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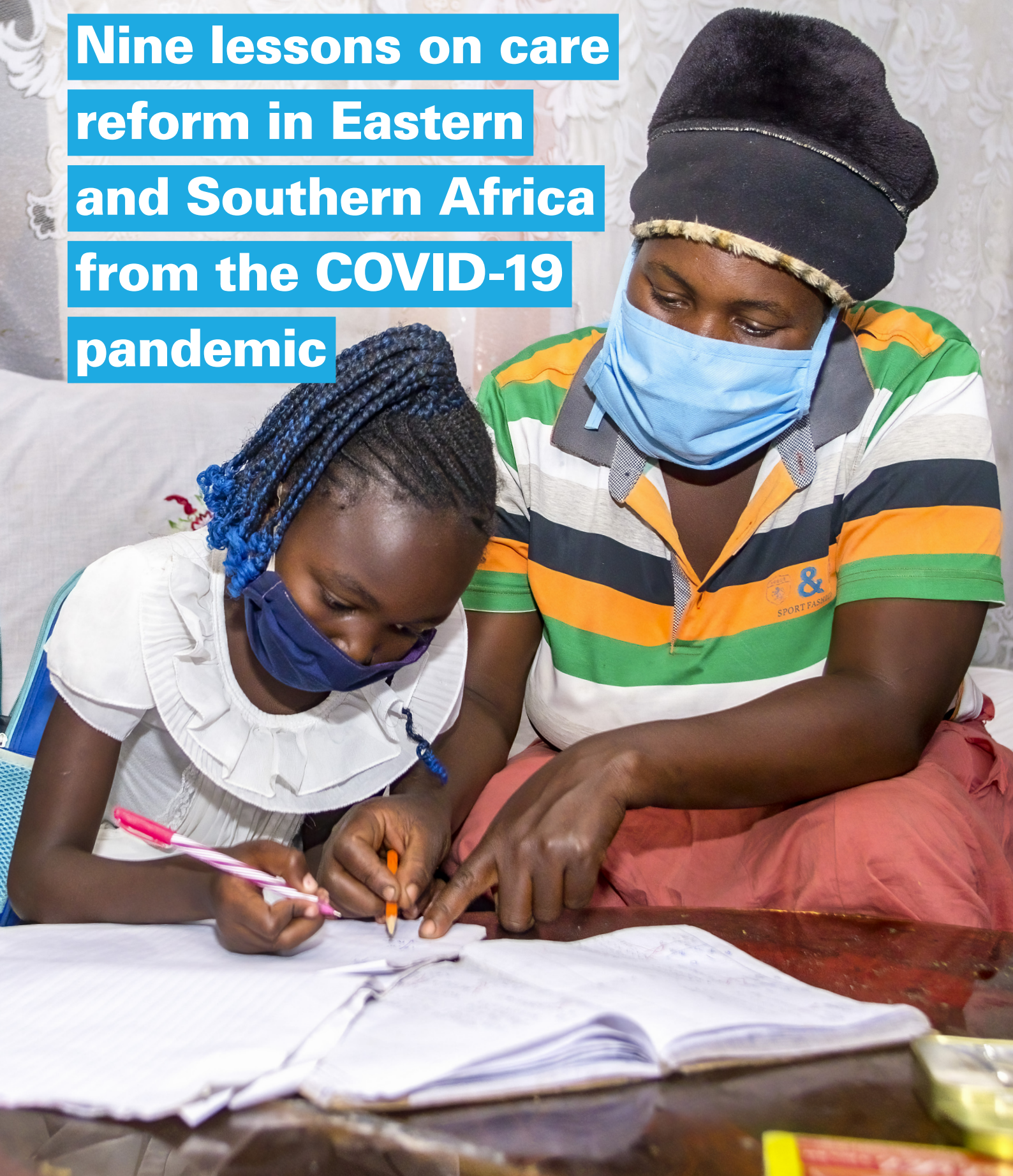
Changing THE WAY WE care

Nine lessons on care reform in Eastern and Southern Africa from the COVID-19 pandemic



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Introduction

The COVID-19 pandemic poses a fundamental threat to the care of children in Eastern and Southern Africa. It exacerbates many causes of separation and violence in families and has placed a huge strain on services that aim to improve children's care. Responding to these challenges has also led to rapid adaptation, innovation, and learning.[1] This short paper captures nine lessons on care reform from experiences during the pandemic. Some of these lessons confirm existing knowledge and practices on care reform in the region; others provide new insights.

Care reform is defined as efforts to improve the legal and policy framework, structures and resources that determine and deliver alternative care, prevent family separation and support families to care for children well.[2] Other key terms are defined in the glossary at the end of this document.

LESSON 1

Improving the care of children is now an even greater priority

Children's care in families and in residential care in Eastern and Southern Africa deteriorated dramatically as a result of the pandemic.

- **Thousands of children lost caregivers**. Globally, over the 20-month period that formed the height of the pandemic, an estimated 6.7 million children lost a parent or caregiver to COVID-19.[3] Of these, 4.5 million children lost a parent and 0.3 million a grandparent who was their primary caregiver. The remainder lost a grandparent who lived with them and contributed to their care.[4] Twelve of the 25 countries with the largest numbers of COVID-19 orphans are in Eastern and Southern

Africa.[5] In South Africa, one in every 200 children has experienced Covid-19 related orphanhood.[6] The speed of this loss has been dramatic. During the HIV/AIDS pandemic, it took ten years for five million children to become orphans globally; the pandemic has led to a similar number of orphans in just under two years.[7]

- **Caregivers faced enormous pressures, inevitably affecting the quality of care within families.** During the pandemic, families across Eastern and Southern Africa struggled to cope with a drop in income and being confined to often cramped homes.[8] With schools closed, the burden on caregivers, especially women, rose.[9] Children's behaviour often deteriorated and many became withdrawn, leaving caregivers anxious about their wellbeing.[10] As stress levels in the home rose, there was an increase in alcohol or drug use and domestic violence became more common.[11] Some caregivers interacted less with children and were no longer as responsive to their needs.[12] This situation was especially acute in poorer households or in challenging settings such as refugee camps.[13] Case study 1 illustrates some of the challenges faced by families during COVID-19.

