Save the Children

Applying the Standards

Improving quality childcare provision in east and central Africa

Practitioners and policy-makers concerned with the care of children face many new challenges. The HIV pandemic has created a new care crisis on top of pre-existing high levels of need arising from poverty, conflict, natural disasters and family breakdown. Yet in many countries, government responses to children's need for care and protection are weak and underdeveloped.

Applying the Standards is the third Save the Children publication focusing on quality childcare. Following on from *Raising the Standards*, which proposed a set of quality childcare standards, *Applying the Standards* provides guidance materials and lessons learned from the process of implementing these standards. It draws on the experiences of five agencies in east and central Africa working in a range of care settings (including community-based provision, transit centres and institutions). It is hoped that childcare agencies, managers and practitioners will use this guidance to engage in collaborative efforts to:

- implement quality childcare standards
- support family- and community-based care efforts, and
- advocate for the establishment of national and international childcare standards.

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FIRST RESORT SERIES

Creating Positive Options for Children

Applying the Standards

Improving quality childcare provision in east and central Africa

Diane M Swales
with Rena Geibel and Neil McMillan

Save the Children

Save the Children fights for children in the UK and around the world who suffer from poverty, disease, injustice and violence. We work with them to find lifelong answers to the problems they face.

Save the Children UK is a member of the International Save the Children Alliance, the world's leading independent children's rights organisation, with members in 28 countries and operational programmes in more than 100.

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Cover photo: *A former child soldier sits on his bed at Bunia CTO (child transit centre). His stay at the centre will be temporary while the centre tries to trace his family, so that he can be reunited with them. Save the Children works in partnership at Bunia CTO.* (Photograph: Anna Kari)

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Preface

At the beginning of the 21st century, new challenges face practitioners and policy-makers who are concerned with the protection and care of children. The HIV pandemic is creating a rapidly escalating care crisis on top of pre-existing high levels of need arising from poverty, conflict, natural disasters and family breakdown. Despite these growing demands, government responses to children's need for care and protection are weak and underdeveloped in many countries across the world, with an over-reliance on institutional care as a solution.

Save the Children's work on care and protection is based on the principles and standards of the 1989 United Nations Convention on the Rights of the Child (UNCRC). Children have the right to live in a caring family environment, to be protected and to participate in all decisions affecting them. At a global level, Save the Children is advocating for policies and practices which promote the care and protection of children in their own families and communities (as a 'first resort'[1]), and the use of institutional care as a 'last resort'.[2] Promotion of children's participation and the application of quality childcare standards in all care settings are also essential.

Work on quality childcare standards by Save the Children and its partners in the East and Central Africa Region has made a significant contribution to global, national and local efforts to improve the quality of care offered to girls and boys. Our earlier publication *Raising the Standards* proposed a set of quality childcare standards. This publication provides key guidance materials and lessons learned from implementing these standards. As part of the 'First Resort' series, *Applying the Standards* draws on the experiences of five agencies working in four countries in east and central Africa in a range of care settings (including community-based provision, transit centres and institutions), and involving a diverse range of care providers (eg, grandparents, community members, non-governmental organisations, government). The DVD and the case studies described in the publication demonstrate the feasibility and value of applying the standards even in resource-poor and emergency contexts, and the impact that applying quality standards can make in achieving real changes in children's daily lives.

At an international level, UNICEF, International Social Services (ISS), Save the Children and others are engaged in advocacy efforts to establish international standards for children deprived of parental care. This publication will contribute to dialogue and action towards the establishment of such international childcare standards and guidelines, and their translation into practical change at national and local levels.

We encourage all practitioners working in care settings to use the guidance in this publication to engage in collaborative efforts to implement quality childcare standards, to support family- and community-based care efforts, and to advocate for the establishment of national and international childcare standards.

Bill Bell
Head of Protection
Save the Children UK

Introduction

This is the second Save the Children publication focusing on quality childcare standards for children. It documents the learning and experiences of five agencies implementing quality childcare standards in four countries in east and central Africa. Each of the agencies utilised the standards set out in *Raising the Standards*, published by Save the Children in February 2005. *Applying the Standards* aims to help childcare agencies, managers and practitioners implement the quality standards, regardless of the nature of the childcare provided. Furthermore, the experience of the participating agencies demonstrates that the application of quality standards will provide immediate, direct benefits to children and that quality standards are achievable – even in resource-poor contexts.

The remainder of this section provides a short overview of the range of alternative childcare options and the regional and international debate about them, as well as introducing the structure of the report.

The range of care options

Family care

For most children, families are for life. The role of families, parents and siblings carries on throughout the human life cycle. In families, daughters work side by side with mothers, aunts and sisters; sons learn from fathers, uncles and brothers; and males learn from females and vice versa. Through such positive bonds, children gain the confidence and knowledge to take their place in the adult world, establish values and feel a sense of belonging, which serve as the foundation for their personal identity. The family and extended family primarily provide the necessary guidance and support to children on how to make their way in the world successfully, and how to handle emotions, social interactions, problems and crises, etc. This guidance and support extends beyond childhood and serves as a source of strength and connectedness throughout the transitions and changes in adult life. No other social unit offers the hope and promise of a lifelong connection to others who care for them, share a common history and share the joys and sorrows of existence.[3]

However, while family-based care in general provides the best environment for children's development and well-being, it is important to recognise that not all families are caring and protective of their children. The abuse, neglect and exploitation of children at the hands of family members is common, especially in contexts where there is a high level of poverty and other forms of stress. Thus, community-based monitoring and response mechanisms are required to protect children, irrespective of their age, gender, disability, socio-economic status, etc. Efforts are needed to support families and prevent the breakdown of care environments. However, in some cases it is not in the child's best interests to remain with his or her family or extended family, especially if the child is in need of protection from his or her primary carers.[4]

Institutional care

Despite growing numbers of children needing care and protection, governmental responses are weak and underdeveloped in many countries across the east and central Africa region, with an over-reliance on institutional care as a solution. Although many individuals, communities, agencies, donors and governments have the intention of supporting and protecting children's rights, understanding is often lacking regarding different forms of care provision, and what forms of care may be in children's best interests. Institutions are often established without thought to the damage they may cause. In developed

countries where high-quality specialist institutional care is available, small-scale and short-term institutional care may be a child's best option in a very small minority of circumstances. However, in most cases institutional care should be considered as a last resort. As highlighted in Save the Children's position paper on children in residential care (Save the Children, 2003), many features of institutional care constitute an abuse of children's rights and pose a serious threat to their normal development processes.

Alternative forms of family- or community-based care

There is no 'one' or 'right' model of alternative care, as children have different needs, experiences and expectations, and the placement of a child must be identified with these in mind. Similarly, communities and cultures have different approaches to childcare and, while basic principles of quality care should be applied, models of how these are implemented may vary in accordance with each cultural context. Some communities may have already established a response for separated children and any external intervention should build on the quality elements of these existing systems. Positive traditional practices should be encouraged and those traditional practices that are harmful to children should be eradicated or amended to comply with children's rights. Any alternative care model should be located in the community and be integrated with community activities, processes, local practices and programmes where these are not harmful to children.

If children cannot remain with their birth family or extended family members, programmes need to make better use of substitute families or community-based models as alternatives to institutional care. However, before children are placed with substitute families, it is important that the necessary approval, selection and training processes for carers are undertaken, and that supervision and monitoring systems are in place. Without this preparatory phase, children may be placed in abusive or exploitative situations.

It takes time to arrange community-based care for children and it may be some weeks before substitute families are available. Therefore, wherever possible, preparations and discussions on alternative care options must be undertaken well in advance (eg, before the death of the parent or primary carer). Succession planning and use of memory books or memory boxes have become popular HIV and AIDS programming responses, and are now being applied to other care contexts. Many countries have established disaster management committees, but few include childcare issues within their mandates. It is therefore helpful for agencies to work with local systems and structures to identify potential alternative care systems within emergency preparedness planning.

Packages of care

Experience shows that children (and their families) may have multiple needs, requiring different responses according to the context. Interagency collaboration can provide an appropriate package of care to a child and their family, and/or can explore a range of care options. The idea of 'packages' implies a range of responses, including prevention efforts to support the child in his or her family context. Planning for individual children requires integrated, multi-sectoral working, involving a high level of co-ordination and co-operation with a variety of stakeholders.[5]

Such packages of care and support options, sometimes described as a 'continuum of care', supports good practice through responding to the best interests of children and offering the most appropriate form of care placements for their needs. The idea of packages of care supports the principles of children's best interests, equity and participation. Interagency collaboration is required for effective referral, regular review and follow-up processes.

Advantages of family- and community-based care

- **Focus on the best interest of the child** – Children can be responded to in a way that recognises their unique and individual qualities, their preferences and opinions.
- **Based on community integration** – Children can be readily integrated and immersed in their culture and learn a range of skills through the experience of community and family life.
- **Attachment and bonding** – A fundamental building block for human development is the attachment and bonding of a child with a consistent primary carer or carers. Without this, children experience developmental delays that have a lifelong impact. Attachment to a family is not just for childhood but continues throughout the life cycle.
- **Reduced stigma and discrimination** – Although orphan children within family and community contexts may still be labelled as orphans and face discrimination, being part of a family can offer some protection, understanding and defence against exclusion and discrimination through adult interventions and advocacy.
- **Ability to form relationships** – Through living within a community and a family, children are able to meet and socialise with a range of children and adults.
- **Life skills and cultural participation** – Children learn many skills and about their cultural heritage through a process of living experience, rather than taught lessons, and through having responsibilities and different roles within their family and community, which gives them a sense of belonging and roots them in their culture and society.
- **Monitored** – **offering greater protection** – As in most institutions, some community-based care may not be monitored or supported, and unscrupulous people in the community as well as in institutions may exploit children. However, friends, neighbours and teachers often carry out informal monitoring of children and support in community-based care, which can ensure greater protection than that offered in the closed environment of institutions.

