Country Care Profile

Kenya

Better Care Network

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The Better Care Network (BCN) in partnership with key stakeholders initiated in 2014 a series of 'Country Care Profiles' to provide an overview and analysis of the national care system reforms efforts across different countries and regions. The goal of the country care profiles is to inform the strengthening of care reform efforts globally, as well as within a particular region. The adoption, in 2019, of a UN General Assembly Resolution focused on the rights of children without parental care has underlined growing international commitments towards supporting family-based care for children, ongoing child protection systems-strengthening initiatives, deinstitutionalization, and reintegration efforts. The profiles can contribute to the exchange of information, between and among countries, on successes and challenges in implementing care reform efforts, facilitate the development of a community of practice across countries, and harness reform and political will among donors, governments, and non-governmental actors. Ultimately, these care reform profiles can increase collaboration between national and regional actors passionate about, and promotive of, safe and nurturing family-based care for children in any context.

To access other Country Care Profiles, see: https://bettercarenetwork.org/country-care-profiles

To access the Kenya Country Care Snapshot providing a high-level overview of the status of children's care and care reform efforts in the country, as well as related research, tools, and news about children's care in the country on the Kenya page of the BCN website, see: https://bettercarenetwork.org/regions-countries/africa/eastern-africa/kenya.

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Acronyms

AAC	Area Advisory Council
ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
CCAC	County Children's Advisory Committee
CCI	Charitable Children's Institution
CHH	Child-headed household
CO	Children's Officer
CPIMS	Child Protection Information Management System
CPV	Child Protection Volunteer
CRSC	Care Reform Sub-Committee
CSO	Civil Society Organisation
CT-OVC	Cash Transfer – Orphans and Vulnerable Children
CTWWC	Changing the Way We Care
CWD	Children with Disabilities
CWSK	Child Welfare Society of Kenya
DCS	Directorate of Children's Services (formerly the Department of Children's Services
DHS	Demographic Health Survey
FBO	Faith-Based Organisation
KES	Kenyan Shillings
KESCA	Kenya Society of Care Leavers
MLSP	Ministry of Labour and Social Protection
MWENDO	Making Well Informed Decisions for OVC
NCCS	National Council for Children's Services
NGO	Non-governmental Organisation
NPRP VAC	National Prevention and Response Plan on Violence Against Children 2019-2023
OVC	Orphans and Vulnerable Children
SCCO	Sub-County Children's Officer
SCCAC	Sub-County Children's Advisory Committee
SCI	Statutory Children's Institution
SDG	Sustainable Development Goal
SGBV	sexual and gender-based violence
SOP	Standard Operating Procedures
UASC	unaccompanied and separated children
UN	United Nations
UNCRC	Convention on the Rights of the Child
UNHCR	United Nations High Commissioner for Refugees
USD	United States Dollars

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1 Executive Summary

1.1 Country context

Kenya is an East African country with a population of close to 50 million people, of whom 46 per cent are children.[1] A middle-income country,[2] it has one of the fastest growing economies in Sub-Saharan Africa.[3] However, climate change and the COVID-19 pandemic have negatively impacted the economy. Two million Kenyans descended into poverty because of the economic shocks in 2020,[4] although the economy did begin to recover from 2021 onwards.[5] Kenya is particularly vulnerable to climate change, with a predicted increase in the frequency of droughts, resulting in major challenges for food security and water availability, and increased extreme events (droughts and floods, combined with landslides).[6] Kenya is also home to some of the world's largest refugee camps, including Kakuma and Dadaab.

Kenya is a republic with a new constitution[7] designed to reflect and celebrate the unique diversity of the country in terms of religion, culture, and identity, while also unifying the country under shared principles. This was important as a means of acknowledging, but, most importantly, moving forward from, ethnic tensions and the impact of its colonial past. In 2013, Kenya adopted a devolved system of governance, with power devolving to the country's 47 counties. Each is led by a governor, elected by residents, who appoints a county executive committee.

1.2 Methodology

Research took the form of a desktop review, key informant interviews and data analysis.

1.3 Key findings

1.3.1 Legislative framework

Kenya is rightly proud of its strong legislative framework related to the role of the family and children's rights to care and protection, and was recognised as one of the most child-friendly states in Africa in 2008.[8] This framework is grounded in the UNCRC, which Kenya ratified in July 1990. The constitution recognises parental responsibility for the care of children by married and unmarried persons, an important change from before, allowing more opportunities for children to grow up in a family environment. The Children Act 2022 was enacted in July 2022,[9] following an extensive consultative process that engaged many within the child protection and care sector. It introduced many elements that support family-based care. In parallel, regulations that will facilitate implementation of the Act have been drafted.[10]

The National Care Reform Strategy, launched in 2022, provides a robust framework for care reform. It also follows from a lengthy consultation and collaboration process. This strategy, and the passage of the Children Act 2022, are important steps forward in enabling care reform. The participatory process to develop the National Care Reform Strategy and identify key roles, responsibilities and milestones was a tremendous effort, and will help map the way ahead, and provide the momentum needed, over the next ten years. The costing of the National Care Reform Strategy, and the development of a monitoring and evaluation framework, are also critical to this effort, and are currently in development.

The role of the social service workforce, in child protection broadly and in care specifically, has been recognised as part of the broader systems-strengthening efforts that began in 2010. However, it is well known that the number of, the capacity of, and the supervisory structures and processes to support, the workforce are insufficient. The National Care Reform Strategy places the social service workforce as a cross-cutting issue, and sets out several specific, measurable actions to strengthen workforce capacity to facilitate care reform in the best interests of children.

The legislative framework is quite clear in recognising the primary role of the family and the responsibility of the government and others to support them in that role. The Constitution of Kenya (2010) states that '[t]he family is the natural and fundamental unit of society and the necessary basis of social order, and shall enjoy the recognition and protection of the State.'[11] The NPRP VAC has family support as one of its five strategic areas.[12] According to the *Kenya National Care System Assessment* (2020), there is a sense that implementation of those laws and policies is not adequate, and that there are significant challenges in terms of ensuring access to services that help families in

their ability to care for children.[13] There is a growing legal and policy framework supporting the strengthening of families through access to social protection and basic services, as well as specialised services for specific populations. However, implementation of those laws remains a significant barrier to families accessing the support they need.

There remain challenges in terms of delivery of, and access to, those services, especially for the most vulnerable children and families. More broadly, there are issues with accessing essential social services for vulnerable families. The national cash transfer programme has been well researched, and is recognised as helping prevent family separation. However, there are concerns about coverage and targeting. Significant progress has been made in improving access to free primary and secondary education, and health insurance, but participants noted that some challenges with coverage and access remain. Many studies have noted that education is not free, and books, uniforms and other 'hidden' fees often prohibit children from attending.

Gatekeeping mechanisms and processes are well articulated in national guidelines, and through the AACs. Application into practice is significantly lacking, however, and very few communities have an active gatekeeping mechanism in place. Recent efforts to develop SOPs for different care options, and gatekeeping guidelines, should help.

Kinship care is the most commonly practiced form of alternative care, and is almost exclusively informal. A 2012 study conducted in Busia County noted that, of the 11 per cent of children living in households without either biological parent, a significant majority were in informal kinship care.[14] The qualitative study found a wide range of socio-economic factors and cultural practices that result in children being placed in kinship care, including: family poverty; family breakdown (divorce, re-marriage, polygamy, early marriage, alcoholism); poor health, death of parent, HIV and AIDS; lack of access to schools, health services or livelihood opportunities; political insecurity, conflict, and disasters; and urbanisation and migration. Recent research into kinship care, undertaken by Family for Every Child, shows that many extremely poor families still take children in through kinship care, despite a risk to their own material well-being.[15]

Kinship care is recognised as a viable care option, and children have reported positive experiences. There are, however, concerns with discrimination and exploitation in some cases, as well as very limited oversight of children's well-being by mandated government bodies. Gender, age and geography all impact kinship care in different ways. The newly drafted standard operating procedures for kinship care should address some of these concerns, and assist in placement procedures guided by good practice. Kinship care has been very common in recent reunification efforts, including during the rapid reunification caused by COVID-19.

Formal foster care placement is defined in the Children Act 2022 as the 'temporary placement of a child or children in the care of a person who is not the parent, relative or guardian of the child.'[16] Informal foster care is not provided for within the Children Act 2022, although kinship care is recognised as an alternative care service.[17]

In previous legislation, foster care required placement through a CCI. This was noted as being one of the biggest barriers to foster care.[18] In addition, people did not understand the term, and confused it with adoption. The Children Act 2022[19] has changed this, and it is hoped that it will, therefore, be easier to place children in foster care, making it a truly viable option for children for whom it is in their best interest.

There is no collated data on the number of children currently placed in formal foster care. Individual COs might have the data, but it is not collated in a standardised manner at the national level. The limited use of foster care as a care option was noted by the CRC in the 2016 Concluding Observations.[20]

Kenya has conducted a significant number of reunifications over the past several years, due in part to concerted efforts by NGOs and government, as well as

in response to the COVID-19 pandemic. These have had both positive and negative results. The national Case Management Guidelines for Reintegration of Children into Family-based Care, developed in response to the need for comprehensive, standardised and harmonised case management approaches to promote family care for children, have been used to support this process.[21] The guidelines were developed by a national government and non-government collaborative working group in 2019, and the completed package includes a caseworker guidebook, a caseworker toolkit and field-friendly handbook, and training resources.

Kafaalah and domestic adoption are both practiced in Kenya. Kafaalah is primarily prevalent in the coastal regions. Between 2021-22, standard operating procedures for kafaalah were developed, overseen by Muslim leaders and Imams, with the intention of standardising the practice and promoting it within Muslim communities.

Domestic adoption is also gaining more traction, especially since a moratorium on intercountry adoption was instituted more than five years ago. Stigma around adoption is being addressed as Kenyan adoptive families join networks and publicise their experiences on Facebook groups. Although fear, misinformation and stigma related to adoption remain, there are concerted efforts to promote it as a valid care option for a specific group of children.

1.3.2 Care during an emergency

Kenya has had to deal with different types of emergencies during the past several decades, including migration, refugees, political turmoil, terrorism, floods, famine, and drought. Kenya continues to confront HIV and AIDS, and, like all countries in the world, is currently adapting to the significant and ongoing impacts of the COVID-19 pandemic.

Kenya is home to 494,874 registered refugees and asylum-seekers, of whom 81,015 (16.4 per cent) reside in urban areas, not in refugee camps.[22] More than half are children, with data from 2021 showing a total of 266,524 children who are refugees or asylum-seeking in Kenya.[23] The humanitarian sector in Kenya has experience in reunification. In refugee camps such as Dadaab and Kakuma, where unaccompanied and separated children often arrive, standardised assessment tracing processes are utilised. The use of family-based alternative care is also prevalent in the camps.

Kenya confirmed its first COVID-19 case on 13th March 2020. On March 17, 2020, the government issued a directive instructing all residential care facilities, including boarding schools and childcare facilities, to release children from care immediately.[24] Following this, a second directive was issued, requiring children's officers and social services to submit a report detailing the number of children released to families, and challenges associated with the process. To support the implementation of the directive, the DCS, with support from civil society members of the working group, conducted a rapid mapping to determine the number of children returned home and the number remaining in residential care facilities. This information was presented, and used to inform appropriate responses.[25] Initial findings showed that more than 20,000 children were rapidly reunified, many with kinship families. However, this was done in a chaotic and unplanned manner, resulting in haphazard, and sometimes dangerous, situations for children. The government and several NGO partners developed and implemented virtual monitoring tools, conducted follow-up visits, and worked quickly to find ways to continue supporting the children's care, despite the challenges posed by the pandemic.

Studies conducted over the past two years illustrate the devastating impact on children's care during the pandemic, including increased rates of sexual and gender-based violence, depression, and suicide. Children have abandoned school, been forced to the streets, and been forced into child marriage. To put this in context, the economic devastation resulting from the pandemic put families at risk of hunger, increased poverty, and made children more susceptible to violence, abuse, neglect, exploitation, and separation. Although most COVID-19 public health restrictions have been lifted, the long-term effects, including the economic challenges, continue to impact on children.

Care leavers have played an important role in the care reform efforts of the last fifteen years. The establishment of KESCA has been instrumental in raising the profile and voices, and securing a place at the table, of those with lived experience. KESCA members have actively engaged in discussions around policy and guidance, and are part of the Care Reform Core Team, and in so doing, comprise a model for other countries. They have highlighted the innate challenges faced by care leavers, including the risk of exposure to trauma in sharing their story, or being engaged in discussions that bring back memories of their own care. They have also brought to the forefront how resources, status and professional experience can, and do, negatively influence their ability to participate in critical activities related to care reform.

1.4 Conclusions

Significant progress over the past decade has established a foundation for a coordinated care reform effort. A strong legislative framework, the adoption of the *Guidelines for the Alternative Family Care of Children in Kenya* (2014), investment in a national cash transfer programme, and recognition by all actors that government, civil society, multi and bi-laterals, and communities, have a unique role to play in care reform. In the past five years, Kenya has built on the foundation by catalysing increased traction and coordination, as well as notable additions such as the Children Act 2022 and the *National Care Reform Strategy*, recognising and training the workforce, and developing standard operating procedures for care options.

A critical element of Kenya's shared and coordinated care reform journey has been understanding how children should be cared for. This is the idea behind the care reform—prevention of separation, expansion of family-based alternatives, and transformation of residential care. Finding ways to define and then disseminate this message amongst key stakeholders at all levels, both within government and in civil society, has made a tremendous difference.

The establishment of the Care Reform Core Team, led by government, created a platform that facilitated communication, visioning, planning and implementation,

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and also played a critical role in fostering coordination and shared ownership of the process. Though far from perfect, the improvements in coordination and collaboration have been noted by key stakeholders. Specifically, there is recognition of the contributions of civil society, and appreciation for the oversight and leadership role government must assume to drive the process forward. The *National Care Reform Strategy* provides for the establishment of an Oversight and Coordination Division and a Care Reform Technical Advisory Committee.[26]

Active leadership and concrete actions by government have the power to influence care reform efforts significantly. Many noted that government taking a stand, and making important decisions, positively influenced the process. Whilst the impact was not necessarily immediate, most agree that they were influential and have been instrumental in the process being where it is currently.

However, there is also concern that lack of enforcement, especially at the local level, can and does result in continued unethical, and sometimes illegal, practices that put children in danger.

Having a legislative framework supported by operational guidance that reflects the core tenets of the care reform agenda is critical. The Children Act 2022 will facilitate implementation of the law, and mitigate the risk of further loopholes, as implementation and practice are being addressed simultaenously within the Act. The National Care Reform Strategy provides a clear framework for care reform, and a road map for implementation. Participatory approaches to designing the instruments have also been critical to ensuring that key stakeholders feel a sense of ownership in the process.

Kenya has clearly situated care reform within a wider systems context. This has reduced duplication of efforts between different actors, reduced the risk of contradictory programming, and enabled children in alternative care to be viewed within a broader positioning of children in need of care and protection. Including family strengthening within the care reform agenda promotes the idea of child well-being, as well as representing a more holistic approach to addressing risks. As such, closer coordination and integration of family strengthening within the education, health and social protection sectors will be important to ensure that care reform is not seen as just an issue of responding to child protection violations, but also of strengthening families and preventing separation.

The concerted effort to focus on prevention and early intervention as part of care reform – but also as part of the VAC agenda, which is the forum around which many of the other sectors have coalesced – and broader child protection system strengthening efforts, could shift minds significantly and enable a more family- and community-centred approach. This will also present a tremendous opportunity to design public awareness campaigns. Utilising the key messages included in the National Care Reform Strategy is an excellent starting point.

Kenya has also placed a renewed focus on, and appreciation of, the role of the workforce as central to implementing the legislative framework. The government and civil society actors increasingly recognise that investing in social service workforce development, including training, increased numbers, and standardised training curricula, tools, and processes – such as gatekeeping or supportive supervision – are a fundamental element of their success. Designing a planned and resourced roll out of the standard operating procedures for the different care options, led by government and supported by civil society is a critical action. Awareness-raising efforts to inform communities about these care options should be designed to accompany the roll out.

The costing and development of a monitoring and evaluation framework for the National Care Reform Strategy is critical in providing a roadmap and resources to continue the important work that remains.

One significant gap is the needs and experiences of children with disabilities, and their families. A concerted effort will be required to ensure the inclusion of children with disabilities in all care reform components, including prevention, access to appropriate services (health, education, psychosocial and economic), alternative family-based care, and reintegration.

COVID-19, the economic downturn, and climate change will have a lasting impact on children and families. These issues can and will make families more vulnerable, which is why it is critical that government and civil society partners utilise the new legislative framework and the National Care Reform Strategy as a roadmap to guide the way forward. To ensure that the progress made in reforming the care system is maintained and built on, all actors will need to remain prepared, continue planning and adapting, as needed, to address new and ongoing threats to children's well-being, and work together.

KAREN KASMAUSKI FOR CRS

2 Introduction

2.1 Purpose and objectives

The Country Care profiles are a series of reports that document the experiences of several countries engaged in care reform. The series aims to provide the reader with an in-depth look at how and why care reform has occurred, who has been involved in the process, what the specific roles and responsibilities are and, perhaps most importantly, and of interest to practitioners and policymakers, how it was done.

The Country Care Profile for Kenya provides an overview of care reform efforts to date, including successes, challenges, and lessons learned from the process. Kenya is the newest addition to the series.

Kenya's experience provides useful contributions to the global story of care reform. Some are shared with other contexts, while others are unique to Kenya. For example, Kenya has leveraged important contributions from the HIV sector, learning from their research and programming about approaches and interventions that strengthen families. With the violence against children (VAC) agenda, there is a similar chance to learn from some of the missed opportunities to link efforts that have occurred in the past.

Kenya also highlights the importance of investing time and energy towards creating a shared definition and vision of care reform by all key actors, now articulated in the National Care Reform Strategy for Children in Kenya - 2022–2032 (referred to as the *National Care Reform Strategy*).[27] The journey towards this common vision and strategy has not always been easy, but the benefits are that government and civil society increasingly share a common understanding of what care reform involves, as well as a commitment to family-based care for children. The past decade has seen the development of several seminal documents related to care, including residential care standards and guidelines. In the past five years, a concerted effort, by both government and civil society, has enabled all actors to move forwards together, towards a commonly understood end goal of sustained care reform.

These are some of the main factors for this success:

- Recent directives by the government, including a moratorium on intercountry adoption, strict registration requirements for new Charitable Children's Institutions (CCIs) as per the Children Act 2022, and a directive to reunify children from CCIs and Statutory Children's Institutions (SCIs) as a means of preventing the spread of COVID-19. These critical actions had a positive impact on the care reform process, contributing to achieving the end goal of transition to family care, as stated in the National Care Reform Strategy.
- Enhanced collaboration between government, civil society, and those with lived experience – especially care leavers – with mutual recognition of roles and responsibilities, illustrated the necessity of active engagement and coordination of all actors.

These successes are critical, and did not come about without significant investment from all actors.

This report details the unique story of the experience in Kenya, taking into account all the key components of care reform. The story is ongoing, but the lessons described in this document can provide both useful information and inspiration to governments, policymakers, practitioners, and others who wish to create a world where children and families are valued, protected, and supported to provide safe and nurturing family-based environments.

2.2 Methodology

Data was largely drawn from a desktop review and key informant interviews, as well as the data analysis used to inform the development of the *National Care Reform Strategy*, the situational analyses, and the *Kenya National Care System Assessment* (2020).[28]

As part of the desktop review, an online search of documents was conducted, on both the Better Care Network website and search engines, using specific search criteria such as 'Kenya + residential care', 'Kenya + care reform', 'Kenya + foster care', 'Kenya + kinship care', and 'Kenya + kafaalah', for example. Documents were also shared by the Government of Kenya departments,

Changing the Way We Care (CTWWC), Stahili, and UNICEF. Resources included laws, policies, standards and guidelines, programme reports, assessments, evaluations, and peer-reviewed articles highlighting issues of care and protection, and were guided by a matrix (see **Appendix 2**) that highlighted the critical elements of a care system. In total, 112 documents were reviewed.

Ten key informant interviews were conducted with critical actors, including government officers within the National Council for Children's Services (NCCS) and the Directorate of Children Services (DCS), UNICEF staff and directors, and NGO practitioners. The interview questions related to the legal and policy framework, services, data, workforce, successes, challenges, lessons learned, and clarifications.

Once the first draft of the document was completed, it was reviewed by Better Care Network, as well as a select number of reviewers, including eight who are members of the sub-committee of the Care Reform Core Team. The review process was overseen by the NCCS, which chairs the Care Reform Core Team.

2.3 Structure

This Country Care Profile provides an overview and analysis of key areas of the care reform process in Kenya, which has its origins in international and national standards relevant to children's care, including the *Convention on the Rights of the Child* (UNCRC), the *Convention on the Rights of Persons with Disabilities*, the UN *Guidelines for the Alternative Care of Children*[29] and the national *Guidelines for the Alternative Family Care of Children in Kenya*.[30] Key areas include:

1. National enactment and implementation of the legislative framework
2. Coordination structures
3. Information management systems, data, and data for decision-making
4. Preventive and family support services including gatekeeping mechanisms
5. The continuum of alternative care services
6. Residential care and deinstitutionalisation efforts, including reintegration and transition of residential care facilities
7. The experiences and voices of those with lived experience
8. Domestic and intercountry adoption
9. Care during an emergency
10. Social service workforce
11. Community awareness

Each section summarises the current context, progress to date, and noted successes and challenges. The structure of the document follows that used for the other Country Care profiles, with some additions based on the Kenya experience. The conclusions are designed to capture key learning from care reform in Kenya that could be helpful to other countries in the region, or elsewhere, considering initiating, or having already begun, a care reform process.

2.4 Country context

Kenya has a population of close to fifty million inhabitants (47,564,296),[31] divided into 47 counties (see Figure 1), with rich and unique cultural traditions and varying geographical landscapes. It has a total of 582,646 square kilometres, of which most (80 per cent) is arid or semi-arid, and only 20 per cent arable.[32] Kenya is particularly vulnerable to climate change, with a predicted increase in the frequency of droughts, resulting in major challenges for food security and water availability, and increased frequency of extreme events (droughts and floods, combined with landslides).[33] The climate emergency disproportionately impacts the poor, displaced, and landless, in particular children[34] – that is, the cohort of the population hardest hit by climate emergency is the one at greatest risk of family separation.

Kenya has a relatively new constitution,[35] which was designed to reflect and celebrate the country's unique diversity in terms of religion, culture, and identity, whilst also unifying the country under shared principles. This was especially important as a means of acknowledging,

Figure 1

Map of Kenya with counties

Retrieved from: https://dhsprogram.com/pubs/pdf/FR380/FR380bis.pdf

but most importantly moving forward from, ethnic tensions and the impact of its colonial past.

Kenya is one of the fastest growing economies in Sub-Saharan Africa, with projected economic growth at 5.6 per cent in 2023.[36] It is a middle-income country, and ranks 152 out of 191 on the Development Index.[37] However, the combined impact of climate change and the COVID-19 pandemic relegated two million Kenyans to poverty because of the economic shocks in 2020,[38] although the economy did begin to recover in 2021.[39] Increases in poverty tend to be accompanied by non-income-related risks, given the stressors on households. For example, poverty can make it challenging for households to feed children, increasing the risk of children being placed in residential care by families unable to provide their basic needs.

Kenya has made significant progress on many of the Sustainable Development Goals (SDGs), including a reduction in people living below the poverty line, an increase in average years of schooling, reduction in maternal mortality, and reduction in the fertility rate.[40] Although the Kenyan population is growing, the rate of population growth is slowing, down to 2.2 per cent from 2.9 per cent ten years earlier,[41] due to significant gains in reproductive and maternal health, and a rise in female education.[42] Data from the 2014 Demographic Health Survey (DHS) shows that 32 per cent of households are female-headed.

The percentage of women with no education has dropped by half over the previous decade, from 13 per cent in 2003 to seven per cent in 2014. [43] Over the same period, the percentage of women with at least some secondary education increased from 29 per cent to 43 per cent. [44]

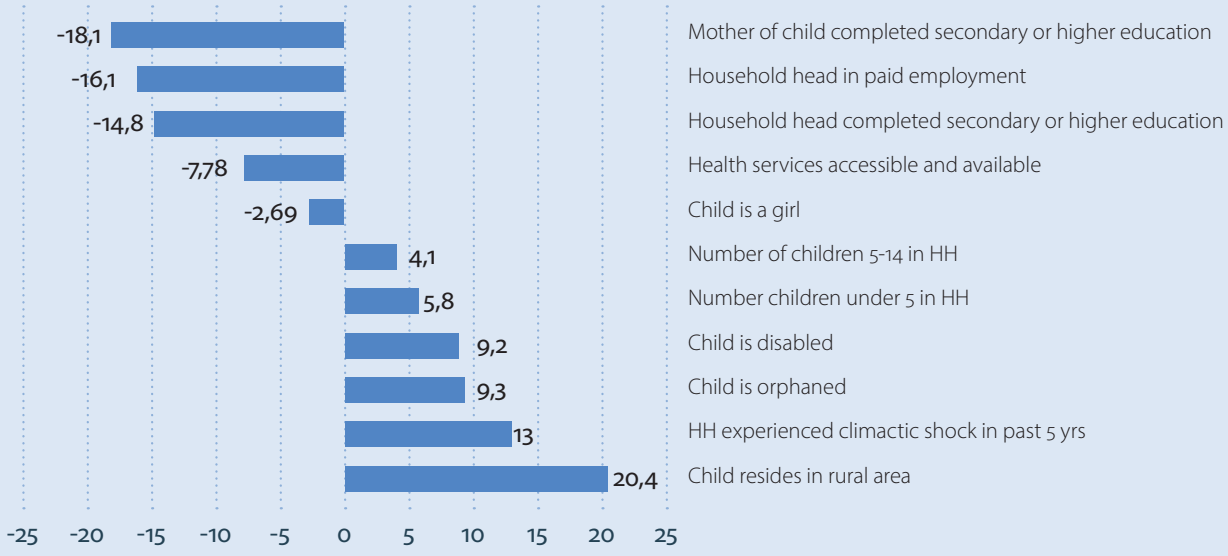
Children make up 46 per cent of Kenya's total population, with a relatively even spread across the cohorts children under four, children aged five to nine, and children aged between 10 and 14 years. The 2014 DHS indicates that, at the time, over half of all children (55 per cent) under 18 in Kenya lived with both parents, 13 per cent of those with living parents lived with neither the mother nor the father, and that a further eight per cent have either one parent dead (seven per cent) or both (one per cent) (see Figure 2).[45]

There is notable wealth disparity, inequitable access to basic services, and ongoing humanitarian situations, both human-made and environmental, impact movement, resources, and the fulfilment of human rights in Kenya. Poverty and inequality are widespread. Although there has been a drop in the percentage of the population living under the poverty line in recent years (from 46.6 per cent in 2005/06 to 36.1 per cent in 2015/16), children (41.5 per cent in 2016), and those over 65 years (39.1 per cent 2016), are more likely to be living below the poverty line.[46] A recent survey of multidimensional poverty found that an even greater proportion of children were 'multi-dimensionally poor', experiencing an average of poverty across more than four basic services and rights.[47] Children are more likely to be multi-dimensionally poor if they live in rural areas, have experienced a climactic shock in the past five years, are orphaned, have a disability, or live in a large household (see Figure 2). This has a strong connection with both 'push' and 'pull' factors into alternative care, as will be discussed later in this document.

Kenya, a republic, has a unitary system of government. There are three branches: the executive, legislative and judicial.[48] Since 2013, Kenya has adopted a devolved system of governance, with power devolving to the country's 47 counties. Each county is led by a governor, elected by residents, who appoints a county executive committee. Fifteen per cent of national revenue is shared out to the counties to carry out the devolved functions of government. These include the provision of health care,

Figure 2

Factors associated with multidimensional poverty in children under 18 years



pre-primary education, and maintenance of local roads and infrastructure.

The devolution process has been seen as very positive in many aspects, but child protection, specifically the DCS, has not been decentralised. Therefore, county government budgets do not necessarily include funds to address child protection issues. There is an effort underway to support county governments in developing county-level legislation and policy to support the fiscal processes related to funds for child protection.