- **Children suffered from high rates of abuse and violence in the home.** For example, in Uganda there was a 13-fold increase in calls to a child helpline at the start of the pandemic, with many calls related to violence in the home.[14] In a survey covering 24 districts of Uganda, 80 per cent of parents reported resorting to hitting children to stop them wandering away from home during lockdowns.[15] There is also evidence of higher rates of violence against children within families in Botswana,[16] Kenya[17] and South Africa.[18]

- **Children in residential care were at heightened risk of poor-quality care, and of isolation from families and communities.** Across the region, government staff were unable to carry out regular monitoring visits to residential care homes, leading to a possible deterioration in the quality of care.[19] Research with small privately-run residential care facilities in countries including Kenya found that funding also declined during COVID, with impacts on standards of care.[20] In South Africa, research shows that although the government issued numerous directives to residential care providers, very little actual support was given to help facilities during the pandemic. The result was that few children were able to maintain contact with loved ones.[21] Many missed their families and worried about how they were coping.[22]

  "I feel sad, disappointed, trying so hard to put a smile on my face, angry, not going to school, upset. I feel like I am being punished for something I didn't do. I feel like I'm in prison."

  "My worries about being in lockdown are that I don't know what happened to my family and what are they eating… is my baby sister protected?" (Children in residential care in South Africa describing their feelings during COVID-related lockdowns)[23]

The care choices open to vulnerable children in Eastern and Southern Africa narrowed severely during the pandemic. Across the region many residential care facilities were mandated to send children back to their families.[24] As discussed below, this reunification was often rushed and poorly supported, placing children at risk. In other instances, decisions were made to pause children's return to families as children were seen to be safer in residential care.[25] Some foster carers felt unable to continue offering care to children due to growing poverty and stress in the home.[26] Social workers were often forced to cut back on support offered to vulnerable children and families as they were not considered essential workers or given protective equipment.[27] As unemployment rose, families struggling to feed children often felt they had little choice but to send children away to work or marriage.[28] These responses left many children with no adult care at all.

The harm caused to children's care during the pandemic will reverberate for years to come, and extensive investment is needed to reverse the negative trends seen during the pandemic. The trauma of abuse, exploitation and separation has been shown to affect children well into adulthood.[29] Relationships damaged by pandemic pressures require time and support to heal. Services that were diminished by the pandemic need to be rebuilt. COVID-19 has also had a lasting impact on factors known to increase violence in the home and family separation. For example, it led to higher rates of household poverty in the region, reducing household assets and capacity to cope with shocks in the future.[30] Many children who stopped attending school during the pandemic are unlikely to return.[31]

Preventing family violence and separation is far easier and less costly than providing alternative care or supporting reintegration. Now is the time to act quickly before more children become separated and abused.[32]

CASE STUDY 1

Preventing family separation during the COVID-19 pandemic in Uganda

Betty[33] lives in a village in Tororo district in Eastern Uganda. Betty's husband went out to work two years ago and never returned. She was pregnant with her fifth child at the time and has since had to bring up her children alone with no support from their father. Betty has always struggled financially but managed to feed her children by taking in her neighbours' washing. When the COVID-19 pandemic struck in 2020, this source of income dried up. Stuck at home with no money coming in, many of her customers started to do their own washing. Betty says that:

> *"Sometimes we would go days without food. I went months without paying rent. The landlord was always on my case. I felt like giving up."*

Betty became desperate and contemplated sending her children to live with relatives. An outreach worker from the NGO Child's i Foundation learnt of Betty's situation and offered assistance. Betty was given emergency financial aid, budgeting and parenting support, help buying school materials and regular visits from social workers and a community volunteer. Betty recalls what a huge difference this made:

> *"After a few days, they returned with an assortment of food items including rice, maize flour, sugar, salt, beans, groundnuts, peas, and milk. They also gave me two sacks of charcoal. You just cannot imagine how excited I, and my children, were."*

After discussions with staff from Child's i Foundation, Betty decided to set up a business selling cold drinks and is now more financially secure. She is no longer thinking of sending her children away. Betty's situation is not unique. Tororo borders Kenya and much cross-border trade dried up because of restrictions imposed by COVID-19. Child's i Foundation staff saw rising rates of poverty, unemployment, stress, and violence against women and children during this period. A combination of school closures and higher rates of poverty has led to concerns about child trafficking. Movement restrictions also made it hard for social workers to visit vulnerable families. Child's i Foundation adapted to meet these challenges by offering emergency financial assistance, converting to remote case management, and using its network of trained community volunteers to identify and support vulnerable families when social workers could not reach them.

LESSON 2

Care reform must be based on a clear understanding of often rapidly changing contexts

The COVID-19 pandemic illustrated how quickly the care of children can deteriorate with a decline in the economic situation, the provision of services and the physical and mental health of caregivers. Although the pandemic was perhaps unique in terms of both the scale and the speed of impact, it is likely that other global trends, such as climate change or rising rates of conflict, will lead to similar impacts on care. Future-proofing systems of care and care reform strategies means seeking to predict, prepare for, and monitor these changes. Box 1 provides examples of methods developed during the pandemic that could be useful for understanding future challenges that may affect children's care.

Guidance on children's care and COVID-19 suggests that the following areas should be monitored in seeking to understand and predict changes to children's care.[34]

- The availability and capacity of social services and the social service workforce.

- The formal system of child protection and care – including legal and policy frameworks, coordination bodies, alternative care and family strengthening services, and the monitoring of services.
- Social norms and community mechanisms that support children's care, including the availability of kinship care (care by extended family or friends of the family).
- Factors that affect family separation or inadequate care within families, such as poverty and access to education.
- The situation of particularly vulnerable groups, such as children with disabilities or refugees.

Each of these areas has been shown to have an impact on care, and monitoring will allow early identification of problems.


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BOX 1

Understanding the situation of children in residential care during the pandemic

The Malawi Human Rights Commission (MHRC) worked with the Ministry of Gender, Community and Social Welfare and the Child Case Review Board to understand the consequences of COVID-19 on the rights of children in residential care.[35] Initially, the MHRC carried out a rapid assessment of a small number of children in and reintegrated from residential care. This provided sufficient evidence to suggest that many children were at risk, prompting a larger study of more than 100 residential care facilities. The results revealed a drop in funding to residential care facilities, a fall in the number of staff, and reduced contact between children in residential care and their parents. This research led to several recommendations to the care providers and the government for improving residential care.