Child exploitation in a community care setting: a case study

Children who crossed into Uganda during the conflict in eastern Democratic Republic of Congo were initially placed together in a hall. Over a short period, they were then individually (or with accompanying siblings) placed in local foster families. This response apparently worked well for both the families and the children. However, during a follow-up visit to one family, it was discovered that the foster father was in the process of arranging the marriage of a 14-year-old girl to an elderly neighbour, with the intent of acquiring a dowry payment. As a justification for his actions, the foster father said the girl was ready for marriage and would be safer if she had a husband. This highlights the importance of monitoring and follow-up systems for children placed in community-based care services.

Alternative forms of childcare relevant to constructing packages of care

1 **Family support** – support provided directly to families in order to prevent separation of the child. This should be the first priority.

2 **Small group homes** – small groups of children living with a core worker as a permanent substitute parent in a substitute family.

3 **Supported accommodation** – small groups of older children living in separate and independent households but supported by visiting staff on a regular basis – daily, weekly, and as requested.

4 **Supported child-headed households** – siblings living as a family, in their own home, with a worker providing ongoing guidance and support. The worker could be supporting a number of such households.

5 **Peer households** – a small group of young people choose to live together and are supported in doing so, learning necessary life skills and being offered initial support and guidance towards independence. The contact can be also maintained on an ad hoc basis at the request of the young people.

6 **Foster care (short- and long-term)** – care within a family of one or two children or siblings, either long- or short-term, informal or formal.

7 **Self-selected foster care** – a child or group of children identify alternative carers in their community, and future care is agreed with the potential carer, the children and the agency.

8 **Sheltered housing** – young people or children live independently with a permanent adult worker living independently on site but available as a mentor for guidance and support.

9 **Respite care** – short-term care for a child in a family home environment, for example, while a parent is too unwell or while a particular danger to the child can be addressed. The child can receive temporary care until the parent is recovered or the situation resolved, and then returned to his or her own family. Respite care is usually for a period of one to two weeks and can be a planned or emergency response.

10 **Drop-in/open door centres** – a non-residential contact point, where young people can be offered a range of services, advice and guidance.

11 **Adoption** – a permanent legal transfer of a child to another family. It is advised that adoption should not be used in emergency situations, as birth families may be found when the emergency has passed.

Developed by Neil McMillan and Diane M Swales for Alternative Childcare Training Workshop, November 2003

The global context

Increasing numbers of children across the world are becoming separated from their families as a result of the death of parents, conflict and displacement, abandonment, trafficking, discrimination, endemic poverty and/or inappropriate child protection responses. The additional impact of the HIV and AIDS pandemic has elevated already high numbers of orphans and other groups of vulnerable children to crisis levels. By 2010, an estimated 106 million children will have lost one or both parents, with 25 million of this group orphaned as a consequence of HIV and AIDS.[6]

Children deprived of parental care are vulnerable to abuse, exploitation and further loss. In this situation, the immediate priority is usually to find ways to keep children with other family members. But for those children whose wider family cannot offer them a protective home or whose family members have died, a range of other interim or long-term care options must be found. Such 'out-of-home' care provision, which in some places has all too often taken the form of institutional care, has frequently been developed without any legislative framework, policy guidance, registration requirements or national standards. The absence of monitoring mechanisms for the protection of children in care often leaves these already vulnerable girls and boys subject to additional neglect, abuse or exploitation by over-burdened or unscrupulous care providers.

Save the Children's work on care and protection is based on the principles and standards of the 1989 United Nations Convention on the Rights of the Child (UNCRC). The UNCRC promotes the care of children within their own families and specifically addresses the situation of children who are unable to live with their own parents, or who are at risk of separation from their families. However, neither the UNCRC nor any other existing, internationally agreed texts sets out comprehensive or detailed guidelines to inform and clarify good practice in care settings, to prevent abuse or to establish responsibilities and accountability.[7]

For this reason, Save the Children is advocating for clearer policies and practices to promote the care and protection of children in their own families and communities as a first resort,[8] and in institutions as a last resort.[9] As part of this work, Save the Children is engaged in international advocacy efforts with UNICEF, International Social Services (ISS) and other agencies to establish international standards for children deprived of parental care.

The regional context

In east and central Africa, Save the Children UK has been working in eight countries: Ethiopia, Somalia, Democratic Republic of Congo (DRC), Rwanda, Tanzania, Kenya, northern Sudan and South Sudan.[10] Many of these countries have been, or still are, subject to the impact of internal conflict, economic upheaval and endemic poverty. The context in each country is different, but one of the most common problems facing governments and societies is how to ensure the care and protection of children without primary carers. As a result of HIV and AIDS, this problem has escalated dramatically in recent years. Furthermore, a related consequence of the pandemic is an increase in family disintegration and separation. Traditional coping systems are overwhelmed. Increasing numbers of families are caring for their relatives' or neighbours' children without sufficient support, and increasing numbers of children are living without an adult or primary carer.

In response to this, governments, non-governmental organisations (NGOs) and private care providers have established a range of services including institutional and community-based care (such as foster care by relatives and others). However, these have been insufficient to respond to the increasing numbers of

children without carers and to meet the support needs of extended families. Some of these services provide good-quality care for children, but for the majority of services, experience shows this is not the case. In many childcare institutions and other forms of care provision, the quality of provision is below a standard which would ensure the protection and guidance necessary for a minimum level of child development. Such poor quality of care stems from a lack of acknowledgement or understanding of the quality of care necessary or acceptable in non-family care services, despite individuals', NGOs' and governments'

Raising the Standards: Quality childcare provision in east and central Africa

Raising the Standards consists of a set of childcare standards primarily intended for managers and practitioners providing childcare services in resource-poor or emergency contexts, across a range of care provision. The standards can also form the basis for advocacy for the establishment of childcare policy and national minimum standards for the care of children in need of special protection.

The standards are in five main groupings:

- professional practice
- personal care
- caregivers
- resources
- administration.

All the standards are equally important and together provide a good baseline for quality assurance within a childcare service. It is intended that the standards can be applied to a whole range of childcare settings, including institutions, foster care, community care programmes, child-headed households, small group homes, etc. Some standards may be more applicable to particular settings, and some standards may not initially appear to apply to some settings. However, all agencies which facilitate the provision of childcare, whether it is foster care or support for child-headed households or another alternative, should aim to comply with each of the standards.

The format of each standard uses a template outlining:

- *standard*: a statement about a practice or issue that is important to the process of caring for a child or for a service that cares for a child
- *indicators*: behaviours, circumstances or indications that would suggest that a standard exists or is in place at an acceptable level
- *contraindications*: behaviours, circumstances or indications that suggest a standard is either not in place or is not operating at an acceptable level
- *basis*: the factors which inform the standard. These are primarily either articles of the UNCRC or good practice experience. There may also be local legislation that informs or determines the basis of the standard. Clearly, legislation varies from country to country. As the UNCRC sets a minimum standard, the local or international framework which sets the highest standard should be applied
- *practice implications*: this is a short summary of matters relating to the standard and highlighting the importance of the standard in the life of the child.

increased awareness of, and intention to support, children's rights.

Concerns about the quality of care for children without primary carers prompted Save the Children's East and Central Africa Regional Office, with funding from the Dutch government TMF project, to commission a consultant, Neil McMillan, to develop a set of basic standards for quality childcare which could be applied in resource-poor or emergency contexts, and across a range of care provision. These standards were published as *Raising the Standards: Quality childcare provision in east and central Africa* in February 2005 and received widespread attention within the region and globally.

While encouraged by the positive response to *Raising the Standards* from other agencies, the Save the Children Regional Office acknowledged that the dissemination of the standards alone might not be sufficient in itself to prompt changes in policy and practice. It was therefore agreed to develop a second publication, *Applying the Standards*, which would document experiences of implementation and provide practice guidance for interested care providers, agencies and governments. Thus, in east and central Africa the Save the Children Social Protection and HIV/AIDS Regional Advisers worked with a core group of five agencies in four countries (henceforth identified as the 'Implementation Team'[11]), to support implementation of the quality childcare standards and documentation of the process over a ten-month period.

Working with a core group of agencies offered opportunities for piloting the childcare standards within different care settings, and for engaging with a range of caregivers and care providers who have different mandates. However, the group was kept relatively small (with approximately 12 participating members) in order to support honest and open debate on care issues and the realities of moving towards quality care. In addition, it was important to work with this range of partners over a sufficiently long period to identify progress over time.

Frequently asked questions and answers

The queries below were raised by a range of stakeholders during the implementation process in east and central Africa. The responses can serve as guidance for the application of *Raising the Standards* within and beyond the African context.

Are the standards appropriate to the African context in situations where endemic poverty is being experienced in communities?

The standards are universal. They were developed through work in east and central Africa and have been reviewed by a range of programmes there, so they are most definitely appropriate to an African context. Children in Africa are entitled to the best quality of care and, at a minimum, the same standards as any other child in the world. Quality standards are not about material goods or luxurious environments; the standards have been developed to ensure the minimum care to ensure the child is supported sufficiently to fulfil their potential as an individual. Families living in poverty, while they may not be able to meet all the rights of children, can provide quality care. Some families living in extreme poverty still manage to provide a loving and secure base for their children, offering attachment, respect and a real sense of belonging, which build resilience in the child.

It is recognised, however, that circumstances can be very difficult in many families, such as where parents or other primary carers are ill or dying. Emotional and psychological bonds will be strained, and there are increasingly limited resources to provide for the care of additional children. Where such children are supported by an agency, it is the agency's responsibility to ensure that any family or service which it supports is able to provide quality care. The agency must not consciously collude with any violation of children's rights.

Creative approaches are needed in order to apply the quality standards to childcare provision in resource-

poor environments. If a service cannot provide quality care for children or support the provision of such care in community-based facilities, then it should not be providing a service. This may appear very harsh, considering the difficulties experienced by many children, but since organisations cannot provide care for *all* children in need, they should at least ensure that what they do provide is of good quality and will not further damage the child's life chances.

Are these standards universal?

The standards are based on the minimum standards set out in the UNCRC, which has been signed by all State governments apart from the United States of America and Somalia. The standards have been informed by best practice experience. It is in this sense that they are universal.

The question of universality often arises when practitioners look at their own context and consider the standards to be alien or in opposition to agency regulations. For example, the standard on privacy suggests that visitors have space to meet in private with the child, yet the agency does not allow one-to-one meetings. However, meeting in private does not mean meeting unobserved behind closed doors. A private conversation can take place with the door open or under a tree.