2.5 Overview of living arrangements

The 2022 DHS[49], together with the Better Care Network (2017) analysis of data from Kenya's 2014 DHS, details the living arrangements of children in Kenya.[50] Important points revealed include:

- More than half of the children in Kenya live with both biological parents (53 percent) and another 31 percent live with a single parent;[51]
- A significant percentage of children in Kenya do not live with a biological parent (14 percent) with important differences across regions; In Western Kenya, almost a quarter of children are not living with a biological parent (24 percent) compared to Central Kenya where the prevalence is much lower at 8 percent.
- More than nine in ten children (94 percent) who do not live with their biological parents have either one living biological parent (17 percent) or both (77 percent), underlining that orphanhood is not the primary reason for children not living with their parents;[52]
- Analysis of the data from the 2014 Kenya DHS also shows that 95 percent of children not living with either biological parent lived with family members, underlying the critical role of kinship care in the country. Almost two thirds of these children were living with grandparents;[53]
- Boys were more likely to live with their grandparents, other relatives or in adoptive care; girls were more likely to live with other relatives, unrelated families, or their spouse; and [54]
- More children lived in non relative households in urban than in rural areas (5.3 per cent to 3.4 per cent), especially in Nairobi, likely linked to domestic labour and access to education.[55]

Data from the 2022 DHS show that a majority of children under the age of 18 in Kenya (53 percent) live in households with both biological parents.[56] In addition, a significant number of children live in single parent households (31 percent), the vast majority with their biological mothers (27 percent).[57]

Fourteen percent of children in Kenya live with neither biological parent, yet over two-thirds of this group (77 per cent) have two living biological parents and 17 per cent have one living biological parent. Only six per cent did not have any surviving biological parents. Therefore, most children living outside of parental care in Kenya have at least one living parent (94 per cent).[58]

Analysis of data from the 2014 Kenya DHS showed that ninety-five per cent of children who did not live with biological parents lived with a relative, assumed to be informal kinship care as formal kinship care is very limited in Kenya. The 2014 DHS data also highlighted that of children 0–17 living with neither biological parent, 62 per cent lived with their grandparents, 23 per cent lived in households headed by other relatives, and six per cent lived with siblings.[59]

As expected, the number of children living without either parent increases with age. Data from the most recent DHS in Kenya (2022) shows that children under 1 year of age (0–1 years) constitute only 3 per cent of children living without a biological parent but for children aged between 2-4 years, that prevalence has already risen to ten per cent. For the oldest age group, 15–17 years, it is 19 per cent. This is most likely because children move to live with relatives to access education, but other factors include parental death, or internal or external migration of parents.

Figure 3

Living arrangements and survival status of parents: Children under 18 not living with a biological parent

Source: ICF, 2015. The DHS Program STATcompiler. Funded by USAID. http://www.statcompiler.com
UNICEF. MICS Surveys. https://mics.unicef.org/surveys. Accessed 5 October 2021.

In the context of the Eastern and Southern African region, Kenya is among countries with a lower prevalence of children not living with a biological parent (see Figure 3)

Table 1 presents data related to children who are vulnerable and potentially at a higher risk of being separated from family and in alternative care.

Table 1

Data on children and vulnerability factors

Categories of children	Number/ estimates	Source
Children living with HIV	110,000	UNAIDS data 2019
Children orphaned by HIV[60]	660,000	UNAIDS, 2020, AIDSInfo
Children living on the streets	300,000	Estimate, IRIN 2007
Children with disability	1.92 million 0-14 years (estimate)	Global Disability Rights Now, drawing on Census and DHS data
Children living with one parent	31%	2022 DHS
Children living in formal foster care	N/A	
Children living in residential care-CCI and SCI	26,198	Recent rapid data collection after COVID-19 reunification process. April 2020
Children domestically adopted/year	N/A	
Female-headed households	32.4%	Kenya Integrated Household Budget Survey, 2015/6 * Disproportionately poor overall
Refugee children	264,757	UNHCR, May 2020 * Registered children; many more are unregistered, including unaccompanied children
Children experiencing all forms of violence	45.9% of girls, 56.1% of boys	Violence Against Children Survey, 2019

Whilst data collection and analysis have become more robust, there is still room for improvement, including leveraging the existing Child Protection Information Management System (CPIMS) and utilising DHS data.

Another group of children that includes children living outside of parental care are those living (either permanently or temporarily) on the streets. Several pieces of research have explored this phenomenon over the past two decades, noting push factors such as the disintegration of traditional family structures, increases in divorce, and poverty, including food insecurity.[61] A 2018 National Census of Street Families highlights the gender influences on street association, with the major reason for males being fear of being reprimanded (92 per cent), followed by corporal punishment (86 per cent); lack of school fees (86 per cent); mistreatment by relatives (81 per cent); and death of parent(s) (72 per cent). Half of all female respondents cited domestic violence as the main reason, followed by being born on the streets (46 per cent) and mistreatment by relatives (36.2 per cent).[62] Research conducted by Save the Children found that food insecurity was the greatest push factor that caused children to drop out of school and move to the streets.[63] Abuse, living with a step-parent, parental death, and inability to cover school fees were also top reasons.[64] A 2014 study of traditional family safety nets and caring traditions found that increased divorce rates, and inheritance structures based on ethnic traditions, were also the major contributors to the increase in children being on the streets and outside of parental care.[65]

Research conducted by the Kisumu Consortium for Street Children in Kisumu, Western Kenya, addresses a common misconception about street children – that they 'have no family'.[66] The study found that most children on the streets in Kisumu have families, noting that 'only five children out of 3,090 rescued street-connected children in a member institution's database had no family or home.'[67] Whilst poverty was identified as one reason children were on the street, it was not the sole reason, and was mostly mentioned in conjunction with other factors, such as violence, lack of school fees and mistreatment by relatives.

Up until 2020, the estimated number of residential care facilities was 850 with approximately 50,000 children in residential care.[68] With the onset of the COVID-19 pandemic, in April 2020, a rapid census exercise was conducted, using tools designed by the NCCS, DCS and members of the Care Reform Core Team. This was in response to the government directive of 17 March 2020,[69] that required all CCIs and SCIs to send children home. Findings from that exercise showed that a total of 45,480 children were in 850 CCIs, confirming the estimates. Of that number, 19,282 were released from care because of the government directive, while 26,198 remained in CCIs.[70] It should be noted here that the number of children and CCIs are those that are known (i.e., reported) and does not include those operating without appropriate registration.

In 2019, county-level data on children in residential care in five counties (Kiambu, Kilifi, Kisumu, Murang'a and Nyamira) was collected by CTWWC, together with DCS. A standardised approach to data collection was used,[71] and the data collated included quantitative and qualitative information about the number of CCIs and SCIs, number and profile of children, push and pull factors for being in residential care, and community perceptions on residential care and family-based care.

The evidence on push factors was mostly anecdotal at the time, as limited research on the topic had been conducted. This changed with the 2019 situation analysis, which found that, in all five counties, the main reasons for entry into CCIs, as cited by CCI directors, were orphanhood, violence/abuse/neglect, abandonment, and poverty. Other factors regularly mentioned include access to education, health care, and services for children with disabilities (CWDs). Reasons for entry into SCIs were truancy, living on the street, or conflict with the law.[72]

Whilst improvements have been made recently regarding data involving residential care, much of it remains either conflicting or incomplete. For example, whilst orphanhood was named by CCI directors as the main push factor of children into residential care in all five counties, a significant number of children were later documented as able to return to biological parents during the rapid reunification

Table 2

Five-county summary of children in residential care. DCS and CTWWC (2020)

Country	Child population	Children in residential care									
		Total	Male	Female	<1 year	1-3 years	4-6 years	7-10 years	11-14 years	15-17 years	18+ years
Kiambu	821,487	3,631	1894 (52%)	1737 (48%)	36 (1%)	148 (4%)	348 (10%)	892 (25%)	1166 (32%)	818 (22%)	223 (6%)
Kilifi	610,036	1,706	951 (56%)	755 (44%)	15 (1%)	95 (6%)	158 (9%)	438 (26%)	656 (38%)	280 (16%)	64 (4%)
Kisumu	674,725	1,734	947 (55%)	787 (45%)	6 (<1%)	36 (2%)	107 (6%)	361 (21%)	693 (40%)	426 (25%)	105 (6%)
Murang'a		635	352 (55%)	283 (45%)	4 (<1%)	33 (5%)	61 (1%)	112 (18%)	225 (35%)	144 (23%)	56 (9%)
Nyamira	391,709	299	178 (60%)	121 (40%)	1 (<1%)	5 (1%)	29 (10%)	65 (22%)	137 (46%)	59 (20%)	3 (1%)

process due to COVID-19. For example, in Kisumu, a little under half of the children in CCIs were returned to family care, including 435 children to biological parents and 498 to kinship care. In Kilifi, of approximately 1,700 children, 339 children returned to biological parents and 390 to kinship care. The fact that high numbers of children in residential care do, in fact, have biological parents, indicates that there is most likely a misreporting of orphanhood as a reason for placement. This could be due to situations where families seeking a placement assume that a child must be an 'orphan', and insufficient assessment of the family situation is conducted by case workers. The five-county situational analysis concludes that gaps in terms of the systematic review of children's situations prior to entry into residential care exist, with a high likelihood that many children stayed longer, or had unnecessary stays, in residential care.

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3 Legislative Framework

Kenya has a robust legislative framework with regards to child protection and children's rights, in the form of ratified international instruments and enacted national instruments.

3.1 Ratification of key international instruments

Kenya has ratified the key international and regional instruments listed in Table 3.

3.2 National instruments

The constitution[74] requires the state to address the needs of vulnerable groups, including children, and take responsibility for the needs of children, including the provision of alternative care (Article 21). Article 45 recognises children's right to a family, and observes that 'the family as the natural and fundamental unit of the society and the necessary basis of social order and should therefore enjoy the recognition and protection of

Table 3

International and regional instruments signed and ratified by Kenya

Instrument	Status	Date of ratification[73]
International Labour Organization Convention No. 138 (on minimum age)	Ratified	April 1979
Convention on the Elimination of All Forms of Discrimination against Women	Acceded	March 1984
Convention on the Rights of the Child	Ratified	July 1990
African Charter on the Rights and Welfare of the Child	Ratified	July 2000
Optional Protocol on the sale of children, child prostitution and child pornography	Signatory	September 2000
International Labour Organization Convention No. 182 (on worst forms of child labour)	Ratified	May 2001
Optional Protocol on the involvement of children in armed conflict	Ratified	January 2002
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ("Maputo Protocol")	Ratified	December 2003
Palermo Protocol (to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations' Convention against Transnational Organized Crime)	Ratified	January 2005
Hague Convention on Inter-Country Adoption	Acceded	February 2007
Convention on the Rights of Persons with Disabilities	Ratified	May 2008

the State.' Article 53 sets out the basic rights of children, including rights to: name and nationality; basic nutrition, shelter, and health care; protection from 'abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour', and 'parental care and protection, which includes equal responsibility of the mother and father to provide for the child, whether they are married to each other or not.' The last issue is notable, as it mentioned both parents' responsibility, and married or not. This important detail was not included in the Children Act 2001, but has been included in the Children Act 2022, in which parental responsibility for the child is recognised, whether married or not, and in which unmarried individuals are eligible to become foster carers or to adopt a child, if they fulfil the other criteria.[75]

Details of the enacted instruments that relate to child protection and care reform are presented in Table 4.[76]

Table 4

Laws relevant to care reform in chronological order

Law and regulations	Relevance to care reform
Persons with Disabilities Act 2003[77]	Establishes rights of persons with disabilities. Establishes the National Council for Persons with Disabilities. Addresses the role of the council, calls for policies to encourage opportunities for education, employment and full participation in community services, anti-discrimination measures, rehabilitation within a person's local community. No specific mention of child protection or care reform-related issues.
Children (Charitable Children's Institutions) Regulations, 2005[78]	These supplement the Children Act 2001, and determine how CCIs should be registered and run. They include provisions on the registration of CCIs, including the role of Area Advisory Councils (AACs) and the Minister. They require that CCIs provide details of staff and children in the institution, a placement plan, the importance of children's views, the need for court orders on all children living in the institution, promoting contact with parents, keeping case records, and promoting children's educational attainment. There are additional regulations relating to safety, health, accountability, staffing, record keeping and premises upkeep. They have, in part, been superseded by the Children Act 2022, which updates the requirements for establishment, registration and supervision.
Counter-trafficking in Persons Act, Revised Edition, 2012	Makes provision for the support and protection of victims of trafficking, and provides definition of trafficking.
Sexual Offences Act 2012, Chapter 62A	Includes definitions of, and punishment for, a range of child protection categories, including sexual violence, trafficking and sex tourism, pornography, sexual harassment, and cultural and religious sexual offences.
Marriage Act 2014	Establishes minimum age of 18 years for males and females.

Table 4

continued…

Law and regulations	Relevance to care reform
The Children Act 2022[79]	Principle legislation for the care and protection of children. The Act domesticates the UNCRC and ACRWC, and gives effect to the constitution, including the provisions of Articles 27, 47, 48, 49, 50, 51 and 53, which relate to child rights. The Act recognises the roles of the NCCS, as established in the Children Act 2001, and the County Children Advisory committees (CCACs). The Act confirms that county governments should provide or facilitate the provision of childcare facilities, pre-primary education, and child welfare schemes. The Act determines that children have the right to parental care, unless a court determines otherwise, in which case they have the right to the best alternative care, giving priority to family-based alternative care (Section 11). The act recognises a range of alternative care options, including kinship care, foster care and kafaalah, which were not recognised in previous legislation. The Act contains sections on SCIs, including both rehabilitation schools and remand homes, and CCIs, defines inspection committees, and covers issues relating to Children's Courts, custody and maintenance, guardianship, judicial orders for the protection of children, children in need of care and attention, foster care, adoption, and child offenders. The Act specifies non-separation of siblings when under care and protection, the child's right to maintain contact with parents if separated, the right to social security for children in alternative family care, and stresses permanency as a long-term goal. The Act makes provisions for both short-term / emergency and long-term foster care, and allows for kinship adoption. The Act specifies time frames for placement of children in residential facilitates, and allows for placement into family-based alternative care immediately on issuing of an interim or court care order.
Adoption, Foster Care and Kafaalah Regulations, 2022 (draft)[80]	These were updated to reflect the Children Act 2022, and are scheduled to be approved in 2023. They will combine the different types of care into one set of regulations, where previously there were separate regulations for each type of care.

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3.3 Enactment and implementation of the legislative framework

Much of the Children Act 2022 was informed by the UNCRC, which Kenya ratified in July 1990. The constitution recognises parental responsibility for the care of children by married and unmarried persons, an important change that allows more opportunities for children to grow up in a family environment. The Children Act 2022 allows for a greater variety of family-based options, including enabling single adults to foster and adopt children of the same sex. It enables placement of a child into family-based alternative care directly following a court or interim care order, and sets strict time limits on placement in CCIs.[81] The Children Act 2022 also details more robust standards and processes in relation to alternative care, including the establishment of 'child rescue centres' for the temporary care of children in need of care and protection pending family-based care, or intervention, specifying that children should be placed for no more than six months. It calls for child protection units at all police stations to provide, on a temporary basis, a safe and non-threatening environment for children in conflict with the law, sets out standards for the establishment of CCIs, and creates an offence for admission of a child into an unapproved CCI, or unregulated operation of CCIs.[82]

In 2022, the NCCS finalised and launched the National Care Reform Strategy, which sought to resolve inconsistencies identified in the legislative framework, and convert the 2014 *Guidelines for the Alternative Family Care of Children in Kenya* (see Table 5) into a robust implementation strategy (see Figure 4). The guidelines recognise the wide range of care options available to children in Kenya. However, implementing and resourcing the care options remains unequal.[83] It is hoped that the Children Act 2022 and the *National Care Reform Strategy* will facilitate leverage for resource mobilisation.

Over the past fifteen years, concerns were raised about unethical practices and disrespect for the subsidiarity principle,[84] with legislation creating barriers to implementing a continuum of care. One significant hurdle was overcome when the government stopped intercountry adoptions in 2014, enabling resources to be redirected towards alternative care options. Some argue that this has enabled the country to take significant steps in reforming the care system.[85]

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Figure 4

National Care Reform Strategy for Children in Kenya – 2022–2032 Results Framework[86]

By 2031 all children and young people in Kenya live safely, happily and sustainably in family and community-based care where their interests are served

Families are resilient so children and young people are not unnecessarily separated and their best interests are served.	Children and young people in need of alternative care are accessing effective family and community-based care which serves their best interests.	Children and young people living in institutional care and unaccompanied and separated children at risk of institutionalisation have safely reintegrated to family and community-based care.




4.1 Legislation, regulations, and policies reformed to be more supportive of family and community-based services	4.2 Increased provision and quality of family and community-based services	4.3 Raised awareness of care reform and the harm of institutionalization	4.4 Funds and personnel redirected from Institutional care to family and community services
4.1.1 Strengthened prevention of family separation and family strengthening policies	4.2.1 Increased provision and quality of family and community-based services	4.3.1 Communications and advocacy strategy developed and implemented	4.4.1 Public domestic funding redirected
4.1.2 Strengthened alternative care policies	4.2.2 Increased provision and quality of alternative care services		4.4.2 Public international funding redirected
4.1.3 Strengthened policies related to tracing, reintegration and transitioning to family and community-based care	4.2.3 Increased provision and quality of services to support transitioning to family and comunity-based care (e.g. tracing, reintegration, case management. etc)		4.4.3 Private funding redirected
4.1.4 Strengthened cross-cutting care refrm policies	4.2.4 Strengthened cross-cutting systems areas to support services information management, workforce, coordination and risk mitigation)		

5.1 At the national level, NCCS and partners manage, coordinate, monitor and fund care reform activites
5.2 At the county level, AACs develop and maintain management, coordination and monitoring structures including county action plans and M&E plans
5.3 Non-state actors implement activities that align with national and county management, coordination and monitoring structures and guidance

Table 5 summarises the key policies related to children's care and protection, family support (i.e. prevention) and alternative care.[87] The *Kenya National Care System Assessment* (2020) recognises that, although there is a fairly strong legislative framework to support alternative care, there is significant room for improvement in terms of its implementation, [88] notably: child and parent/caregiver participation in matters and decisions affecting their care, including administrative and judicial proceedings; formal placements made in close proximity to child or family's home to facilitate regular engagement between child and family/community; avoiding placement of children three years of age and younger in residential care; and the establishment of safe complaint or feedback mechanisms for children and families within the care system.[89] All of these are included in the Children Act 2022 and the *National Care Reform Strategy*. The focus, moving forward, must be on translating the policy and strategy into tangible actions, especially at county and sub-county levels.

Table 5

Relevance of policies and implementation plans for care reform

Policies and Implementation Plans	Relevance to care reform
National Plan of Action for Children (NPA) in Kenya 2015–2022[90]	• Intersectoral plan for the realisation of children's rights for national prosperity. The plan specifies that the NCCS is responsible for ensuring resource mobilisation (p. 45), with specific reference to building the capacity of the child sector workforce through needs-based training at regular intervals. The plan commits to phasing out CCIs, and focuses on community-based care. It commits to implementing the 2014 guidelines, and sensitising communities to alternative care arrangements. • Specific care reform commitments include introducing a policy to improve monitoring of child rights in alternative family care, especially foster care; establishing rescue centres and places of safety for affected children; implementing the After Care Policy for care leavers; reducing intercountry adoptions to internationally recommended good-practice levels. • Calls for a family-centred approach to child development programmes, and promotes positive parenting programmes.
National Policy on Family Promotion and Protection[91] (draft)	Focuses on the concept of 'family' and its need to be supported by the state. Defines the family as a 'societal group that is related by blood (kinship), adoption, foster care or the ties of marriage (civil, customary or religious) of two persons of opposite sex'. Recognises that the greatest challenge for families is poverty, especially for female-headed households. Calls for a range of family-strengthening initiatives, and focuses on recognising the importance of fatherhood in family cohesion and stability, the need to support elderly caregivers in skip-generation households, and engender stronger intergenerational ties. Kenya is developing national positive-parenting guidelines and a related training package that will be instrumental in helping to support the core content of the policy. It is targeted at both biological and alternative family-based caregivers.
National Children's Policy, 2010[92]	Has a strong focus on family-based care for all children, and is in line with the 2014 guidelines. States that all children living in alternative family-based and institutional care must be protected from abuse and exploitation, and that CCIs are a last resort and should be temporary. The juvenile justice aspects promote diversion wherever possible, and call for the reintegration of children in conflict with the law.

Table 5

… continued

Policies and Implementation Plans	Relevance to care reform
Framework for the National Child Protection System for Kenya, 2011	A statutory mechanism, its structure clearly defines the roles and responsibilities of each level of government, and its partners, as they jointly undertake activities to safeguard the rights and welfare of children. A shared understanding of actors' respective roles and functions facilitates co-ordination and efficiency. Places responsibility for child protection with the Ministry of Gender, Children and Social Development, through the DCS. Sets out the core roles and functions of the NCCS, sub-national AACs, and the judiciary (responsible for establishing and running of children's courts).
County Child Protection Systems Guidelines, 2011	Spells out the roles and responsibilities of all actors at county level, sets out the standards of operation for child protection services, including adherence to laws, policies, and guidelines; staff availability, competence, and training; organisational child protection policies; quality service guidelines; accountability structures among actors; and confidentiality. AACs are mandated as coordinating structures, with the Child Protection Working Group reporting to AAC. Includes an implementation checklist for child protection system rollout. The Children Act 2022 revised the definition of AACs for the establishment of CCACs, with specific roles and responsibilities.
National Standards for Best Practices in Charitable Children's Institutions, 2013[93]	Cover key operational considerations, including staffing, management, child protection and care, including gate keeping considerations and quality standards for children's well-being while in care. The Children Act 2022 further allows for regulation in relation to establishment and operation of CCIs.[94]
Guidelines for the Alternative Family Care of Children in Kenya, 2014[95]	• Central policy document for care reform in Kenya, aligned to UNCRC, the UN Guidelines for the Alternative Care of Children, the ACRWC, the Hague Convention on Inter-Country Adoption, as well as the Constitution of Kenya (2010), the Children Act 2022, and the CCI Regulations 2005. • Includes those over 18 years in, or leaving, alternative care. Sets out the continuum of care, including services to prevent family separation. Provides detailed guidelines on all areas of alternative care (kinship care and kafaalah, foster care, places of safety and temporary shelter, guardianship, adoption, recognising and supporting child-headed households, supported independent living, institutional care (with a focus on CCIs), preparation and follow-up aftercare, and care of children in emergency situations. • Transition guidelines to support the transformation of CCIs into other forms of community or family-based services have been drafted and are set to be finalized and published by end of 2023.
Throughcare Guideline Remand Homes Section[96]	Sets out procedures from arrest through to family and community reintegration, and aftercare.
National Social Protection Policy[97] and draft Kenya Social Protection Strategy 2018/19–2022/23[98]	• Commits to a life-cycle social protection system with a roadmap to implement the policy. Includes the existing main cash transfer schemes (Cash Transfer – Orphans and Vulnerable Children Programme – CT-OVC), with plans for expansion into a universal means-tested child benefit scheme, starting with children aged 0-5 years in 2021/2. The Cash Transfer Programme for Persons with Severe Disabilities will become a disability benefits scheme for adults and children, with payments to caregivers of CWD. • Proposes expansion of the National Health Insurance Fund to universal health coverage. Prioritises economic opportunities for young people via the Kenya Youth Employment and Opportunities Project, initially for vulnerable young women and men between 18 and 29 years of age (care leavers may be eligible). • Development of a National Social Work Strategy that will focus on adult and children's personal social services, building on current DCS social work responsibilities and linking social protection with psycho-social support.

Table 5

… continued

Policies and Implementation Plans	Relevance to care reform
Sector Policy for Learners and Trainees with Disabilities[99]	Provides a clear framework for the provision of inclusive education and training in Kenya.
Moratorium on new CCIs	The government suspended the registration of new CCIs in November 2017, citing inappropriate placement of children in institutions rather than family care options, and concerns about possible child trafficking.[100] In February 2020, recognising that many CCIs where now unregistered and operating illegally, the principal secretary of the Ministry of Labour and Social Protection (MLSP) called for fast-tracking of CCI registration renewal.[101] The moratorium on registering new CCIs is still in effect.
Moratorium on inter-country adoption, 2014[102]	The Government of Kenya introduced a moratorium on adoption by foreigners on 26 November 2014. This was to allow government to conduct a comprehensive audit of policy and implementation related to adoption. It has not been lifted.
National Prevention and Response Plan on Violence Against Children in Kenya 2019–2023[103]	Developed in response to the 2019 VAC Survey. It is designed to mobilise broad-based community and government action to prevent all forms of VAC. One of the six strategic pillars is family strengthening, through providing access to quality parenting education programmes.
National Case Management for Reunification and Reintegration Guidelines, 201)	The package for case management was collaboratively developed by a national government/non-government working group in 2019, and includes a caseworker guidebook, a caseworker toolkit, and a training package. The package was developed out of the need for comprehensive, standardised, and harmonised case management approaches to promote family care for children in Kenya. It is a guidance tool for policy makers, programme designers and practitioners for carrying out safe and sustainable reintegration of children.
National Gatekeeping Guidelines, 2021	The guidelines are based on the existing AAC guidelines. Articulates what gatekeeping is, its role in child protection and care, and the roles and responsibilities of key actors. Details the formation of sub-national gatekeeping mechanisms (care reform sub-committees – CRCs), and their accompanying operating protocols and procedures.
Standard Operating Procedures for Alternative Family Care, 2021 (soon to be launched)	Closely connected to the Gatekeeping Guidelines,[104] these standard operating procedures (SOPs) were developed in a participatory process over 2020-21. Each care option highlighted in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014) has its own set of SOPs that describe the how-to of the placement process, including roles and responsibilities, and step by step instructions. These SOPs, when launched, will be instrumental in providing useful information that aims to facilitate good practice and the standardised use of different care options for children.
National Street Families Rehabilitation Policy (draft)	The policy has been developed under the stewardship of the Street Families Rehabilitation Trust Fund Board of Trustees, under the MLSP and the State Department for Social Protection.

3.4 Broader child protection systems strengthening

From a systems-strengthening perspective, Kenya has benefited from child protection systems-strengthening initiatives, in particular workforce strengthening, establishment of the CPIMS, and case management processes. As per sections 61 and 62 of the Children Act 2022, counties are required to develop County Children policies to address provisions in the Act.[105] Much of this work has been the result of programmes aimed at orphans and vulnerable children (OVC). While designed to target children affected by HIV, they have had a positive impact on overall systems strengthening and awareness raising, which, in many ways, has benefited the care reform agenda.

Figure 5

Chronology of main steps in care reform in Kenya

2001
- Children Act 2001 provides for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children.
- Mandates NCCS and DCS to oversee child protection and care in Kenya.

2008
- Assessment of alternative care identifies challenges with care, including over-reliance on residential care, unethical adoption practices and limited family-based options. Informs amendments to the Children Act 2001 and proposes development of the *Guidelines for the Alternative Family Care of Children in Kenya* (2014).
- Significant tracing and reintegration of street children as part of the response to the 2007 election violence, and ongoing work within refugee camps.

2010
- Constitution recognises need for all children to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhumane treatment and punishment, and hazardous or exploitative labour, and affirms children's right to parental care.
- Framework for the National Child Protection Systems developed and approved.

2012
- Revised Children Act 2001.

2013
- National Standards for CCIs approved.
- Increased focus on kinship care and children connected to the street.

2014
- Introduction of national *Guidelines for the Alternative Family Care of Children in Kenya*.
- Moratorium on international adoption, and comprehensive audit of the legislative framework, processes, procedures and players involved in adoption.

2015

- National Plan of Action for Children 2015-2022.

2016

- Association for Alternative Family-based Care launched.

2017

- Moratorium on registration of new CCIs due to inappropriate place

2018

- Pilot programme on care reform initiated in Kisumu, with UNICEF support.
- Scaled-up to another three counties with TWWC support (Kisumu, Kilifi, Nyamira) and Stahili Foundation support in Murang'a County.
- Research on street children in Kisumu conducted.