The main research in Malawi took place in August 2021, after some pandemic related restrictions had been lifted, allowing for a large-scale, comprehensive study. Other researchers in the region conducted smaller scale, rapid research remotely at a time when entry into care homes was still highly restricted. For example, Nhep and van Doore carried out 21 remote key informant interviews across seven countries (including Kenya) with the managers of small privately-run residential care facilities to understand the impact of the pandemic on funding and care provision.[36] Wilke, Howard and Goldman surveyed 67 providers, over half of which were in Kenya and Uganda, on the impacts of government mandates to reintegrate children during COVID.[37]

In South Africa, two research teams used staff in residential care homes to gather information when they could not access homes themselves due to lockdown. Swanzen and Jonker asked care home managers to provide reflections on the experiences of children and residential care home staff locked down in residential care for 177 days.[38] Haffejee and Levine briefed a social worker and a counsellor to carry out participatory research with 32 children in residential care.[39]

LESSON 3

Children's care must be considered in preparing for future pandemics and other emergencies, drawing on valuable lessons from the COVID-19 pandemic

The pandemic illustrated how strategies to address all child rights should be included in emergency responses. A tendency to focus on the health implications of COVID-19 led to other rights, such as those related to care and protection, being neglected in some countries, with damaging implications for children. For example, in South Africa government mandates during the pandemic centred on health outcomes.[40] Some efforts were made to allow child protection proceedings to continue, and to provide emergency financial aid to vulnerable families. However, these measures were insufficient in the face of heightened levels of violence and inadequate care.[41] In some cases, failing to consider children's care and protection meant that government directives exposed children to further harm. Confining children to their homes led to children being trapped with their abusers. As schools were closed, children had no opportunity to report this abuse to an adult outside their family. Strict movement restrictions, particularly at the start of the pandemic, prevented already separated children from returning home or receiving visits from family members.[42] Whilst such measures may be necessary to stem the spread of disease during a pandemic, they need to be balanced by efforts to mitigate risks to care and protection. Box 2 below outlines some of the key care considerations for preparing for future emergencies, based on learning from COVID-19.

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BOX 2

Lessons from COVID-19 on how to prepare for future emergencies in a way that promotes the better care of children

- **Put a range of measures in place to prevent family separation.** During COVID-19, social protection, parenting supports (including mental health support), and child helplines were found to be particularly effective.[43] Case management was also needed for particularly vulnerable families to identify needs, make referrals, and monitor progress and risk.[44] For example, in Kenya the Tushundie Children's Trust took a holistic approach, providing help with schooling, livelihoods, psychological support, and access to national health insurance schemes. Social workers used case management to support the more vulnerable families in the community.[45]
- **Ensure that legal and gatekeeping mechanisms can function during emergencies so that decisions can continue to be made around children's care.**[46] For example, during COVID-19, in many settings, gatekeeping mechanisms went online.[47] For further guidance see here.
- **Recognise that many emergencies lead to increased demand for alternative care, and ensure that there are a range of appropriate care options available.** Focus on providing family-based care and do not expand institutional care, which is harmful to children.[48]
- **Prioritise support to kinship carers as the most common form of alternative care in Eastern and Southern Africa and globally.**[49] Recognise that kinship caregivers are often elderly and vulnerable and in need of additional assistance during emergencies.[50] During COVID-19, specific guidance was developed on supporting kinship care which can be found here and here.
- **Provide guidance to foster carers and residential care providers to ensure that they can continue to protect children during emergencies.** During COVID-19, the Government of Kenya provided key messages for residential care providers which included steps to reduce the risk of COVID infection and ensure that children could maintain contact with families (see here).[51] Guidance for foster carers during COVID-19 can be found here. Guidance for residential care providers should include the safe reintegration of children, discussed in further detail below.
- **Ensure additional supports are available to parents and other family caregivers to avoid a deterioration in children's care.** For example, the Government of Kenya developed key messages for parents during the COVID-19 pandemic which could be adapted for other emergencies (these can be found here). These include explaining how stress and anxiety can affect children's behaviour and giving parents strategies to cope with these challenges.
- **Make sure that social workers can continue to work during emergencies, and that case management processes are adapted to meet changing needs**. For example, Changing the Way We Care used learning from Kenya and other contexts to develop specific guidance on adjustments to case management processes for COVID-19 (see here and here).[52] Similar guidance was also developed by the Alliance for Child Protection in Humanitarian Action[53] and the Government of Ghana[54] which can be found here and here. Examples of adaptations include adjusting criteria for who receives case management to recognise new risks associated with the emergency, and contingency planning if social workers become sick or otherwise incapacitated.
- **Have plans in place to support groups of children who are particularly vulnerable to inadequate care during emergencies.** For example, in its guidance for parents during the COVID-19 pandemic, the Government of Kenya suggest that the caregivers of children with disabilities develop a contingency plan for the care of their child if they become sick. Specific guidance was also provided for refugee and street connected children (see here).[55]

LESSON 4

Addressing poverty and lack of access to education is essential for enabling families to care for children

The COVID-19 pandemic highlighted the strong links between poverty and inadequate care, and the potential for social protection programmes to improve children's care. For example, a review of parenting programmes across a range of contexts including Mozambique found that during COVID-19 families most urgently required material support. Addressing these needs was vital for building relationships of trust with social workers, and a pre-condition for the success of parenting programmes:

> *"Parent and caregivers were unlikely to benefit from responsive, playful parenting, and other programmes if their basic needs were not met."*[56]

Similar evidence on the important role played by social protection in care reform during COVID-19 was found in Kenya (see Box 8). The pandemic showed that social protection is most effective in improving children's care when it is combined with other measures.[57] Examples of these programmes, commonly referred to as 'cash-plus', are included in Box 3.

The COVID-19 pandemic also confirmed the connection between education and children's care. As noted above, during the pandemic school closures placed pressure on families, leading to a deterioration in care in many homes. In Kenya, the recent re-opening of schools led many children who had been reintegrated with families during COVID to return to residential care. Caregivers felt that the lack of availability of quality schooling close to home meant that this was the only way for children to receive a decent education.[58]

BOX 3

'Cash-plus' care during the COVID-19 pandemic

In Zambia,[59] an emergency cash transfer programme was rolled out during the pandemic to provide additional support to households already enrolled in Zambia's National Social Cash Transfer Programme. The Children in Families – Emergency Cash Transfer Scheme was implemented by the government with the support of UNICEF. It aimed to prevent family separation during the pandemic and was targeted at 12,560 vulnerable households, including families with children who transitioned from residential to family-based care. Overall, 38,086 children were supported to remain in the care of their families. As well as the cash transfers, the government worked with community volunteers to provide families with community case management support. This included home visit to provide direct assistance and/or refer beneficiaries to relevant services. Community volunteers were overseen and mentored by government Community Development Assistants and District Social Welfare Officers.