Haven't others (such as UNICEF) already developed childcare indicators or standards?

UNICEF has developed some childcare indicators, but these are primarily focused on gathering quantitative data on national-level care provision. Furthermore, UNICEF and USAID have developed some indicators for orphans and vulnerable children (OVC) programming. The UNICEF/USAID indicators are also focused on national level provision and are quantitative in nature. Examples of these include: number (or percentage) of OVC who received community care or support; number (or percentage) of OVC benefiting from improved access to education; number (or percentage) of OVC benefiting from improved healthcare; number (or percentage) of OVC benefiting from nutritional or agricultural assistance. While such indicators are critically important for monitoring changes in the situation for children and for planning at national level, they do not provide guidance on how to assure quality care by all stakeholders involved. The Save the Children quality childcare standards focus on the 'what and how' of quality childcare – rather than recording the situation of children and changes over time. The Save the Children quality childcare standards and the UNICEF/USAID indicators are, however, complementary and both are necessary.

If countries have policies or local legislation covering the quality of childcare, why do we need these quality childcare standards?

While countries may have legislation or policies, implementation, reporting and follow-up is not always carried out, monitored or supported. Some services established by governments, NGOs, private care providers and communities do provide quality care for children. Our experience has shown, however, that, for the majority of services, quality care is not achieved. Often, there is no accompanying guidance to support consistency in the quality of childcare or any regulatory framework which holds carers accountable for ensuring minimum standards. The Save the Children work on quality standards aims to establish a basis for such national and international quality childcare standards.

What is non-family care?

In this document, non-family care refers to situations where a child is cared for by those other than his or her birth parents, and where an organisation supports extended family members or a substitute family to care for a child or has arranged that placement of the child. In all such instances, the application of quality childcare standards must apply. Non-family care also includes care of children by non-related adults in children's homes, residential

care homes or children's institutions. Essentially, if an organisation supports carer-givers or arranges the placement of a child, it has an obligation to ensure that quality standards apply, including that the child's best interests are recognised and that the placement is regularly reviewed.

The standards at first glance appear to target institutional care. How can programmes that support families through community mechanisms use the standards?

The standards apply to all forms of care including community-based care, for example, in foster care, substitute family care or support to child-headed households, as well as different forms of institutional care. All agencies that support families in their care of children should have an awareness of quality standards; they also have an obligation to ensure compliance with these standards. Agencies can offer support and guidance to families on the personal care of children, but they also need to ensure and adhere to the other standards which offer appropriate policy and guidance frameworks, and ultimately, the protection of the child. While it is important that we apply the standards appropriately in each context, the basic standards remain the same.

How can agencies that work mainly through partners, collaborators or volunteers utilise the standards?

All agencies that support families in their care of children should have an awareness of quality standards, and they have an obligation to ensure compliance with these. Agencies should assist partners in setting aims and objectives, identifying admission criteria for children in need of support and identifying potential carers. Agencies can use the standards as a basis for training and development opportunities for carers, community leaders and agency staff. Agencies can also use the standards to monitor different aspects of care provision.

How can agencies providing other types of support to children (eg, food security, education, health) apply these standards?

Any agency providing a service for children should ensure that the best interests of those children are paramount and that children's voices are heard. Thus, they can ensure they recognise children's rights when planning, delivering and reviewing their service. Some agencies will use a particular focus, eg, food provision, as an entry point to work with vulnerable families. While an agency may not necessarily focus on children as the primary beneficiaries, the standards may help to focus on children, and to consider issues of protection, participation or privacy in the delivery of that service.

What capacity does an agency need in order to meet these standards?

Often limited capacity is an issue for many service providers. The standards therefore have been developed in a way that supports the building of capacity, and recognises that many staff involved in childcare have no formal training in childcare or child development. Agencies will need to identify areas where capacity should be developed and how this can be achieved within their own agency. Interactions with other child-focused agencies and their personnel through secondments or working exchanges can be of benefit. While specific training materials are of assistance, the need to internalise such learning is critical, and mentoring, support and follow-up in the process of their daily routines is thus vital.

Do you need to be an expert social worker to assess whether the standards have been met?

No, it is not necessary to be an expert to assess whether the standards have been met. Consideration of the issues, observation and an objective understanding of the context of care provided will offer a sound basis for measuring existing practice against the standards and moving towards better standards of care. Although individuals may not know about the quality childcare standards themselves, they

may have a good sense of quality care – for example, if a child is unhappy or sitting alone, one would question 'why?' and seek an appropriate response for the child.

Are there minimum standards that need to be implemented?

Any assessment of childcare would assume that basic needs are met as a starting point, ie, the provision of food, water, shelter and clothing. In crisis situations, families are not necessarily able to provide basic items at a minimum level, but children do survive and develop to varying degrees. This brings us into current discussions on children's resilience and vulnerability, and the ultimate interrelationship and interdependency of quality childcare standards. Western cultures have identified situations where children have such basic needs met, yet without love, affection and bonding with their carer they fail to thrive. Obviously, basic needs should be met, but equally important are children's emotional and psychological needs. Children's needs must be considered holistically, and thus all the quality standards are important. There is, therefore, no simple answer or way to prioritise quality childcare standards.

Isn't the cultural context likely to impede the realisation of some of these standards? For example, developing a written childcare plan may not be appropriate in an oral culture.

No culture is completely 'oral', although some individuals, families or communities may not be literate and may rely on oral traditions to retain information. The point raised here highlights the need to clarify where responsibility lies for each area of the standards. The agency supporting a carer would demonstrate professional practice through developing and keeping appropriate records for each child accessing their services, and this would include a written childcare plan. Such a plan would be developed in collaboration with the carer, the child and the others closely involved in the child's life. This care plan would be discussed and agreed by the carer and the child, but retained on behalf of the child by the agency. Regular reviews of the care plan would also be undertaken to ensure the plan is being progressed and remains valid. Such an approach would not require the carer to be literate but does offer the child a sense of security and purposeful direction in his or her life.

Do we need to implement all of the standards together? Is it feasible to address all standards simultaneously?

The standards are closely interlinked and the Implementation Team predominantly felt that it would be difficult to implement one without the other. Before deciding what progress needs to be made in improving the quality of care provided or which areas need to be prioritised, a baseline assessment should be undertaken. This will determine where a given organisation providing care is currently placed in relation to all or any elements of the quality standards.

It would be difficult for an organisation to improve quality across all of the standards simultaneously. Although some standards can be put in place fairly readily, eg, children's discussions or suggestion boxes, others may require a more progressive implementation, eg, developing and establishing a child protection policy. One approach could be, in a community setting, to focus initially on areas where an organisation has the capacity to implement change and to build towards other quality standards from this positive starting point. Strategies for achieving longer-term change objectives could then be set and worked on over time. In reviewing progress, it may be more important to focus on the distance travelled and to what extent the organisation has reached a defined target, rather than whether or not they have met the all the standards completely.

How can we support families when they do not have enough money to survive?

As mentioned previously, no one agency has all the answers. We need to consider the government's role in

fulfilling its obligations in relation to children's rights. Persuasive lobbying of governments and donor agencies is needed to strengthen policies and practices which support and strengthen families and communities to provide better care for their children. More immediately, other agencies in communities may have skills and abilities in agricultural extension programmes or livelihood support, which could be used as referral points for families in difficulties. While such agencies will have their own priorities, it is important to lobby them to take on the wider issues of children's care and protection and the application of quality standards. Ultimately, we need to work more effectively with what does exist and seek advice and expertise in relation to issues impacting on families that are beyond our own area of competence.

What should be done when carer-to-child ratios are very high – eg in the case of one institution where there were only 12 care staff for 120 children?

Clearly, it is not possible to provide quality care in such a context. Either numbers of staff should be increased or the numbers of children reduced. Institutional care should be considered only as a last resort. Children are often inappropriately kept in institutions when they have families that could more effectively care for them (perhaps with some support). Thus, strategies for family reunification (including assessment and family support follow-up) may be pursued. Additionally, strict admission policies should be followed. Government rules and regulations and a functioning inspectorate would greatly reduce the numbers of children being held in such institutions. However, where the government is not functioning, child protection agencies need to have clear policy responses and strategies on how children can be supported more effectively.

Where insecurity prevents travel and it is difficult to ensure follow-up in a conflict situation what should we do?

Such situations do occur and it is suggested that follow-up is undertaken at the earliest opportunity after security is regained. Agencies supporting reunification have a duty to ensure follow-up takes place at regular intervals wherever possible, and as soon as possible once access is secured. Furthermore, during secure periods community-level structures could be established to enable more localised, ongoing monitoring and response to child protection issues.

Is there a training manual available?

Training manuals are useful, and after attending training participants can feel inspired, enthusiastic and committed to change on return to their workplace. However, after this initial optimism, entrenched negative customs and practices generally re-emerge. This is primarily because participants cannot translate their learning into their own workplace context at all levels, and ongoing mentoring and support is not provided. Thus, broader strategies of capacity-building are required that will involve management structures and ongoing monitoring processes.

How do the standards relate to other standards and initiatives?

As the standards are based on the UNCRC, they have universally agreed foundations and are complementary to other standards or initiatives relating to quality childcare, such as *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*.[12] As can be seen by the comparison below, the quality childcare standards do not address all the issues highlighted in the *Framework*. The standards focus on the roles and responsibilities of childcare itself and aim to address the actual care of children. The Save the Children quality childcare standards are not intended to apply to all related development issues, such as poverty alleviation, income generation or legal aid.[13] However, the recommendation to advocate for policies on quality childcare and for national minimum standards would prompt discussions on the areas identified in the *Framework* which are not directly addressed in the standards.