2019

- Establishment of the national Care Reform Core Team, comprised of government and NGOs, and development of a concept note and roadmap to develop a National Care Reform Strategy for Kenya by NCCS.
- NCCS and DCS include care reform in the annual workplan, with decreased reliance on residential care, promotion of family-based alternative care, and increased prevention of family separation.
- 'Design and delivery of a Strategic Transforming Care Training course for highlevel Ministry, UNICEF and civil society professionals to mobilize on care reform agenda.
- Situational Analysis of Residential Care conducted in five counties.

2020

- Senior level study visits to review care reform.
- Finalisation of core practice documents and regulations (e.g. Case Management for Reintegration to Family and Community-based Care SOPs, forms and training package, Alternative Family Care Training package, National Gatekeeping Guidelines and training package).
- Kenya National Care System Assessment (2020) completed.
- Process to develop the National Care Reform Strategy initiated.
- Undertaking Research on funding streams.
- Review of CCI Vetting Criteria making it more stringent.
- COVID-19 response activated including data collection on reunifcation.

2021

- Ongoing support (cash plus care) to reunified families due to COVID-19.
- Finalisation of SOPs for Alternative Family Care.
- National Care Reform Strategy submitted for approval.
- National positive parenting guidelines and curriculum drafted.

2022

- Children Bill enacted, July 2022
- National Care Reform Strategy for Children in Kenya 2022-2032 launched

4 Key Stakeholders

4.1 Government

4.1.1 National government

The MLSP is responsible for all aspects of child protection, including care reform. The MLSP oversees the two primary actors mandated with child protection and care, the NCCS and the Office of the Secretary of Children Services under which sits the Directorate of Children Services (DCS).

The NCCS was first established under the Children Act 2001 and its role- accountability and oversight, and design of policy, standards and guidelines related to child protection- was reaffirmed under the Children Act 2022, Section 42. Under it, the Council's functions include to advise the government, in particular the Cabinet Secretary, on matters relating to child protection as well as domestic and inter-country adoption; to develop policy, codes of conduct regulating good practice relating to child protection and child welfare, to regulate and coordinate the efficiency and effectiveness of all social programmes established in the interest of children by government and non-state actors; to monitor compliance with set standards for children, including ensuring their compliance with international and regional obligations; to regulate, approve and monitor the implementation of programmes proposed by charitable children's institutions and receive, record and report from these institutions; to accredit and license duly registered adoption and child protection agencies and act as the central authority for the purpose of the Hague Convention on Inter-Country Adoptions. The Council must also establish, maintain and update a database of children in Kenya.

The NCCS is composed of 10 members including the Principal Secretary for the Ministry responsible for children services, the Principal Secretary responsible for financial matters, the Attorney General (or their representatives), and the Secretary of Children Services. In addition three members are to be appointed by the Cabinet Secretary representing respectively civil society organisations working on children's issues, faith based organisations, and the private sector. The chairperson of the council is appointed by the President and the Chief Executive Officer of the council recruited and appointed by the council to serve for a term of 5 years as its secretary, overseeing its day-to-day operations. The chairperson and members of the council who are not public officers serve for a term of three years and all members except the CEO serve on a part-time basis. The NCCS established, and chairs the multi-agency Care Reform Core Team which is driving care reform, including the development and launch of the *National Care Reform Strategy, the Kenya National Care System Assessment* (2020), and several other guidelines promoting good practice in care.

The NCCS is represented at the county and sub-county levels by the County Children's Advisory Committee (CCACs) and the Sub-County Children's Advisory Committee (SCCAC). The CCACs have a mandate to: 'assist and collaborate with the Council in the performance of its functions within its local Jurisdiction [and] to provide a platform for collaboration between the national government and the county government on children matters within its jurisdiction'.[106] In Kenya's decentralised governance system (as noted in section 2.1), their role is pivotal in overseeing child protection and care reform.

The Office of the Secretary of Children Services draws its mandate from the Constitution of Kenya, The Children Act 2022 and the Executive Order No. 1 of 2023 to safeguard and protect the rights and welfare of children for national prosperity. The Directorate of Children Services (DCS) is the government agency that supports the Secretary of Children Services to perform his duties of planning, executing, and direct implementation of the child protection programming and services.[107] The DCS is represented at county and sub-county levels by children's officers (COs). It has several department sections specifically related to care, including Alternative Family Care, and Institutions (CCIs and SCIs). The directorate provides oversight, planning and coordination of the child protection programmes and services in Kenya. The following are the key functions of the Office of the Secretary of Children Services related to care: [108]

1. regulate, coordinate, manage, and supervise children's officers in delivery of the welfare and administration of children services;

2. be responsible for establishing, administering and maintaining child protection centres, rehabilitation schools and a remand homes in every county;
3. maintain up-to-date records and data on management of children services including access to welfare amenities for children;
4. investigate, monitor and report cases of children facing hardship;
5. identify, formulate and develop programmes to mitigate children facing hardship for the consideration of the Council;
6. assist children in hardship, including children with disabilities, children living in the street, orphaned and destitute children, children who abuse drugs, children who are sexually abused and children who are affected by domestic violence;
7. inquire, investigate, assess and prepare reports in accordance with the Children's Act or any other written law in accordance with any direction of a court;
8. implement any direction of court including providing social or administrative support;
9. safeguard the welfare of a child placed under care by virtue of a care order or interim order;
10. procure accommodation for a child who is abandoned, in need of refuge, safety or appropriate custody;
11. provide services to trace, reintegrate or restore a lost or an abandoned child with parent or a guardian;
12. intervene and secure the removal of a child in need of care and protection to a place of safety;
13. promote family reconciliation and mediate in disputes involving children, parents, guardians or persons who have parental responsibility in the manner provided under the Act;
14. provide services to assess a child placed under care and support services to counsel, and guide children and families;
15. facilitate medical treatment for a child in police custody or in a children's remand home;
16. provide guidance and assistance for a child during a proceeding in court;
17. supervise administration of children institutions including children's rehabilitation centres, charitable children's institutions and remand homes in order to safeguard and promote the welfare of a children;
18. provide quarterly reports relating to management of children's rehabilitation centres, charitable children's institutions and remand homes;
19. safeguard the welfare of children in foster care.

Another actor that has played a key role in children's care for several decades is the Child Welfare Society of Kenya (CWSK), established in 1955. It is a parastatal organisation mandated with the care, protection, welfare and adoption of children in Legal Notice No. 58 of 23/05/2014. It includes the National Adoption Society for Kenya and the National Emergency Response, Welfare and Rescue Organisation for children. In 1969, it founded the oldest post-independence residential care facility, Mama Ngina Children's Home.[109] Like the NCCS and the DCS, the CWSK is funded by government to undertake interventions for children in emergencies (floods, draught, fires, etc.), and to provide temporary safe places. The CWSK has 26 facilities aimed at providing safe places, offers tracing and reunification services to separated children, and facilitates family-based options, including adoptions. It should be noted that the government has sought to address some of the previous overlaps in mandates between the CWSK, the DCS, and the NCCS through the Children's Act 2022. The CWSK is not mentioned in the Act but it is a semi autonomous government agency (SAGA) established to support and complement the role of the Directorate in implementing government services.

4.1.2 Sub-national government

The Constitution of Kenya has devolved some functions of government to county levels and in its fourth schedule has defined the national and the devolved functions.

The devolved functions are managed by 47 county governments which have a number of sub-counties and wards as operational units of providing government services. The devolved functions have placed significant responsibilities and budgets with the county governments to enable them plan, design and provide assigned services to the public.

Child protection services are not among the devolved function and hence they are managed by the national government through the structures of DCS and NCCS.

The DCS has established, through the Office of the Secretary of Children Services, County and Sub-County offices and deployed Children Officers to these offices. The Children Officers implement the child protection, child care, and welfare services at the county and sub county levels as prescribed in Section 38 of the Children Act 2022. Their role is complimented by government and non-state actors operating in the county and sub-counties. Additionally, DCS has engaged a cadre of para-professions known as Child Protection Volunteers (CPV) at the sub-county levels using the lower government administrative structures of wards, locations and villages. There are advocacy efforts by DCS partners such as UNICEF to have the government fully recognize the CPV by providing them with official appointment letters and covering their stipend.

The Children Act 2022 (Section 54 and 55) requires the NCCS to establish County Children Advisory Committees (CCAC) and Sub County Children Committees (SCAC) respectfully to help the Council better the performance of its functions. Both the CCACs and SCACs draw their membership from county government ministries in charge of education, health, security, child and social protection and also from national government ministries in charge of child protection (i.e. children officer), national government administration, security, public prosecution, probation, civil registration, labour as well as civil society organizations working on rights and welfare of children including for children with disabilities. Both CCACs and SCAC provide a provide a collaborative platform between national and county governments, make recommendations to the Council on matters relating to children, provide information that may be required by the Council and provide overall support in the coordination of implementation of children services. The Secretary of these two committees is the NCCS and, at writing of this report, NCCS is engaged in recruiting additional staff to oversee the establishment and the functioning of these structures.

The leadership of implementation of the care reform programme at county and sub-county level is led by officers of DCS at county level who coordinate with county government, other national government agencies represented at the county and sub county levels as well as CSOs, Charitable Children Institutions and community members working on care and welfare of children.

At the time of writing, coverage by the County and Sub County Children Advisory Committees (CCAC & SCCAC) is still limited. At the same time, budgets for national and county governments to implement care reform are also limited and there is high dependence on donor support for implementation of care reform. As a result, only thirteen out of forty-seven counties are undertaking care reform processes. There are efforts in place to resolve the disconnect between the national care reform framework, county-level policies, and practice. There are a few examples where county governments have shown the intention to support care reform programs by initiating the process of having in place policies and budgets that would support such initiatives, for example Muranga, Turkana, Embu, and Kisumu.

The CCAC and SCCAC should have representation from a wide range of stakeholders, including key actors from health, education, police, courts, COs, and civil society representatives, including NGOs, faith-based organisations (FBOs), and child representatives. COs and child protection volunteers (CPVs) are often the face of CCAC and SCCAC at the county, sub-county and local levels. More information on these key members of the workforce is included in Section 5. They are designed to act as a type of gatekeeping mechanism, reviewing decisions made related to care, especially the decision

to place and the type of placement. This role has been further articulated with the recent development of the SOPs for the different types of alternative care, as well as the National Gatekeeping Guidelines.

The function of DCS is not listed as one of the devolved function in Kenyan Constitution. However, the DCS function is represented at the county and sub-county levels via the presence of COs, but the budget is held by central government. This creates a challenge in terms of reflecting and addressing the unique child protection and care needs of each county. To address this gap, there are initial efforts, supported by UNICEF and other development partners, to develop county government-level child protection legislation and child protection costing models that would enable counties to plan for, budget and contribute resources from the Treasury to fund child protection-related efforts at the county level. In addition, the Children Act 2022 in Section 61 and 62 requires the county governments to work with Cabinet Secretary in charge of children to develop policies and programmes for provision of child care facilities and child welfare programmes.

4.1.3 Coordination mechanisms

Coordination of key actors and processes, across sectors and between the sub-national and national levels, is essential for care reform. The Care Reform Core Team is central to care reform, and is coordinated within the MLSP through the NCCS and the DCS.

Kenya established the Care Reform Core Team in 2019 to help guide technical support for the development of the National Care Reform Strategy. A sub-committee was formed during the onset of the COVID-19 pandemic to develop rapid responses and tools for data collection on children in CCIs and those reunified, as well as key messages relating to COVID-19 and care, targeting CCI directors and staff.

The NCCS is, at the time of writing, in the process of putting the following structures, outlined in the National Care Reform Strategy, in place.

- **National Care Reform Steering Committee:** comprised of the NCCS Board, with the inclusion of co-opted members for the purpose overseeing the care reform process. It has strategic responsibility and accountability for the care reform process, and strategic decision-making authority on all matters concerning care reform. It meets every four months.
- **National Care Reform Coordination and Oversight Division:** The Division will be established within NCCS as one of the programme operations units. It will comprise a team of inter-agency and multi-disciplinary staff dedicated to implementing the National Care Reform Strategy through a series of Steering Committee-approved national work plans and budgets for each phase of implementation. It is directly accountable to the Steering Committee.
- **National Care Reform Technical Advisory Committee:** comprised of the existing Care Reform Core Team along with any additional members required to support the care reform process. It is an inter-sectoral and multi-agency advisory committee made up of service managers and technical experts in areas related to care reform. It provides technical advice to the Steering Committee and the Oversight Division. It assists the Oversight Division in the practical implementation of phased national work plans, and provides recommendations for policy changes for consideration by the Steering Committee. It meets every two months.[110]

4.2 Civil society

Kenya has an active civil society sector that provides a diverse range of child protection-related services. These vary from very small, locally resourced community initiatives through to national and international NGOs in both the development and humanitarian sectors. Organisations work in the care reform sector directly, through delivery of care services for children in alternative care, and in family strengthening, such as household economic strengthening, life skills and parenting support for children, adolescents, and families, as well as broader child rights-related community development initiatives.

Many CSOs work within the guidance and framework as set out by the government, owing to the robust legislative framework and oversight mechanisms, but there are challenges in coverage and quality. It should be noted that many international, local and faith-based organisations have been involved in children's care over the past several decades. Annex 1 provides information on development partners, international and national NGOs, and faith-based actors. The list is far from complete and only highlights some examples of organisations involved in recent efforts, and that are members of the Care Reform Core Team.

4.3 Child and youth participation structures

Although the legislative framework provides for children to participate in all matters that affect them, this is not always facilitated in practice, as recognised in the recent situation analyses of the social service workforce and children in residential care.[111] Kenya has a formal child participation mechanism at both the national and the sub-national levels. The Kenya Children's Assembly was established in 2011, by the DCS, at the national, county, and sub-county levels. At a local level, there are student councils in secondary schools, and children's governments in primary schools. These forums have not, to date, been involved in any type of activity related to care reform.

There is an active association of care leavers and care-experienced members, the Kenya Society of Care Leavers (KESCA), that seeks to empower care leavers to lead meaningful lives and to actively participate in the promotion of the rights of children without parental care.[112] Members of KESCA have been involved in the development of key documents such as *Standards of Best Practices in CCIs, Alternative Family Care SOPs*, *Case Management for Reintegration Package*, and the *National Care Reform Strategy*. They have also developed their own guidance document on how to engage care leavers in care reform, and a package of life skills manuals for different age groups. The manuals were developed in collaboration with CTWWC.[113]

There is a paradox in having participation reflected in the legislative framework, and platforms to facilitate child participation, yet have concerns raised that these platforms and opportunities are underutilised and underfunded. This was recognised in the 2016 Concluding Observations of the African Committee on the Rights and Welfare of the Child.[114]

In 2021, UNICEF supported a care leavers study to inform policy and programme for preparing children and young persons in residential care for leaving care as they age out and settle into families/community.[115] Several key findings helped inform advocacy messages. The study notes challenges faced by young people leaving institutional care in Kenya and presents key recommendations to address these issues. Despite progress in care reform, care leavers encounter difficulties in transitioning to independent living, including lack of employment opportunities, support networks, life skills, and mental health issues. They face increased risks of homelessness, poverty, and social isolation. The brief emphasizes the need for recognizing care leavers as a vulnerable group and calls for the development of Aftercare Policies, budgeted action plans, and strengthened support systems for care leavers by the government, NGOs, UN agencies, and Charitable Children's Institutions (CCIs). It also highlights the importance of genuine participation of care leavers in decision-making processes and the establishment of peer support networks. Additionally, preventing family separation and addressing structural drivers of institutionalization are essential to improving the outcomes of care leavers. NGOs and UN agencies are urged to support government efforts and deliver services for care leavers while considering their diversity and specific needs, such as those with disabilities.[116]

4.4 Information management system

A robust information management system is at the heart of an effective care reform process, as data is critical to inform both policy and programming. At the individual child and family level, it is a tool to support effective case management, while at the policy and planning level, it is essential for effective targeting of prevention and early intervention and family-strengthening services, as well as assessing and tracking progress on care reform (e.g., identifying trends in family reintegration from residential care or assessing progress of gatekeeping at all levels). Information management has been a challenge in Kenya, as

it is in many countries facing resource challenges, including a scarcity of qualified social service workforce systems and related equipment for both data collection and analysis.

As part of the broader child protection systems strengthening, there have been investments in a national CPIMS, hosted by the Government Information and Communication Technology Authority, at the Government Data Centre,[117] on behalf of the NCCS within the MLSP.[118] All child protection data, including care reform data, should be entered, analysed, and applied via the CPIMS. COs are primarily responsible for inputting the data for each county. The monitoring and evaluation framework, and related indicators being developed for the National Care Reform Strategy, will also contribute to this effort.

The core functions of the CPIMS are to:[119]

1. Facilitate the monitoring and evaluation of child protection interventions in Kenya, inform policy and evidence-based decision-making;
2. Provide access to accurate, timely and reliable aggregate-level child protection data;
3. Facilitate record keeping and information management on individual cases of child protection;
4. Track vulnerable children, longitudinally and geographically, to ensure continuity of care and protection, including children in institutional care;
5. Facilitate appropriate information sharing between stakeholders and service providers in the best interest of the child; and
6. Be flexible and extensible over time to cater for emerging needs in the children sector.

The CPIMS is accessed by all COs and sub-county children's officers (SCCOs) (internet access permitting) and is designed to track intervention services, including: rescue from harm and placement in place of safety; alternative family care (adoption, foster care, guardianship, kinship, kafaalah); family re-integration, reunification; tracking and supporting children in conflict with the law through the child justice system, legal and rehabilitation processes; arbitration; supervision (with or without court orders), parental bonds, written promise, joint parental agreements; and support services (counselling, family support). It also tracks referrals between the various governmental and non-governmental child protection actors, and tracks court orders, including orders related to placements and adoptions, committal to institutions, and supervision.[120]

Since 2020, the CPIMS has been in use in all counties, although with some difficulties in some counties. Children in SCIs are tracked and updated daily. The process of developing an alternative care-specific tracking system, including relevant indicators, is being piloted in Kisumu, with CCIs in Kisumu entering information of every child in care. For children in residential care facilities, this includes admission and exit dates; details of temporary custody while following the juvenile court process; steps taken towards re-integration into the community; health and welfare; and services and referrals provided while in institutions.[121] The plan is to eventually roll this out to all CCIs.[122]

As noted above, the fact that care reform has always been placed within the broader child protection framework is a strength, and the information generated by the CPIMS has the potential to support programming and strategic care reform decisions, as well as broader child protection decisions, if regularly collected and analysed. At present, this is not possible because of limited access.

The recent COVID-19 data collection and analysis experiences (see Section 10.2) has generated information about what gaps still exist, and why. Although the CPIMS gathers data on a wide range of statutory information about child protection, there is still a need for further engagement and application, notably from privately owned CCIs. It is a comprehensive IMS tool that can increasingly be used to strengthen care reform efforts at all levels, and there appear to be discussions on including care-related indicators within the CPIMS.[123]

The 2020 *Kenya National Care System Assessment* noted some gaps in completion and application of care reform data within the CPIMS. For example, while SCIs are

supposed to input monthly caseload data into the CPIMS, not all institutions are doing so, and of those that are, they are not always consistent.[124] Also absent is data that describe the reasons why children are placed in alternative care, and data on the length of stay in the facility, disability type, ethnicity and religion of the child is patchy.[125] The CPIMS does not easily lend itself to monitoring of children leaving formal care placements across the country,[126] and does not include data on the number of children who are unaccompanied or separated in emergency situations. This is of concern, given that Kenya has several large refugee settings serving thousands of children.[127]

VAC studies conducted in the past have demonstrated the importance of having robust data to inform and translate into national plans of action, and likewise, to inform policy and programming.

4.5 Interface of the child protection and care systems

Kenya's national child protection system is divided into nine key elements, as illustrated in Figure 6.[128]

Kenya's alternative care system is situated within the national child protection system. The laws and policies on child protection include all care reform elements, the social service workforce is drawn from the child protection workforce, and envisioned programmes and services are within the child protection system. The CPIMS can record care data alongside other child protection data.

Figure 6

Components of Kenya's national child protection system[129]

Care reform is recognised as a priority issue for both the NCCS and the DCS, and is integrated into their child protection efforts. Both bodies are making a concerted effort to work together rather than in isolation. One official commented, 'Now we are working as a team. Before, we did so in isolation.'

The development of the *National Care Reform Strategy* is also recognised as an important opportunity to bring in new actors that have a role in child protection and care, and help them take ownership of the concept and energise the broader child protection system. This was noted in terms of including the ministries of Education and Health in the Care Reform Core Team.

The intentionality with which child protection systems strengthening efforts have included care reform appears to have made a significant difference in recent years. Perhaps one of the most notable is the improved understanding that care reform is not synonymous with only deinstitutionalisation. Rather, it is a three-pronged approach that encompasses family strengthening, prevention of separation, and expansion of family-based alternative care (see Figure 7). This approach appears to have helped strengthen the linkages between care and the broader child protection system.

Figure 7

Strategic Approach to Care Reform Diagram

5 The Social Service Workforce

5.1 Overview

The social service workforce forms part of the broader systems-strengthening efforts that began in 2010. A child protection system mapping exercise in 2010, followed in 2013 by a workforce assessment, highlighted the critical role of the human resources dedicated to child protection, including alternative care.[130] These assessments revealed that the government workforce was insufficient in terms of coverage and numbers, consistently under-resourced, and lacking in critical processes and supervision mechanisms. For example, a 2015 study showed that the number of COs at the county and sub-county levels was far from adequate to meet child protection needs, and that many related structures were not in place.[131]

A strong government child protection workforce is critical, given their mandate. Child protection staff, working under the auspices of the DCS (i.e., COs), have the legal mandate to 'effect protection', meaning that they are recognised as officers of the court. This function plays a critical role in terms of presenting care recommendations to the court. NGO staff are not able to fulfil this function.

In 2019, the DCS and UNICEF, with technical support from Maestral International, conducted a rapid mapping and assessment of Kenya's workforce for child protection in five counties – Nairobi, Kisumu, Nakuru, Kilifi and Turkana.[132] The rapid assessment found that the overall number of COs was very low, given the overall child population. [133] The most recent count, conducted by the DCS in February 2019, yielded 510 COs, and 171 children assistant officers, teachers and technical instructors, a total workforce of 681 in the country.[134] Additional child protection personnel include 388 social development officers and 1,800 social development lay volunteer counsellors working for the DSD at the county and sub-county levels.[135] There are also more than 100,000 community health volunteers, mostly trained and supported by NGO projects focussing on HIV and OVC programmes, and fifty-seven disability officers work at the national and county levels. The government workforce for child protections face challenges, but key informants noted that COs are well trained, very knowledgeable, and that there is little turnover. All positive factors.[136]

The rapid mapping assessed the skills and knowledge required of those in the workforce against what they have. COs are required to hold a bachelor's degree in one of social work, sociology, community development, guidance and counselling, child psychology, criminology, social development and management, or anthropology. COs working in grades K and above must also have a specific number of years of experience. The mapping found that, in practice, COs and SCCOs have often entered the career without the required qualifications, and less than 25 per cent have formal social work qualifications. Whilst many COs have considerable expertise, and have learned much through practice and in-service training, some of the core social work competencies have not been formally taught.[137]

Several higher education facilities offer bachelor's degrees in social work and one year diploma programmes in social work and child development.[138] Two universities offer master's degrees in social work programmes that have been developed in the past decade,[139] and several offer degree or diploma programmes in related disciplines, including social welfare, early childhood development, psychology, community development, HIV and AIDS management, and medical and health counselling.[140]

There is a professional social work association in Kenya, but how active it is it is not clear. In the 2019 rapid mapping, many COs noted that they were not members of the association, noting reasons of cost, time and perceived benefit of membership.[141] There is also a professional association for counsellors that operates at the national level, and has branches in several counties. [142]

One area where workforce strengthening is needed is coverage at the community level. A new cadre of CPVs was established in 2019, under the auspices of DCS. CPVs play a front-line role within the child protection system, engaging directly with children, families and communities, frequently acting as the bridge between the community and the SCCO, or CO. CPVs report to, and are supported by, a CO, but also report to the CCACs As the name implies, the CPVs are volunteers, not employees and do

not receive pay for their work. They are not given any stipend for expenses, and their hours are limited, though the limits are not always observed. Criteria for CPVs include a demonstrated passion for, and commitment to, children's rights and well-being, to be aged between 25 and 65 years, have at least a Class 8 or equivalent education level, and possess a valid police clearance. A recommendation from an area chief is also a requirement. CPVs may not volunteer for longer than six years, though many serve longer. At the time of writing, approximately 350 CPVs operate in all counties across Kenya.[143] There is no 'typical' profile of a CPV. Many are retired professionals (teachers, social workers), while others are young students who have graduated, are searching for a job, and hope that their time as a CPV might strengthen their resume. CPVs are both men and women. There are several issues related to roles and accountability that need to be clarified to facilitate successful roll-out. A CPV manual has been developed, which outlines roles and responsibilities, competencies and reporting protocols. A five-day child protection training course was developed in 2021 for the para-professional workforce, which CPVs form a part of. Kenya has costed the child protection system, including three costing scenarios to expand the number of CPVs.[144]

The child protection workforce also includes professionals within NGOs, civil society and FBOs, whose staff play an important role, and who work at the national, county, sub-county and community levels. These professionals include social workers, counsellors, child protection officers, child and youth care workers. For some, their role is exclusively dedicated to child protection, while for others, child protection forms a component of their broader social service role. A significant number of staff members of private CCIs, for example, also form part of the child protection and care workforce. Given that there is an estimated 850 CCIs, the number of workers responsible for social work-related tasks that address children's care could potentially be in the hundreds, although this needs to be confirmed.

There are no national training curricula for non-government child protection-related professional workers, and because the vast majority of CCIs are private, each one operates, and provides their training, differently. The national standards for CCIs include minimum staffing, and specifies responsibilities. The standards require that all CCI staff have written job descriptions, have certified academic qualifications, and the necessary skills and competencies must be spelt out for every job level.[145] The standards require that CCI management must ensure that potential staff meet all outlined qualifications before they are recruited, and that there is a staff development plan and supervision. It is not possible to say if these standards are being implemented in all CCIs, as oversight is limited. Furthermore, the NCCS is behind with approval processes for re-registering CCIs, since the moratorium on registrations of new CCIs was introduced in 2017.

5.2 Workforce-strengthening actions and linkages with other sectors

A framework for strengthening the child protection workforce was drafted in 2020, informed by the 2019 mapping findings as well as the global *Framework for Strengthening the Social Service Workforce for Child Protection*.[146] At the time of writing, this framework is in final review with the DCS.[147] The DCS the and NCCS, with UNICEF support, are currently investing in the development of the child protection workforce, with a particular focus on strengthening the competencies (skills, knowledge and attitude) of core cadres, and establishing clear processes and procedures in terms of onboarding, supervision, and data collection and use for decision-making and service delivery. This momentum to strengthen the workforce is leveraging the important work around VAC and care reform that has been underway in the past decade.

The adoption of the SDGs,[148] and, for the first time, specific goals and targets to prevent and respond to all forms of VAC (SDGs 5, 8 and 16), represents an unprecedented opportunity to address violence, abuse, neglect and exploitation of children. In 65 out of the 169 SDGs, the workforce plays a critical role in attaining the goal. This which is why UNICEF has prioritised the strengthening of the social service workforce for child protection in their strategic plan. Kenya has recently finished its second VAC study (discussed in Section ???), and recognises the unique opportunity to use the findings to highlight the

importance of having a trained, resourced and supported workforce to prevent and respond to VAC.

The draft *Kenya Social Protection Strategy*[149] mentions the development of a *National Social Work Strategy*, which will focus on the provision of social services targeting vulnerable adults and children, and the need for an expanded government workforce dedicated to child protection.

5.3 Care reform workforce considerations

The 2019 rapid mapping identified interesting information relevant to children's care.[150] The first is that the child protection workforce is not precisely defined in any legal instrument in Kenya, but the Children Act 2021 does set out a mandate for those assisting 'children in need of care and protection' and their families, and sets out the roles for oversight, recruitment and management of COs to carry out this mandate.[151] The Social Workers Bill is, at the time of writing, tabled in Parliament and should provide criteria around number, accreditation and certification.

The *County Child Protection Systems Guidelines* includes information about what members of the child protection workforce must know, implement, and participate in.[152] The guidelines specifically mention the importance of the training, skills, and competency of the child protection workforce.