In Mozambique,[60] UNICEF has supported the government to pilot a 'cash and care' family support programme for the most vulnerable recipients of the national child grant. The child grant is targeted at poor and vulnerable households with children aged under two years and at high risk of malnutrition. It reaches over 15,000 children. In three districts, 572 households eligible for the grant were selected to receive additional case management support for a period of nine months. This support included counselling, awareness raising on positive parenting practices and information on and referrals to services. Several adjustments had to be made to the programme during the COVID-19 pandemic, including carrying out some case management remotely through phone calls or text messages. Care plans that used to be developed alongside families in their homes were drafted in the office and then shared with families for sign-off. High-risk cases were always seen face to face providing there were no cases of COVID-19 in the family. There was also more remote oversight and support of social workers. Despite these adaptations, the programme continued to yield positive results. Evidence from a recent evaluation shows several beneficial outcomes related to children's care, including during the COVID-19 pandemic. These outcomes were particularly apparent in households receiving case management support in addition to cash transfers. In these families, caregivers spent more time engaged in activities with children, there were lower rates of violence against women and children, and there was a reduction in children being separated from their caregivers.

LESSON 5

Working across sectors and close collaboration between stakeholders have never been more important

Already widely acknowledged as a key component of successful care reform,[61] coordination between sectors and agencies became even more vital during COVID-19. Those working to improve the care of children relied heavily on assistance from the social protection, education, and health sectors.

Similarly, agencies trying to limit the spread of COVID-19 and respond to higher levels of household poverty needed the help of social workers to identify and reach target groups. For example, in Uganda social workers from Child's i Foundation were able to rapidly identify and access vulnerable households. Using existing connections to these families, they could quickly share information about the risks of COVID-19, and provide emergency medicines and material assistance.[62]

Evidence from South Africa and Kenya suggests that coordination bodies were needed to ensure effective collaboration during COVID.[63] These should be established during 'normal' periods and continue to operate in emergencies (see Box 4).

BOX 4

Coordinating care reform during the pandemic[64]

Kenya has a national committee working on care reform which functioned online during the pandemic. The committee constantly reviewed and responded to the risks faced by children and families. For example, they drafted protocols on emergency cash transfers and procedures for residential care providers. The committee was replicated at the sub-national level, enabling joined up localised responses and collaboration in case management.

LESSON 6

Effective innovations in remote policy making, case management, parenting supports, and social worker capacity building should be continued after COVID-19

Restrictions on face-to-face contacts during the pandemic led to many innovations in remote working. Key lessons learnt about when and how to work remotely to support the better care of children from the region include the following.

- It is possible to carry out complex participatory policy making processes online (see Box 5).
- There are numerous ways to support social workers remotely, including WhatsApp groups, online or telephone mentoring, online training, and podcasts (see Box 6).[65]
- As well as face-to-face sessions, caregivers can receive support on parenting in a variety of ways including WhatsApp groups, phone calls, messaging on TV, radio or social media, and written materials.[66]
- It is valuable to have a range of ways to build social worker or caregiver capacity remotely because individuals have access to and respond to different tools.[67] Some adults and children prefer online sessions, especially if they have social anxiety.[68] Generally tools and platforms that the target audience is already familiar with work best.[69]
- Social workers and caregivers should be provided with the necessary devices and data if they are expected to take part in online sessions. They may need tuition in how to use these devices and online platforms such as Zoom. Any online capacity building sessions should be kept short and, if possible, interactive.[70]
- Trainers must be aware of context. Individuals may be joining from busy homes and may feel stressed and tired because of their responsibilities.[71] Sessions should be timed appropriately, with some flexibility to accommodate competing demands on participants' time.
- Low-tech face-to-face training outside is still valuable if it is not safe/possible to meet inside.[72]
- Remote case management can be helpful; for example, to conduct some aspects of risk assessment, for regular monitoring of lower risk families, and for family group conferences.[73] Remote case management can be especially valuable for reintegrated children

who are often dispersed over long distances, making regular visits logistically difficult.[74] If caregivers cannot be reached by phone/online, in-person visits should be carried out instead.[75]

- Some case management must be done face to face, including with the most high-risk groups or at particularly delicate points in the child's care journey (for example when a child has just reintegrated from residential care).[76] Effective triaging is essential to identify those in need of this in-person support.[77]
- Social workers must be designated as essential workers so that they can continue to have some contact with children and families at times when social distance measures have been imposed.[78]
- It can be very hard for social workers not to be able to visit vulnerable children and families. They may feel that this invalidates their role and need reassurance that they can still provide assistance without these visits, and that their own safety and health matter.[79]
- It is not possible to speak with children confidentially when carrying out remote case management, as caregivers or others may be listening in. As a result, remote case management cannot be reliably used to identify cases of violence against children. If violence is suspected, a visit is necessary.[80]

BOX 5

Developing Kenya's 10-year National Care Reform Strategy at a distance[81]

The Government of Kenya began to develop the National Care Reform Strategy with UNICEF's support just as the pandemic hit the country in March 2020. The strategy was completed in 2022 with only one face-to-face meeting. Consultations were carried out with 120 stakeholder groups through 64 online events, and online workshops were convened to enable comments on drafts of the strategy. Although switching online was originally viewed as a constraint, it ultimately provided an opportunity to reach a wider range of individuals from across the country. The strategy has now been endorsed by the government and UNICEF report a widespread sense of ownership amongst stakeholders.

BOX 6

Examples of remote support to social workers

In Uganda, Catholic Relief Services developed several ways to support government social workers during the pandemic, including the following.[82]

- Uploading materials on COVID-19 to the government's social service workforce website.
- Pairing more experienced social workers with less experienced colleagues and establishing regular mentoring calls.
- Having regular group calls with social workers who had identified common problems (such as an increase in family separation). During the calls, social workers brainstormed solutions to the challenges that they faced.
- Setting up a WhatsApp group and using it to build a culture of question asking.
- Creating podcasts.

The remote working initiated during COVID-19 has had a lasting impact, with many of the initiatives started during COVID lockdowns continuing once restrictions were lifted. The technical working group that supports care reform has realised that remote work can be used to support social workers in remoter districts.

At a global level, a free short online course was developed on adapting case management during COVID.[83] The course taught social workers how to adjust case management procedures and work more effectively with others in response to child protection needs. It provided examples of promising practice from across the world to stimulate discussion between learners. The course was extremely popular, with over 8,000 participants. As noted in Box 2, agencies such as CTWWC also developed useful tools for remote case management.