Table 1. Key strategies and standards

Five key strategies in the framework	Standards
1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support.	
a) Improve household economic capacity	Not directly discussed in standards
b) Provide psychosocial support to affected children and their caregivers	Addressed in personal care standards, eg, attachment, recreation
c) Strengthen and support childcare capacities	Related to staffing and care-givers section
d) Support succession planning	Care planning
e) Prolong the lives of parents	Not directly discussed in standards, but in keeping children with families as the 'first option'
f) Strengthen young people's life skills	By applying quality child care standards children's capacity to function as adults – ie, development of their life skills – will be supported
2. Mobilise and support community-based responses.	
a) Engage local leaders in responding to the needs of vulnerable community members	
b) Organise and support activities that enable community members to talk more openly about HIV and AIDS	
c) Organise co-operative support activities	
d) Promote and support community care for children without family support	Recommended in *Raising the Standards*
3. Ensure access for orphans and vulnerable children to essential services, including education, healthcare, birth registration and others.	
a) Increase school enrolment and attendance	Personal care section
b) Ensure birth registration for all children	Personal care section
c) Provide basic healthcare and nutrition services	Personal care section
d) Improve access to safe water and sanitation	Personal care section
e) Ensure that judicial systems protect vulnerable children	
f) Ensure placement services for children without family care	Professional practice section
g) Strengthen local planning and action	
4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to communities.	
a) Adopt national policies, strategies and action plans	Recommended in *Raising the Standards*
b) Enhance government capacity	Recommended in *Raising the Standards*
c) Ensure that resources reach communities	
d) Develop and enforce a supportive legislative framework	Recommended in *Raising the Standards*
e) Establish mechanisms to ensure information exchange and collaboration of efforts	Recommended in *Raising the Standards*
5. Raise awareness at all levels through advocacy and social mobilisation to create a supportive environment for children and families affected by HIV and AIDS.	
a) Conduct a collaborative situation analysis	
b) Mobilise influential leaders to reduce stigma, silence and discrimination	
c) Strengthen and support social mobilisation activities at the community level	

The structure of *Applying the Standards*

This publication shares practical implementation guidelines and experiences learned from the piloting of *Raising the Standards* in the east and central Africa region. The report draws on the work of the Implementation Team, including five regional workshops, one workshop in Ethiopia, and various presentations in east Africa and Austria.[14]

The publication is accompanied by a DVD, which records key challenges, learning and suggestions from members of the Implementation Team. It is anticipated that others working towards the implementation of quality standards may meet similar challenges and constraints in their workplace. This publication (report and DVD) provides a basis for reflection and debate on the implementation of childcare quality standards in diverse care settings. Additionally, the DVD highlights the benefits of applying quality childcare standards in a range of care settings in resource-poor and emergency contexts, and may be used as an advocacy tool to promote their application.

The written publication consists of four main parts. Part One outlines the process of applying the standards in diverse care settings in east and central Africa. Information is given on the implementation process, including details of the Implementation Team and the training and experience sharing which facilitated the implementation process. Reflections from members of the team regarding the challenges and benefits of applying the standards are also included.

Part Two focuses on assessment methodologies for gathering necessary baseline information from children and adults in diverse care settings. Making use of an assessment template or format (based on the quality childcare standards), the main section shares assessment tips, approaches and information designed to promote ethical practice when involving children in assessment processes. An additional section draws on information concerning a range of care options that would provide better-quality services, and outlines methodologies for assessing and improving staff:cost ratios and budget allocations in different care settings.

Part Three of the report shares detailed case studies from each of the implementing agencies, highlighting key challenges, lessons learned and the impact of implementing the childcare standards.

Part Four of the report highlights a range of critical issues that were debated by the Implementation Team. From the beginning of the work on quality standards in east and central Africa, it became apparent that there were certain aspects of the theory and practice of providing quality childcare which practitioners found problematic, and Part Four of the report focuses on these. Debates concerning key thematic areas, including more conceptual issues such as the determination of children's best interests, children's participation and child protection policies are included. This report is not intended as a training manual, as it has been found that practitioners often have existing knowledge; rather, the report aims to encourage reflection and debate which promote practical application of key good practice childcare principles.

In conclusion, and recognising the scale of the care crisis, the final section of this publication focuses on policy-level advocacy.

Part One: The implementation process

The implementation process

As a part of Save the Children's efforts to pilot *Raising the Standards* in east and central Africa, a broad range of agencies providing, or supporting the provision of, childcare were invited to attend an initial briefing meeting in Nairobi in early September 2004. The meeting provided an opportunity for the Save the Children to introduce the standards and their purpose, and to outline a planned implementation process involving a core group of agencies. The process of implementing the quality standards was to be undertaken over a ten-month period from September 2004 to June 2005. The overall aim of this collective process was to produce these guidelines and learning materials to accompany *Raising the Standards* for those working to improve the quality of care for children without primary carers.

As a result of the meeting, five agencies (working in four different countries in east and central Africa) made a firm commitment to the process and, accordingly, identified staff members who would participate in the implementation process as core members of the Implementation Team.[16]

Time-line of the implementation process

- Briefing meeting: September 2004
- Training workshop: September 2004
- Follow-up workshop: December 2004
- Follow-up workshop: February 2005
- Programme visits: February – April 2005
- Final workshop: April 2005
- Feedback on draft guide: May 2005
- Publication and dissemination: June 2005[15]

The Implementation Team came together on five occasions, at two-monthly intervals. Initially, they would receive training inputs necessary to implement the quality standards, and then would ensure regular opportunities to report back on progress and discuss critical issues arising in each context.

Initial training workshop

The training workshop with the nominated staff members (making up the core Implementation Team) took place in Nairobi in late September 2004. This three-day workshop enabled the core team members to familiarise themselves with the quality childcare standards, to discuss practical elements of implementation in individual contexts, and to determine how they could best contribute to the documentation process.

The Save the Children advisers provided sessions on key ethical issues and on the assessment methods necessary to gather baseline information relevant to the assessment and better implementation of quality childcare standards. Furthermore, based on the participants' experiences, some key areas were identified for exploration in the ongoing documentation process:

- dilemmas and challenges for implementation
- application within different care models
- developing professional practice
- resource implications
- HIV and AIDS issues
- children's participation
- application of best interests determination.

A practical fieldwork assessment exercise on quality care was used to enable participants to familiarise themselves with the standards and the different

Table 2. The five agencies involved in the implementation process

Agency	Status	Location in east and central Africa	Focus group	Nature of work
Nairobi Children's Home (NCH)	Government institution	Nairobi, Kenya	Children aged 0–10 years in need of special protection	Institutional care for children.
Gulu Support the Children Organisation (GUSCO)	Indigenous non-government organisation	Uganda	Children affected by armed conflict in northern Uganda	Transit centre and community-based work to provide temporary care, rehabilitation and reintegration of war-affected children.
Save the Children	International non-government organisation	Uganda, DRC (east, west and Kinshasa), South Sudan	Children aged 0–18 years, especially the most marginalised as a result of poverty, war, HIV, etc	Work with government and local NGO partners to strengthen care and protection policy and practice. Community-based care, protection and participation work.
Uganda Reach the Aged Association (URAA)	Non-government organisation	Uganda	Vulnerable older men and women, including those caring for orphans or dependent grandchildren	Improving the welfare of older women and men. Strengthening support systems and access to services.
HelpAge International	International non-government organisation	Uganda and other countries in east and central Africa	Disadvantaged older people, including those who have a significant role in caring for children	Support to older people in their caring role. Practice and policy development advocacy to achieve a lasting improvement in quality of their lives.

ways in which they can be met in institutional and community-based services. The participants were given background information on the two field visit sites in addition to an outline of the standards on an assessment format sheet (see Appendix 2). The assessment format was designed to determine whether a standard was fully met, partly met or not met at all. The assessment format can also be used to monitor progress on quality standards over time.

In preparing for the assessment, participants were briefed on specific issues that they should consider, for example, how to elicit children's views, key issues to observe, determining who would lead the assessment and who would ask what questions, what approaches would be used to elicit the necessary information and how they would verify information acquired. There were also presentations and discussions on the ethics of undertaking research with children.

The participants then prepared for an assessment visit to the respective sites. They planned and implemented an assessment schedule with defined roles for each member of the assessment group, using a range of methods including individual interviews, focus group discussions, observation, and review of documentation and administrative systems. The field visits were undertaken on the second morning of the workshop.

The participants returned to the workshop in the afternoon to prepare the findings of their assessment, identifying areas where standards were not met and how these could be met in that particular care context. These practical field visits undertaking initial assessments proved to be an invaluable learning exercise for the team. They enabled effective engagement with the quality standards as a tool to assess existing care provision, and prompted key areas of debate relating to the use of the standards and their practical application in different settings.

Having gained some experience in the assessment process, participants then developed their plans for implementation of the quality childcare standards in their own work context. To assist their planning, it was

Tools for facilitators: use of role plays and case studies

This box briefly describes some of the role plays and case studies that were used as exercises during the core group workshops held as part of the implementation process. The role plays and case studies were developed with the aim of:

- demonstrating the range of settings in which quality childcare standards may apply and how they may be implemented
- eliciting observations from participants and enhancing understanding of both poor and good practice
- stimulating debate around how difficulties in providing good-quality care may be overcome.

Thematic issues which were explored through the role plays and case studies included:

Role play 1 – Involving children in planning and review of placement

Role play 2 – Considering children's best interests in admission to a care facility

Role play 3 – Working with sanctions for behaviour

Role play 4 – Using available resources

Role play 5 – Convincing your boss (local advocacy)

Case study 1 – Working with carers on quality standards in a community setting[17]

Case study 2 – Child protection issues

Case study 3 – The best interests of the child

In each scenario, facilitators briefed the 'actors' before the role play and allowed adequate time for actors to understand their roles. Participants were encouraged to be realistic in their roles and not be soft on the other actors.

Workshop evaluation forms clearly indicated that the Implementation Team found role plays and case studies useful, enabling them to apply the practice standards to real experiences and to consider more effective ways of involving children in the care planning process. Discussions following role plays and case studies allowed participants to collectively explore ways of approaching problems without compromising quality standards. Details of the role plays and case studies, including the facilitators' notes to prompt debates among the participants, are included in Appendix 3.

suggested that different stages could be considered, such as:

- undertaking a self-assessment and analysis
- identifying priority areas to address
- identifying which areas are linked most closely together and could be part of a process
- identifying how each area for improvement will be tackled and when, within the strategy timeline
- identifying resource requirements and person(s) with lead responsibility.