Whilst much of the legislative framework, and existing guidance and standards, represents efforts to prevent separation or support family-based care, there remain contradictions, including the lack of resources dedicated to prevention and family-based alternative care, and the requirement in the Children Act 2001 to only place children in foster care from a CCI.

The current job description for registered COs has a strong focus on alternative care, with a mandate to 'rescue children from hostile environment' and commit children to safe places. The functions articulated in the job description have limited focus on prevention, early intervention and family strengthening, which are key to preventing family separation and supporting family-based alternative care.[153]

The Children Act 2001 also recognises other 'authorised officers', such as police officers, administrative officers, an approved officer, a labour officer, an adoption officer or 'any other officer authorised by the Director for the purposes of this Bill',[154] enabling close collaboration between the child protection sector and other sectors. The Children Bill 2021 is not specific about county- and sub-county-level personnel, other than to confer authority to the Director of the DCS to delegate his or her power to implement the bill, including the appointment of personnel. Again, given the predominant focus on residential care in legal provisions, and the lack of harmonised legislation and policy at the national and county levels, remains a challenge.

As an immediate action informed by the findings of the 2019 rapid mapping, DCS, the Kenya School of Government, UNICEF and Maestral developed a standardised ten-day training for professional child protection practitioners[155] and a five-day training for CPVs, covering all aspects of child protection, but with close attention to care reform. In the longer term, the strategic framework described in Section 6.2, and the three-year action plan to guide the implementation of the framework, have a strong focus on care reform. Key care reform-related components of the workforce-strengthening framework include:

1. A ten-day standardised training for the professional child protection workforce, including COs and recognised civil society-employed child protection professionals, and a five-day course for CPVs to enhance their capacity to prevent and respond to violence, neglect, exploitation, and abuse against children more effectively. Content for the training is informed by key approaches, tools and case studies developed by key care reform actors to ensure consistency across government and civil society actors.
2. A proposal to articulate minimum national standards for child protection work, including care reform-related aspects, and a standardised model for child protection services.[156] As an example of areas that need greater articulation in the proposed minimum standards, are cases where CPVs conduct monitoring visits to children who have been reunified, or are at risk of separation, on

behalf of government and often in close collaboration with civil society organisations (CSOs), in effect acting as the 'eyes and ears' of the community.[157] Given the number of children in residential care that will be reunifited, ensuring that CPVs are adequately trained and that their actions reflect minimum standards will be critical for reintegration to happen safely.

3. Clear definition of the child protection system and its stakeholders in each county, to facilitate clarity about governance, roles and structures, effective referral pathways and shared training.

4. Proposed professionalisation of the volunteer cadre of CPVs, requiring COs to hold a degree in Social Work as an entry qualification, and substantial investment in increasing the number of SCCOs.[158] These actions would have significant care reform benefits, including greater ability to focus on awareness-raising and prevention of family separation at the community level, and prioritising the family-based alternative care approaches as set out in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014).[159]

Strengthening the workforce responsible for children's care and protection is recognised as a critical piece of the puzzle. There appears to be strong agreement and coordination in terms of better equipping the workforce with the skills, knowledge and tools needed to successfully fulfil their mandated functions. There is also a clear recognition that the workforce is a combination of government and civil society, and there are concerted efforts to create more opportunities and synergies for cooperation, including speaking a common language and utilising common approaches, procedures and tools. However, there is a prevailing need for increased resources, including standardisation of reimbursement in cash or kind for the current volunteer workforce, as well as strengthened supervision and improved coordination.

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6 Preventing the Need for Alternative Care

Kenya is made up of many cultures and communities, all of whom place a strong emphasis on family and place family values central to daily life. Yet together with this positive emphasis on family, tribe and community, there are also many factors that make Kenyan families vulnerable and hinder or undermine their ability to care for, protect, and provide for their children. The HIV epidemic, political violence, climate change and most recently COVID-19 have placed many families under intolerable stress.

The legislative framework is quite clear in recognising the primary role of the family and the responsibility of the government and others to support them in that role. The *Constitution* (2010) states that: 'The family is the natural and fundamental unit of society and the necessary basis of social order, and shall enjoy the recognition and protection of the State.'[160] The *National Prevention and Response Plan on Violence Against Children 2019-2023* (NPRP VAC) has family support as one of its five strategic areas.[161] According to the *Kenya National Care System Assessment* (2020), there is a sense that implementation of those laws and policies is not adequate and there are significant challenges in terms of ensuring access to services that help families in their ability to care for children.[162] There is growing legislative support for strengthening families through access to social protection and basic services, as well as specialised services for specific populations, yet implementation remains a significant barrier to families accessing the support they need.

There remain challenges in terms of delivery of and access to those services, especially for the most vulnerable children and families in Kenya. For example, the 2009 Census showed that 17 per cent of CWD never attended school, compared with just 10 per cent for children without disabilities.[163] Other estimates suggest that the education gap for CWD may be even higher than the Census figures, but it is hard to quantify due to lack of data.[164] The *Concluding Recommendations* on the Kenya Report (2016) of the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) noted that 'Children with disabilities are mostly disadvantaged in health care services. The Committee implores the State Party to give attention to children with disabilities, particularly autistic children, and adopt an inclusive structure of receiving health care.'[165]

More broadly, there are issues of access to essential social services for vulnerable families. In the *Kenya National Care System Assessment* (2020), participants noted concerns about the coverage and quality of services aimed at building the potential of families to better care for their children.[166] There was recognition that while the national cash transfer programme does help prevent family separation, there are concerns about coverage and targeting. Whilst recognising that significant progress has been made in the expansion of free primary and secondary education, as well as health insurance, participants noted that challenges remain with coverage and access. Many studies have noted that education is not free, and books, uniforms and other 'hidden' fees often prohibit children from attending.

The following are examples of government-provided services or interventions that support vulnerable families. Whilst not directly designed to prevent separation, these interventions address many of the root causes.

Orphans and vulnerable children cash transfer programme:[167] the CT-OVC was launched in 2004 to meet the needs of the increasing number of children made vulnerable by poverty, and HIV and AIDS. The programme seeks to provide a regular cash transfer of KSH 2.000, or USD 20, to families living with OVC and considered to be living in poverty (OVC includes children who have lost one or more parent, and those susceptible to, or living with, HIV and AIDS). Specific objectives of the CT-OVC are to increase school enrolment, attendance and retention, reduce early childhood mortality, promote civil registration of children, and strengthen the resilience of households through linkages with other programmes. It began as a pilot project in three areas of the country, Garissa, Kwale and Nairobi. The programme eventually scaled-up, with international donor support, and in the 2020 Social Protection report, 293,000 households were receiving the CT-OVC, of which more than 75% are female-headed households.[168] In 2020 and 2021, there was a concerted effort to increase the value and coverage of

cash transfers as the pandemic affected already vulnerable households.

Cash transfer programme for those with severe disability was launched in June 2011.[169] It targets adults and children with severe disabilities who require the full-time support of a caregiver. The programme seeks to enhance the capacities of households and reduce poverty through cash transfers of KSH 2,000 per month (USD 20) to improve the livelihoods of persons with severe disabilities and the reduce negative impact of disability on households. It is a national programme, and data provided by DCS in June 2021 indicated 34,356 households with CWD.

Older Persons Cash Transfer: started in 2007 as a pilot in three districts, Thika, Nyando, and Busia, and has since been expanded nationally.[170] The objective is to provide regular, predictable cash transfers of KSH 2,000 per month (USD 20) to poor and vulnerable older persons (65 years and above) in identified households.

Kenya has been recognised for its well-established cash transfer programme, including the use of online banking systems like M-Pesa, that support roll-out. However, it is not without its challenges and limitations. The Concluding Observations of the CRC mentioned that 'Increased budget allocations in certain areas, including education and social protection, still do not match the overwhelming needs in these sectors.'[171]

Universal Health Care and Education: Kenya has made significant strides in the past several years in its aim to be a leader in region with the provision of universal health care.[172] The Universal Health Care Programme launched in December 2018 in several different counties, including Kisumu, Machakos and Isiolo. The focus is on scaling-up immunisation, family planning, antenatal and postnatal care services. Other areas of focus include prevention of waterborne, vector-borne, and sexually transmitted diseases, as well as TB and HIV. The programme also aims to improve the nutrition of women, and children during their first five years of life, There remain challenges with access and affordability in certain areas of the country.[173]

Universal education: Free and compulsory education is stipulated in the Basic Education Bill 2012. Kenya's strategic development plan, Vision2030, has acknowledged education as a component of the social pillars. Advancement towards free education started in the 1970s with the adoption of free primary education.[174] In the past several years, significant gains have been made in fulfilling the right to education for Kenya's children, including gender parity, more than 100,000 new teachers trained, roll-out of a competency-based curriculum,[175] and a recent proposal for compulsory secondary education. More recently, the government has proposed free and compulsory secondary education.[176] Despite these positive steps, there are still challenges to all children accessing this right. Financial status and geography are factors, as parents or caregivers must still find the resources to pay for uniforms, books and other fees. This often creats insurmountable barriers to accessing the classroom.[177]

Until recently, there has been limited investment in family-strengthening initiatives, although these are increasingly being set out in, for example, the *Guidelines for the Alternative Family Care of Children in Kenya* (2014) and the NPRP VAC.[178] The draft *National Policy on Family Promotion and Protection* further states the importance of investing in family strengthening.[179] This will hopefully address one of the core anachronisms of Kenya's care reform process – the focus on individual children rather than the family. One recent example is the formation of a national Technical Working Group to develop the *National Positive Parenting Guidelines* and a national positive parenting training programme, which has a focus on preventing VAC, one of the drivers of family separation.[180] Key stakeholders mentioned that one of the great benefits of the Children Bill 2021 becoming law is that prevention and the important role of a family environment is clearly articulated. 'There is a clear message about children within families and the importance of preventing separation and promoting reintegration.'[181]

A study of Kenya's over-reliance on residential facilities notes that 'solutions which focus on removing children from their families are also rooted on an exclusive focus on children, that is, children are viewed in isolation,

with little or no consideration given to the role of their environments and their primary care givers in assuring their consistent care, protection, and overall well-being. In a way, the emphasis and focus on "orphans" legitimizes this approach."[182] This study proposes a root-cause approach that would integrate child protection interventions with poverty-reduction and family-strengthening ones.[183] This same idea was highlighted in the 2016 Concluding Recommendations of the ACERWC (see Box 1).

Box 1

The need for a root-cause approach to family strengthening

In the 2016 Concluding Observations of the ACERWC, the importance of supporting families to prevent separation and abandonment was highlighted (p. 9).

> The Committee appreciates the steps the State has taken to safeguard the family. However, the Committee notes with concern that there are many children who are abandoned and who are orphans; and that the State Party has limited resources to address this situation. The Committee hence encourages the State Party to: a. Expedite the adoption of the Family Protection Bill; b. Raise awareness on the value and importance of family for the wellbeing of children and tackle the current decline of the family; c. Raise the budget allocated for the protection of the family in accordance with its need; d. Prevent breakdown of families by providing mediation and addressing the root causes of family breakdown.

The *Guidelines for the Alternative Family Care of Children in Kenya* (2014) includes a section on prevention and support services, which provides detailed information on the types of services aimed at preventing separation. Many of these suggested services do not exist yet, are not provided by the government, or are being provided by programmes that are not sustained in terms of funding or duration. CSOs provide programming and services focused on supporting families, including positive parenting programmes, support groups and advocacy for parents of CWD (many are founded and led by parents who themselves have a child with a disability).

The concept of prevention and early intervention is not yet clearly translated into government guidance. However, the VAC work has influenced and promoted the idea of prevention. Parenting and family care is one of the six strategic areas of the NPRP VAC, and the Government of Kenya and UNICEF finalized and began rolling out a national parenting programme aimed at addressing VAC in 2023. The strategic area on family care explicitly focuses on family-based care. Furthermore, the content on the need for, and importance of, shifting the focus from response to prevention has now been included in the standardised training for professional child protection practitioners, and child protection training for CPVs.[184]

6.1 Prevention and early intervention efforts in related sectors

Despite the limited focus on preventing family separation (and on the root causes of family separation, including violence and lack of access to essential services) in the care reform and child protection policy sector until relatively recently, a significant positive development was the 2019 VAC study (see Box 6 in Section 8), which shed light on the high rates of VAC occurring within families. This highlighted the urgent need to reach families with the appropriate skills, knowledge and services to, first and foremost, prevent violence. Where VAC does occur, there must be appropriate and accessible services to respond to, as well as to protect, children in need. With nearly half of surveyed females aged 18–24 years, and more than half of males of the same age, reporting that they experienced childhood violence, the need to reach more families with support that addresses the core triggers of violence, is critical.[185] Key informant interviews also confirmed the need for more early intervention and diversification of interventions, including drug and alcohol prevention and treatment, which are often linked to violence.[186]

The findings informed policy recommendations, many of which aim to address preventing violence through targeted family-strengthening interventions.[187] Examples of key recommendations from the study include:

1. Parenting education to promote positive parenting and prevent all forms of violence at home, including meaningful male engagement.
2. Increasing availability of critical psychosocial support and mental health services for survivors of violence.

Services that exist are often in urban areas, project funded, and not accessible to those outside of the immediate location or the project area.

3. There needs to be recognition of the linkages between VAC and violence against women, and an awareness that, usually, both are occuring in the same home. Designing services that prevent and respond to both is critical.
4. The harmful attitudes, values and social norms that condone VAC and violence against women at the household and community levels must be addressed.
5. Violence prevention must have a life-cycle approach, with particular attention given to the understanding and prevention of violence in early childhood, given its negative impact on childhood development.[188]

At the time of writing, the DCS is disseminating the findings of the NPRP VAC to the county level, where decentralised plans are expected to be developed. There have been calls for technical support in the areas of promoting of positive parenting, and an extensive review of gender-based violence, including that perpetrated against adolescents. The proposed national positive parenting programme will be based on existing curricula that have integrated actions on intimate partner violence.[189] It will also align with the draft *National Policy on Family Promotion and Protection*, and will have a strong focus on addressing the links between VAC, violence against women and gender-based violence. A national task force was established in 2020, and there have been frequent public statements on mental health.[190] This is yet to be translated into tangible results at the family level.

Programmes aimed at OVC in Kenya have led the way, over the past decade, in providing a combination of integrated services aimed at both preventing HIV and strengthening parent/caregivers' ability to provide safe, stable, and nurturing environments for children affected by HIV and AIDS. This service 'package' includes case management, access to health and education services, parenting programmes, livelihoods (cash plus care) and life skills for adolescents. Whilst not specifically targeting children at risk of separation, the combination of services has greatly influenced the way in which combining services is understood by the care sector.[191] There are also concrete examples of how OVC programmes have been leveraged to positively impact care by, for example, sharing key messages about the harmful effects of residential care with parents affected by HIV and AIDS. In a recent effort by CTWWC to track the children who were rapidly reintegrated from residential care because of COVID-19, 19 children affected by HIV and AIDS were linked to an OVC programme in their geographical area to benefit from services and support.[192] The President's Emergency Fund for AIDS Relief (PEPFAR)-funded DREAMS initiative, which addresses violence against girls and HIV prevention, has reached thousands of adolescent girls with evidence-based VAC and GBV prevention information.[193]

The most recent OVC programme, MWENDO, was implemented by Catholic Relief Services, with partners Maestral International and Family AIDS Care and Education Services, from 2018 to 2021, with funding from the United States Agency for International Development. It was piloted in Western Kenya and Nyanza, and was then scaled-up to Nairobi and four coastal counties. MWENDO aimed to ensure children remain healthy, safe, stable, and schooled by addressing the social determinants of health to improve the well-being of children orphaned and made vulnerable by HIV. It also sought to enhance the capacity of caregivers and communities to sustainably provide care and support to OVC, and strengthen the institutional capacities of formal and informal structures to respond to children's welfare and protection needs.[194]

6.2 Gatekeeping mechanisms

Gatekeeping is the policies, systematic procedures, services, and decision-making that ensure alternative care for children is used only when absolutely necessary, and that children receive the most suitable support and/or care to meet their unique individual needs, thereby upholding the best interest of the child.[195] It is a process that helps determine whether placement in alternative care is necessary and, if so, which type is the most appropriate. Gatekeeping is mentioned in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014).

CCIs should have proper gatekeeping measures in place to ensure that placement in institutional care is in the best interests of the child and a last resort. CCI social workers should counsel parents or legal guardians wishing to relinquish a child permanently or for a temporary period. The care providers should establish linkages with interdisciplinary social services to address the reasons for the child being abandoned.[196]

At the county and sub-county levels, the county children coordinator, CCAC and SCAC are responsible for gatekeeping. Box 2 provides more detail as to the membership and responsibilities of the Care Reform Sub-Committee (CRSC).

Whilst gatekeeping is included in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014), there was initially a limited understanding of the concept, and how gatekeeping mechanisms are implemented in practice. CRCs have a clear gatekeeping role as part of their mandate, and some, like those in Kisumu, have started making care decisions.

A series of meetings was held with key government and non-governmental actors in 2019–2020 to establish a common definition of gatekeeping, and outline the roles and responsibilities, and key outcomes, of a standardised gatekeeping process.[197] The meetings revealed gaps in child protection professionals' understanding of the definition and purpose of gatekeeping. challenges of implementing a gatekeeping role for the CCAC and SCCAC. Furthermore, there have been bottlenecks to operationalising the envisioned gatekeeping mechanisms due to the delay of, or limited, resources committed to establishing CCAC and the CRSC (see Box 2).

At the time of writing, DCS has approved *National Gatekeeping Guidelines*, which were launched in 2022. They are based on the *Guidelines for the Alternative Family Care of Children in Kenya* (2014) and clearly articulate the 'how' of the guidelines. Figure 8 was developed to help key actors visualise and better understand the role, place, and function of gatekeeping in the care system.

Box 2

Gatekeeping mechanisms in Kenya

The CRSC is the formal gatekeeping mechanism. The National Care Reform Strategy defines the committee as a 'sub-committee of the AAC that oversees and monitors the implementation of care reform at the county level and sub-county level.' The committee must ensure that children are not unnecessarily separated from their families and, when separation occurs, ensure that the most suitable alternative care option is provided.

Specifically, the CRSC:

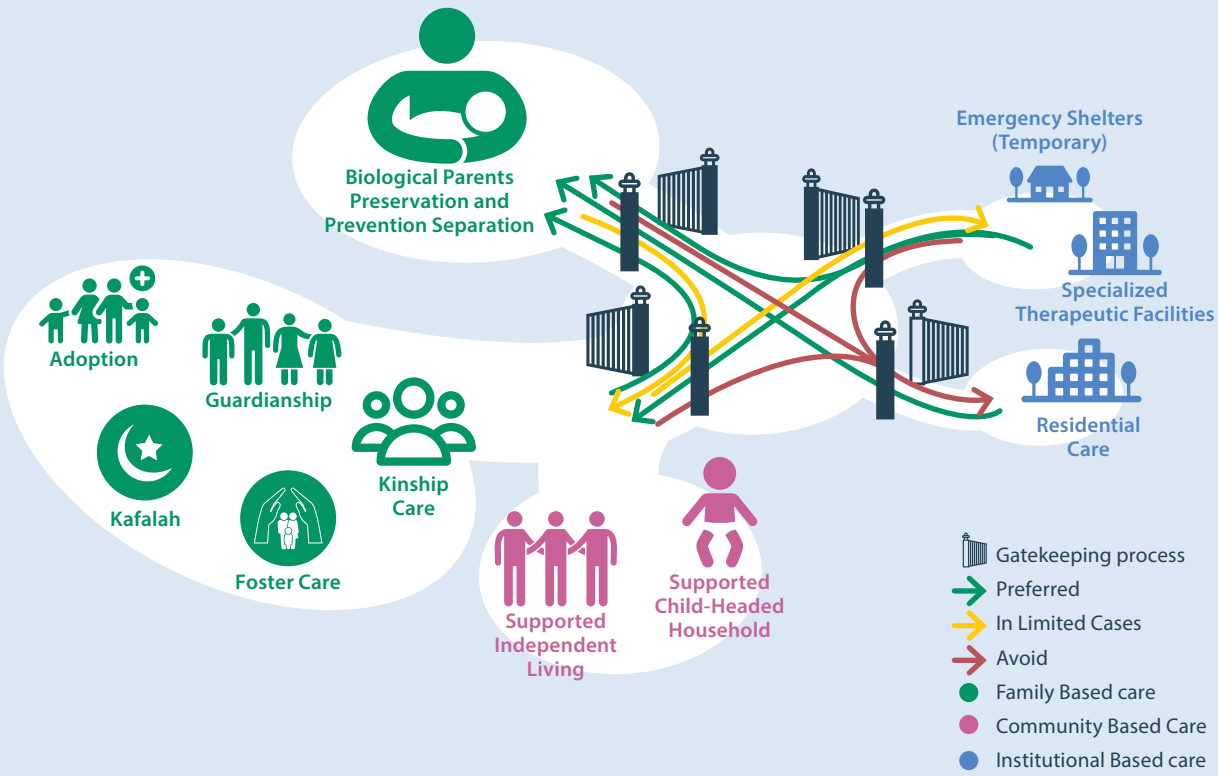
1. coordinates and reinforces family strengthening, alternative care services and referral networks among relevant service providers.
2. makes decisions about the placement of children into alternative care.
3. monitors the progress of children whilst in alternative care.

According to the *Guidelines for the Alternative Care of Children in Kenya*, the CRC should be composed of representatives from:

1. sub-county children's office
2. judiciary
3. police
4. Ministry of Health
5. local administrators
6. civil society involved in alternative care.

Figure 8

Gatekeeping in Kenya's care system



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7 The Continuum of Care in Kenya

The continuum of care is well articulated in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014).[198] It encapsulates the range of care options available to children, from family-based through to residential care. Figure 9 was developed in consultation with key stakeholders and, together with the *Guidelines for the Alternative Family Care of Children in Kenya* (2014), has been instrumental in helping to solidify a broad understanding of what is included in Kenya's care options for children.

Prevention of family separation, and family support services, are discussed in Section 6. In this section, family-based options are considered, followed by community-based care options and, finally, residential care. The focus within the care system to date has tended to be reactive, with residential care – the right side of the diagram – dominating. Preventive or family support measures have been observed, but have lacked regulation or operational detail. With the recent shift in focus, the balance is now moving towards the left side of the diagram.

7.1 Family-based care options

7.1.1 Reintegration and reunification

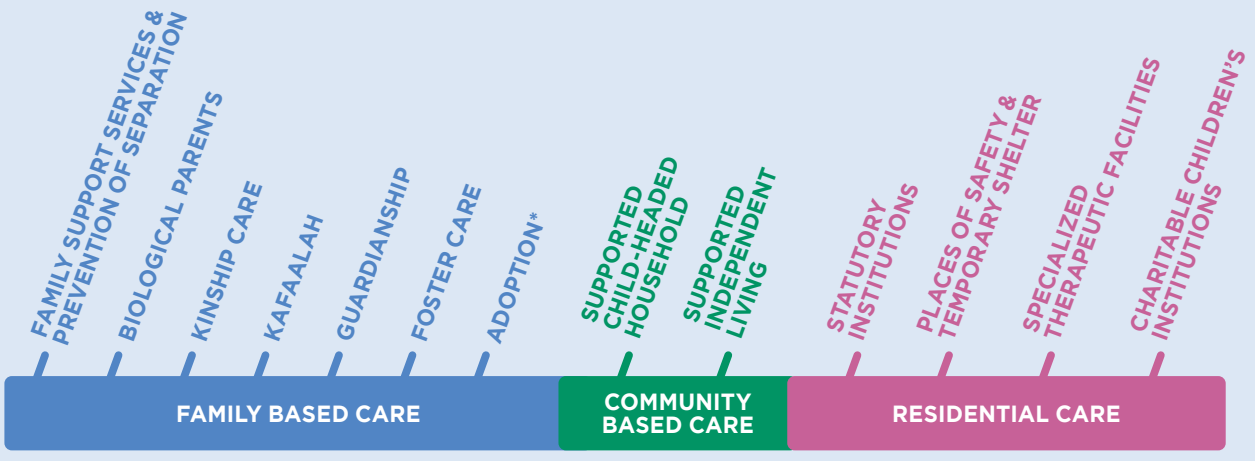
Reunification is the physical placement of a child back into a family-environment, while reintegration – whereby the child is in a safe, stable, and nurturing family environment – is the end goal. During the reintegration process, activities are undertaken to equip both the child and the family with the necessary skills and resources for proper reintegration and readjustment.[199] This differentiation is a cornerstone of care reform, and has informed the development of approaches and tools to support the process.

The legal provisions for family reunification and re-integration are specified in the Children Act 2022 s 125(2)(a), and their processes addressed in more detail in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014). The recently developed *Case Management for Reintegration* SOPs and toolkit were launched by the Government of Kenya in 2021, reflecting a significant step forward in detailing how reintegration is promoted and practiced.[200]

The NCCS and the DCS worked closely with civil society actors in 2019 to design the *National Case Management Guidelines for Reintegration of Children into Family based Care*, developed in response to the need for comprehensive, standardised and harmonised case management approaches to promoting family care for

Figure 9

Continuum of care in Kenya



GRAPHIC BY M. OLIEL, STAHILI

children in Kenya.[201] The completed package includes a caseworker guidebook, caseworker toolkit and field-friendly handbook, and training resources. It is aimed at policy makers, programme designers and practitioners, and promotes the safe and sustainable reintegration of children. The package was informed by the case management tools and approaches promoted by the 4Children Project,[202] the Global Social Service Workforce Alliance[203] and the Interagency Group on Children's Reintegration.[204]

International and local NGOs have been engaged in reintegration efforts in Kenya, with many having done this work for years. As a result, several actors have a lot of experience. While not all of it has been systematically documented, the use of family group conferencing in the reintegration process of children from SCIs in the mid-2000s[205] and the reintegration of children from the streets have provided useful lessons learned.[206]

There are also important lessons and experiences around family tracing from the humanitarian sector. In refugee camps such as Dadaab and Kakuma, unaccompanied and separated children often arrive at the camps, and standardised assessment tracing processes are utilised. The use of family-based alternative care is also prevalent in the camps (see Section 10).[207]

Over the past decade, improvements in the availability of antiretroviral drugs to treat HIV have resulted in more children living with HIV remaining at home, and HIV+ caregivers able to care for them due to longer lives and services provided by OVC programmes.[208]

There has been less success in the reintegration of CWD. It was difficult to identify any concrete examples of reintegration efforts for CWD in either the literature or key informant interviews. A 2018 study of CWD and their caregivers – in residential facilities and family care – found that CWD were far more likely to remain in residential facilities after they turned 18. In two institutions visited, there was a man of 30 and a man of 36 respectively.[209] The CRC and the ACERWC have both noted that services targeting CWD are limited, and whilst the issue of residential care and reintegration was not specifically mentioned, it can be assumed that it is also the case.[210] However, in 2015, the Committee on the Rights of People with Disabilities stated that '[t]he Committee is deeply concerned at the abandonment of children with disabilities who are rejected by their families and at negative stereotypes against them, particularly in rural areas. It is also concerned about the institutionalization of children with disabilities and the prevalence of residential care.'[211]

The *Kenya National Care System Assessment* (2020) notes a lack of routine data for monitoring reunification/reintegration programmes. This issue will hopefully be addressed by adaptations being made to the CPIMS and its national roll-out at the time of writing. However, it is not clear if private CCIs will adapt to, and adopt, the added responsibility of inputting this data on a regular basis.

During the care system assessment process, stakeholders mentioned the need for an effective system to collect these data, and for improved quality assurance mechanisms for the existing data. Theyalso mentioned the lack of feedback loops or satisfaction measures – soliciting feedback from children and families about the process and services provided.

The COVID-19 pandemic provided a unique opportunity to collect primary and secondary data on children and families who were part of a rapid reunification process ordered by government in March 2020.[212] The process demonstrated the necessity for a robust and real-time monitoring system. While it has been recognised that the rapid reunification process was not carried out in a safe or standardised manner, ongoing monitoring, and provision of services and support to families has meant that many of the reunified children can remain with families.