LESSON 7

To improve children's care, it is vital to invest in community volunteers, structures, and caregivers

With social workers often unable to reach children, the role of community members in supporting vulnerable children and families was enhanced during the pandemic. Across Eastern and Southern Africa, community volunteers are a crucial part of the social services workforce. During lockdowns, before these para-professionals were able to carry out socially distanced visits to families, identify at-risk children, provide assistance, and make referrals to social workers where necessary (see Box 7).

Much violence within families in the region was already dealt with by the community prior to the pandemic.[84] Evidence from the Dadaab refugee camp in Kenya shows how reliance on community structures to resolve conflicts and seek justice increased during COVID-19. Unable to access trusted social workers, community members who experienced violence relied on committees of male elders known as Maslaha.[85]

Most children who either lost or were separated from a caregiver due to the pandemic were likely to have been cared for within the community by extended family or friends of the family. This kinship care was already the most common form of alternative care in the region before COVID-19.[86] The closure of many residential facilities further narrowed children's care choices, suggesting an increased reliance on kinship care during the pandemic.


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These findings show that care reform must be based on an understanding of the role of communities in supporting care and build on these considerable strengths. Of course, it is also important to understand and mitigate any risks associated with community contributions.

BOX 7

The role of community volunteers during COVID-19

In Rwanda, government-run networks of community volunteers working on family strengthening were often the first to assist extremely at-risk groups during lockdowns. With UNICEF support, these volunteers were able to provide emergency financial support and other forms of assistance whilst households applied for cash transfers. Volunteers also helped children with disabilities reintegrating from residential care during the pandemic.[87]

In Kenya, UNICEF and its partners trained community volunteers to support children reintegrating from residential care. Volunteers were taught basic case management, including how to make referrals to government social workers if abuse was suspected or identified. Volunteers' contributions to children's wellbeing were so effective it is likely that this role will continue after the pandemic.

For social workers from Child's i Foundation in Uganda, reliance on volunteers provided a key lesson from the pandemic.

> *"I have learnt that it is importance to ensure community structures are functioning on their own. When we could no longer visit families as social workers, the community volunteers who live within communities were able to step in and visit families to make sure that they had everything they need to survive the pandemic."*[88]

LESSON 8

Without adequate supports, the reunification of children from residential care to communities and families is risky and often unsustainable. If accompanied by proper investment, COVID-19 offers a major opportunity to reduce the reliance on residential care

In countries including Kenya and Uganda, government directed residential care providers to send most of the children in their care back to their families to reduce COVID-19 infections. The rushed nature of this reunification meant that many providers could not adhere to global and national guidance on reunification and reintegration. This guidance suggests that successful reintegration requires assessments of children and families, extensive preparation to address the factors that led to the original separation and follow up monitoring and support to ensure children are safe and well cared for.[89] A survey of providers in Kenya and Uganda found that on average staff had less than two weeks to prepare children and their families.[90] Most providers felt that this time was insufficient to address the causes of separation or rebuild relationships.[91] Providers were particularly concerned that the pandemic had increased poverty and limited access to schooling, worsening the capacity of already struggling families to care for children well.[92] Many providers were also unable to conduct visits to check on children's wellbeing.[93]

As the pandemic progressed, government and NGO partners in countries such as Kenya were able to give some assistance to reintegrating children. Anecdotal evidence suggests that this reduced vulnerability, further confirming the importance of properly supported reintegration (see Box 8 and Case study 2).

Temporary restrictions on the use of residential care during COVID-19 prompted a re-think amongst some residential care providers. Research with 21 managers of care homes in seven countries including Kenya found that around a third of providers were questioning their model of care.[94] Having seen the potential benefits of supporting children in their family settings, some providers have started to shift resources to family-based care.[95] Others may be prompted to reform by financial necessity. Many rely on financial contributions from international volunteers and this source of funding dried up during COVID-19 due to travel restrictions.[96] This evidence suggests that there is now a major opportunity for the transformation of residential care across the region.

BOX 8

Supporting children's reintegration during COVID-1997

On March 17th 2020, the Government of Kenya issued a directive stating that all 'congregate care' (which includes residential care facilities) should release children from their care immediately. Children were only allowed to remain if they had no family to return to. Prior to the pandemic there were an estimated 40–45,000 children in registered charitable children's institutions (CCIs) (and up to 200,000 in unregistered residential care facilities).[98] Access to services and education were found to be the main factors leading to placement.[99] Research by CTWWC in three counties revealed that 57 per cent of the children in residential care left as a result of the pandemic, with an estimated 95 per cent of these children going to live with parents or other relatives.[100]

Government agencies, UNICEF and NGOs involved in care reform quickly realised that families could not be expected to suddenly care for an extra child at a time of great financial hardship without support. Families were assisted with emergency cash transfers and information about the pandemic, child abuse hotlines, and key services. Case management guidance was also adjusted to ensure that social workers could identify and address child protection concerns. With the support of UNICEF and CTWWC, both social workers and CCI managers were provided with online training on meeting the needs of reintegrating children and their families. The government sought to keep track of the situation by issuing a second directive requiring that government social workers report the number of reintegrating children and any challenges that they were facing.

CASE STUDY 2

Reunification during COVID-19

Mary is a 12-year-old girl from Kenya. When she was seven years old, Mary's parents died and she was placed in the Vision of Charity Children's Home by her extended family, who felt they could not care for her or ensure that she continued with her schooling. When the government issued the directive requiring most children from residential care to return to their families, Mary was sent to live with her maternal grandparents.

CTWWC collaborated with a local organisation, Coastal Interfaith Council of Clerics (CICC), to determine the needs of Mary and her family. Initially, the family was given emergency material support to help them deal with the loss of income associated with the pandemic and to support Mary's care. To ensure Mary's grandparents could look after her in the long term, CICC helped the family to apply for government cash transfers and the National Health Insurance Fund. The family was also given a grant to start a small business selling eggs and firewood. Due to COVID-19, social workers' travel was curtailed, and initial contact with Mary was conducted by phone to check that she was well. Once social workers were designated essential workers and travel restrictions were lifted, Mary and her grandparents were able to meet with their case worker.

Mary missed her friends from Vision of Charity Children's Home and found rural life hard. She described challenges adjusting to a new home, getting to know her grandparents and other family members, contributing to household chores, and adapting to the simpler life of the village. She remembers desperately wanting to be back in the familiarity of the children's home with her friends.