After developing their plans, the team members worked collectively to plan for the subsequent workshops to ensure effective learning and documentation of the implementation process.

Follow-up workshops

During the subsequent workshops, the team members were able to review their progress, share key challenges and successes, and collectively offer a range of practical responses to challenges faced during the implementation process. The members exchanged strategic ideas for overcoming constraints and discussed advocacy efforts for wider implementation of quality childcare provision. In general, this process was felt to be empowering for the team. Furthermore, the Save the Children facilitators were able to draw on case studies and role play to further debates and reflection on key concepts that are central to implementation of the standards.

Implementation methodologies and monitoring

The agencies participating in the implementation process differed from each other in terms of services they provided, the context and focus of their work, and the resources available to them. As a result, each programme approached implementation in a unique manner, based on their most pressing needs. For example, Save the Children's programme in west Democratic Republic of Congo (DRC) focused on institutional inspection standards, HelpAge

Common features of implementation

- Each programme commenced with internal advocacy to gain approval and agency ownership for quality childcare standards.
- Thereafter, further training for and lobbying of staff, partners and other stakeholders was undertaken to raise their understanding and ownership of the standards.
- This was followed by planning processes to ensure that initial steps were taken to improve the quality of childcare.
- All programmes involved some level of consultation and discussions with children.
- All programmes used some form of monitoring, feedback or documentation to assess changes enacted.
- The quality childcare standards were incorporated into existing training programmes, manuals, and meetings.
- All programmes agreed that the quality childcare standards were appropriate to the African context.
- All programmes identified attitude change towards children's needs and the process of childcare.
- All programmes reported improvements in the quality of provision for children, with no additional cost requirement.

International (HAI) emphasised internal advocacy in order to include children's issues in predominantly elderly-focused programming, and Nairobi Children's Home (NCH) and Save the Children's east DRC programme began implementation with initiatives to change staff attitudes and direct changes in some personal care practices.

Thus, while it was not possible to establish a standard monitoring framework for the Implementation Team, each programme established their own mechanism to monitor change – eg, the use of internal assessments (by the Uganda Reach the Aged Association (URAA)), or less structured approaches, such as in the case of NCH, which utilised staff reflection and dialogue with children to monitor change. Despite the variety of methodologies used, Implementation Team members identified some common features of implementation.

Reflections on the implementation process (an introduction to the DVD)

The DVD accompanying this publication illustrates the value of the quality childcare standards for application in different care contexts within and beyond east and central Africa. Following an introduction to the care context in the region, and a brief history and overview of why and how the quality childcare standards were developed, the DVD focuses on sharing the views and experiences of the Implementation Team members during the implementation process. These are summarised below.

The value of the quality childcare standards

Interviews with Implementation Team members highlight how their initial concerns regarding the applicability of the quality standards were overcome once efforts were made to understand and apply the standards in particular care contexts.

Some participants initially found the *Raising the Standards* document "vast" and questioned the usefulness and applicability of the standards, assuming they had been developed by outsiders without understanding of the local context, particularly resource constraints. However, after attending the training workshop that introduced the standards, their purpose and the methodologies for assessing the current standard of care provision, participants understood the standards and the principles underlying them. Following preliminary opportunities to apply the standards, participants felt the standards were "vital", and were in fact quite "simple" for non-experts to understand and apply in any care setting. They expressed strong views about the value of the standards in safeguarding children's rights, helping to dignify the lives of children in different situations, and improving and evaluating the quality of care provided to children in different contexts.

Implementation Team members highlighted the importance of focusing on children, enabling their views to be heard and involving them in assessment and decision-making processes. They felt rewarded by the positive changes brought about in children's lives and the joy expressed by children, as a result of staff listening to their views and acting upon their concerns. There were changes in relationships between adult carers/staff and children, with increased mutual confidence and respect established. Staff were less over-worked and were able to listen more to children. Children were more happy and relaxed.

Implementation Team members also felt rewarded when managers, donors and partners associated with their programmes recognised the importance of the quality standards and supported their implementation. Team members felt empowered in their work and better prepared to implement minimum standards in their care programmes.

There were also positive changes in policies and practice relating to the treatment of staff and recognition of their professional roles. Training, support and supervision of staff had increased. Furthermore, a child focus was effectively brought into organisations that have a primary focus on working with older people (eg, URAA, HelpAge International). As a result of their involvement in the implementation

process, these agencies have integrated a focus on children, care planning, children's participation and better support to adults in their caring role.

Key challenges in implementing the standards

Key challenges highlighted by team members during the implementation process included:

- difficulties in getting partner agencies to accept and 'own' the standards (rather than seeing them as imposed by Save the Children)
- initial resistance among staff and negative attitudes regarding the need for the standards and their applicability
- need for a change in culture so that there is a primary focus on the holistic needs and rights of individual children
- lack of understanding regarding what quality childcare means, seeing it as a Western idea which is relevant only when there are lots of material resources
- a focus on institutional care, rather than care options which allow children to remain in their own communities
- lack of effective legislation in the country.

Overcoming the challenges

Interestingly, the main challenges highlighted by the team were not financial resource limitations, but related more to understanding the standards, the need for attitude change among carers and agency staff, gaining ownership of the standards, and developing clear roles and responsibilities for their implementation. Thus, strategies to overcome the main challenges included:

- working with local authorities, stakeholders and partners
- discussing the standards through participatory methods
- discussing how the standards could be applied to the local context
- carrying out assessments based on the standards and identifying ways to improve the care for children.

In general, discussions, assessments and training led to local ownership of the standards by communities and care providers, resulting in positive changes for children.

Broader responses: what else is needed

Implementation Team members put forward broader responses for better implementation of *Raising the Standards*. These included:

- developing awareness of the standards and their value
- putting an advocacy strategy in place to ensure the systematic implementation of the standards (eg, creation of an advisory group to support implementation)
- securing organisational commitment to implementation of the quality childcare standards
- the importance of training (eg, on quality care, principles of child rights) that draws on existing experience, with opportunities for follow-up, reflection and support to re-work practice
- ensuring the involvement of a broad range of practitioners who are working with children with diverse care needs, including children affected by HIV and children separated from their families because of conflict or poverty
- lobbying the government to develop and implement a policy and legislative framework to guide implementation of the quality care standards
- work to promote de-institutionalisation, family reunification, prevention of family breakdown and the development of a range of family- and community-based care options.

Part Two: Assessing the standard of care provision

In order to implement the quality childcare standards it is necessary first to assess the current standard of care provision, based on the standards. A simple assessment format based on the quality childcare standards (shown in Appendix 2) has been designed for undertaking initial assessments, as well as to support ongoing monitoring of progress towards full implementation of the standards.

A range of methodologies can be used to assess the current standard of care provision, including individual interviews, focus group discussions, participatory activities, observation and review of documentation and administrative systems. Information needs to be sought from a range of stakeholders, including children, family and community members, care providers, agency managers and government officials.

The first step in assessing care standards is to clarify roles and responsibilities to ensure that action and accountability takes place at all levels. Therefore, this section begins by describing where roles and responsibilities lie and which actors and agencies have responsibilities to ensure implementation of the quality standards at different levels.

Drawing on the experiences of implementation, this section then sets out lessons learned in carrying out assessments of care quality and information on key aspects of relevant assessment methodologies (with a particular focus on the ethics of children's participation in assessment).

Finally, this section outlines different approaches to substitute care for children, and examines the key issues of the staff:child ratios and budget allocations necessary for ensuring quality childcare. Building on the Implementation Team's experiences, assessment methodologies for calculating and improving staff:child ratios are described, as are methodologies for assessing and improving budget allocations towards better-quality care provision.

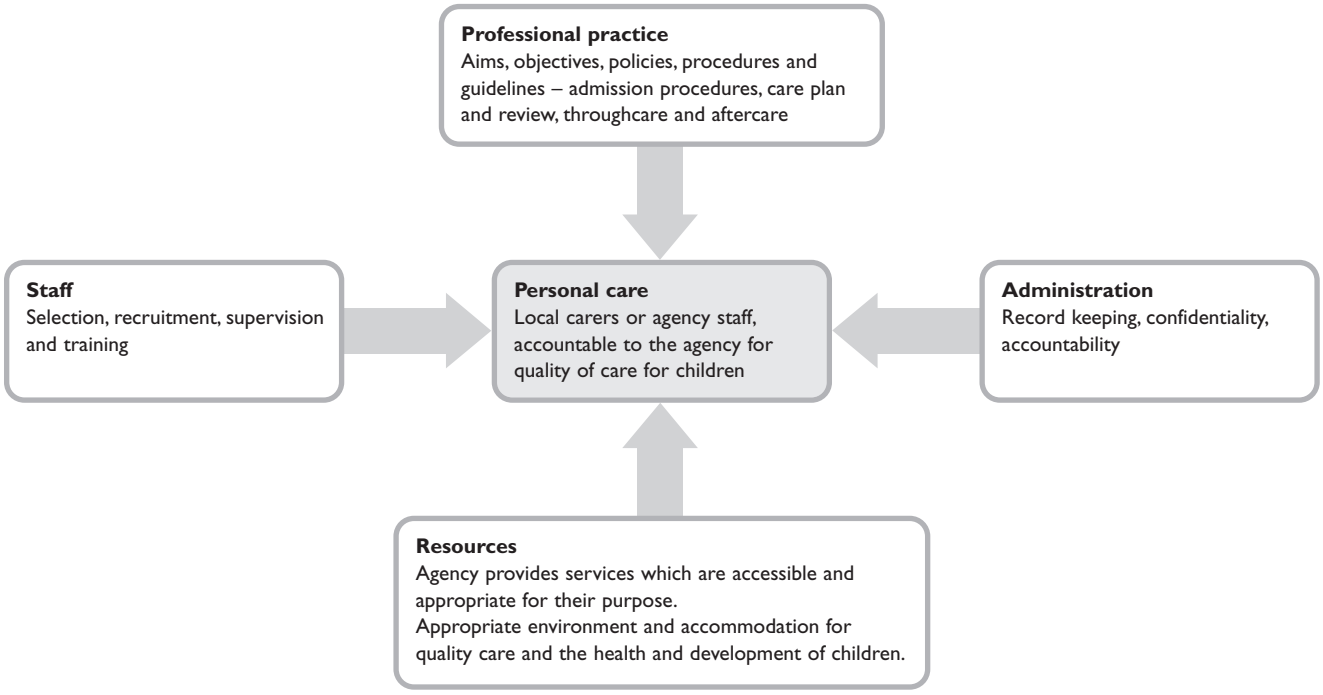
Roles and responsibilities for quality childcare standards

It is important to know which actors and agencies have responsibilities for ensuring that quality standards are implemented. This section highlights where roles and responsibilities lie, considering the range of care providers, the levels at which they operate and the mandate of agencies. The figure opposite outlines the interrelationship of the five areas incorporated in the quality childcare standards.