7.1.2 Kinship care

Kinship care is the most common form of alternative care in Kenya, and is almost exclusively informal. Informal kinship care is defined as 'a private arrangement within the family environment whereby the child is looked after on a temporary or long-term basis by his/her extended

family from either the maternal or paternal side, without being ordered by an administrative or judicial authority. The family members include grandparents, aunts, uncles, older siblings and first cousins.'[213]

In 2012, Save the Children conducted a study in Busia County which noted that, of the 11 per cent of children living in households without either biological parent, the large majority were in informal kinship care.[214] The qualitative study found a wide range of socio-economic factors and cultural practices that result in children being placed in kinship care, including: family poverty; family breakdown (divorce, re-marriage, polygamy, early marriage, alcoholism); poor health, death of parent, HIV and AIDS; lack of access to schools, health services or livelihood opportunities; political insecurity, conflict, and disasters; and urbanisation and migration. Recent research undertaken by Family for Every Child into kinship care showed that many extremely poor families in Kenya still take children in through kinship care, despite it risking their own material well-being.[215] This was also observed when the 2014 DHS data was analysed.[216] The greatest percentage of children who live in a household headed by a grandparent (without biological parent) are in households from the poorest quintile (70 per cent).[217] They are also far more likely to live in a rural rather than an urban environment – 67.4 per cent vs 45.5 per cent. Interestingly, this was not the case for those living with other relatives or siblings.[218] Many children in kinship care live in over-crowded households and face difficulty in meeting their basic needs, particularly when kinship carers are elderly and female.

A 2015 study by Save the Children found that – in line with studies in many other countries – kinship care is a positive experience for some children, enabling them to be cared for and loved by family members, and maintain a sense of identity, culture and inheritance, while for other children, the experience is one of discrimination and significant protection concerns. Globally, living with grandparents who offer love, care and a sense of belonging has better outcomes, including improved care and reduced violence, despite the health and socio-economic challenges faced by elderly caregivers.[219]

Interestingly, contrary to assumptions given the presence of strong gender norms in Kenya, gender does not determine the placement of girls or boys in kinship care. Gender does appear to determine who the children live with when not in parental care.[220]

Gender also seems to play a role in determining who children live with when living outside of the care of their biological parents. More boys aged 0-17 years live with their grandparents (66 percent vs. 59 percent), siblings (6.2 percent vs. 5.1 percent), and adoptive families (3.3 percent vs. 3.1 percent) than do girls. More girls living with neither biological parent are found to live with other relatives (26 percent vs. 20 percent) and unrelated families (4.1 percent vs. 3.6 percent) than boys.[221]

Gender plays a role in kinship care, with a general preference for girls because they can help with housework and provide an opportunity to claim bride price.[222] Paternal relatives are reported to often prefer boys, as it may increase their chances of claiming inheritance.[223] Decisions about kinship care tended to be influenced by a patriarchal system, where decision-making is predominantly male dominated, with very limited consultation with affected children.[224]

Despite kinship care being a prevalent form of care, the desktop review found no evidence of any specific services to meet the needs of kinship carers. Rather, it was found that social protection schemes are often inaccessible to kinship carers, given its predominantly informal nature as well as its absence in social protection policies.[225] This appears to contradictone of the initial reasons for the development of the CT-OVC, which was to support households caring for OVC – many of whom are in kinship care, given the impact of HIV and AIDS mortality during the 2000s.

The CTWWC and Stahili Foundation-led situational analyses, conducted, in collaboration with government, in five counties in Kenya,[226] identified the high potential for many of the children in residential care to be reunified into kinship care, as most had been reunified with families and other relatives.

Box 3

Perspectives from kinship caregivers: the benefits and challenges of kinship care

I take care of children who are not biologically mine because I am willing to do so and because the children have nowhere else to go. I do not do it for any benefits. It is nice having children at home though, it makes the house lively, always. The children also provide me with company.

– Atieno

I live with my grandsons, seven of them. Two of them were rejected by their parents and one of them is severely disabled. I took two of the children to two orphanages but when I started learning from an NGO doing reunification, I realised a CCI is not the best place for them, I brought them back home. The two children have changed since they came back. It's been two years since they came back home. Their school performance has remarkably improved. Also, there has been improvement in the health of my grandson with disability. This is [because] we were able to get health insurance (NHIS) for him.

– Ruth

It would be great if government or partners provided school fees and even better if paid directly to the schools because, if I am given cash for school fess, I may be tempted to use portions for other basic needs. School education is so expensive these days and the more the children, the bigger the expense. So, instead of supporting meals, NGOs or government could assist kinship caregivers with school requirements such as uniforms and scholastic materials instead of supporting meals. They could also provide some financial support for businesses where possible.

– Omingo

The analysis also identified the potential for investing in traditional kafaalah practices in Kilifi county (for which it recommends further mapping) and traditional Gusii community care practices in Nyamira. One care leaver in Murang'a county commented that kinship care placements with grandparents 'avoid rejection', a recurring theme expressed by care leavers when they return to their families and communities. Box 3 includes examples from kinship caregivers of the benefits and challenges of providing kinship care.[227]

Global data suggests increased risk of younger-than-average sexual debut for girls and sexual activity for boys in kinship care households, due to inadequate monitoring by family members.[228] The 2019 VAC study was not able to disaggregate risks of different forms of violence, including sexual violence, but did note that this was a priority (see Section 9). Research has shown evidence of some kinship carers facing difficulties in disciplining children in their care, and this resulting in conflict.[229] Most recently, this has been brought up in grandparent-led households, where their type or style of discipline differs from newer approaches that are not harsh nor violent.[230] All in all, these challenges highlight the vital need for support for kinship caregivers and, where necessary – and *only* where necessary – monitoring by social workers. In the Kenyan context, the informal nature of kinship care means that there is, at the time of writing limited monitoring other than through OVC programmes. The report of the *Kenya National Care System Assessment* (2020)[231] notes that kinship care placements are not standardised, monitored, or regulated in practice, despite this coming under the mandate of the NCCS and the DCS. It also notes that, until 2021, there were no SOPs to guide kinship placements to ensure quality support for kinship care, or guidelines on when reunification back to birth families would be appropriate. However, with the drafting and planned launch of the *Standard Operating Procedures for Alternative Family Care*, this should be resolved. Review of the legislative framework, as well as key informants, highlighted that monitoring and support for kinship carers, especially informal ones, is not available.

7.1.3 Foster care

Foster care placement is defined in the Children Act 2022 as the 'temporary placement of a child or children in the care of a person who is not the parent, relative or guardian of the child'.[232]

Under the Children Act 2001, foster care required placement to take place from a CCI or a rehabilitation school. This was noted, in situation analyses, as one of the biggest barriers to foster care.[233] Also noted was that people do not understand the term and confuse it with adoption. The Children Act 2022 s 172(1) explicitly provides for an additional option of placing a child into foster care with the secretary's direct intervention. The law then mandates the secretary to supervise and assess the condition of the child, and to safeguard the welfare of the child until either the care order is discharged, the placement period specified by the institution expires, the child turns eighteen years old, or the foster parent dies. In addition, the Children Act 2022 also provides for

the possibility of transitioning foster care into adoption (in the same family), in the spirit of ensuring stability and the best interests of the child.

Although there are national, standardised indicators to monitor foster care, there is no national-level standardised, collated data on the number of children in formal foster care at the time of writing. Individual children's offices might have some. In the Rapid Assessment of Residential Care conducted by the DCS, CTWWC and the Stahili Foundation, questions about alternative family-based care placements included foster care. Between one and five per cent of children in CCIs included in the studies were placed in foster care, which is not surprising, as very few CCIs reported knowing about, or engaging in, foster care.[234]

The CRC, in its 2016 Concluding Observations, specifically recommended the government 'to support and facilitate family-based care for children wherever possible and establish a system of foster care for children who cannot stay with their families, with a view to reducing the institutionalisation of children.'[235] At the time of writing, several NGOs have piloted foster care programmes, and the DCS is leading a process of developing practitioner manuals for foster care, and a training manual for foster parents. These have already been validated by stakeholders, and are awaiting the final stages of approval before being launched. Preparations are underway for piloting the manuals with COs, not only in the pilot counties of Nyamira and Kisumu, but also in other counties that have expressed the desire to join in 2023. This reflects the growing interest in the topic, especially as it relates to deinstitutionalisation efforts. The drafting, and eventual approval, of the *Standard Operating Procedure for Alternative Family Care* therefore represent an important starting point for standardising the approaches to foster care placement.

SOS Children's Villages, Fondazione L'Albero Della Vita and the Stahili Foundation, with the oversight of the DCS, are piloting foster care services.[236] The *Kenya National Care System Assessment* (2020) notes that one reason mentioned for the DCS not providing direct foster care services is an inadequate number of SCCOs.[237]

The Stahili Foundation observed that they have had to deal with confusion in the community about the difference between adoption and foster care. They also note that, in the case of emergency foster care (i.e., on weekends or at night), there needs to be a great degree of flexibility and availability of workforce. However, they note that in their experience, it is well worth the time and energy, as they have been able to prevent many children from entering residential care by having emergency foster families available to care for children.[238]

Fondazione L'Albero Della Vita, while piloting in the counties of Nairobi and Nakuru, managed to place more than 60 children into foster care. They note that the recruitment of foster parents is greatly facilitated through collaboration with religious organisations, who manage to generate appealing messages relevant to foster care during awareness creation initiatives. However, their efforts were derailed by the COVID-19 pandemic, which resulted in job losses for some of the foster parents. Furthermore, teenage pregnancies became a national dilemma. They also note that a significant number of informal foster care cases were identified within the urban setup, highlighting the need for greater awareness on the importance and process of formalisation.

Those involved in the provision of foster care, as well as those who are interested, have high hopes that the Children Act 2022 will facilitate an easier placement process. An estimate of the costs associated with foster care services has not been calculated. Overall, the government is neither budgeting for foster care services nor allocating any money towards it. The financial contributions of NGOs supporting foster care are not known or tracked by the government.[239]

7.1.4 Kafaalah

Kafaalah is a common form of care practiced by those of the Islamic faith. In Kenya, it is informally monitored through religious community-based systems, but there is no formal support or monitoring system by the government.

Kafaalah has historically been overseen by customary law, but is now recognised in the Children Act 2022.

Regulations are currently being developed. The *Guidelines for the Alternative Family Care of Children in Kenya* (2014) contain a proposed set of procedures to guide Kafaalah, with defined roles and responsibilities for the DCS, Kadhi Courts, Imams, kafiils, and other Islamic religious leaders and NGOs.[240] The SOPs being developed for alternative family care include kafaalah, and will help to standardise the steps involved in the process, as well as to familiarise non-Islamic professionals with information on the placement. Furthermore, the SOPs should help to strengthen the links between Islamic leaders and the DCS to ensure that the DCS can support kafaalah, and for kafaalah data to be captured.

There is limited data available on the experiences of children under kafaalah. The *Kenya National Care System Assessment* (2020) notes that 'kafils [sic] are sometimes, but not always, assessed to determine their need for support services to care for the child. However, since most children in kafaalah care are placed within a family setting, they are perceived to have most of their basic needs met. Further, during kafaalah care, there are unstructured "community orientations" that may provide some special support to families.'[241] During the development of the SOPs, the Kadhis noted that kinship kafaalah is by far the most common type of kafaalah arrangement.[242] Because severing of blood ties is prohibited within Islamic law, maintenance of family ties is viewed as mandatory.

The care system assessment made several recommendations on kafaalah, many of which have been acted on in the last several years, including inclusion in the Children Act 2022, SOPs, indicators and increased community awareness.[243] Care indicators in the CPIMS now include kafaalah. The CPIMS allows for the collection of data on kafaalah, although numbers are not currently available.

In the past two years, a concerted effort by government, UNICEF and CTWWC has focused on scaling the practice of kafaalah, with efforts at both the national level and in the counties of Garissa, Kilifi, Kisumu and Mombasa. This included the participatory design of regulations, an implementation framework and SOPs, and a concerted effort to standardise good practice. It also included training Muslim leaders in the practice of kafaalah and how to align it with child rights, including the best interest of the child, the formation of county-level kafaalah steering committees, building awareness in communities about the practice, and training key actors on data collection in the Garissa, Kilifi, and Kisumu counties.

7.1.5 Guardianship

The Children Act 2022 defines a 'guardian' as a person appointed, by will or deed, by a parent of a child, or by a court order, to assume parental responsibility over a child on the death of the parent, either alone, or jointly with the surviving parent of the child in accordance with the provisions of the Act.[244] There is no national data on the total number of children placed in guardianship each year. Whilst individual courts might have the data, it is neither collated nor analysed in the CPIMS.

The *Guidelines for the Alternative Family Care of Children in Kenya* (2014) outlines the roles and responsibilities for the DCS and the Judiciary (Children's Court) in supporting guardianship. These include assessing guardians and children before, and during, placement, but there are no provisions for ongoing support after the child is placed with guardians. There is no policy provision for services to support guardians, including respite care and specialised services for guardians of CWD.[245]

Guardianship placements, overall, do not appear to be regularly monitored. While there are court orders for guardianship placements, routine data for decision-making is not captured.

7.1.6 Domestic adoption

Adoption is included as a legal provision of the Children Act 2022. Adoption rules are made by the Chief Justice for the purposes of guiding judicial practice on the issue. Regulations are made by the executive, and guide standards and practice. As of February 2023, the new rules and regulations in support of the Act had not been passed, making adoption difficult. At the time of writing, five adoption societies are authorised to place children in domestic adoption.[246]

Challenges with the adoption process for domestic, foreign resident and international adoptions were first highlighted in a 2008 report by the DCS.[247] The findings illustrated a potential conflict of interest in adoption agencies running their own CCIs, i.e., reserving children for adoption, pre-selection, and a lack of aggregated data on guardianship, adoption and foster care. The report did some initial aggregations of numbers of domestic adoptions from 2000–2008, which fluctuated between 112–191 per year.[248] Official data on domestic adoption is only available if aggregated from each of the courts responsible for issuing adoption approvals.[249] Anecdotal data provided by adoption agencies demonstrated that an average of 400–500 domestic adoption cases were in fact completed each year. One key informant running an adoption agency mentioned that the number of families involved in domestic adoption at the time of writing was only a fraction of those who were interested. The challenge is that many do not know who to approach, or how to approach it, as there is significant misinformation and limited information. This enables unscrupulous behaviors of different actors wanting to profit from couples not understanding the legal process involved, and has resulted in some desperate couples resorting to baby stealing. The same informant mentioned seeing an increase in black market approaches because the adoption process is still unknown to many.

The domestic adoption process is often viewed as cumbersome, lengthy and, at times, corrupt. A study of domestic adoption in 2017 explored common beliefs about domestic adoption, including its legal implications, the centrality of lineage as a means of defining family members, and strong stigma regarding infertility.[250] Qualitative interviews with those who have adopted highlighted useful information that helps to explain why domestic adoption is viewed as challenging.[251] These included corruption, fear or shame of not being able to conceive, and financial impediments. Other documents exploring the topic identified the cost implications as a major hindrance to adoption. However, one study found that adoptive parents felt that training, honest communication about the process and the health and background of the child, and a partnership approach, were the key ingredients to a positive adoption experience.[252]

> *… domestic adoption in Kenya has taken tremendous steps in the right direction. Networks of adoptive families have formed associations to serve as supportive platforms for current and prospective adoptive families. Each week, passionate ministers take to the pulpit and proclaim the gospel of adoption.* – SIMON NJOROGE

Interestingly, in late 2020, the High Court of Kenya released a new document designed to explain the domestic adoption process in simple, user-friendly language. This type of documentation aims to encourage and demystify the domestic adoption process[253] and, together with the Children Act 2022, it is hoped that the challenges associated with domestic adoption will decrease.

Another important development that will potentially facilitate domestic adoption is the 2021 amendments to the Employment Act, allowing adoptive parents up to one month of leave prior to the adoption of a child.[254] 'The pre-adoptive leave granted to an adoptive parent shall guarantee such adoptive parents an uninterrupted opportunity to make all the necessary arrangements that may be required before the adoptive parent takes full custody and responsibility over the adopted child.' This is a significant move in terms of recognising adoption, and allowing those in the adoption process with the time needed to ensure they can complete the process and prepare for the child's arrival in the same way that those who prepare for parenthood do when expecting via pregnancy.

Despite the challenges associated with domestic adoptions, there are also success stories. During the month of November, which is Adoption Month globally, there are often newspaper articles that promote positive stories of domestic adoption. Simon Njoroge, an adult adoptee, shares his experiences to promote the positive side of adoption and reduce the stigma of being adopted. He also published an article in January 2023 in a US Christian-facing newspaper. The article was promoting domestic adoption in Kenya, urging faith-based donors to

Figure 10

Poster advertising an adoptive family event

orphanages to learn more about the topic and promote family care over orphanages.[255] Other adoption advocates, themselves adoptees, are also speaking out about the benefits of adoption.

The first meeting to bring together young people who have been adopted was organised in 2018. Similarly, a Facebook group 'Adoption is Beautiful'[256] has existed for several years, and is a means of both promoting domestic adoption as well as serving as a mutual support mechanism for families interested in the process, or those who have already adopted. In 2019, an group for adoptive families was formed (see Figure 10).

7.1.7 International adoption

As a signatory to the Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption, Kenya's Central Authority is the National Adoption Committee within the DCS, which is included in the Children's Act 2022. On 26 November 2014, a moratorium was placed on all international and foreign resident adoptions due to concerns about unethical practices, particularly with regards to international adoptions.[257] The concerns were first noted in a 2008 study, and a 2010 article raised concerns around the consent process. 'In Kenya, consents for adoption must be written. It is also the explicit obligation of the court, before making an adoption order, to be satisfied that every person who has given consent "understands the nature and effect of the adoption order."'[258] As noted earlier, the Children Act 2022 did not necessarily clarify some of the grey areas, and, in some ways, complicated matters.[259]

Prior to 2014, international adoption in Kenya was overseen by the National Adoption Committee, with the DCS acting as Secretariat. Whilst reliable data on the number of intercountry and domestic adoptions is difficult to obtain for the years prior to the moratorium, one article notes that, of the figures available (the total recorded ranges from 100 to 199 adoptions per year), domestic adoptions accounted for an average of 60 per cent of the total number of adoptions between 2003–2008, and international adoptions the remaining 40 per cent.[260] Data from 2007 shows that boys were adopted more frequently than girls (67 per cent compared to 56 per cent) and not surprisingly, given the population and access to courts, Nairobi and Mombasa had the highest number of adoptions reported (100 in Nairobi and 5 in Mombasa). However, these numbers are, at best, an estimate, as reporting comes primarily from lawyers, and not the courts, to the Registrar General.[261]

In February 2015, the state established an Expert Committee – later renamed the Steering Committee – to review and develop a detailed legislative framework to regulate and manage child adoptions in Kenya. There were concerns with membership of the Steering Committee and potential conflicts of interest.[262] There is little information available on the outputs of the Steering Committee to date.

Since the original moratorium, domestic adoptions have been reinstated. The moratorium has also been contested in court. However, at the time of writing, the moratorium remains in effect.[263] In 2016, the CRC recommended action to amend the situation and bring national legislation in line with the contents of the Hague Convention.

The Committee urged the Kenyan government to expedite the amendment of the Children Act (2001) and other regulations on adoption in line with Article 21 of the Convention. The Committee also recommended that the State party accelerate the harmonisation of national legislation with the Hague Convention on Protection of Children and Cooperation in respect of Intercountry

Adoption and ensure that all safeguards provided in the said Hague Convention are met when children are adopted to countries that are not parties to the said Hague Convention.[264]

The Children Act 2022 includes important content that addresses the CRC's concerns.

7.2 Community-based care

The *National Care Reform Strategy* defines community-based care as 'A range of approaches designed to enable children to remain with their own (or extended) family and prevent the need for separation, or to be placed with an alternative family within his or her community.'[265] In Kenya, there is a long cultural tradition of care within the community, or tribe. Pastoralist communities such as Maasai and Gabra have a long tradition of collective responsibility for child-rearing.[266] Increased urbanisation, as well as the tremendous impact of AIDS and the related stigma had on Kenyan communities, means that these care patterns are changing.[267] Child-headed households (CHHs) were and remain a care option for many children. Supported independent living is also included in this section, with a particular focus on those exiting care.

7.2.1 Child-headed households

CHHs are defined as a household in which a child, or children (typically an older sibling), assumes the primary responsibility for the day-to-day running of the household, providing and caring for those within the household. The children in the household may or may not be related.[268] The Children Act 2022, in Article 144, specifically recognises CHHs as representing 'child in need of care and protection.'[269]

At the time of the report that was not aggregated data on the number of CHH in Kenya. A 2016 UNICEF report noted that Makueni sub-county had the greatest number of children living in CHHs, at 26,469, followed by Kakamega, Nakuru and Kirinyaga sub-counties at 21,643, 16,539 and 15,571 children respectively.[270] Among the four major cities, Nakuru had the most, with 16,539 children living in CHHs, followed by Nairobi with 13,341. In all 47 counties, there are more male children than female children living in CHHs.[271]

CHHs are mentioned in the Children Act 2022, and the draft SOPs include CHHs. In the draft SOPs, the importance of identifying a community mentor is emphasised. Households that are child-led should have a community safety net to call upon in case they need it.

For the past several decades, OVC programmes have often included this group of children, given that many have lost parents or caregivers to HIV, or are living with HIV themselves. The Social Assistance Act 2013 provides for social assistance for OVC, which includes children living in CHHs.[272] The guidelines recommend support for CHHs for children 14–18 years of age (with an option to extend support to 21 years of age).[273] The proposed support includes legal protection, education/vocational training, health and nutrition, psychosocial support and economic strengthening, and should be provided through the DCS in partnership with community leaders, chiefs, community structures and civil society. Whilst the content of the guidelines includes a holistic approach to supporting this group of children, unfortunately, in practice it is far short of the ideal.

One of the recommendations coming out of the *Kenya National Care System Assessment* (2020) is that CHH eventually be transitioned into kinship or guardianship, or even domestic adoption, as a means of both ensuring the presence of adult caregivers and bringing them into a more formalised care situation.[274] The assessment expressed concern that the new requirement of a national identity card might limit CHH members from receiving CT-OVC. If they were with an adult caregiver who had a national identification, the caregiver could apply for the cash transfer and use it to support the child(ren).[275]

7.2.2 Supported independent living

Supported independent living arrangements are understood to occur when a young person is supported in their own home, a group home, hostel, or other form of accommodation, to become independent. The support prepares the young person to transition from a situation of formal alternative care to independence and adulthood. It can include learning time keeping, budgeting, cooking and job-seeking, among other skills.[276]

Supported independent living is included in the Children Act 2022 as a recognised alternative care service, and in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014).[277] The draft SOPs also include a section on independent supported living.

There is no collated data on young people in supported independent living, except for supported group homes implemented by humanitarian agencies in the Kakuma refugee camp (see Section 10.1). Individual CCIs or SCIs might collect and report the data, but it is not collected or analysed at the national level, and was not identified as an option in the recent CCI assessment.

The *National Standards for Charitable Children's Institutions* includes minimal language around supporting the transition of older children to independent living, recommending that CCIs support the following:

1. Preparation and counselling on the new arrangement.
2. Supporting educational and vocational training.
3. Facilitating the acquisition of national identification cards.
4. Support the improvement of life skills and employment skills.
5. Provide, whenever possible, financial and material support and training, e.g., advice on starting a business, and financial management.
6. Initiating the opening of a bank account, and support to save money.[278]

When support for independent living arrangements do not meet minimum standards, the consequences are stated in the Probation of Offenders Act 2009 (Cap 64) in the case of children leaving statutory care institutions through the juvenile justice process. At the time of writing, there appears to be no national monitoring mechanism, only limited mandated oversight mechanisms, to provide the required oversight to identify and address such this lack of service.[279]

The *Guidelines for the Alternative Family Care of Children in Kenya* (2014) are quite detailed in both the types of services and support that should be provided, as well as the roles and responsibilities of actors. Unfortunately, this excellent content has not been implemented on a large scale, and there is limited literature on supported independent living in Kenya. The draft SOPs for Alternative Care do include supported independent living so, once finalised and rolled out, should help. The importance of transition, including preparing for and supporting during and after placement from alternative care back into a family or the community, is well articulated in the case management SOPs as well as in the SOPs for alternative care.

Some of the positive examples of supporting independent living are highlighted in the *Kenya National Care System Assessment* (2020). These include the probation and aftercare services under the Ministry of Interior and Coordination that are providing some support for independent living, and the Faraja Foundation, but it was recognised that the support available is limited in scope and coverage.[280]

The lack of services that facilitate the supported transition of young people from residential or other form of alternative care into independent living is a notable gap in the provision of care. KESCA and others have voiced frustration and concern about this; stories of hardship and the lack of a community or safety net during the transition are some of the main reasons KESCA was founded.[281] Despite this, and the growing recognition and importance placed on supporting those transitioning from care (through either supported living arrangements and/or other aftercare services such as access to employment, counselling where needed, or health, educational or vocational training support), positive examples are still scarce. Ensuring that young people receive the support and services they need to make a safe, successful transition is one of the ongoing demands of those who have lived through the experience (see Box 4).

Box 4

Those with lived experience in care

Kenya has had a strong care-leaver presence for over a decade, with the founding of the KESCA in 2009. Stephen Ucembe established the network after his own experience as a care-leaver illustrated just how difficult and lonely transition to independent living could be, and how virtually no services existed to support the process.[282] KESCA is a locally registered society designed for and by adults (18+ years) who spent all or part of their childhood in children's homes, orphanages and/or rehabilitation centers.[283] KESCA's vision is to see empowered care-leavers lead meaningful lives, and actively participate in the promotion of the rights of children without parental care.[284] Over the past decade, KESCA members have participated in, and brought the voices of care-leavers to, critical activities related to care reform, such as the design of the *Guidelines for the Alternative Family Care of Children in Kenya* (2014), the *Standards of Care for Charitable Children's Institutions* and the Children Bill (2021).

At the same time, KESCA and its individual members have been a leading voice for care-leaver participation, and empowered and sustained engagement, in the care agenda at the regional and global levels, representing and expressing views at meetings with the African Committee on the Rights and Welfare of Children (ACRWC), the Violence Against Children in All Forms of Care Conference[285] and many others. Similarly, members of KESCA have been vocal advocates for increased and meaningful roles for care-leavers in policy and programming, increased services to support the transition to independent living, and an end to orphan tourism. They have used various platforms to spread this message, including podcasts, webinars, programming documents and peer-reviewed articles and videos.[286]

In 2018, KESCA and CTWWC produced guidance outlining how care-leavers want to be meaningfully engaged in care reform.[287] The document was developed after a series of workshops engaging 30 care-leavers. It includes recommendations for how, and how not, to engage care-leavers based on their own lived experiences, both within the care system and as participants in various care reform processes and activities. The two organisations have also been developing life skills manuals for use in supporting children preparing to transition from residential care to independent living. The content is designed by those who have experienced and exited care, and is intended for use by those working with young people, or are themselves, preparing to exit care.[288]

KESCA members have also been vocal advocates for acknowledging and addressing trauma received from growing up in residential care. Several dozen care-leavers have been trained in *Singing to the Lions*, a programme designed to help children and young people address their past to lessen the effects of the violence, abuse and related trauma.[289] The end goal of KESCA's participation was to a) promote personal healing and b) train and serve others in similar situations. The voices of care-leavers are often the ones that keep conferences, activities and ideas grounded, reminding other actors of what is at stake in terms of children's health, well-being, and the longer-term costs to society when care-leavers are not supported, using their own stories of challenges related to abuse, unemployment, mental health issues, and drug and alcohol abuse, as examples.

Whilst KESCA is a recognised name within care reform at the national, regional and global level, it is not immune to the challenges of existing as a network – primarily as a network of volunteers. Members of KESCA leadership donate their time, many whilst working other jobs. Strategies are being designed to increase the organisational capacity of the network, including instituting systems and processes to ensure smoother running. However, this also requires funding, which has presented challenges, and is an ongoing issue KESCA struggles to address.

In the past several years, other care-leaver groups, mostly informal, have been formed by care-leavers from the same CCI or county. To date, there have not been many opportunities to link these groups with KESCA so that joint learning and exchanges can happen, though there have been discussions about the possibility of establishing county-based KESCA groups. In some instances, individual KESCA members have worked or collaborated with care-leaver groups, providing suggestions for programming, services, etc.