> *"I just wanted to be with my friends… I didn't want to share a bed with my cousins. I wanted familiar meals and to go to my old school again."*

When schools and residential care facilities re-opened, Mary returned to the Vision of Charity Children's Home. Her grandparents supported this move as they wanted Mary to be happy and educated and assumed the schooling would be better in the children's home than the village. However, the COVID pandemic had given Mary an opportunity to reconnect with her grandparents, wider extended family, and community. Social workers continued to emphasise the importance of family care and provided counselling to Mary and her family. Mary was able to visit her grandparents regularly. With further collective work from the residential care home staff, CTWWC and government social workers, and, most importantly Mary and her grandparents, a decision was made for Mary to go home permanently. To ensure safe and long-term reintegration, the family was given support with their business and the Vision of Charity Children's Home supported Mary to attend a local private school. Mary's social worker reports that Mary is now living happily back with family, and describes a scene she recently witnessed:

> *"She was returning home from school. She was with a whole group of friends. They were laughing, smiling, skipping, sharing stories of their day… Mary's happiness, her comfort at home, is visible."*

Mary highlights how important support from social workers is for successful reintegration:

> *"I like having someone who understands that it takes time for me to get used to the changes… I can call Jane [Mary's social worker] and she listens to me and pays attention to what I'm going through. Her advice has helped me to learn how to be at home."*

LESSON 9

Support to mental health and emotional wellbeing is a crucial component of ensuring the better care of children

The COVID-19 pandemic placed an enormous strain on the emotional wellbeing of children and caregivers and the professionals working to support them. In families, levels of stress, anxiety, loneliness, and unhappiness increased due to fear about the spread of COVID-19, the loss of work and incomes, school closures, and isolation from friends and communities.[101] Professionals had to continuously adapt to changing rules and regulations, and to cover for colleagues off sick from work. Many felt impotent in the face of increasing harm to already extremely vulnerable children and families.[102] The pandemic showed how a failure to support mental health can lead to a deterioration in children's care. Stress was a major cause of violence in the home, and led to social workers becoming burnt out and no longer able to effectively support children and caregivers. The pandemic provided several promising practice examples of support to mental health that could be adapted to meet these needs in the future (see Box 9).

BOX 9

Strategies to support mental health that worked during COVID-19

- **Helping children to better understand change and risk.** For example, through story telling or books, to explain the COVID-19 virus and reduce anxiety.[103]
- **Providing activities to occupy children and reduce the burden on caregivers.** For example, in Uganda, Save the Children social workers distributed home learning packs which included short games and activities to keep children busy and help them deal with stress.[104]
- **Strategies for parents and other caregivers to cope with stress.**[105] For example, in Ethiopia the provision of stress management guidance helped foster carers to continue to care for children during the pandemic.[106] In Somalia, parenting messages delivered via TV and radio included guidance on how to cope with stress.[107]
- **Including assessment of mental health and strategies to respond to mental health needs in case management guidance and processes.** This includes ensuring the availability of up-to-date information on mental health services to make referrals where necessary.[108] Case workers found that some home visits were vital for truly determining the emotional wellbeing of children and caregivers and providing support to those in greatest distress.[109]
- **Extra training for Child Helpline or other staff working with children and families.** For example, in South Africa the Children in Distress Network developed a training manual for health workers on psycho-social support for children and families.[110]

Conclusion

As many countries in the region shift from crisis mode to 'learning to live with COVID', there are two likely scenarios in relation to the future of children's care in Eastern and Southern Africa and globally. If nothing is done, the deterioration of children's care during the pandemic will continue, with more children facing violence in the home or separated from their families. However, if governments and others use learning from COVID-19 to invest wisely in strengthening care and protection systems, there is now a unique opportunity for progress. Evidence highlighting the current high level of risk to quality care, and the challenges associated with the reliance on residential care during the pandemic, can be used to push reforms forward.

The pandemic has confirmed the value of a systematic approach to reform which begins with an in-depth understanding of context, places a strong focus on coordination and collaboration, includes a well-trained, equipped, and supported workforce, and recognises the vital role of extended families and communities. Care reform should emphasise prevention, but also include steps to enable safe reintegration for already separated children. If families are to care for children well, they now need particular assistance in relation to poverty alleviation, and access to education and mental health services. Some children cannot live with their families and the pandemic has further illustrated the need for a range of quality alternative care choices.

The pandemic has shown that children's care must be a key feature of all future emergency preparedness and response. Although COVID is now having less of an impact on children and families than at the start of the pandemic, new variants mean that the effects of COVID may be strongly felt once again. By demonstrating multiple examples of effective remote working and other adaptations, the pandemic has shown the great capacity of those working on care to innovate. Many governments, NGOs and UN agencies have revealed a determination to continue with reform, even during highly challenging periods. Families and communities have also confirmed their willingness to support the care of the most vulnerable children; and children themselves have been found to have great resilience. These strengths can and should be utilised in the battle to incorporate the better care of children in efforts to build back better after COVID-19.

Glossary

Care reform	Efforts to improve the legal and policy framework, structures and resources that determine and deliver alternative care, prevent family separation, and support families to care for children well.[111]
Alternative care	The formal and informal care of children outside of parental care. Children outside of parental care are children not in the overnight care of at least one of their parents, as parents are unwilling or unable to care for children.[112] The Guidelines for the Alternative Care of Children outline several different forms of formal and informal alternative care including kinship care, residential care and foster care.[113]
Residential care	Care provided in any non-family-based group setting.[114] Institutional care is one form of residential care and involves care in large-scale facilities where children are cared for in large groups, usually involving shift-systems, a common set of rules, children sleeping in dormitories, and isolation from wider communities.[115]
Family-based care	Care in a family environment. Family-based care includes kinship and foster care (see below for definitions) and care by the child's biological or adoptive parents.
Kinship care	Family-based care within the child's own extended family or with close friends of the family known to the child.[116]
Foster care	Foster care is a formal arrangement whereby a competent authority places children in the domestic environment of a family other than the child's own that has been selected, qualified and approved for providing such care.[117]
Case management	Case management is a key means of ensuring that vulnerable children and families get the services they need. Case management uses standardised guidance to support social workers in identifying needs, making referrals to appropriate services, monitoring children and families, and keeping effective records.[118]

Endnotes

1 See for example: Hackett, K., Proulx, K., Alvarez, A., Whiteside, P. and Omoeva, C. (2021) *Case studies of programmes to promote and protect nurturing care during the COVID-19 pandemic*. USA: FHI 360.