At the centre of quality childcare is the direct **personal care** given to children. Personal care may be undertaken by various individuals (including local foster carers, extended family members, older siblings, community members, paid childcare staff or institutional care staff).

Personal care can be provided by carers in a range of settings (from day care facilities to permanent placement in a childcare setting, either community-based or institutional). Such carers are, however, only able to provide quality care if they are supported and guided by community members, local organisations or agency representatives. Such support must come from the managing agency, whether this is a local community-based organisation (CBO), a local non-governmental organisation (NGO), an

Five key standards areas



international NGO (INGO) or a government department. Managing agencies may, in turn, be guided or supported by various rules, regulations, procedures and guidelines, most usually formed by government. In addition, donor agencies or facilitating international agencies, supporting CBOs, NGOs or governments may have requirements which aim to improve the quality of care provided, for example, a child protection policy, recording and monitoring systems, or financial auditing. Thus, issues in relation to defining professional practice are the responsibility of the agency rather than the personal care providers.

Ultimately, under the United Nations Convention on the Rights of the Child (UNCRC), governments have a "duty of care" for any child without a primary carer, and are obligated to *"…provide special protection for a child deprived of their family environment and to ensure that appropriate alternative family care or institutional placement is made available…"* (Article 20, UNCRC Summary). In reality, few governments are fulfilling their responsibilities in this respect, and as the HIV and AIDS crisis escalates, it is becoming more and more critical that governments are assisted to fulfil their obligations towards children without primary carers. The UN, international NGOs, donors, faith-based organisations and local organisations need to work in partnership with governments to ensure quality care provision for all children, in their own families and communities wherever possible. Governments should be encouraged to implement policies and practices that strengthen families and promote and ensure quality care for children in their communities.

Agencies running programmes which support care provision have a responsibility to support carers in their **professional practice**. Training, development opportunities and advisory services should be provided to carers. Agencies must also have effective **staff and volunteer carer selection, recruitment, supervision and training policies and procedures**, adequate **resources** and proper **administrative systems** to support and enhance the quality of care provided to children for whom they have a responsibility.

This basic framework of the five areas of the quality childcare standards can therefore be applied to any childcare context and the various roles and responsibilities applied appropriately.

Approaches to assessment

Implementation Team members approached the assessment process in different ways: some undertook internal self-assessments, while others established assessment teams from a range of partners who then undertook external assessments (ie, an assessment which did not involve staff from the assessed project or programme). Each approach has its merits, with feedback from team members highlighting these as:

Internal self-assessment:

- prompted members of the Implementation Team to realise their own strengths and weaknesses
- was less harsh than external assessment yet it provoked honesty and reflection
- enabled staff to approach management with ideas to extend the range of practice
- revealed that staff had previously been focusing on quantitative data (such as number of wells dug), without adequate attention being paid to the qualitative impact on the community
- could be ongoing as part of routine planning and monitoring.

External assessment:

- many gaps were identified that participants felt would never have been identified by other means
- enabled an external viewpoint and analysis by those not working in the project
- injected new ideas into the project and highlighted issues that people involved in the project had not previously considered
- partners are asking for external assessments and are using them within their own work for reflection and monitoring.

Carrying out assessments of the standard of care provided: lessons learned

Drawing on their assessment experiences in a range of care settings, the Implementation Team developed the following advice for carrying out initial assessments on the standard of care.

- Use the assessment format (Appendix 2) to ensure comparability of information gathered by different assessors.
- Allow sufficient time for pre-assessment preparations, including review of project documentation, previous assessments and reports in order to design a more informed assessment schedule, with appropriate questions.
- Ideally, a team of people with mixed skills, experience, and ability should carry out the assessment. This will make the observations and findings more objective and collaborative than if it is done by one person. Designated roles can be divided among the team.
- The assessment team should schedule sufficient time (at least a few hours) to discuss roles and responsibilities and the methodologies to use during the assessment visit. The assessment can be undertaken at various levels, depending on the scale of the project, familiarity of the assessment team with the approaches, and whether it is an initial assessment, a more in-depth intensive assessment or a monitoring assessment.
- Team members should decide in advance who should be spoken to individually or in groups, which groups and for what length of time. Special consideration should be given to who will interact directly with children and what types of activities will be used to involve children of different ages and abilities. Team members should also decide who will focus on personal care and who will focus on administration, staffing and other areas of the quality standards.

- It is important to involve all individuals with a role in the childcare initiative – for example, interviews with security staff, neighbours or community leaders can give insights into gaps, weaknesses or strengths which are not apparent in a more exclusive assessment process.
- Various methods should be applied during the assessment to ensure triangulation of information gathered from different sources.
- Methods can include: direct observation, guided questions with small groups of children, staff or community members, one-to-one interviews, interactive methods with children, focus-group discussions and selected visits to families. If the assessment is for a community-based model of care or a foster programme, create space to meet with families or 'beneficiaries' without the presence of the donor or CBO which is providing the assistance. Similarly, the assessment team should have the opportunity to meet children without their carers, staff members without their managers, etc to insure these respondents can speak openly about their concerns.
- Discuss the assessment plan with key stakeholders involved in the childcare project being assessed. It is important to brief the children, as well as the project staff/carers, on the nature and intent of the assessment and allow time for clarification on any points.
- Ensure that cover is made available for the care of the children so that staff and carers are released from their duties when required for assessment purposes. However, the assessment group will also need to observe normal daily practices, and assessors should incorporate this in their plans.
- The assessment should reserve at least one day for analysis, discussion and agreement on the observations. Do not give feedback before a full analysis is completed.
- Practical recommendations which do not require increases in budget allocation should be made, in addition to recommendations which may require budgetary reallocations or increases.
- The assessment team should schedule a feedback session for the key stakeholders involved in the childcare project and seek further clarification as necessary. The feedback should reinforce the positive practices, as well as identifying negative or potentially harmful practices, and should offer practical ways in which any recommendations could be fulfilled.
- If possible, develop a realistic timescale for implementation of the recommendations, ie, whether they can be implemented immediately, in the medium term or in the long term. For example, the Implementation Team gave examples of an immediate action such as shower curtains being purchased to ensure privacy when children were bathing, a medium-term action as setting up a care planning system for all children supported by the service, and a longer-term recommendation to incorporate the quality childcare standards in programme documentation, including training manuals and policy documents.

Wider benefits of assessment

Members of the Implementation Team discovered that the assessment process had an impact far beyond the establishment of a baseline of current practices. The assessment process enabled practitioners to contextualise, internalise and apply the standards. For example, in the Democratic Republic of Congo (DRC) the team member introduced the quality childcare standards to partner agencies and encouraged them to undertake an assessment in a childcare facility managed by one of the partners. This proved such a valuable experience that the partners have subsequently established regular assessment processes among themselves to evaluate movement towards quality and compliance with the standards.

Wider benefits of assessment

- Staff became more familiar with the quality standards as a package and started to see links between the different standards.
- Assessments are an opportunity for staff development and consultations with children.
- The assessment process provided a basis to review existing strategies, change the focus of work plans and approaches, and incorporate advocacy components into the programme.
- Assessments allowed more time for self-reflection in our work.
- The assessment process prompted managers to look at the impact of our work rather than just the process.
- Being involved in the assessment meant that partners were open to the findings and were able to see the level of care they were providing for children.
- We gained insight into a broader spectrum of issues.
- An objective/analytical mindset was applied to our work.
- Group assessments protected individuals when giving unwelcome feedback.
- We began to see the commonalities of the different projects.

Key issues in assessment

The ethics of children's participation

There are a number of reasons why it is important to involve girls and boys in assessment processes and to actively seek their views.

✓ **Participation is a right** – Internationally accepted standards (eg, the UNCRC) state that children and young people have a right to have their opinions heard on all matters that affect them, taking into account their age and maturity; children also have rights to information, expression and association.

✓ **Better knowledge of their views and priorities** – Children have their own views and opinions. Involvement of children in the assessment enables illumination of their key issues and concerns, and offers a way to find out how policies and programmes affect them.

✓ **More effective action** – When children and young people are directly involved in the assessment the process is more reality-based. Children and young people can also be effectively involved in decision-making, follow-up action and ongoing monitoring efforts.

✓ **To genuinely measure how effective we are** – Bringing about meaningful change in children's lives involves asking them about the impact of practice interventions. Without children's involvement at every stage of the process, we cannot know how successful and effective we have been or how to improve our practice. This means we should get children involved in defining the focus of the assessment, what should be assessed, how to collect such information, how to interpret it and how to act upon the findings.

✓ **Empowering children and young people** – If boys and girls are able to share their opinions and ideas this creates an atmosphere where children can feel safe to speak up about issues affecting them, and allows a joint analysis based on a more equal power relationship between adults and children.

In a very positive sense, children's involvement is now viewed as key to respecting their role as social actors who can actively contribute to improving their own lives, their communities and wider society. Furthermore, approaching children with a focus on their competencies and strengths builds their resiliency, and thus their ability to cope with adversity.

However, while building on children's strengths, their vulnerable position and lack of power in relation to their adult caretakers must also be appreciated. Child respondents in the assessments may be particularly vulnerable, as they may be dealing with loss, abuse, neglect or discrimination. Furthermore, existing power relations may make it hard and/or risky for children to speak up about any concerns relating to their care situation. For example, children are the weakest members of powerful institutions (including the family and orphanages) which have an interest in maintaining themselves. Managers may have a strong interest in maintaining the charitable reputation of the institution. Many institutions in the region are closely linked to people of political or religious prestige, who also have an interest in maintaining a positive image in society. These factors might make it difficult to intervene in cases where children speak out because their rights are being violated.