In the little more than a decade since KESCA was formed, the long-term impact it has made on the care system in Kenya is impressive. Any high-level meeting to discuss policy or programming related to care reform usually includes a KESCA representative. The presence of KESCA in Kenya has raised the voices and influence of care-leavers to important platforms, with the result that many stakeholders now understand, respect and value the lived experience of those who have been in care.

WILL BAXTER / CRS

7.3 Residential care

7.3.1 CCIs and SCIs

Residential care flourished in Kenya over the past two decades due to a range of factors, including a combination of religious identification and motivation (i.e., a person believing they are called by their faith to support those in need, very often children 'in need' or 'vulnerable'); political and economic challenges; and limited support to prevention of child-family separation.[290] Research has shown that the proliferation of Charitable Children Institutions (CCIs) in Kenya is a 'standard approach to child protection—which consists of addressing the symptoms—[and] is inadequate at best and counter-productive at worst.'[291]

The same article explores the range of factors reinforcing Kenya's over reliance on residential care. One of the main reasons mentioned is the legislative framework, which is currently skewed to support residential care and a disconnect between the family and community around the child.[292] These issues were highlighted by key informants, as well as in Njoroge's article exploring the history of residential care in Kenya.[293]

Charitable efforts, and the draw of volunteers, have resulted in significant amounts of human and financial resources going towards residential care. However, the 2017 moratorium on the registration of new CCIs made the sector take stock, analyse the situation and its origins, and determine what needs to be done to reform the system.

As of April 2020, based on the rapid data collection exercise, there were a total of 45,480 children in 910 CCIs. It should be noted that of those CCIs, 581 were registered and 329 were not registered.[294] Regarding Statutory Children's Institution (SCIs), there are 30 institutions, of which: two are reception centres, five are rescue homes, 14 are remand centres, and nine are rehabilitation schools. As of March 2021, there were 1,101 children in SCIs. This is a reduction from the 1,428 in SCIs prior to the Covid-19 pandemic and the rapid release. Data illustrates that close to 80 per cent of children in SCIs have never committed an offense, raising concern about the placement process and the management of their cases.[295] There are an additional 300 children in Probation and Aftercare Service-managed probation hostels.[296]

After the rapid reunification, 13,756 children were reported to have been released from residential care, with 7,986 (58 per cent) returning to biological family and 5,770 (42 per cent) to kinship care. More than 300 children left SCIs. Due to the lack of support, the rapid reunification did not represent a care reform success, and many children returned to CCIs once schools reopened in January 2021. A joint monitoring exercise in three counties, Kilifi, Kisumu, and Nyamira found that out of the 1905 children who were released from residential care facilities in those three counties, 514 children (311 Kilifi County, 111 Kisumu County, and 92 Nyamira County) were reported to have returned to the institution following the re-opening of schools.[297]

Prior to the onset of COVID-19, the DCS, CTWWC and Stahili Foundation also conducted a county-level data collection on residential care.[298] A standardised data collection tool was used so that information was collected, stored, analysed, and published in a similar manner. The exercise collected both quantitative and qualitative information relating to the number of CCIs, number and profile of children in care, reason for placement, as well as the perceptions and attitudes of community members, staff and government actors. In the five counties included in the exercise – Kiambu, Kilifi, Kisumu, Murang'a and Nyamira – there were a total of 310 residential care institutions – 302 CCIs and eight SCIs.[299]

Push factors noted include orphanhood, violence, abuse or neglect, poverty, and access to education.[300] Interestingly, despite orphanhood being regularly noted as the main reason for placement, when the rapid reintegration directive was issued, the number of children able to be reunified with biological parents or extended family contradicted their supposed orphan status.

It was found that children were often perceived as better behaved when placed in residential care. Some parents recognised that placing their children in CCIs made it easier for them, as they did not have to deal with either parenting or providing for their child. There was also a

common perception that, when children were placed back into the community, they could be negatively influenced by peers.[301] Young people who had been in care mentioned the challenges with exiting care and how many ended up on the streets.[302]

Recommendations include addressing the root causes that lead to separation, conducting transformation from residential care to family or community-based care over time – combined with community sensitisation measures – and supporting children and families following reintegration to prevent secondary separation, including linking them to relevant social protection programmes.

The findings provide a useful baseline for care reform planning. The data collection toolkit has been endorsed by DCS, and civil society actors have been encouraged to use it in other counties.[303]

7.3.2 Children with Disabilities and care

There are limited data on CWD living in all forms of alternative care. DCS data from 2019 found that 0.3 per cent of children in SCIs have a physical disability, 0.5 per cent have an intellectual disability, and 0.2 per cent have both physical and intellectual disabilities.[304] The CTWWC and Stahili Foundation situational analysis[305] found that 5 per cent of children in the institutions researched have disabilities. They note that there may in fact be a higher number of CWDs in institutions than recorded, as their disabilities may not have been recognised by staff.

Research undertaken in the Nairobi Children's Remand Home[306] found that, whilst remand homes are meant to be for children in conflict with the law, in practice they are being used for CWD and other special needs. The study found that, whilst the CWD in remand homes did have their food and medical needs catered for, only 5 per cent reported the presence of a nurturing, healthy attachment between children and staff. The research found that there was limited accessibility in the buildings themselves and, despite a commitment to inclusive education, staff were not receiving any training in inclusive education methods or sign language, and teaching aid provision, such as sensory items, toys, games, exercises, etc., were inadequate. The study also noted that children stayed in remand homes for long periods – significantly longer than other children do – because, in many cases, families were not claiming them. There was a lack of exit planning.

A 2018 Disability Rights International investigation into CWD in families and institutions in Nairobi and Mombasa[307] found extreme levels of stigma and discrimination against CWD overall, with strong pressure for mothers to commit infanticide – 37 per cent of women in Nairobi with CWD at home or in residential facilities said they were pressured to kill their child, while 54 per cent of women from the more rural areas felt pressure to kill their children.[308] This, and discrimination against families with a CWD, often leads to a denial of access to childcare. These mothers are often abandoned by their families and unable to find work, resulting in them placing their child in residential facilities. However, the discrimination towards CWD often continues in the CCIs.[309] The report also noted that mothers with a disability have an increased risk of their children being taken away from them and put in a residential facility.

The report documents a wide range of abuse and exploitation in institutions funded by international private donors. Whilst these affect all children, CWD experienced:

- Shocking conditions in all institutions, but far worse in facilities designated for CWD – 'dangerously so.'
- Overcrowding and lack of staff and supervision. In the 21 institutions Disability Rights International visited, there were approximately 3,400 children.[310] In the majority of institutions visited, the study found 'overcrowded and filthy conditions, children spending lengthy time in restraints and isolation rooms, overall lack of staff and untrained staff, neglect, and the withholding of medical care –treatment is readily available, yet children with disabilities are intentionally left to die.'[311]
- In one institution, children were locked into their rooms overnight, with no supervision for 13 hours or more. In another, children with cerebral palsy were tied to chairs and left to feed themselves, despite being unable to hold spoons. In this home, there were 87 children, all with disabilities, and only four staff members (some of whom were barely teenagers) and two volunteers.[312]

The report includes a recommendation to place CWD at the forefront of deinstitutionalisation. Doing so will require active interventions to tackle stigma and provide support to families.

In 2021-22, UNICEF commissioned a study of disability in Kenya specifically looking at how best to include children with disabilities and their families in the national care reform effort.[313] Accompanying technical guidance was also developed.[314] Both are expected to be finalized and rolled out across the country to ensure that all children, including those with disabilities, and their caregivers are included in and have access to critical social services that facilitate family care.

7.3.3 Transforming residential care

Transforming residential care is one of the three components of care reform. The word transformation is preferred over deinstitutionalisation, as the latter has negative connotations. The *National Care Reform Strategy* includes content regarding the transformation process, but the legislative guidance to outline or support the process was still in development at the time of writing. Many of the Care Reform Core Team members have this as part of their overall objective, and the guidance and tools used are global in nature.

In 2020–21, in tandem with the rapid reunification measures, ongoing technical assistance from organisations, and increased government engagement in care reform efforts in certain counties, some CCIs began a transition process. At the time of writing, there are a handful of positive examples of CCIs that have transitioned to family- or community-based services. In 2023, CTWWC reported that they were supporting more than twenty CCIs interested in, and at some stage of, the transformation process. Box 5 describes one case.[315]

In 2022, Changing the Way We Care worked with Johns Hopkins University in a pilot study of the Child Functioning Model in 18 CCIs in Kisumu, Nyamira and Kilifi. The pilot included 395 children; 24 between the ages of 2-4 and 371 between the ages of 5-17.[316]

The Child Functioning Module was developed in 2011, as a collaboration between UNICEF and the Washington Group. The tool helps users assess child functioning. The tool asseses the following areas: seeing, hearing, walking, communication, learning, relationships, and playing, emotion, behavior, concentration, and coping with change were added. It is applicable to children between 2-17 years of age. Field testing was conducted in several different countries and settings, and the final tool was used for this study.

The study aims to pilot disability measurement among children in residential care in Kenya and finds that current policies need improved implementation, training for staff to support children with disabilities, and better data systems and indicators for monitoring. The Child Functioning Module is seen as a valuable tool to support family care and reunification efforts. The study calls for greater focus on children with disabilities in care reform at the national level in Kenya and provides comparable data for other contexts using the CFM in alternative care.

The Child Functioning Module is identified as a comprehensive resource that can aid in understanding the needs of children, and its implementation in 18 facilities is explored, including the feedback from facility staff who found it to be an easy-to-use tool integrated into case management protocols.[317]

Given Kenya's care reform efforts, the study emphasizes the importance of engaging with the government to ensure children with disabilities are not overlooked, and tools like the Child Functionality Module become a part of the case management toolkit. The study also advocates for data-driven decision-making to support policy implementation and monitoring, with a focus on reintegration. Collaboration between the government and alternative care services, including residential care facilities, is essential for strategic planning and monitoring care reform.[318]

The study also highlighted that because **not all disabilities are visible, identification and referral** of children with disabilities can be challenging. There is a

need to increase provider awareness of child development overall, and disability assessment tools; staff are aware of general categories of assessments, but not of specific tools. One provider noted that perhaps "campaigns or trainings [would] equip people with knowledge so that we can easily identify people with disabilities", and early identification may lead to early intervention.[319]

Lack of awareness surrounding disability leads to stigmatization within and beyond residential care facilities. Most providers understand disability as simply an inability to perform basic human functions, but the outside community, residential care facility staff, and other children in the facility harbor preconceived notions surrounding disability. **Education and lived experience** can help with sensitization and changing mindsets.[320]

Box 5

The transformation journey of a CCI

The centre was established in 2010 in a Kenyan county on the coast, and registered as a CCI in 2012. The DCS referred children who experienced abuse, abandonment, or were orphaned to be housed and cared for by the home. Funding was primarily provided by an international private foundation.

The centre began the care reform journey in 2017. The request for transformation was first presented by the DCS through a series of informational meetings. There were many concerns with the idea. Initially, the manager of the CCI was resistant, believing the idea of transitioning institutions and reintegrating children into their families to be unnecessary. The director expressed concerns about maintaining staff employment once the children were reintegrated into the community. In addition, it was unclear how the government would support the CCI's efforts to reintegrate children into the community and families.

The DCS organised and hosted meetings, and presented at forums such as network meetings of CCI managers and social workers. These meetings provided a good opportunity for the managers and social workers to understand the concept further through interactive question and answer sessions, and demonstrated the strong government support. The Association of Charitable Children Institutions Kenya generated and shared additional information on care reform, demonstrating effective case management and targeting CCI managers and social workers to impart case management skills.

As the facilitators of the transition, the staff received training to initiate the centre's transition to a family-based service provider. An SCCO took great care training CCIs on the transition process and care planning for children, working closely with NGOs.[321] An NGO provided training on case management tools for child and family assessment, care and safety planning within the community, and case conferencing, follow-up and case closure. With this training, the staff were prepared to support the children through the process of reunification and reintegration by utilising a case management system to track the children's needs and progress. The centre also contracted a counselor to meet with each staff member and work through their own anxieties surrounding the transition and job insecurity.

Family reunification was unexpected by the children as, historically, children had remained in the centre until class 8, or age 13. They had many concerns, from fear of the unknown to worrying about missing meals and 'leaving the luxurious life' the centre provided. To support the children emotionally, a counselor from an outside organisation met with them to prepare them for the transition. The counselor met with each child approximately four times. The centre's manager and social worker engaged the children as well. In alignment with best practices regarding self-determination and child-centered decision-making, the children contributed to the decision of where they would be placed. Some children returned home to their parents, while others were placed into kinship care.

Once the centre settled on a full transition to family-based care, donor representatives from outside of Kenya were invited to participate in a caregiver support meeting. The meeting had the dual purpose: educating donors, and preparing caregivers for the reunification and reintegration process. Caregivers highlighted their concerns regarding education, given high school fees. Donors had the opportunity to assure caregivers that the families would continue to receive education support. The donor representative also had the opportunity to meet with the DCS to ask questions about the government's approach to care reform.

The emphasis on donor education and involvement resulted in continued support. Once the representatives of the sponsoring organisation better understood the importance of family-based care and how the resources would be utilized, they continued to support the children in their family placements. The centre's manager and social worker initially assessed families to ensure the homes were safe for reunification. Working together with the children and their families, they created a transition plan for each child, as well as for the centre's to continue offering services to the children once the transition was complete.

All children were reunified to their relatives except for one, who was placed into a foster care family through the DCS office. Support extended to the families ranges from income-generating activities to food products, bedding and cash transfers. With the reunifications complete, the centre continues working to ensure a

Box 5

continued…

fully supported reintegration process. The centre's manager and social worker conducted follow-up meetings with children and families to monitor the child's safety and transition into the family and community on an ongoing basis. This was mostly done through phone calls due to the COVID-19 pandemic restrictions. When possible, the manager and volunteer social worker physically visited the households to observe the children at home.

The centre formally partnered with the children's schools to further assist with the reintegration. As part of the collaboration, teachers monitor and report on the child's academic progress and behavior. The centre's staff meet regularly with teachers to follow-up and assess what educational supports are needed, as education assistance is a major area that the centre extends to the children post-transition.

The centre has plans to lease the buildings to a medical school, and will use the proceeds to continue supporting the children in the community. The plans are at an advanced stage.

The transformation journey of this CCI provides useful insight into not only the success of transforming a CCI, but also into some of the challenges of the process. With the change of purpose, many of the CCI staff did end employment. Although there were efforts to retain a model of community service that would be able to offer employment, that did not happen.

There were also incidents of children misbehaving or being difficult to manage within the family. This highlighted that reintegration is a long process and that, often, ongoing psychosocial support to the children and parents is needed. Finally, some donors were concerned about the reunification efforts and worried that children's well-being would be negatively impacted. This required ongoing and consistent communication with the donors and clear explanations, setting of realistic expectations and risk-mitigation efforts. The onset of COVID-19 coincided with the transformation efforts, which resulted in economic challenges for many of the families. Additional or extended support was required.

In February 2023, The Better Care Network and CTWWC published a learning document exploring the key factors contributing to, or inhibiting, the transition process of CCIs. The document, *Understanding Catalysts for Transition: Dynamics Leading to the Uptake of Transition Amongst Charitable Children's Institutions in Kenya*, included 26 CCIs in eight counties. Out of the total, four had fully transitioned, twelve were in the late stages of implementing their transition, nine were in the early stages, and one was in the planning and preparation phase.[322]

In examining what influences CCI directors' decision to transition, the study found three distinct aspects. These include attitude and openness, feasibility and organisational vision. Important elements impacting openness towards transition were engagement with, or observation of, children who had been reintegrated, and engagement with, and testimony from, care-leavers. In terms of feasibility, directors mentioned that participating in training that explained the 'how to' of transition was useful, and very influential in terms of making them believe that change could be possible. Factors that positivity influenced the third component, organisational vision were training, and clear communication that transition is a change process and not necessarily closure. Another element was donor buy-in.

The findings support the roll-out of the *National Care Reform Strategy*, the importance of training of key actors in an approach that utilises standardised messages promoting collaboration, and an emphasis that change is not necessarily closure, or an us-vs-them. The role of care-leavers cannot be overstated. All of these should be implemented in future efforts aimed at transitioning CCIs. With a growing number of CCIs and their directors having gone through such a process, it provides an opportunity to utilise this group as champions who could influence other CCI directors, and mentor or accompany them on their transition journey.

To promote continued transition of the care system, the National Council of Children Services of the Government of Kenya released the National Guidelines for Transitioning Child Care System in Kenya. The guide, developed with input from key civil society actors, and launched in November 2023, aims to provide practical guidance on

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how to safely transition the child care system to one that is anchored in family care. The guide includes content on transitioning institutions, including how to best prepare children to transition from living in a CCI to exit eventual placement in a family or community.[323]

At the same time as the Transition Guidance, the National Council for Children Services also launched the National Guidelines and Standards for Child Welfare Programming. This document aims to provide information on how to design, implement and monitor child welfare programming, and is framed within core child rights and principles. The two documents are useful together in that CCIs that might be transitioning to another model of care, can use the second document to help inform the design of the new service model.[324]

8 Violence, Abuse, Exploitation and Neglect in Alternative Care

The data in Kenya on the scale and scope of abuse and exploitation of children in all forms of alternative care reflects global evidence.[325] Abuse and exploitation in alternative care needs to be viewed in the context of the scale and scope of the violence all children in Kenya are exposed to. The 2019 VAC Survey[326] highlighted the scope of violence (see Box 6). One of the challenges of the VAC Survey is that the data is household-based. There is no data on VAC experienced by children living in residential care.[327]

The risk of abuse and exploitation in alternative care is not explicitly recognised in the Children Act 2022, and is not recognised in the *Guidelines for the Alternative Family Care of Children in Kenya* (2014) as a specific risk for family separation, a reason for entering alternative care, or a risk in all forms of alternative care, beyond a general acknowledgement of the importance of supporting children experiencing violence. The *National Plan of Action Against Sexual Exploitation of Children in Kenya 2018–2022*[328] only refers to alternative care in the context of listing three child protection centres that run rescue and rehabilitee services for child survivors of sexual exploitation in Malindi, Nakuru and Garissa. The recent NPRP VAC[329] also does not refer to any form of alternative care, but does set out family-strengthening and community-based violence-prevention strategies that are important for preventing family separation.

Box 6

Kenya's VAC Survey 2019

1. Nearly half of surveyed females aged 18–24 years and more than half of males experienced childhood violence. Physical violence is the most common (two out of five females and half of all males).
2. Nearly two-thirds (62.6%) of the 15.6% of females who experienced childhood sexual violence experienced multiple incidents before age 18. Perpetrators are most commonly intimate partners (44.4% of first incidents).
3. Childhood physical violence by parents, caregivers, and adult relatives affects 28.9% of females and 37.9% of males.
4. Childhood emotional violence by peers is also common, affecting 30.9% of females and 31.0% of males.
5. Two out of five females who experienced childhood sexual violence told someone. Two out of five females and males who experienced childhood physical violence told someone.
6. Only 12.5% of females experiencing sexual violence sought assistance, and only 10.7% successfully received services. Rates are even lower for males, with 3.2% seeking and 3.2% successfully receiving services for sexual violence.
7. Only one out of three females who had experienced physical violence knew where to go, less than 1 in 10 sought assistance, and only 7.2% received services. Two out of five males who experienced physical violence knew where to go for services; less than 1 in 10 sought and only 6.4% successfully received services for an incident of physical violence.
8. Females who did not seek services for sexual violence indicated that the most common reason was that they did not think it was a problem (53.6%).

The situation analysis of residential care facilities in five counties in Kenya found that violence, abuse and neglect was the most common reason for placement cited by CCI and SCI directors in one district (Murang'a), the second most common reason, after orphanhood, in three of the five counties, and the third most common in one (Nyamira).[330] It is difficult to accurately identify the extent to which abuse and violence are drivers for placement. For example, a 2013 study of reasons for children entering residential care facilities used the category 'maltreatment' to include all forms of abuse, neglect, medical neglect, school deprivation, abandonment, and child labour,[331] with the other category being 'destitution'.

The data on violence experienced in alternative care is similarly scant. The data on kinship care is included in the 2019 VAC study (see Box 6), although there is no disaggregation between biological family and other forms of family-based alternative care. One study that estimated the lifetime prevalence and annual incidence of potentially traumatic events experienced by orphaned or separated children living in both institutional and family-based care in five countries, including Kenya, found that annual incidence of physical or sexual abuse was higher in family-based settings (19 per cent) than in institutions (13 per cent). This has been questioned since the comparison was made with vulnerable families that did not receive any support. The same study also found that over half of orphaned or separated children in institutions (50 per cent) and family-based care (54 per cent) had experienced physical or sexual abuse by age 13.[332]

A recent study of abuse experienced by adolescents living in three CCIs in Nairobi found that, of the 115 adolescents

surveyed (who all had symptoms of mild or moderate anxiety disorder), 61 per cent experienced neglect, 42 per cent experienced emotional abuse, 26 per cent experienced physical abuse and 13 per cent experienced sexual abuse. Males had a higher prevalence of physical abuse and neglect, while females had a higher prevalence of sexual and emotional abuse.[333] Almost nine out of ten of the surveyed adolescents had been placed in CCIs due to family poverty or in order to access education. The study found that the children tended to blame themselves, and were not receiving any support for the experiences that led them to be in the CCI, whether it was parental death, or physical or sexual violence. A related study of the same cohort found that 84 per cent of 232 respondents in the same CCIs experienced anxiety, more than half experienced depression (50 per cent) and more than one in five experienced PTSD (22 per cent).[334]

At the time of writing, there is growing recognition of the impact of VAC on children's well-being, and strategies emerging from the NPRP VAC, such as the development of a national parenting programme, include recognition of the violence faced by children both in and outside of parental care, and the importance of a care reform focus on violence prevention. This is addressed in the DCS's standardised child protection training for child protection professionals and CPVs. The *Gatekeeping Guidelines* provide a framework for preventing the placement of children in residential care in response to family violence. However, there are still insufficient mechanisms and safeguards in place to recognise and respond to children's prior experience of violence when entering alternative care, and there is a significant gap in terms of professionals who are skilled in trauma-informed approaches.[335]

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Box 7 discusses voluntourism and trafficking in CCIs as drivers of abuse in institutional care settings.

Box 7

Orphanage voluntourism, abuse and trafficking

Orphanage voluntourism[336] is a feature of Kenya's residential care facilities, although there is no robust data detailing just how many individual volunteers come to Kenya to volunteer in orphanages each year. An analysis of the global volunteering market, conducted for The Better Care Network in June 2018, found that Kenya was the second highest global orphanage voluntourism hotspot after Nepal.[337] The USA, the UK and Australia are the top three countries from which volunteers to orphanages overseas come.[338] The recent situation analysis of CCIs in five counties noted the high numbers of volunteers working in CCIs.[339] In Murang'a, the majority of CCI funding seems to come from local donors rather than international, but the research revealed a case of trafficking, and a CCI that had been shut down due to trafficking issues, but had re-emerged as a boarding school.[340] These CCIs predominantly have local volunteers, but also some foreigners. There is also high numbers of foreign volunteers working in CCIs, particularly in tourist areas on the coast of Kenya, with a possible connection between voluntourism and child trafficking.

The large number of unregulated residential facilities, many of which rely on private international 'sponsors' and donors, suggest that numbers will be high and the harms considerable.[341] The recent situation analysis of residential care institutions in Kilifi[342] – a coastal area frequented by foreign tourists – shows that 99 per cent of children living in institutions in the county are in the four coastal sub-counties, out of a total of seven, which are located along the main highway frequented by tourists. The report also notes that half the institutions in Kilifi rely on a workforce of foreign volunteers. It notes that tourists, together with their sponsorship and donations, may have created a pull factor for children into institutions. A study of institutions and families with CWD identified a large number of volunteers visiting institutions with safeguarding concerns across the board, and in some cases, significant levels of sexual abuse. The study noted that volunteers were not going to residential facilities that housed CWD.[343] There have been well-documented and high-profile cases of abuse by volunteers engaged with children in residential care, including a case involving a British Airways pilot.[344]

In 2021, a class action lawsuit was filed in the US Federal Court of Illinois on behalf of donors and volunteers against a US-based non-profit that runs a CCI in Nairobi County, under the Racketeer Influenced and Corrupt Organisations (RICO) Act. The lawsuit claims that the organisation recruited Kenyan children from vulnerable families to 'profit orphanages' designed to attract donations from well-meaning contributors and voluntourists.[345] Children at this institution 'are used to perform for American voluntourists and deny that their parents are still alive', with no effort made to reunify them with their families. Volunteers were not required to undergo background checks, and were given instructions to lie to Kenyan authorities about their reason for entry into Kenya. The High Court of Kenya, in one case, emphasised the dangers of having short-term volunteers who do not undergo appropriate screening and fail to obtain appropriate work permits.[346] While the case initially commenced as a property dispute among quarrelling institution operators, the case addressed issues including foreign volunteers and the institution management's use of the institution for financial gain, among other things.

Care leavers in Kenya are mobilising to raise awareness of the harm this brings. In media reports, and many documents published by KESCA or individuals with lived experience, there are frequent mentions of the role of volunteers and the negative impact associated with them.[347] Similar issues are raised about foreign volunteers and possible orphanage trafficking. Care leavers report being 'used by the care institutions to get money to maintain the care institutions'.[348] They also advocate to volunteers and FBOs that volunteering in CCIs 'might not promote the best interests of children', and instead advise that they should use their platforms and voices to promote family-based care.[349] These sentiments were also highlighted in the county-level situational analysis reports.[350]

There is limited data on orphanage trafficking in Kenya, in part because it is not explicitly included in any national policies relating to trafficking, exploitation or alternative care. One reason, provided by

Box 7

continued…

the cabinet secretary, for the suspension of registration of new CCIs in 2017 is that '[i]t was evident that some of the children's homes were involved in unscrupulous practices which may include child trafficking.'[351] The link between residential facilities, adoption and child trafficking in relation to adoptions was referenced in a directive from the cabinet secretary in 2019, noting that the government would 'stop at nothing to deal firmly with any forms of child trafficking in the name of adoption.'[352] There have been court cases in Kenya related to volunteers and operators, and unethical behaviour such as the exploitation of children.[353] As more high-profile cases of orphanage trafficking are uncovered, exposed and prosecuted, and the issues are included in national and international news, it is hoped that behaviours will change. Several academics have written about the topic, including examples from Kenya within their documents.[354]

A study of institutions and families in Kenya with CWD identified children being trafficked both from and to institutions in Kenya.[355] The field research undertaken with institutions and families in Nairobi and Mombasa documented children being trafficked to institutions for exploitation, with 'foreigners' paying to visit the children and allegedly to sexually abuse them.[356]

There are documented concerns regarding the international funding streams in private CCIs. One institution named in the 2018 Disability Rights International study, for example, sought US$50 per month to sponsor a child, with 35 out of 60 resident children being reportedly sponsored by international donors. Despite this funding, the institution had only hired two non-professional staff.[357]

As care reform efforts move forward and more scrutiny is placed on CCIs, especially those that are not meeting standards, it is important for the Government of Kenya bodies mandated with licensing, inspecting and responding to charges of violence, abuse or exploitation within CCIs to have clear protocols, well-trained personnel, and appropriate information collection tools in place, plus the resources to adequately sustain them. When there is an investigation into alleged violence, abuse or exploitation against children and young people, investigative protocols must reflect good practice, especially in terms of interviewing techniques, with an aim to avoid any words or actions that could provoke or cause further trauma to victims.

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9 Care During an Emergency

Kenya has been subject to different types of emergencies during the past several decades. These include migration, refugees, political turmoil and terrorism, and floods, famine and drought. Kenya has also had to deal with, and continues to confront, HIV and AIDS, as well as the effects of the COVID-19 pandemic. As a result, Kenyans have developed resilience, and adapted long-standing traditions into models of care that are contextually driven and designed to meet the immediate needs of children and families. For example, responding to the significant numbers of refugees in Kenya presents challenges, especially in the context of political sensitivities, but has also generated innovations that can be more broadly applied to care in non-emergency settings. Specifically, foster care and CHH, and supported/independent living situations have been present for many years in the Kakuma and Dadaab refugee camps, but only in the past few years have these efforts been noticed by care actors beyond the emergency setting. Similarly, a decade ago, children with HIV, or those orphaned by HIV, were stigmatised. Many were sent to CCIs, as the shame of having a child living with or affected by HIV was seen as too risky.[358] With the arrival of medication, improved understanding of disease management and extensive OVC programmes, most children with HIV are no longer living in CCIs, but have been reintegrated with their families.[359] The COVID-19 pandemic was also a potential opportunity to design, adapt or adopt new models of care, advocate for more support, and use the rapid reunification as a stepping-stone for more reintegration.