2 Adapted from: https://bettercarenetwork.org/toolkit/glossary-of-key-terms#C

3 COVID Collaborative et al. (2022) *Urgent action to overcome the threat of COVID-19-associated orphanhood and associated death*, p.3. See for full list of agencies https://bettercarenetwork.org/sites/default/files/2022-02/Save%20Lives%20Now_COVID-19-associated%20orphanhood_41%20LOGOS%2024%20Feb%202022%20-%20FINAL%20sent.pdf

4 Ibid., p.2.

5 Ibid. The 12 countries are: South Africa, Ethiopia, Zimbabwe, Kenya, Zambia, Uganda, Namibia, Malawi, Mozambique, Angola, Eswatini, and Lesotho.

6 Unwin, H., Hillis, S., Cluver, L., Flaxman, S., Goldman, P., Butchart, A., Bachman, G., Rawlings, L., Donnelly, C., Ratmann, O., Green, P., Nelson, C., Blenkinsop, A., Bhatt, S., Desmond, C., Villaveces, A., and Sherr, L. (2022) Global, regional, and national minimum estimates of children affected by COVID-19-associated orphanhood and caregiver death, by age and family circumstance up to Oct 31, 2021: an updated modelling study. *The Lancet Child & Adolescent Health* 6(4): 249–259.

7 COVID Collaborative et al. 2022, p.3.

8 Haffejee, S., and Levine, D. (2020) '*When will I be free': Lessons from COVID-19 for child protection in South Africa*; Human Rights Watch (2021) "*I must work to eat": COVID-19 poverty and child labour in Ghana, Nepal and Uganda*. New York: Human Rights Watch; Katz, I., Priolo-Filho, S., Katz, C., Andresen, S., Bérubé, A., Cohen, N., Connell, C., Collin-Vézina, D., Fallon, B., Fouche, A., Fujiwara, T., Haffejee, S., Korbin, J., Maguire-Jack, K., Massarweh, N., Munoz, P., Tarabulsy, G.M., Tiwari, A., Trutert, E., Varela, N., Wekerle, C. and Yamaoka, Y. (2021) One year into COVID-19: What have we learned about child maltreatment reports and child protective service responses? *Child Abuse & Neglect* 130(1); Save the Children (2020a) *Save the Children protection assessment on the impact of COVID-19 in Uganda*. UK: Save the Children; Sserwanja, Q., Kukuki, J. and Kim, J. (2020) Increased child abuse in Uganda amidst COVID-19 pandemic. *Journal of Paediatrics and Child Health* 57(2): 188-191.

9 UN Women (2020) *Whose time to care? Unpaid domestic work during COVID-19*. USA: UN Women; UNICEF (2020a) *It's time for care. Prioritising quality care for children during the COVID-19 pandemic – challenges, opportunities and an agenda for action*. UNICEF: New York.

10 ChildFund, Plan International, Save the Children, SOS Children's Villages, Terre des Hommes and World Vision (2020) *Keeping children safe in Uganda's Covid-19 response*. Uganda: ChildFund, Plan International, Save the Children, SOS Children's Villages, Terre des Hommes and World Vision; Save the Children 2020a.

11 ChildFund et al. 2020; Haffejee and Levine 2020; Save the Children 2020a; Save the Children (2020c) *Impact of COVID-19 on protection and education amongst children in Dadaab refugee camp, Kenya*. UK: Save the Children.

12 Hackett et al. 2021; Save the Children 2020a; WHO–UNICEF–Lancet Commissioners (2020) *After COVID-19, a future for the world's children? The Lancet* 396(10247): 298–300.

13 Save the Children 2020c.

14 Sserwanja, Kukuki and Kim 2020.

15 Ibid.

16 Samboma, T. (2020) Vulnerability of children in Botswana during COVID-19. *International Social Work* 63(6).

17 Save the Children 2020c.

18 Fouche, A., Fouche, D. and Theron, L. (2020) Child protection and resilience in the face of COVID-19 in South Africa: A rapid review of C-19 legislation. *Child Abuse & Neglect* 110(2); Katz et al. 2021.

19 Nhep, R. and van Doore, K. (2021) *Impact of COVID-19 on privately run residential care institutions: insights and implications for advocacy and awareness raising*. USA: Better Care Network; interviews with UNICEF country office staff.

20 Nhep and van Doore 2021.

21 Haffejee and Levine 2020; Swanzen, R. and Jonker, G. (2020) *COVID-19 and alternative care in South Africa: children's responses to the pandemic. A case study from a child and youth care centre in Mogale City*.

22 Ibid.

23 Cited in Haffejee and Levine 2020.

24 Wilke, N., Howard, A. and Goldman, P. (2020) *Rapid return of children in residential care to family as a result of COVID-19: Scope, challenges, and recommendations. Child Abuse & Neglect* 110(2).

25 Haffejee and Levine 2020.

26 http://www.covid19-childprotectioncasemanagementmooc.com/index.php/en/followup

27 ChildFund et al. 2020; Fouche et al. 2020; Katz et al. 2021; Save the Children 2020a; Save the Children 2020c; The WHO–UNICEF–Lancet Commissioners 2020.

28 ChildFund et al. 2020; Human Rights Watch 2021.

29 https://www.cdc.gov/violenceprevention/aces/fastfact.html

30 ChildFund et al. 2020; Haffejee and Levine 2020; Human Rights Watch 2021; Save the Children (2020b) *COVID-19 impacts on African children – how to protect a generation at risk*. UK: Save the Children.

31 Save the Children 2020b.

32 COVID Collaborative 2022.

33 Names have been changed to protect identities.

34 Alliance for Child Protection in Humanitarian Action, the Better Care Network, Save the Children and UNICEF (2020) *Guidance for alternative care provision during COVID-19*. USA: Alliance for Child Protection in Humanitarian Action, the Better Care Network, Save the Children and UNICEF.

35 From interview with the MHRC and Malawi Human Rights Commission (2021) *Child care institutions monitoring report*. Malawi: Malawi Human Rights Commission.

36 Nhep and van Doore 2021.

37 Wilke et al. 2020.

38 Swanzen and Jonker 2020.

39 Haffejee and Levine 2020.

40 Fouche et al. 2020.

41 Ibid.

42 Ibid.

43 Alliance for Child Protection in Humanitarian Action (2021a) *Strengthening caregiving environments: prioritising family-based care in humanitarian settings during COVID-19*. Geneva: Alliance for Child Protection in Humanitarian Action.

44 Changing the Way We Care (2020a) *Case management considerations for children in residential care during the COVID-19 pandemic*. USA: CTWWC.

