?

No [] Yes, to some extent [] To a large extent []

Is the child pushy or does he or she demand a lot from others?

No [] Yes, to some extent [] To a large extent []

Does the child feel irritated?

No [] Yes, to some extent [] To a large extent []

Does he or she vomit or feel sick in the stomach more than others his or her age?

No [] Yes, to some extent [] To a large extent []

Does the child get angry enough to threaten others?

No [] Yes, to some extent [] To a large extent []

Does the child cause trouble when bored?

No [] Yes, to some extent [] To a large extent []

Has the child ever hit his or her head hard on a tree, the wall, or the floor?

No [] Yes, to some extent [] To a large extent []

Does his or her face, arms, or body muscles twitch or jerk?

No [] Yes, to some extent [] To a large extent []

Does the child destroy property on purpose?

No [] Yes, to some extent [] To a large extent []

Does the child have a hard time concentrating, thinking clearly, or sticking to tasks?

No [] Yes, to some extent [] To a large extent []

Does he or she get hard on himself or herself and blame himself or herself for things that go wrong?

No [] Yes, to some extent [] To a large extent []

Has he or she lost a lot of weight without being sick?

No [] Yes, to some extent [] To a large extent []

Does he or she seem to act without thinking and doesn't worry what will happen?

No [] Yes, to some extent [] To a large extent []

Does the child's heart beat unusually whilst he or she seems to sweat without engaging in any strenuous activity?

No [] Yes, to some extent [] To a large extent []

Does the child not forgive himself or herself easily for things done wrong?

No [] Yes, to some extent [] To a large extent []

Does the child complain of not having much energy?

No [] Yes, to some extent [] To a large extent []

Does the child complain that he or she does not have friends or that no one cares about him or her?

No [] Yes, to some extent [] To a large extent []

Does the child get upset or frustrated and easily gives up?

No [] Yes, to some extent [] To a large extent []

If the caregiver scores the child:

60 or more as "No," then there is not much problem.
Critical items would have to be explored.

20 or more on "Yes, to some extent," then there is
the need for referral to a psychologist.

20 or more on "To a large extent," there may be the
need for the child to be treated as an inpatient.

ANNEX 19:

CHILD HEALTH ASSESSMENT

IMMUNISATION

Have immunisations been done appropriately?

Kindly check child record booklet and tick [✓] as applicable:

- [] At birth: BCG, Polio 0
- [] 6 Weeks: Penta, Rotavirus, PVC, Polio, Pneumococcal vaccine
- [] 10 Weeks: Penta, Rotavirus, PVC, Polio, Pneumococcal vaccine
- [] 14 Weeks: Penta, Polio, Pneumococcal, Polio 2 vaccine
- [] 6 Months: Vitamin A supplement
- [] 9 Months: Measles/yellow fever
- [] 12 months: Vitamin A supplement
- [] 18 Months: Measles, Vitamin A supplement
- [] No immunisation records identified

PHYSICAL

Body Screening: Eye and Mouth

Inspect eye and mouth and kindly tick [✓] as applicable:

	Good	If there is no coloration of the eye and no discharge from mouth and tongue; if there is no oral thrush; if there are no dental caries (holes in the teeth).
	Fair	If there is a little coloration (red, yellow, brown) of the eye and slight patches of discharge; if there is a little development of oral thrush and whitish dental caries (holes in teeth).
	Bad	If there is a lot of coloration (red, yellow, brown) of the eye with moderate discharge; if there are a lot of white patches in the mouth and tongue and holes in more than two teeth.
	Very bad	If there is a lot of coloration (red, yellow, brown) of the eye and impedes vision with severe discharge; if there are a lot of white patches in the mouth and tongue and holes in two or more teeth.

Skin

Inspect for bruises (e.g., cane marks), rashes, and wounds, and kindly tick [✓] as applicable:

	Good	If there are no bruises (e.g., cane marks), rashes, and wounds.
	Fair	If there are little bruises (e.g., cane marks), rashes, and wounds.
	Bad	If there are lots of bruises (e.g., cane marks), rashes, and wounds in some parts of the body.
	Very bad	If there are lots of bruises (e.g., cane marks), rashes, and wounds all over the body.

Extremities

Inspect arms and legs for pain, deformity, bruises, or muscle twitches, and kindly tick [✓] as applicable:

	Good	If there is no pain, nor are there deformities, bruises, or muscle twitches.
	Fair	If there is little pain or there are small deformities, bruises, or muscle twitches.
	Bad	If there is serious pain or there are deformities, bruises, or muscle twitches.
	Very bad	If there is severe pain or there are deformities, bruises, or muscle twitches that limit body movement.

Body Position

Inspect body position and kindly tick [✓] as applicable:

	Good	If shoulders are equal, back is not bent, and inner spine curve is not deep.
	Fair	If shoulders are a little unequal, back is a little bent, and inner spine curve is a little deep.
	Bad	If shoulders are unequal, back is bent, and inner spine curve is deep.
	Very bad	If shoulders are seriously unequal, back is severely bent, and inner spine curve is very deep.

Hearing, Speech Pattern, and Articulation

Interact with child and kindly tick [✓] as applicable:

	Good	If the child's response to sound, speech, and articulation is age appropriate.
	Fair	If the child's response to sound, speech, and articulation is a little lower than his/her age.
	Bad	If the child's response to sound, speech, and articulation is delayed or age inappropriate.
	Very bad	If child is not responding to sound and does not speak or articulate.