While enabling children's participation in the assessment and ongoing process of implementing the quality childcare standards, staff must consider ethical issues and undertake careful preparation to ensure that children are protected from manipulation or further violence, abuse and exploitation. Thus, ethical participatory practice with children has to be integral to the process. Key issues relating to the participation and protection of children were presented and discussed among the Implementation Team prior to planning the assessment process. Core Save the Children materials were drawn upon to guide good practice, in particular, guidance concerning ethical research with children from the publication *Research for Development: A practical guide*.[18] There are many practical materials available to guide ethical research and participatory practice with children, some of which are shown in the box below.

Key materials to guide ethical participatory practice with children

Boyden, J and Ennew, J (1997) *Children in Focus: A manual for participatory research with children*, Save the Children Sweden

Laws, S, Harper, C and Marcus R (2003) *Research for Development: A practical guide*, Save the Children UK and Sage Publications, London

Population Council (2005) *Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and resources*, Available at www.popcouncil.org/horizons/childrenethics.html

Save the Children (2005) *Practice Standards in Children's Participation*, International Save the Children Alliance

Save the Children (2003) *Promoting Children's Meaningful and Ethical Participation in the UN Study on Violence against Children*, International Save the Children Alliance

Save the Children (2003) *So You Want to Consult with Children? A toolkit of good practice*, International Save the Children Alliance

Additional preparations that can be undertaken to ensure ethical participatory practice with children include:

- risk assessment in relation to the assessment process and the impact of involving children, identifying risks and developing strategies to minimise them
- providing clear information to children about the assessment, enabling them to make an informed choice about whether to participate
- taking time to build trust with children and gaining the broader support of adults locally to ensure that children's participation gains wider support
- gaining children's consent and permission from their carers
- developing good communication skills to work with the children, using a range of participatory, creative activities that may elicit the views of girls and boys of different ages and abilities
- enabling children to meet in a space where they feel safe and comfortable to express their views
- ensuring there is a strategy to respond sensitively to disclosures of child abuse within care settings
- ensuring confidentiality of individual children's views wherever possible. Adults must be clear with children about what level of confidentiality and anonymity can be offered
- providing opportunities for information exchange, cross-checking of information and feedback to children, so that the children's version of information can be compared with other information gathered
- ensuring systematic follow-up of concerns raised by children.

One strategy to further the meaningful participation of children in ongoing efforts to improve quality standards is to empower children within care and/or community settings to develop their own children's groups or associations. Children can be empowered through their own collective initiatives to have a stronger voice in ongoing assessment, practice and policy developments. Through their collective initiatives, girls and boys can support each other to raise any issues affecting them, and they have greater bargaining power to bring these issues to the attention of adults.

Children are more able to protect and promote their rights through their collective efforts, and can develop friendships, gain confidence, develop life skills and challenge different forms of discrimination. Working collectively, or through their own representatives, children can meet regularly with concerned duty bearers, developing and strengthening adult–child partnerships to address their concerns. Through the implementation process, efforts could be made to enable children in care/community settings to develop and strengthen their own children's associations. Supporting children's associations is a starting point for creating possibilities for children to engage with decision-makers in ongoing practice and policy improvements to ensure the application of quality standards.

Child protection and responding to disclosures of abuse

As well as assessing potential risks, it is important to agree a strategy for responding to disclosures of abuse by any child during the assessment process. Save the Children UK has a Code of Conduct and a Child Protection Policy that apply to all staff, volunteers, temporary consultants and researchers to help them report and respond appropriately to child protection issues.

Children and young people should be involved in discussions relating to their concerns and to possible responses. The young person's or child's competence, understanding and ability to effect change in their current circumstances must be taken into account. Responses could take the form of support for the young person, or a child protection referral to the authorities, if there are serious concerns regarding the safety of the young person or of other children.

The fact that in many parts of the world reporting child abuse by no means guarantees a sensitive and positive response from the authorities is, of course, a huge problem. However, this is not a good enough reason to turn a blind eye to what a child discloses. While it may not be possible to guarantee a wholly appropriate response from others, it is also true that assessment team members are unlikely to have all the

skills needed to assist a child who is in an abusive situation. The child, and adults supporting her or him, may well need help from others. Thus, networks of suitably skilled practitioners could be established prior to any assessment processes, so that their advice and guidance could be drawn upon and referrals made in time of need.

Staff:child ratios

The different types of care services provided by those involved in the implementation process provided a unique opportunity to explore the realities of staff:child and carer:child ratios.[19] Regardless of the form of substitute care provided, the number of children under the direct care of an individual carer or staff member can give an immediate indication of whether quality childcare can be realised or not. This section outlines how the staff:child ratio can be calculated and what its implications are in different forms of provision.

Among all the staff required to implement a childcare programme or provide childcare in an institutional setting, those who provide direct personal care for children – such as grandparents, community volunteers, social workers, paid caregivers, or foster parents – are the most critical. Staff:child ratios must be sufficient to ensure that children's care and protection needs are met, that the child can become bonded and attached to their carer, and that the carer has sufficient time to give each child some individual attention on a daily basis.

Staff:child ratios should vary in accordance with the numbers, ages and gender of the children in care, and the number of children with specific care or protection needs, eg, very young children or children with disabilities. In addition, staff:child ratios will vary in accordance with the competencies of the carers themselves. For example, if the staff or carers are new, untrained, young or inexperienced, or elderly, more staff will be required. Ancillary, medical, administrative or security personnel should not be included in calculations of childcare staff, nor should they be used as substitute childcarers.

While the number of care staff needs to be decided according to each context and may change over time according to the age and nature of the children requiring the service, a basic minimum standard is required for guidance. In Western contexts, government and local authority policies have established very specific staff:child ratios depending on the age, gender and particular needs of each child, and there are additional requirements in relation to carers' experience and professional status. Thus, care of young babies requires a staff:child ratio of 1:1 or 1:2 if the child's needs are to be fully met. With older children, a nominal ratio could be one staff member for five young people, with available back-up support. In general, back-up support would be a senior staff member with relevant childcare experience who would be available in times of crisis, such as when a carer has to attend a meeting or if there is an emergency within the household or care environment. Back-up support should always be available.

It is recognised that in resource-poor countries, such regulation or guidance is not always available for childcare providers, and it may be difficult to set staff:child ratios and other elements of quality childcare. Yet, the critical role of childcare personnel must be appreciated and careful consideration of staff:child ratios in different contexts must be made. For example, if a ratio of staff to children is established as 1:10, this may be barely acceptable if care is being provided to 12-year-old girls or boys in a collective living arrangement, but wholly unacceptable in a babies' home where no individual carer could provide adequate care, bonding or attention for ten infants. During the implementation process, comparison was made with African families that have ten children. However, such families have a mixed age range of children, with differing abilities and, often include two adult carers (eg, mother and father), which gives a carer:child ratio of 1:5. In addition, the varying needs and capacities of the differing age range potentially allows the parents opportunities to give each child the individual attention necessary for quality childcare.

Thus, exploration of staff:child ratios is an important element of any baseline assessment and offers immediate information as to the potential to provide quality childcare. Specifically, staff:child ratios can provide information as to whether:

- programme staff are being deployed effectively for quality childcare
- there are sufficient care staff to support quality childcare
- children's basic protection needs are being upheld.

Calculating staff:child ratios

Any calculation of a staff:child ratio should focus solely on the staff or carers who have responsibility for the direct personal care of children. Exclude those who may be part of the care environment, such as cooks, security guards, teachers, nurses, etc, but who have other responsibilities.

For the purposes of this exercise, the budgets of three projects from the implementation process were reviewed: a transit care centre for the temporary care of former child soldiers; a government-run children's home; and a community-based project supporting the elderly, many of whom care for grandchildren orphaned as a result of AIDS.

Within the *community-based setting*, the ratio is easily calculated. The average number of children cared for by their grandparents was six – ie, a carer:child ratio of 1:6.

In order to calculate the carer:child ratio in an institutional setting, good employment practice principles must be applied, as follows:

- care staff should work no more than eight hours in any one day (resulting in the need for three shifts for each 24-hour period)
- care staff should work no more than 40 hours a week (eg, five eight-hour shifts in one week)
- in any given day, it should be assumed that some care staff may be on leave, sick, attending courses, etc.

It must be remembered that childcare staff may have their own children, and if excessive shift patterns or prolonged working days are instituted, the carer's own children will be adversely affected through the absence of their own primary carer.

Table 3 shows a typical three-shift pattern, using the transit care centre as an example and based on good practice principles of eight hours per shift, for the minimum 24-hour coverage required for children's care. The transit care centre has six social workers responsible for the direct care of the children (identified as letters A through to F), working five eight-hour shifts a week (40 hours a week). It is evident, from the table, that there is an insufficient number of staff to provide two people for each shift. In addition, there are no extra staff available to support or replace staff in the event of an emergency or crises within the centre.

Table 3. A three-shift pattern

Shift	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7am–3pm	A C	A C	A C	A C	A C	B D	B D
3pm–11pm	B F	B F	B F	D F	D F	D	E
11pm–7am	E	E	E	E			

(from Transit Centre Application of Best Practice Staffing Schedule for 6 Social Workers)

By scheduling the six care staff in five shifts per week, we see that only one or two care staff are on duty at any one time, resulting in an average maximum staff:child ratio of 1:133 for the 200 children in the centre. This ratio is wholly inadequate to ensure a level of childcare and protection sufficient for children's survival and development.

The same scheduling technique can be applied to the children's home. In the children's home, 12 care staff serve 120 children under ten years of age. The current complement of children comprises of babies, children who are lost, abandoned or orphaned and other children who are admitted for reasons of abuse – all of whom require more intensive or specialist care. Applying best practice principles and scheduling the 12 care staff (letters A to L) in five shifts per week would provide for two to three care staff being on duty at any one time, as shown in Table 4. Therefore, the staff:child ratio varies from 1:60 to 1:40. Ideally, this ratio should be, at a very minimum, 1:5, given the age and needs of the children residing in the home.