9.1 Refugee children and care

The *Guidelines for the Alternative Family Care of Children in Kenya* (2014) include a chapter on caring for children in emergency situations that covers guiding principles, legislative frameworks, roles and responsibilities of stakeholders, and other information.[360] Several legislative instruments specifically mention child protection and care in emergencies, including the *National Children Policy 2010*[361] and the *National Plan of Action for Children in Kenya 2015–2022*.[362] It is worth noting that the UNHCR has developed excellent tools and resources related to the best interest determination and case management processes that have greatly informed existing tools developed by others working in the care sector. [363]

Kenya is home to 494,874 registered refugees and asylum-seekers, of whom 81,015 (16.4 per cent) reside in urban areas, not in refugee camps.[364] More than half are children, with data from 2021 showing a total of 266,524 children.[365] Thousands more are estimated to remain unregistered, in part due to the difficulties in registering as asylum-seekers and refugees in Kenya.[366] There is limited data on the numbers of unaccompanied and separated children (UASC), but UNHCR data from 2016 reported that 7 per cent of all refugee children were UASC. If this is true, that would result in more than 18,000 UASC using 2020 data. Unlike UASC in camps supported by the Kenyan government and UNHCR, urban UASC appear to have fallen through the cracks. A study of UASC in Nairobi in 2017 identified a largely informal system of alternative care that leaves UASC vulnerable to violence, abuse and exploitation due to the lack of a proper grounding in the child protection framework, the absence of reporting mechanisms and a failure in law enforcement.367 The study noted that, on arrival, children tend to move frequently between homes, largely arranged with strangers met on the street or people of the same ethnic group, and are often exposed to child labour such as domestic servitude, and sexual exploitation and violence.[368] The study reported anecdotally that placements are either self-identified with little oversight or family tracing, or into CCIs. UASC struggle to access legal registration as refugees, and are therefore extremely reluctant to report violence or abuse.[369] Box 8 describes alternative family-based care practice in one of the refugee camps.

Box 8

Foster care in Kakuma

Kakuma Camp is in the far north of Kenya, and was established in 1992. Today, it hosts one of the largest refugee populations in the world. As of June 2020, Kakuma Camp and the nearby Kalobeyei Integrated Settlement[370] hosted 196,666 registered refugees and asylum-seekers originating from South Sudan, Sudan, Democratic Republic of Congo, Ethiopia, and Somalia, among other countries.[371]

Forty seven per cent of the residents in Kakuma and Kalobeyei are female and 60 per cent are children – 75 per cent of whom are of school-going age (5–17 years). Approximately 13 per cent of the child population (or over 15,000 children) are unaccompanied, separated or otherwise vulnerable children, creating a high demand for care and protection services.

During population registration, children with protection concerns (including UASC) are screened and assessed by trained case workers, and supported via a case management approach with data entered in the CPIMS. Where an unaccompanied child is identified, a best interest assessment takes place and alternative care is sought. The agencies active in Kakuma Camp facilitate both foster care (99 per cent of which is provided by families living within the camp) and supervised CHHs (primarily for large sibling groups and adolescent boys). Placements into either care option are accompanied by in-depth care plans, created by a core case worker and approved by a senior case manager. Care plans include a schedule of visits for monitoring, and senior case manager approval is required for any changes to the placement.

A member of an NGO supporting alternative care in Kakuma Camp noted the importance of projecting the number of unaccompanied children expected to enter Kakuma both quarterly and annually, in order to identify, recruit, train and pre-approve a pool of foster families ready to receive children when their unaccompanied status is confirmed. Those involved in this effort note the success of local awareness-raising forums (conducted within each of the camp's 'blocks', and led by the block leader) among the refugee population to identify prospective foster families. The staff noted that families most often have a preference for fostering girls of all ages, and younger boys (perceived to be more respectful, easier to parent and to bond more easily) over older/adolescent boys.[372]

Foster families are supported with a package of essential items for both the child being fostered and other children in the household (mattress and bedding, clothes, shoes, etc.), and the household's monthly food ration is also increased according to the number of children fostered (often distributed via mobile money at a rate of KSH 800 per person per month, so families can purchase food from local refugee-owned and host community-owned businesses, stimulating the local economy).

Box 9

Children living with HIV and in residential care

Increased access to HIV testing and treatment services have made a life-changing impact to the number of children living with HIV, as well as the number of parents and caregivers who are now living healthily with HIV on treatment. According to UNAIDS data,[373] in 2018, HIV prevalence was at 4.7 per cent, with 89 per cent of people living with HIV knowing their status, and 75 per cent of adults over 15 years of age, and 63 per cent of children aged 0–14 years, living with HIV on treatment. Ninety-one per cent of pregnant women living with HIV accessed antiretroviral medicine to prevent transmission of the virus to their baby, and early infant diagnosis was 67.3 per cent. The number of new HIV infections annually have decreased by 44 per cent since 2010, and deaths from HIV have fallen by 59 per cent since 2010.[374]

Consequently, the driving force for accessing HIV-related health care, or stigma-related 'push' factors out of family care, is likely to have reduced. Whilst poverty is still a barrier to accessing health care, HIV treatment is generally widely available and free. HIV-related stigma and discrimination still present considerable challenges for children and their caregivers, especially female caregivers. Whilst access to health care was mentioned in some cases, HIV specifically was not reported as a cause for entering institutions in the recent situation analysis in five counties.[375]

Access to HIV-related prevention and treatment services would be a priority, and it is currently not known whether children in residential care are accessing HIV services. Where health care is accessible and robust case management is in place, it is likely that children are accessing treatment and adolescents accessing prevention methods, while in poorly managed institutions, this is less likely.

9.2 The COVID-19 pandemic

Kenya boasts a rich and beautiful landscape perfect for tourism. Yet, with the benefits of tourism come challenges, including care reform-related challenges – exacerbated during COVID-19 – that contribute to and influence childcare patterns, and community, civil society and state contributions to care reform and child protection. The tourism industry was hard hit in 2020, most likely including orphanage tourism. While this was positive outcome in some respects, it also resulted in a severe lack of funds and CCIs closing, forcing children and young people to return to unprepared families or, in the worst cases, to the streets.[376] As a director of a CCI in Kenya mentioned early during the pandemic, 'We have locked up the gate and do not allow any visitors. None of the staff leaves the compound either. This lockdown means we are losing in a big way; many have cancelled their visits and donations too.'[377]

Kenya confirmed its first COVID-19 case on 13th March 2020. In response to the gradually increasing numbers of confirmed cases, the Government of Kenya took proactive action and ordered the closure of Kenya's international airports, introduced a nightly curfew, closed schools, and recommended that those who could work from home do so to observe the principles of physical distancing. In support of containment measures, the NCCS and the DCS took several immediate actions aimed at preventing and responding to the unique needs of children in residential care. On 17 March 2020, the government issued a directive instructing all residential care facilities, including boarding schools and childcare facilities, to release children from care immediately.[378] In response to this, the NCCS, with support from UNICEF and other partners, convened a working group whose primary objective was to design guidance and key messages about COVID-19. The first product was a set of key messages targeting children, parents/caregivers, residential care facilities and community members on how to prevent the spread of COVID-19, truths versus falsehoods, treatment of those who have COVID-19, and information about key services and hotlines to report abuse or get up-to-date health information.[379]

A second government directive was issued that required COs and Social Services to submit a report detailing the number of children released to families, and challenges associated with the process. To support the implementation of the directive, the DCS, with support from civil society members of the working group, conducted a rapid mapping to determine the number of children returned home and the number remaining in residential care facilities. This information was presented and used to inform appropriate responses.[380]

At the same time, the NCCS, the DCS and CTWWC worked closely together to develop guidance related to the case management process, with specific focus on children remaining in residential care and those who have been reunified because of COVID-19.[381] This guidance was shared with government and the non-governmental actors responsible for case management of children's cases. UNICEF also worked with the DCS to address the capacity of COs regarding skills and knowledge needed to address child protection during the pandemic. Efforts were also focused on providing support, albeit virtually, for children who had been rapidly reunified, including not only the gathering of data on their whereabouts, but also collection of critical information to ensure the children were safe and their needs being met post-reunification. The data collected showed that a significant number of children returning to family-based care were in kinship care.[382] A virtual monitoring tool was utilised by several of the working group members to ensure that key areas of child well-being, and that of their family, were assessed.[383] The same process and tools are used by several CSOs to monitor young people who have moved to independent living situations.

Maestral International helped to design and conduct a series of twelve webinars to cover thematic areas of child protection impacted by COVID-19. One such webinar addressed residential care, and more than 70 directors of private and statutory institutions were invited to attend.

As the pandemic wore on, the impact on Kenya was documented – especially the risks to children, who were made even more vulnerable as the pandemic affected livelihoods. The World Bank estimates that two million Kenyans were thrown into poverty because of the economic shocks.[384] Increasing poverty tends to correlate with non-income risks given the stressors on households – poverty can make it challenging for households to feed children, and increases the risk of children being placed in residential care by families unable to provide them with their basic needs.

Kenya's emergency measures, coupled with the economic crisis and a lack of access to education, led to reports of significant increases in physical, emotional and sexual VAC. There is some evidence that sexual VAC increased during COVID-19, with data suggesting that violence is increasingly predatory and less dependent on parental or caregiver oversight: child victims are younger, more likely to be victimised by a neighbour in a private residence, and in the daytime, compared to pre-pandemic. [385]

The University of Birmingham and the Institute for Global Innovation released a study in July 2020 highlighting the increased vulnerability of women and girls in Kenya under COVID-19.[386] The State Department of Gender Affairs reported a 42 per cent increase in sexual and gender-based violence (SGBV) cases the same month. Prior to the pandemic, child survivors of SGBV averaged 16 years of age, but this fell to an average age of 12.3 in 2020 (with children ranging in ages from 5–17). Family members and neighbours were the majority of perpetrators. On July 6, President Kenyatta called for the National Research Centre to investigate the rise in SGBV, especially against girls. In December 2020, the New York Times published a comprehensive report on the sharp rise in cased of child marriage and cutting in Samburu County.[387] Married girls are highly unlikely to attend school, with lifetime consequences.

An individual supporting the drafting of the *National Care Reform Strategy* summed up the relationship between COVID-19 and care reform in Kenya quite articulately.

> "The COVID-19 emergency has the potential to 'make or break' the care reform agenda in Kenya. Huge momentum has been built and progress made in

relation to care reform in Kenya over the last few years. However, there may soon be those making arguments that care reform is no longer a priority for Kenya in the post-COVID-19 context. From a child protection perspective, this view could not be further from the truth. In periods of instability and insecurity the evidence is clear that children are best supported and protected in family-based care environments, with support from relevant services to maintain family unity, stability and safety, as appropriate.[388] It is therefore vital that child protection actors in Kenya use COVID-19 as a motivation to redouble efforts to reform the care system, so as to allow children to live in safe and sustainable family and community-based care, where we know they can be best protected and they can fully achieve their rights." [389]

WILL BAXTER / CRS

10 Public Awareness and Advocacy

There is a dichotomy between the evolution of children's care system in Kenya and public perception. Whilst extended family care is prevalent and has always been a traditional form of care, findings from the situational analysis of residential institutions noted that many community members believe that CCIs are better for children. Most key stakeholders, including COs, believe in the benefits of family-based care, yet prevention and family-strengthening efforts still lag far behind residential care placements, primarily because of a lack of family-strengthening services. The child protection framework stresses the importance of prevention and family care, yet the roles and responsibilities of the child protection workforce focus extensively on response and have limited focus on family strengthening or family-based alternative care.

There has been significant data collection and analysis on the push and pull factors that result in children being in residential care in Kenya. The root causes, poverty, access to education, and disability, are well known. Awareness campaigns must address the root causes and include behaviour change strategies.[390] It does appear that huge progress has been made in terms of national- and county-level government actors understanding, being able to articulate, and believing in, care reform and what it stands for. Key informants noted that this was an achievement of the past several years, and that there was 'no more need for convincing Children's Officers.'[391] However, a significant number of donors, community members and leaders do believe that children are better off in residential care, illustrating why sensitisation and awareness-building must continue and even be expanded. If parents and community leaders still believe that placement in a CCI is the only option for a family in crisis, more needs to be done to change their attitudes and practice. What needs to be done as a next step is widespread promotion of family-based care and the provision of clear information about why placement in residential care should be an option of last resort. Utilising community-based platforms like CCAC and SCCAC, churches, mosques, local radio stations and TV to spread the message is vital for full-fledged change to take place.

Key stakeholders mentioned that when COs, chiefs and other leaders are informed and committed, change can, and does, happen.[392] The *National Care Reform Strategy* includes a section on advocacy, and appendices listing key messages for specific topics, and target audiences. This information should be used to guide awareness-raising campaigns targetted at, but not limited to, community leaders, parents and caregivers, teachers, local leaders, national and sub-national government, social workers and psychologists, and the mass media. Awareness-raising should also be designed to address foreign organisations, donors, and tourists interested in, or engaging in, voluntourism in CCIs.

Advocacy groups like KESCA, Adoption is Beautiful, and the Association of Alternative Care Kenya must also continue to raise their voices and demand change, promote alternatives, and collect data that proves their case. Social media outlets should be utilised, given that Kenya is a tech-forward country. As care reform continues, the directors, staff and children from CCIs that have successfully transitioned should contribute their voices and experience and show how change can be done.[393]

A two-pronged approach that raises awareness inside Kenya, whilst also working to change donor patterns from outside of Kenya, is critical. As noted in one article on the topic, the 'absence of any campaigns geared towards deconstructing local attitudes through which institutions have come to be considered good solutions for children from poor families, in particular within communities situated in regions where the presence of numerous foreign sponsored residential child-care facilities are functioning as pull factors for parents who are struggling to provide for their children's most basic needs.'[394]

11 Conclusion

The story of care reform in Kenya provides valuable insight into moving towards a national care system that prioritises family care over residential care. It is a story that is not complete, but has successes and challenges that can provide learning for others. Significant progress over the past decade has established a strong foundation for further care reform. The *National Care Reform Strategy*, the fruit of a strong legislative framework, is an excellent stepping-stone for the future. The national cash transfer programme, the child protection system, and recognition by all actors that government, civil society, multi- and bi-laterals, and communities, each have a unique role to play in care reform. The past five years have seen increased traction and coordination, along with notable additions such as the Children Act 2022, the *National Care Reform Strategy*, recognition and strengthening of the child protection workforce, and the myriad SOPs and tools to support the range of care options.

These achievements motivate stakeholders engaged in the sector. The development of this Country Care Profile demonstrated that a wide range of stakeholders share a commitment to, understanding of, and desire, seeing the process through to the end. Kenya has reinforced its robust legislative framework to prioritise family care through the passage of the Children Act 2022. The *National Care Reform Strategy* provides an anchor and a framework within which a wide range of actors have clear actions, roles and responsibilities to reach the long-term goal of a strengthened care system that prioritises family. There is palpable excitement when stakeholders speak of strengthening families, advocating for support to enable families to care for children, and findings ways to strengthen the 'traditional ways of prioritising children and their care.'

Several critical elements stand out that can inform other countries seeking to begin their own care reform process. The first is the importance of a common understanding of what care reform is and what it means for children. The three-pronged pie chart representing the pillars of prevention of separation, expansion of family-based alternatives, and transformation of residential care proved an easy, yet critical, conceptual aid. It has been instrumental in providing all actors with a shared vision.

The second critical element is strong coordination and collaboration between actors. This is not always easy. The establishment of the Care Reform Core Team, led by government, created a central platform to facilitate communication, visioning, planning and implementation. With the passage of the *National Care Reform Strategy*, the Oversight and Coordination Division plays a key role in implementing the strategy. Efforts to engage with one another, share tools and approaches, and conduct trainings with government and civil society, have all played an important role in promoting not only a collaborative environment but also a coordinated approach. There has been intentionality in ensuring the inclusiveness of the process, and room has been made for many. There is acknowledgement, by all stakeholders, of the contributions civil society can make and, conversely, appreciation for the oversight and leadership role of the government in driving the process forward. There is also recognition that long-term care reform success also requires other sectors, like health and education, to do their part.

The third critical element is active leadership and concrete actions by government. This has the power to greatly influence care reform efforts. Many stakeholders noted that the 2014 *Moratorium on Adoption* and the 2017 *Moratorium on Registration of New CCIs* were both instrumental moments in the care reform journey. Whilst there were concerns about how these were rolled out and enforced, the existing focus on care reform meant they enabled a discussion and a shift in gear towards more rapid action. Many noted that government taking a stand and making important decisions positively influenced the process.

Kenya has clearly situated care reform within a wider systems context. This has reduced duplication of efforts between different actors, reduced the risk of contradictory programming, and enabled children in alternative care to be viewed within a broader positioning of children in need of care and protection. Including family strengthening within the care reform agenda brings the idea of child well-being to the forefront, and promotes a more holistic approach to addressing risks. As such, closer coordination

and integration of family strengthening within the education, health, justice, and social protection sectors will be important to ensure that care reform is not just seen as an issue of responding to child protection violations but also of strengthening families and preventing separation. Moving forward, it is important for key actors, especially those in government, to clearly articulate, both within their own sector and to other sectors, that care encompasses prevention and response.

Kenya has placed a renewed focus on, and appreciation of, the role of the workforce as central to implementing the legislative framework. The government and civil society actors increasingly recognise that investing in social service workforce development, including increasing numbers, and standardising the training curricula, tools and processes – such as gatekeeping or supportive supervision – are a fundamental element of success. Workforce strengthening will play a role in ensuring the successful establishment and functioning of the CRCs. These groups are instrumental to gatekeeping and, as such, planning and resources committed to training and continual on-the-job coaching is critical. Related to this, training of CSVs, including lay volunteer counsellors, will be important given their role in family strengthening, including identification of families at risk and the delivery of positive parenting education.

The active engagement of care-leavers in the policy agenda has proved particularly useful. The successes in this area are the result of a strong, committed and strategic group of care-leavers. Their organisation positioned itself well and effectively advocated to contribute to the development of a more inclusive process and an enabling environment. The inclusion of their voices and opinions, and active engagement of those with lived experience, has made the care reform process in Kenya much richer, serving as an example of good practice for other countries. However, all care actors must remain mindful of this quote by a Kenyan care-leaver: 'My story is unique. My situation is unique. My future is unique. There can never be a cut and paste approach to working with children and care leavers.'[395]

There are also opportunities for Kenya to continue to strengthen existing efforts while addressing some of the identified gaps or challenges that inevitably occur in a long-term and comprehensive reform effort.

The *National Care Reform Strategy* provides a detailed and comprehensive roadmap for the next decade. The time, thought and detail put into the participatory approach to developing the strategy has resulted in a foundational tool guiding reform. The strategy contains everything needed to inform the roles and responsibilities of key actors engaged in the process. The finalising of the monitoring and evaluation framework for the strategy will complete the package, and allow the Government of Kenya and other actors to track the process and hold themselves accountable to achieving what is clearly laid out in the strategy. Continued resources, both financial and human, must be committed to implementing the strategy, at the national and local levels, as well as prioritising donor strategies and commitments.

Care reform can be further enhanced by connecting the care reform's concerted effort to focus on prevention of separation, and early intervention for family strengthening with the national VAC agenda. VAC prevention and response is the forum around which many other sectors are coalescing. Ensuring that care reform is part of broader child protection system-strengthening efforts could shift minds significantly, and enable a more family- and community-centred approach to come to the fore. The passing of the Children Act 2022 is a solid foundation that requires ensuring a mindset change within the workforce towards prevention and early separation, and away from response, at all levels, but especially the CSVs who interface with children and families. This presents an opportunity to decrease family separation and strengthen the services geared towards families. This is also an opportunity to design public awareness campaigns promoting key components of the Children Act 2022, key messages designed around prevention of separation, and the promotion of foster care and adoption, as means of providing a family-based environment for children, will be essential. Engaging the faith community and the private

sector in creative ways will create valuable platforms to share these messages.

Early intervention as part of a broader effort to strengthen families and reduce separation is critical. Expanding childcare, positive parenting approaches, cash transfers and other household economic strengthening activities, and facilitating better access to health and education services, is critical. A cash-plus-care approach to preventing separation is even more critical given the significant negative impact of COVID-19 and the global economic downturn on Kenyan families.

Continued engagement with young people who have experienced care, and utilising their voices, experience and knowledge about care will be critical to inform not only policy but programming, especially around the transition to supported independent living and reintegration. Many have lived through the process and know what to, and what not to, do. Finding ways to professionally engage care-leavers and other affected children and young people, including employment or internship opportunities, will be mutually beneficial to the individuals and to the sector.

Kenya must find a way to address the international funding that has fostered the growth of CCIs in the country. Continuing to address voluntourism is one important way, as is finding ways to collaborate with local and international organisations that build awareness and change the behaviour of faith communities that regularly contribute to, or engage in, the establishment or ongoing financial support of CCIs.

Related to the above, the mandated government bodies must continue to regularly review, visit and provide oversight to CCIs, using the National Standards as a guide. As awareness about the risks of violence in residential care increases, the Government of Kenya must secure appropriate resources and put protocols in place to respond to cases of violence and address the perceived culture of impunity. This will require trained personnel, clear protocols to protect survivors, and punishment of perpetrators. Successful prosecutions of cases of VAC within residential care should be used as examples of what happens to those responsible.

One significant gap noted in this review is the needs and experiences of CWD and their families. A concerted effort will be required to ensure the inclusion of CWD and their families in all care reform components, including prevention, access to appropriate services (health, education, psychosocial and economic), alternative family-based care and reintegration. Kenya can learn from the experiences of countries in which reintegration efforts stalled due to the lack of an inclusive approach. Kenya can do it differently by being intentional about addressing the unique needs of CWD, and ensuring that services to prevent separation and promote reintegration are inclusive.

The Government of Kenya and civil society, with support from donors and communities, will need to maintain its focus, energy, resources and commitment to the care reform agenda to ensure that the strong legislative framework is translated into implementation on the ground through programmes, services, an effective gatekeeping and monitoring system, a workforce with sufficient skills and resources to deliver and supervise those services, and a budget that reflects a commitment to decreasing reliance on residential care and supporting families to enable them to care for children, including expanding services in health, education and social protection. There must be continued recognition that this is a long-term process that involves multiple actors and every level of society. Kenya's care reform journey has provided ample evidence that change is possible. However, Kenya is now at a critical junction where a renewed commitment by all actors to stay the course is needed to reach their shared vision of a care system that puts family care first.

Appendix 1:

Glossary of Terms

Abuse: Abuse is '[a] deliberate act with actual or potential negative effects upon a child's safety, wellbeing, dignity, and development. It is an act that takes place in the context of a relationship of responsibility, trust, or power.'[396] There are four primary types of abuse:

1. **Emotional or psychological abuse:** When a caregiver acts or behaves in ways that have an adverse effect on the emotional health and development of a child. Such acts include: restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection, and other non-physical forms of hostile treatment that deny the child an appropriate and supportive environment in which to thrive. They are acts that may result in psychological and social deficits in the growth and development of a child.
2. **Neglect:** The deliberate or wilful failure of a caregiver to provide for, or protect, the child. Forms of abuse that are neglectful include caregivers' failure to report violence against a child.
3. **Physical abuse:** A caregiver's use of physical force to cause actual, or possible, physical injury or suffering.
4. **Sexual abuse:** When a caregiver involves a child 'in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society'.

Adoption: Adoption is the complete severance of the legal relationship between a child and their biological parent(s) and birth family, and the establishment of a new legal relationship between the child and their adoptive parent(s). Adoption is a permanent care solution and, because of its permanent nature, is not considered alternative care. In Kenya, domestic (national) adoption is adoption of a Kenyan child by a Kenyan couple/individual resident in Kenya. Children who reside in Kenya, are under eight years old, but whose nationality is unknown but assumed Kenyan, are also eligible for domestic adoption. Applications for domestic adoption are initiated through a registered local adoption society. Foreign resident adoption, in Kenya, is adoption of a Kenyan child by a couple/individual who are not Kenyan nationals, but have lived in Kenya for over three years. International adoption is adoption by a couple who are not citizens, or residents of, Kenya.[397]

Adverse childhood experience: Stressful or traumatic events, including abuse and neglect. Examples include household dysfunction such as witnessing domestic violence, or growing up with a family member who has a substance misuse disorder. Also included are humanitarian contexts (e.g., drought, famine, flood, human conflict, terrorism, environmental pollution). Adverse childhood experiences are strongly related to children's development, and the prevalence of a wide range of health and psychosocial problems throughout a person's life.

Alternative care: A formal, or informal, arrangement whereby a child is looked after at least overnight, outside the parental home, either by decision of a judicial or administrative authority, a duly accredited body, or at the initiative of the child, their parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents. It includes kinship care, *kafaalah*, foster care, guardianship, adoption, traditional approaches to care, and places of safety and temporary shelter. Alternative care is the second pillar of care reform.[398]

Best interests of the child: The well-being of a child, determined by the individual circumstances of age, level of maturity, presence/absence of parents, and the child's environment and experiences.[399]

Best interests determination: The formal process of making a decision on the basis of all information requested and/or made available with respect to decisions about a child's well-being. The formal process of determining best interests is particularly important when there is a conflict of opinion, or where there is no primary caregiver. The rights and interests of any other party should be

considered, as well as other factors. The solution should always be the one considered to be the most positive for the child, immediately and in the longer term.

Caregiver: A person or guardian who is charged with responsibility for a child's welfare.[400]

Care leaver: Anyone who spent time in alternative care as a child. Such care could be foster care, institutional care (mainly children's homes), or other arrangements outside the immediate or extended family.[401]

Care reform: A change process within the systems and mechanisms that provide care for children separated from their families, or at risk of separation. It consists of three pillars, all of which need to function and fulfil their purpose for care reform to be holistic and sustainable:

1. Prevention of separation, and family strengthening.
2. Alternative care.
3. Tracing, reintegration and transitioning to family- and community-based care.