45 Alliance for Child Protection in Humanitarian Action 2021a.

46 Changing the Way We Care (2020b) *Gatekeeping considerations during the COVID-19 pandemic*. USA: CTWWC; Alliance for Child Protection in Humanitarian Action et al. 2020.

47 Alliance for Child Protection in Humanitarian Action et al. 2020.

48 Changing the Way We Care 2020b; Alliance for Child Protection in Humanitarian Action et al. 2020.

49 Family for Every Child (2020a) *Prioritising support to kinship care in response to COVID-19*. UK: Family for Every Child.

50 Ibid.

51 Republic of Kenya, Ministry of Labour and Social Protection (2020) *Preventing and responding to COVID-19. Key messages to support those working with vulnerable children and families in Kenya – April 2020*. Kenya: National Council for Children's Services.

52 Changing the Way We Care (2020c) *Case management considerations for children at risk of separation, including recently reunified children, during the COVID-19 pandemic*. USA: CTWWC; Changing the Way We Care 2020a.

53 Alliance for Child Protection in Humanitarian Action 2020.

54 Republic of Ghana, Department of Social Welfare, Ministry of Gender and Social Protection (2020) S*pecial guidance of child protection case management – preventing and responding to COVID-19*. Ghana: Republic of Ghana, Department of Social Welfare, Ministry of Gender and Social Protection.

55 Republic of Kenya 2020.

56 Hackett et al. 2021.

57 UNICEF and Changing the Way We Care (2022) *Creating synergies between social protection and care reform in Eastern and Southern Africa*. Kenya: UNICEF.

58 From interview with UNICEF Kenya.

59 From: UNICEF and Changing the Way We Care (2021a) *Care reform in Zambia. A virtual study tour*. Kenya: UNICEF.

60 From interviews with UNICEF Mozambique country office staff and Bonila, J., Castro-Zarzur, R., Seidenfeld, D, Peterman, A. and Brukauf, Z. (2022) *24 month impact evaluation of the child grant 0-2 component in the Nampula province in Mozambique – endline report*. American Institute for Research and UNICEF: Mozambique; UNICEF (2021) *Case study of child marriage in the Republic of Mozambique*. Kenya: UNICEF.

61 UNICEF (2020b) *Caring systems. Maximising synergies between care reform and child protection system strengthening in Eastern and Southern Africa*. Nairobi: UNICEF.

62 Child's i Foundation (2020) *The Child's i Foundation impact report summer edition 2020: COVID -19*. UK: Child's i Foundation.

63 Fouche et al. 2020; Haffejee and Levine 2020.

64 From interview with UNICEF Kenya.

65 The Alliance for Child Protection in Humanitarian Action (2020) *Technical note: Adaptation of child protection case management to the COVID-19 pandemic- Version 2* Geneva: The Alliance for Child Protection in Humanitarian Action

66 Save the Children (2021) *Adapt. Imagine. Innovate. Child protection during COVID-19: A catalogue of innovations and adaptations*. UK: Save the Children; Hackett et al. 2021; Alliance for Child Protection in Humanitarian Action 2021a.

67 Hackett et al. 2021.

68 Hackett et al. 2021.

69 Save the Children 2021.

70 Hackett et al. 2021; Save the Children 2021; interviews with UNICEF Kenya.

71 Save the Children 2021.

72 Hackett et al. 2021.

73 Changing the Way We Care 2020a; Save the Children 2020c

74 From interview with CTWWC in Kenya.

75 Changing the Way We Care 2020a.

76 Bonila et al. 2022; Changing the Way We Care 2020a; interviews with UNICEF country offices; Alliance for Child Protection in Humanitarian Action 2020.

77 Bonila et al. 2022; Changing the Way We Care 2020a

78 Alliance for Child Protection in Humanitarian Action 2020; Changing the Way We Care 2020a.

79 From interview with CTWWC in Kenya.

80 Changing the Way We Care 2020a.

81 UNICEF and Changing the Way We Care (2021b) *Care reform in Kenya. A virtual study tour*. Kenya: UNICEF

82 From interview with Catholic Relief Services, Uganda.

83 https://www.futurelearn.com/courses/covid-19-adapting-child-protection-case-management

84 UNICEF 2020b.

85 Save the Children 2020c.

86 UNICEF 2020b.

87 From interviews with UNICEF Rwanda.

88 Child's i Foundation 2020.

89 The Inter-agency Group on Children's Reintegration (2016) Guidelines on children's reintegration. UK: Family for Every Child.

90 Wilke et al. 2020.

91 Ibid.

92 Ibid.

93 Ibid.

94 Nhep and van Doore 2021.

95 Ibid.

96 Ibid.

97 Unless otherwise stated, the information in this box is from Alliance for Child Protection in Humanitarian Action et al. 2020.

98 Aben, C. (2020) *Preliminary report on the status of child protection in charitable children's institutions in Kenya*. Kenya: National Crime Research Centre.

99 Ministry of Labour and Social Protection, State Department for Social Protection, Department of Children's Services (2020) *Situation analysis report for children's institutions in five counties: Kiambu, Kilifi, Kisumu, Murang'a and Nyamira. Summary report*.

100 Changing the Way We Care (2020d) *Coronavirus disease 2019 (COVID-19) situation report – May 2020*. Kenya: CTWWC.

101 UNICEF 2020a; Hackett et al. 2021.

102 Changing the Way We Care 2020a; interviews with UNICEF country offices and partners across the region.

103 The Alliance for CP in Humanitarian Action (2021b) *COVID-19 Synthesis number 6- Topic: Mental Health and Psychosocial Support Among Children in Humanitarian Settings*

104 Save the Children 2021.

105 UNICEF 2020a

106 Alliance for Child Protection in Humanitarian Action 2021b.

107 Ibid.

108 Save the Children 2021.

109 Ibid.

110 Family for Every Child (2020b) *Psychosocial support for children and families during COVID-19 – CINDI*. UK: Family for Every Child.

111 Adapted from: https://bettercarenetwork.org/toolkit/glossary-of-key-terms#C

112 United Nations General Assembly (2010) *Guidelines for the alternative care of children*. GA Res 142, UNGAOR, 64th session, supplement number 49, Vol.1 (A/64/49 2010). New York: United Nations.

113 Ibid.

114 Ibid.

115 Family for Every Child (2012) Towards a family for every child. Conceptual framework. London: Family for Every Child.

116 United Nations General Assembly 2010.

117 Ibid.

118 UNICEF and the Global Social Service Workforce Alliance (2019) *Guidelines to strengthen the social service workforce for child protection*. New York: UNICEF.

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