Visit: [https://www.asha.org/public/speech/development/45/for age appropriate hearing and speech milestones](https://www.asha.org/public/speech/development/45/for-age-appropriate-hearing-and-speech-milestones).

ANNEX 20:

FACTORS THAT DETERMINE A CHILD'S "BEST INTERESTS" CHECKLIST

All factors listed below are of relevance when determining which among the available options is in the child's best interests, including identifying the follow-up measures required. The weight of each factor inevitably varies according to the individual child.

VIEWES OF THE CHILD

- Child's wishes and feelings: Were these obtained from the child directly?
- The weight to be given to them in light of the child's age and maturity
- Child's ability to comprehend and assess the implications of the various options

SAFE ENVIRONMENT

- Safety is normally a priority. Exposure or likely exposure to severe harm usually outweighs other factors. Consider:
 - safety in the geographical location/household under consideration
 - availability of life-saving medical treatment for sick children
 - past harm (frequency, patterns, trends)
 - ability to monitor
 - whether root causes of past harm still persist

FAMILY AND CLOSE RELATIONSHIPS

A) General factors:

- Quality and duration of the relationship and degree of attachment of the child to:
 - siblings
 - other family members
 - other adults or children in the cultural community
 - any potential caregiver
- Potential effect of separation from family or change in caregivers on the child
- Capacity of current and potential future caregivers to care for the child
- Views of persons close to the child, where relevant

B) Factors specifically relevant to durable solutions for unaccompanied or separated children:

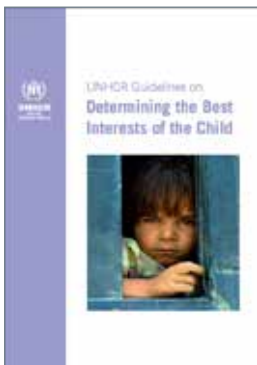
- Possibility of family reunification (normally presumed to be in the best interests). Consider whether:
 - tracing has been initiated and its results
 - efforts have been made to contact the parents/family directly
 - the family relationship to the child has been verified
 - the child and family member are willing to be reunited and, if not, reasons for any reluctance

C) Factors specifically relevant to temporary care arrangements:

- Retention of family and sibling relationships
- Prospects for care in a family setting
- Prospects of using community care systems (provided they are safe and effective)

DEVELOPMENT AND IDENTITY NEEDS

- The child's cultural and community network
- Continuity in the child's ethnic, religious, cultural, and linguistic background
- Specific considerations based on age, sex, ability, and other characteristics of the child
- Particular physical or emotional needs
- Physical and mental health considerations
- Educational needs
- Prospects for successful transition to adulthood (employment, marriage, own family)



Adopted from the UNHCR Guidelines on Determining the Best interests of the Child 2008

DOWNLOAD

Source: <https://cms.emergencyunhcr.org/documents/11982/43375/HCR%2C+Guidelines+on+Determining+the+Best+Interests+of+the+Child%2C+2008/fca91406-2455-4342-83ea-78949f5b284f>

ANNEX 2I:

QUESTIONNAIRE FOR RHC SELF-ASSESSMENT TO EMBARK ON DI

Name of RHC: _____

Date: _____

The following questions are to guide you in conducting a self-assessment of your RHC prior to DI. It is for the purpose of reflecting on, discussing, and planning the process of transition from residential to family-based care. It is advised that five or more individuals representing various departments and leadership give response to this questionnaire.

HISTORY

When was your RHC established?
What was the intention when your RHC was opened?
a. What was the need at the time of establishment? Has that need in the community changed?
b. How have services changed since the establishment of the home?
Where is the location of your RHC?
Who are the founders of your RHC?

PHYSICAL ENVIRONMENT OF THE RHC

What facilities do you have in your RHC? Consider office space, transportation, buildings, furniture, technology, etc.

How would you describe the compound of your RHC?

CHILDREN

How many children do you have in your RHC?

How many categories of children are in your RHC? How many are children with special needs/have living parents/are a total orphan/etc.?

a. Is there support for children in your RHC? E.g., access to developmentally appropriate toys, therapeutic services, educational resources, nurturing environment.

b. What are the specialist services/resources you have for children with special needs?

What is the ratio of caregivers to children?

Are caregivers trained in childcare? List type of training.

What are the age ranges of the children?

What are the common premises for placement in your RHC?

What is the living condition of the children?

How is a typical day for the children like in your RHC?

Is your service meant for children's care temporarily or long term?

FAMILY

What is the life status of birth families of the children?

What led to the separation of children from birth families?

What factors are considered when tracing families?

STAFFING

How many people are currently working in your RHC?

What is the minimum education requirement for staff?

Do caregivers have appropriate working conditions and motivations for working in your RHC?

FUNDING

How does your RHC get its funding?

Are there other support engagements for your RHC?

COMMUNITY

What are the resources available and their accessibility in the community?

Are you connected to other community resources? If yes, which ones, and how?

GOVERNMENT

How well-informed are you on the current family-based care structures in place through the government?

TRANSITION

What are the plans for the children in your RHC moving forward?

What are the plans for your facility in the future?

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