It involves the redirection of resources from institutional care to family- and community-based care, as well as the retraining and redeployment of institutional personnel. The care reform process changes the attitudes and practices of duty bearers and other stakeholders towards family- and community-based care solutions, and away from institutional care as a primary response. It strengthens duty-bearers' accountability in meeting their obligations to ensure children's rights are met. It involves the meaningful participation of children and young people. It will result in more children living safely, happily and sustainably, in families and communities where their best interests are served.[402]

Case conference: A multidisciplinary meeting at which child protection actors explore, from different perspectives and disciplines, a problem of a particular child, or group of children. A case conference can be called at the case planning, implementation, or follow-up stages. Case conferences can be held at different levels, including organisation, sub county, and county levels (CCAC).[403]

Case file: A record kept for every child who is receiving services. The file contains all documents that pertain to the child/case.[404]

Caseload (see also Workload): The number of cases (children or families) assigned to an individual worker in a given time period. Caseload reflects a ratio of cases (or clients) to staff members, and may be measured for an individual worker, all workers assigned to a specific type of case, or all workers in a specified area (e.g., agency or county).[405]

Case management: The process of ensuring that an identified child has their needs for care, protection and support met. This is usually the responsibility of an allocated social worker who meets with the child, the family, any other caregivers, and professionals involved with the child, to assess, plan, deliver or refer the child and/or family for services, and monitor and review progress.[406]

Case manager: Coordinates all the efforts and service providers involved in the case management process. In Kenya, the CO at the DCS is the case manager, unless there is an emergency, in which case humanitarian agencies can become the case manager.[407]

Case plan: This is a written document that outlines how a child's needs will be met, when, and by whom. It is developed by caseworkers or case managers, in collaboration with the child and caregiver.[408]

Caseworker: This is a key worker, trained in child protection systems, and authorised to maintain responsibility for the case from identification to closure.[409]

Charitable Children's Institution: An institution established by a person, corporate or non-corporate, religious organisation, NGO or PBO. In Kenya, registered CCIs have been granted approval by NCCS to manage a programme for the care, protection, rehabilitation, or control of children. Non-registered CCIs offer similar services, but have not been granted approval by NCCS.[410]

Child-headed household: A household in which a child or children (typically an older sibling) assumes primary responsibility for the day-to-day running of the household, providing and caring for those within the household. The children in the household may or may not be related.[411]

Child abuse: Acts of commission (deliberately choosing to do something) and/or omission (deliberately choosing not to act) that result in harm to the child. See definition of abuse for other types.[412]

Child in conflict with the law: A child who is suspected, accused or found guilty, of having committed a criminal offence, displays anti-social behaviour, or is in violation of the law. A child is considered to be in conflict with the law when they have committed an act or omission that amounts to a cognisable offence in the Penal Code, or any other law in force.[413]

Child in contact with the law: All children going through a justice system for whatever reason (victims, witnesses, children in need of care and protective custody and child offenders).[414]

Child participation: The informed and willing involvement of children, including the most marginalised and those of different ages and abilities, in any matter or decision concerning them. Participation encompasses the opportunity to express a view, and to influence decision-making and achieve change. Children should be provided with relevant information in an age- and development-appropriate manner, enabled to participate effectively, and their views be given due consideration in accordance with their age and maturity. General Comment No. 12 of the Committee on the Rights of the Child specifically mentions the need to introduce mechanisms to ensure that children in all forms of alternative care, including in institutions, are able to express their views, and that those views be given due weight in matters of their placement, the regulations of care in foster families or homes, and their daily lives.[415]

Child protection: The process of ensuring that children are protected from all forms of harm through structures and measures to prevent and respond to abuse, neglect, exploitation and violence, including putting into place the procedures necessary for handling situations or issues that may arise.[416]

Child protection system: A set of laws and policies that protect children from violence and exploitation; a central government coordination mechanism bringing government departments and civil society organisations together at all levels; a centralised information management system that ensures regular collection of information on both prevalence and incidence of child protection issues; and services and responses that are effectively regulated and coordinated.[417]

Child trafficking: The recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation. It is a violation of their rights and their well-being, and denies them the opportunity to reach their full potential.[418]

Community-based care: A range of approaches designed to enable children to remain with their own (or extended) family and prevent the need for separation, or to be placed with an alternative family within their community. It includes supported child-headed households and supported independent living, and is reinforced by broader prevention of separation and family strengthening services.[419]

Continuum of care: A range of services and placement options for children, including family preservation or prevention of separation (i.e., remaining with biological parent(s)) and placement in residential care centres/facilities. Other care options are kinship care, temporary foster family care, long-term foster care, domestic adoption, monitored child-headed households, small group homes, intercountry adoption, high-quality residential care (including orphanages) and supported independent living. A continuum should represent a wide range of options to provide the necessary and appropriate care.[420]

Counter-trafficking of children: Activities, including prevention, protection and prosecution, to counter the

recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation.[421]

Disability: '[L]ong-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder (a person's) full and effective participation in society on an equal basis with others.'[422]

Exploitation: When an individual in a position of power and/or trust takes, or attempts to take, advantage of a child for their own personal benefit, advantage, gratification or profit. This personal benefit may take different forms: physical, sexual, financial, material, social, military or political. Exploitation may involve remuneration in cash or in kind (such as social status, political power, documentation, freedom of movement or access to opportunities, goods or services) to the child or to a third person.[423]

Family: This includes relatives of a child, including both immediate family (mother, father, stepparents, siblings, grandparents) and extended family, also referred to as relatives, or 'kin' (aunts, uncles, cousins).[424]

Family-based care: Short- or long-term placement of a child in a nurturing family environment with one consistent caregiver, where the child is part of a supportive family and community. It includes parental care, kinship care, kafaalah, foster care, guardianship, adoption, and traditional community approaches to care.[425]

Family- and community-based alternative care: All forms of alternative care where children are placed in family- or community-based care. It does not include parental or institutional care.[426]

Family preservation: Interventions intended to help keep children at home with their families, safe and secure. Services might include household economic-strengthening initiatives (e.g., social protection, income generation), links to community support mechanisms, specialised support for alcohol or drug addiction, parenting support and individualised coaching.[427]

Formal care: All care provided in a family environment that has been ordered by a competent administrative body or judicial authority, and all care provided in an institutional environment, including in private facilities, whether or not as a result of administrative or judicial measures. Examples include foster care, guardianship, kafaalah, etc.[428]

Foster care: Placement of a child with a person who is not the child's parent, relative or guardian, and who is willing to undertake the care and maintenance of that child.[429]

Gatekeeping: The prevention of inappropriate placement of a child in formal care. Placement should be preceded by some form of assessment of the child's physical, emotional, intellectual and social needs, matched to whether the placement can meet these needs based on its functions and objectives. Gatekeeping is the process of preventing children from entering inappropriate and unnecessary care, and making decisions about care that are in the best interests of each and every child.[430]

Gender: The social definition of women and men among different communities and cultures, classes, ages, and during different periods in history.[431]

Gender-based violence: Violence visited on a person based on their gender, including: child marriage; female genital mutilation; forced marriage; forced wife inheritance; interference from in-laws; sexual violence within marriage; virginity testing; widow cleansing; damage to property; defilement; harassment; incest; intimidation; physical abuse; sexual abuse; stalking; verbal abuse; or any other conduct against a person where such conduct harms or may cause imminent harm to the safety, health or well-being of the person, or any other act that results in, or is likely to result in, physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.[432]

Guardianship: This term is used in three different ways:

1. A legal device for conferring parental rights and responsibilities to adults who are not parents.

2. An informal relationship whereby one or more adults assume responsibility for the care of a child.
3. A temporary arrangement whereby a child who is the subject of judicial proceedings is granted a guardian to look after their interests.

Informal care: Any private arrangement whereby a child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others, in their individual capacity, at the initiative of the child, their parents or other person(s), without this arrangement having been ordered by an administrative or judicial authority, or a duly accredited body.[433]

Kafaalah: According to Islamic law, the commitment by a person or family to voluntarily sponsor and care for an orphaned or abandoned child. The individual or family sponsors the child to meet their basic needs for health, education, protection and maintenance. *Kafiil* refers to an individual who is providing kafaalah to a child. Normally, the kafiil is a Muslim.[434]

Kinship care:

1. **Informal:** A private arrangement within the extended family whereby a child is looked after, on a temporary or long-term basis, by their maternal or paternal extended family, without it being ordered by an administrative or judicial authority. Family members include grandparents, aunts, uncles and older siblings.
2. **Formal:** The same as informal, but the arrangement is ordered by an external administrative or judicial authority.[435]

Neglect: The intentional or unintentional failure of a caregiver – whether individual, community or institution (including the state) with clear responsibility, by custom or by law, for the well-being of the child – to protect a child from actual or potential harm to the child's safety, well-being, dignity and development, or to fulfil that child's rights to survival, development and well-being. Harm may be visible or invisible. An act may be categorised as neglectful, whether or not the caregiver intends to harm the child.[436]

Orphanage tourism and volunteerism: Orphanage tourism and volunteerism are terms used to define a spectrum of activities related to visiting or volunteering in children's institutions, known as 'orphanage voluntourism'. These activities relate to the support of children's institutions by individuals who are primarily, or were initially, tourists on vacation. In most cases, they involve a tourist who wishes to include an element of social work-oriented volunteering in their vacation or travels, and who chooses to do this by volunteering their time – sometimes coupled with financial or material support – to an institution. For some tourists, this may be planned in advance, while for others it may be spontaneous. It is common for the tourist to pay for this experience, either directly to the institution or through a volunteer agency or tour company. Having volunteered in an institution, some tourists return to their place of origin and continue to financially or materially support their chosen institution, and may even establish more formalised fundraising mechanisms to achieve this. In some instances, the tourist may establish a registered charity or an international NGO to continue financially supporting the institution.[437] Orphanage tourism and volunteerism can also include faith-based mission trips and other non-professionals who visit institutions for short periods, motivated by philanthropic or experiential purposes. In Kenya, orphanage tourists and volunteers include Kenyans as well as foreigners.[438]

Orphanage trafficking: The active recruitment of children into orphanages or residential care institutions in developing nations for the purpose of ongoing exploitation, particularly through orphanage tourism.[439]

Places of safety and temporary shelter: A place of safety or temporary shelter is a safe environment where children in distress are placed for a short time (from a couple of hours to a maximum of six months), while arrangements for family reunification, or placement in alternative care, are made. It includes halfway homes, safe havens and rescue centres. While the care is temporary, the child should be cared for in a stable, nurturing and safe environment.[440]

Parent: Mother or father of a child, and any person who is, by law, liable to maintain a child or is entitled to their custody.[441]

Placement: A social work term for arranged out-of-home accommodation provided for a child on a short- or long-term basis.[442]

Positive parenting: Parental behaviour, based on the best interest of the child, that is nurturing, empowering and non-violent, and provides recognition and guidance that involves setting of boundaries to enable the full development of the child.[443]

Prevention of separation and family strengthening: Support measures and services that strengthen families, and prevent children being separated from their families. These include education, health care, social protection, food security, livelihood support, positive parenting, psychosocial support, day-care facilities, community-based rehabilitation services for children with disabilities, employment support, support for child-headed households, etc.[444] Prevention of separation and family strengthening is the first pillar of the National Care Reform Strategy.

Psychosocial support: A continuum of love, care and protection that enhances the cognitive, physical, emotional, social and spiritual well-being of a person, and strengthens their socio-cultural connectedness and resilience.[445]

Redirection of resources: The principle that existing financial and non-financial resources within the institutional system of care can be effectively redirected to support a reformed system of family and community-based care, thus ensuring that this reformed system has the resources it needs to support children to live in family and community-based care.[446]

Referral: The process of formally requesting services for a child or their family from another agency (e.g., cash assistance, health care, etc.) through an established procedure and/or form.[447]

Referral mechanism: A collaborative framework in which different service providers cooperate to fulfil their obligation of providing protection and assistance services to children and families. The framework should define each actor's roles and mandates and the steps involved in the referral process.[448]

Reintegration: The process of a separated child making what is anticipated to be a permanent transition back to their immediate or extended family and community (usually of origin), in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life.[449]

Small group home: A form of residential care for children that does not have an institutional culture. Also called small family home and small-scale residential care. Family for Every Child defines a small group home as a form of residential care in which children are cared for in smaller groups, with usually one or two consistent carers responsible for their care. This care is different from foster care in that it takes place outside of the natural 'domestic environment' of the family, usually in facilities specially designed and/or designated for the care of groups of children. UNICEF defines small-scale residential care as a public or private, registered, non-family-based arrangement providing temporary care to a group of four to six children, staffed by highly trained, salaried carers, applying a key-worker system, with a high caregiver-to-child ratio that allows for individualised attention for each child, based on a professionally developed case plan that takes the voice of the child into account.[450]

Statutory Children's Institution: These are children's institutions established by the Government of Kenya. These include:

1. DCS-managed: reception centres (to receive a child prior to being referred onwards to another type of SCI); rescue homes (to rescue children in need of care and protection); remand homes (confining children in conflict with the law while their cases are being handled in court); and rehabilitation schools (rehabilitating children who have been in conflict with the law);

2. Probation and Aftercare Service-managed probation hostels (for juvenile offenders serving a community sentence);
3. Prisons Service-managed borstal institutions, youth corrective training centres and prisons; and
4. Government-managed special therapeutic health institutions.[451]

Strengths-based approach: Building on the existing resources, strengths, agency and potential contribution of the child, caregiver and family, rather than focusing exclusively on the needs of, or problems faced by, the child, caregiver and family.[452]

Supported independent living: Where a young person is supported in their own home, a group home, hostel or other form of accommodation to become independent. Support/social workers are available as needed and at planned intervals to offer assistance and support, but not to provide supervision. Assistance may include timekeeping, budgeting, cooking, job-seeking, counselling, vocational training and parenting.[453]

Tracing, reintegration and transitioning to family- and community-based care: This relates to the safe and sustainable transition of institutionalised children, and unaccompanied and separated children, to family- and community-based care. This includes tracing, reintegration and case management, as well as support for leaving care, aftercare, and supported independent living.

Toxic stress: When a child experiences strong, frequent and/or prolonged adversity – such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship – without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt brain and other development, and increase the risk of stress-related disease and cognitive impairment well into the adult years. [454]

Unaccompanied and separated children: Unaccompanied children are children who have been separated from both parents and other relatives, and are not being cared for by an adult who, by law or custom, is responsible for doing so. Separated children are children who have been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may include street-connected children, lost and abandoned children, children on the move, and refugee and asylum-seeking children.[455]

Violence against children: Using the definition applied in the 2019 VAC Study, which used the World Health Organization definition, violence against children is defined as: 'the intentional use of physical force or power, threatened or actual, against oneself, or another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.'[456] It can include physical, sexual and emotional violence.

Workforce for child protection: Part of the larger social service workforce, it is comprised of social service workers who have the mandate to fulfil prevention and response functions. Furthermore, the child protection workforce is engaged in promotive activities that include advocacy, policy development and furthering the profession. The workforce for child protection should operate under the regulation and supervision of the government, in line with international standards on these issues. These workers may be affiliated with a government or an NGO, and may or may not hold a professional title.[457] In Kenya, the government child protection workforce includes COs officers, probation officers and CPVs.

Appendix 2:

Matrix to guide desk review

Availability of reports, research and general information about alternative care			
	Question	List and Describe	Sources
1	Are there country-level child protection systems or child care assessments; reports, studies, research, websites on alternative and childcare available for the country?		
2	If reports are available what are the main issues, challenges and successes highlighted in the reports about child care reform in the country?		
Country Level Legal and Policy Framework			
	Question	List and Describe	Sources
3	Has the country ratified key child protection human rights instruments (CRC, Hague Convention etc.)? Please list the instruments and dates of ratification		
4	Are there laws, policies, guidelines and regulations and standards specific to childcare and alternative care?		
5	In general, is the country's legal and policy framework in line with the CRC and Alternative Care Guidelines principles (i.e., best interests of the child)?		
6	Does the legal and policy framework reflect the Hague Convention for the Protection of Children and Cooperation in Respect of Adoption especially the subsidiarity of intercountry adoption to domestic family-based care options?		
7	Is there a government-approved strategy for bringing about deinstitutionalisation of the alternative care system? In general For children under 3-5 years For children with disabilities With a target timeframe		
8	Are there existing efforts to reform the child care/alternative care policy and legal framework?		
9	Does legislation require the implementation of specific measures and services to prevent family separation?		
10	Does legislation require the implementation of given processes and measures to ensure that the suitability of family-based alternative care for a child is considered before envisioning placement in a residential facility?		
11	Is the process of leaving and after care supported in the law?		

Description of Child Protection/Child Care System			
	Question	List and describe their roles and responsibilities in service delivery, advocacy and networking.	Sources
12	Description of the population of children living outside of family care or at risk. This should conclude description of the particular threats to children and families that lead to children living outside of family care (i.e., HIV, disability, armed conflict, disaster, trafficking, labour, abuse etc.)		
13	Description of the key social welfare workforce groups/cadres and service providers of children in alternative care, including government, NGOs, FBOs, IGOs, for profit. Also mention if these service providers work together and if there are collaborative mechanisms in place for this type of coordination		
14	Description of other actors involved in alternative care: alternative care networks; youth or care leavers network; foster parent association; etc.		
15	Are children and caregivers actively engaged in policy and programming that directly affect them and does the legal and policy framework support this?		
16	Description of key donors supporting child protection and alternative care		
17	Describe the political will and commitment of the government in relation to child care/alternative care. E.g., Executive Branch leadership; alternative care in national development plans etc.		
18	Describe lead mandates, roles, and responsibilities for child protection, child welfare, and for the care of children more specifically in government at national and other sub-levels of administration including mechanism for oversight and coordination at these different levels (and how they are operating in practice).		
19	Does the national budget include line item on child protection and specifically alternative care?		
20	Is there a national information management system specific to child protection, in particular collecting data on children in alternative care? Is it operating and what data is collected and updated and at what level?		
21	Is there a national level knowledge management mechanism on children's care and protection that enables sharing of laws, policies, data, information about services and stakeholders, as well as care reform efforts, accessible to the general public as well as service providers, and if so, how is it managed and coordinated?		

Preventive services			
	Question	List and Describe	Sources
22	Describe the range of services and the quality of services that are available to prevent family breakdown and separation. E.g., cash transfers, day care, respite care, income generating activities, PSS, etc.		
23	Are they specific services and interventions to prevent concealment, neglect and abandonment of children with disabilities and address stigma and discrimination in the community/society?		

Formal alternative care services			
	Question	List and Describe	Sources
24	Are there data or credible estimates of the number of children placed in formal alternative care? E.g., Residential care, formal foster care, small group homes, etc.		
25	How many children are in residential care versus family-based alternative care (i.e., formal foster care, formal kinship care)?		
26	What is the range of formal alternative care options available to children?		
27	Are there legally recognised alternative care options specifically for: emergency care; short-term care, long-term care?		
28	Are there national reform efforts in place to try to strengthen and expand family-based alternative care service provision?		
29	In general, what is the capacity of government and non-government actors to properly carry out various forms of alternative care service delivery?		
30	Are there trainings and capacity building initiatives to address capacity/ skill gaps for the social welfare workforce and for caregivers?		
31	What are the main reasons/driving factors for placement in alternative care? How and who has documented this?		
32	Are there clear gatekeeping mechanisms and admission policies and procedures in place for residential care? Foster care? Other types of alternative care? At what level and how are they functioning?		

33	Are children placed directly in alternative care by family members, relatives, or community members and how are these placements decided, regulated or reviewed?		
34	Are children given clear care plans and monitored throughout placement? Residential care? Foster Care? Other types of alternative care?		
35	To what extent are children in alternative care being reintegrated into their families or communities of origin?		
36	To what extent those reintegrated children remain in those placements, 6 to 12 months after placement.		
37	Are children/youth provided with preparation and support upon leaving/exiting care? Please include who provides this preparation and support, if known. Proportion of children/youth provided with what type of support.		
38	Are formal alternative care facilities authorised, registered, inspected, and monitored by authorising bodies on a regular basis?		
39	Are there standards of care developed, disseminated and utilised in the formal alternative care facilities?		
40	What type of formal alternative care services are available for children with special needs?		
41	What is the quality of formal foster care in general?		
42	What is the quality of residential care in general?		
43	Are there general and widespread concerns about rights violations of children's rights in formal care settings (including orphanage trafficking and other forms of exploitation) and what mechanisms and efforts are in place to address them (such as independent complaint mechanism etc.)		
44	Is volunteering in orphanages (linked to tourism or faith-based missions) allowed and taking place in the country or part of the country, and are there any policies, efforts or mechanism to prevent, address, or regulate it?		

Informal alternative care services			
	Question	List and Describe	Sources
45	Are there data or credible estimates of the number of children without parental care, including children in Kinship Care or other type of community-based care? E.g., with grandparents, with other relatives, with local community, in sibling groups (child headed households) etc.		
46	Has the State taken any initiatives to establish or improve support or oversight of informal arrangements? E.g., Voluntary registration of informal carers Provision of financial allowances Making available/increasing access to support services Combating exploitative practices		
47	Are there general and widespread concerns about rights violations of children in informal care settings?		

Adoption (Domestic and Intercountry)			
	Question	List and Describe	Sources
48	Are there data or credible estimates of number of children placed in domestic adoption? Intercountry adoption?		
49	How widely is domestic adoption practiced (describe type of adoption, definition and criteria)? If practiced widely, what are the reasons and good practices? If not practiced widely, what are the challenges?		
50	Describe mechanism for vetting and authorising adoption including whether there is a central authority, licensing system for adoption agencies, matching mechanism and recruitment mechanism for potential adoptive parents.		
51	How widely is ICA practiced? What are the main issues and concerns in terms of ICA? Is there, or have there been legal efforts in place to curtail, enable, or regulate it and how effective have these been?		
52	If there are concerns with adoption practices, are there reform efforts to address these issues?		

Care During an Emergency			
	Question	List and Describe	Sources
53	Has the country recently experienced an emergency or experiences a chronic emergency situation? If so, how has it responded in terms of alternative care? Challenges? Successes?		
54	Has the emergency resulted in childcare reform efforts? If so, please describe.		
56	What specific mechanisms are in place, if any, for the care of children in emergency situations, including displaced, refugee and migrant children?		

Public Awareness and Advocacy			
	Question	List and Describe	Sources
57	What are the key child care advocacy initiatives in place?		
58	Is there any national awareness raising campaign specific to children's care? If yes, please describe.		
59	What is the role of media in childcare and awareness raising? Role of government? Civil society?		
60	Has the government and/or civil society organised conferences or workshops on this issue for key stakeholders?		
61	What is the general public perception on child care provision, role of residential care, availability and acceptance of other alternative care options, etc.?		
62	Have there been any documented and publicised abuse, exploitation and neglect of children in alternative care?		

Appendix 3:

Development Partners and Civil Society Organisations Engaged in Care Reform

Name of organisation	Summary of main area of engagement
UNICEF	UNICEF has been a leading figure in children's care for the past two decades. Instrumental in supporting the legislative framework to reflect children's rights and good practice, UNICEF also supported the development of the Guidelines for Alternative Family-based Care of Children in Kenya, a document that has provided a guiding framework for the most recent care reform effort. UNICEF is also supporting the implementation of the guidelines in the Kisumu, Garissa and Turkana counties, and part of Nairobi, partnering with local government and civil society partners. UNICEF has also been engaged in, and supported, children's care in refugee settings, and placed the strengthening of the workforce as central to VAC and the care reform agendas. It will support the government to design a range of support for families with CWD to aid their deinstitutionalisation, as well as an integrated child and social protection programme for street-connected children and adolescents.
The Association for Alternative Family-based Care	The Association for Alternative Family-based Care was established in 2016 as the Alternative Care Alliance – Kenya, and brings together individuals, government and NGOs to work towards the implementation of the *Guidelines for the Alternative Family Care of Children in Kenya* (2014). The association consolidates diverse knowledge, skills and voices to shape and promote childcare reforms that will strengthen and preserve family- and community-based care approaches. There are currently 25 members and four sub-committees targeting case management and reunification, family support and strengthening, alternative care and advocacy.[458] The association includes members who are actively engaged in the delivery of family-based alternative care, and are some of the leading voices engaged in shaping policy, practice and advocacy related to children's care.
KESCA	Established in 2009, KESCA is an organisation registered as a society in Kenya by and for adults (18+ years) who spent all or part of their childhood in children's homes, orphanages, and/or rehabilitation centers. Its vision is to see empowered care-leavers lead meaningful lives and actively participate in the promotion of the rights of children without parental care.[459] KESCA has been very active in raising awareness about the lived experiences of care-leavers, especially the lack of support when young people transition out of care. KESCA has been actively involved in the development of guidelines and policies, as well as participated in the design and delivery of training, data-collection processes, and case management and gatekeeping guidelines. KESCA is a member of the Care Reform Core Team.
Stahili Foundation	Born out of a desire to reduce reliance on residential care and strengthen family-based options for children in Murang'a County, Stahili Foundation has been actively engaged in deinstitutionalisation efforts, the provision of foster care, and strengthening of families to prevent separation. Stahili Foundation conducted one of the five county-level situational analysis of residential care, and is a member of the Care Reform Core Team.
Changing The Way We Care	CTWWC is a consortium of two partners (Catholic Relief Services and Maestral International), and is an initiative designed to promote safe, nurturing family care for children in residential care or children at risk of child-family separation. This includes strengthening families and reforming national systems of care for children, including family reunification and reintegration, and development of alternative family-based care. CTWWC works closely at that national level to support the Government of Kenya to promote family care through improvement and uptake of policies and investment in the workforce. CTWWC is also working to improve data about children in care, promote safe and lasting reintegration, family-based alternative care and family strengthening efforts that prevent separation. They are doing this in three demonstration counties: Kisumu, Nyamira and Kilifi. CTWWC is a member of the Care Reform Core Team.
Hope and Homes for Children	Hope and Homes for Children is an international organisation working on the eradication of institutional care in three key spheres: service development, capacity-building and policy. Supporting governments and CSOs to close institutions, reunite children with families or place them in alternative family-based care, they work in partnership with other agencies – including governments – to develop services such as fostering, adoption and a wide range of prevention services, and with governments to underpin family-based care systems through the development of a legislative framework. Hope and Homes for Children is a member of the Care Reform Core Team, and is engaged in different types of care-related advocacy efforts in Kenya and the East African region.

Name of organisation	Summary of main area of engagement
Lumos	Lumos is an international organisation with experience in achieving national high-quality care reform. Lumos aims to build expertise to enable governments and strategic stakeholders to intentionally design and implement holistic care reform, guaranteeing the right of children to grow up in families. Lumos works alongside government, civil society and communities, championing the cause of children who continue to live in orphanages and other institutions, and advocating for evidenced-based approaches to childcare reforms. In Kenya, Lumos is member of the Care Reform Core Team and a Technical Working Group member of the National Parenting Programme and has been instrumental in advocacting for legislatative reform during the development of Children Act 2022. LUMOS is currently supporting the government to implement care reform programme in Embu County and training of CCIs to use CPIMS care reform module to capture children within their institutions.
The Association of Charitable Children's Institutions in Kenya (ACCIK)	ACCIK was established in 2009 as a means of 'playing a leading role in coordination, capacity building and sensitisation of legally registered CCIs across the 47 Counties in Kenya.[460] Their website lists approximately 300 members.[461] ACCIK is regularly engaged in care issues and is also represented on the Care Reform Core Team. Key stakeholders recognise the efforts of ACCIK, including their experience in tracing and reunification of children. ACCIK members have recently expressed interest in, and support for, alternative care options, deinstitutionalisation and transition opportunities, although some members expressed fears that care reform means closure of facilities, job loss, etc.
SOS Children's Villages	Operating residential care facilities in Kenya for decades, and most recently engaged in the provision of foster care and family-strengthening services, SOS is also a member of the Care Reform Core Team. It should be noted that, in May 2021, the media exposed an internal global report highlighting abuse and corruption at SOS facilities in Kenya, and in other African and Asian countries. In Kenya SOS has provided financial support for training of government officers and CCI staff in use of CPIMS to capture data of children within their institutions. [462]
Association of Sisterhoods Kenya	The Association of Sisterhoods of Kenya is an umbrella association for consecrated women, founded in 1962. The association has a total of over 150 registered member congregations, out of which 90 are active with over 5,505 religious women. Membership is widespread within the 25 Catholic diocese and the 47 counties in Kenya. The association has, for the past three years, been engaged in a process of reflection around the provision of children's care, including a mapping of Catholic Care.
The Legacy For Children (L4C) Kenya Program	The L4C Kenya program is a Legatum-funded initiative supporting implementation of childcare reform in Kenya. Specifically, the program aligns with the Government of Kenya vision of transitioning from a system of care where all children and young people are living in institutional care, or are unaccompanied or separated, to a system that allows all children to live safely, happily and sustainably in family and community-based care. Initiated in 2022 and covering Meru, Murang'a and part of Kiambu counties, the L4C Kenya program has 7 county-level implementing partners: Catholic Diocese of Meru, Catholic Diocese of Murang'a, Meru Children and Adults Welfare (MECAWE), Weza Care Solutions, CFFK- Child in Family Focus Kenya (CFFK), Stahili and Go Economic Empowerment Program Kenya (GEEP Kenya). At the National Level, the program has supported the NCCS in developing the 2023 National Guidelines for Transitioning Childcare System in Kenya.
Tree of Life Kenya- FADV	ADV is a trust with a vision of a world without poverty where children can enjoy their rights; grow up in a safe family environment, protected from all kinds of violence and with access to equal opportunities. Its operations in Kenya began in 2010, focusing on child protection, education, emergency and development. Through their project ' every child deserve a family' have promoted foster care in Kenya since 2018 and their experience has contributed to the development of training manuals and operating procedures for the implementation of foster care in Kenya. Through the RISE project that started in 2022, FADV strengthen inclusion, health and education for children and youth, both vulnerable and in conflict with the law. This is done by partnering with DCS in the in 29 statutory institutions through supporting family tracing, reintegration and transitioning to supportive communities. FADV has also promote children programs that prevent their separation from families through their house of philanthropy that provides learning opportunities for vulnerable children so as to explore and enhance their potentials. This is in line with the National guidelines and standards for child welfare programmes that were launched in 2023..

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