Reflection on practice

In practice, neither the transit centre nor the children's home follow the model of staffing standards set out above. For example, at the transit centre there are no care staff on duty at night from 17:00 to 07:00. The duty of care for the children during the nights falls on the groundskeeper and a standby driver. Currently, the deployment of care staff in the transit centre involves a three-shift system of four social workers working from 08.00 to 17:00 and two social workers on duty from 07:00 until 18:30 on weekdays. At the weekend, two social workers provide cover of one staff member for each day of the weekend (Saturday and Sunday) with time off in lieu mid-week. Thus, on two days during the week, the care staff complement will be reduced by one, resulting in the staff:child ratio during weekdays varying between 1:33 and 1:40, and at weekends a ratio of 1:200. It is clear that the centre cannot provide even minimum levels of care and protection for the children.

Improving staff:child ratios

Building on the range of care provision options, some agencies could enhance their current staff:child ratio by developing alternative models of childcare.

In the community-based care case example above, carer:child ratios of 1:6 already offer the potential for quality childcare. However, while the assessment (undertaken as part of the implementation process) gave clear evidence[20] of children's emotional and psychological needs being met through such community-based care, the demands of 24-hour

Table 4. Alternative shift pattern

Shift	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7am–3pm	A C H	A C H	A C I	A C J	A C J	B D J	B D J
3pm–11pm	B F J	B F K	B F K	D F K	D F K	D G K	E G L
11pm–7am	E G L	E G L	E G L	E I L	H I	H I	H I

(from Children's Home Application of Best Practice Staffing Schedule for 12 Childcarers)

care for six children may be an onerous task for an elderly carer. In response, the community-based programme run by Uganda Reach the Aged Association uses volunteers, identified as 'nominees', who provide day-to-day support for the elderly carers and their children. In addition, the programme's social workers undertake regular assessment visits to the family in relation to any material support needed. The programme may wish to make use of the 'nominees' system in a more formal manner, including temporary short-term respite care when the elderly carer is ill or exhausted. Or the programme might consider developing a drop-in centre for children, providing opportunities for play and recreation for children and rest time for the elderly carer.

Alternative care models in institutional settings

As identified in the staff:child ratio assessments, the staff in the transit home and the children's home could not currently offer even minimum quality childcare. In each context, they need to reduce the number of children in the care facility or increase the number of staff in order to offer the basis for even adequate childcare. Building on some of the alternative care models, the agencies could develop different care models which would improve the current staff:child ratios and the potential to provide quality childcare. Using the Nairobi's Children's Home as an example, some alternative care approaches are outlined in the box opposite.

Calculating the cost

Many childcare providers in resource-poor environments feel it is only possible, and often sufficient, to satisfy the basic needs of food and shelter for children without a primary carer, and that an improved quality of care is neither affordable nor necessary. The common practice of perceiving institutional care as the best means to respond to children without a primary carer, is, thankfully, changing. However, many of the families and communities now expected to care for such children are themselves living in poverty, and face significant constraints in providing adequate healthcare or education for their birth children. While this is recognised by agencies supporting such families and communities, many of these agencies do not have a background in childcare or child development. As a result, the support focuses on basic survival needs (eg, food and shelter). From the work undertaken on *Raising the Standards*, it is clear that, while children do need food, shelter and healthcare to survive, other developmental factors are also critical. Too often, this is overlooked by supporting agencies, resulting in support of a standard below that necessary to ensure the protection and guidance needed for a minimum level of child development.

This prompts two core questions: 'What is quality childcare?' and 'How much does this cost?' The first question is answered in the publication *Raising the Standards*, but the second question has been problematic for a number of reasons. First, the care of children does cost money and the amount is largely dependent on the care context (eg, institution or community-supported independent living) and the cost of living in a particular society. Second, many families living below the poverty line do provide a sufficient quality of care that allows the child to develop personal resilience and to work towards fulfilling their potential as adults in society, while some children in financially better-off homes may develop less well.

In response to the impact of the HIV and AIDS pandemic and the increasing numbers of children requiring some form of care, work has been undertaken by agencies such as the World Bank, UNICEF, USAID and others to identify the costs of childcare. However, many of the approaches used do not include quality dimensions, but focus instead on more easily quantified material aspects, such as food, shelter, healthcare, education, clothing, etc. Some work has been undertaken to measure psychosocial or well-being aspects of care, but the resulting indicators tend to be developed primarily from a reactive stance,

Alternative care approaches to the Nairobi Children's Home

- **Greater emphasis on early reunification with families**: Obviously, where possible, the first priority should be the prevention of children becoming separated from their families and entering formal care systems. This requires a range of prevention efforts, including the strengthening of existing social work systems to seek early resolution of the issues which are precursors to separation. Where separation has occurred, the same systems need to be in place to support the reunification of children with their parents or extended family at the earliest point possible.
- **Care staff living with small groups of children in the available housing in the children's home compound**: Currently, there are ten small houses in the children's home compound, initially intended as housing for staff members and their families. Combined with a rigorous application of their mandate and regulations, the number of children could readily be reduced to a maximum of 60 children. Thereafter, if care staff took on a broader role of housemothers or house parents living as 'family-style groups', these 60 children could be provided with an increased quality of care through living as a family unit and sharing the normal responsibilities and routines of children in a family setting. Utilising ten care staff as housemothers, the remaining children's home managers and administration staff could provide additional support, guidance, monitoring and back-up support to the housemothers. Staff:child ratios would therefore be reduced to 1:6.
- **'Family style' groups housed in the local community**: Small properties could be identified in the local community, and a small group of children of mixed ages, gender and ability could live together as a family with a team of two principle carers for each 'family group' acting as house parents. This model would offer greater flexibility for the carers. With 12 care staff for 60 children, this model would support a staff:child ratio of 1:5. Again, this model could be monitored and supported by the existing children's home managers and administration staff.
- **Comprehensive localised short-term foster care**: It is often assumed that foster care is a very cost-effective means to care for children. However, if appropriate carers are to be identified, trained, monitored, supervised and supported in the care task, an appropriate support and supervisory infrastructure is essential. In addition, some small remuneration may be necessary to offset the costs of the children's material needs, such as education, clothing, food and healthcare.
- **Adoption**: Adoption for children who cannot be reunified with their families or where it is not in the child's best interests to be reunified offers the best long-term, permanent solution for children. The need for advocacy on non-related adoption in contexts where formal adoption is not a cultural norm requires a significant investment of personnel – potentially three dedicated staff members. In addition, the selection, assessment, approval and matching of prospective adopters with a child requires skilled staff who carry a limited number of cases at any one time, in a ratio of approximately 1:6. In addition,

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there are considerable legal requirements, with the provision of legal support for the children and legal advice for prospective adopters. For a group of 60 children, half of whom may be available for adoption, a legal team of three advisers and an administrator should be sufficient. In such a context, the overall staff:child ratio for children being adopted would be 1:5, but again this would result in a carer:child ratio as low as 1:1, depending on the number of children in the adoptive family.

In order to provide foster care for the 60 children in the children's home, it would be necessary to provide interim care for the children until foster care placements are established. Therefore, a progressive approach to developing a foster care option is initially required.

First, on the basis of placing two children with each foster family, a total of 30 families would need to be identified, assessed, and trained. This process would require two social workers and one administrator. Second, the trained foster carers and the children would all require preparation and matching for each family and child. Thereafter, regular follow-up visits and ongoing supervision by staff with the capacity to respond to emergency placement or foster care breakdowns would be required. This phase would require one training officer, four social workers, an administrator and an on-call emergency supervisor. In addition, the work would require an experienced manager to oversee the work, ensure policy development and implementation, compliance and guidance on legal issues where such issues arose. Longer-term placement options would require a worker to be involved in negotiation and outreach work with other agencies and authorities. Therefore, on the basis of two children being placed with each family and the infrastructure to support children in their foster care placements, we would require social work support staff on a ratio of 1:5 at a minimum. However, the actual carer:child ratio could be as low as 1:1 or 1:2, depending on the number of children in the foster family. In addition, this model could be extended to support a much larger group of children once the infrastructure was established and capacity developed.

eg, expressions or symptoms of emotional distress, rather than establishing indicators of quality dimensions which evidence a preventive approach, including positive aspects of children's resiliency and coping strategies.

Undertaking a cost analysis

The implementation process offered a unique opportunity to explore the cost of putting quality childcare into effect, and to identify additional costs incurred in improving the quality of existing care. This latter expectation proved to be unnecessary, given that the positive changes implemented in the projects had little, if no, budgetary implications.

An initial step in analysing budget expenditure within the implementation process was to establish the existing budgets of care provision and analyse how current expenditure was allocated within their various services. Thus, all team members were asked to collect financial baseline information, including

What can a cost analysis tell your project?

- Cost analysis allows one to view major areas of expenditure and the proportional balance across budget areas.
- Cost analysis, specifically pounds sterling (GBP)/per child/per year, can measure the programming inputs independent of the quality of the results.
- Cost-analysis calculations can clarify the amount spent, eg, on personal care (food, medical care, hygiene) but they will not measure a result indicator such as the percentage of children malnourished or the percentage of children vaccinated.
- Cost analysis can offer indications of where quality care would be constrained, eg, low staff:child ratios, or high proportion of cost going to personnel with a low percentage allocated towards personal care, or low budget allocations for recreation or staff development.

current childcare project expenditure and/or project budgets. Team members were also asked to track any additional expenses incurred in implementing the quality childcare standards.

Some limitations

The cost analysis process provides some extremely useful information in assessing the quality of childcare any agency provides (see Appendix 4), but there are some limitations.

- In some agencies, some personnel functions are carried out at a head office level or within Ministries; therefore, the cost of their services may not be included in the analysis.
- It may be difficult to gather information concerning the entire implementing costs of the programmes, as some programmes are funded by multiple donors and funding sources, with separate bookkeeping. To do a comprehensive cost analysis, all running costs of the project need to be considered.
- The analysis does not disaggregate the cost per child by age or the ability of the child. If the project supported babies, the cost per child per month may be higher than a project supporting ten-year-olds, due to the high cost of formula, the need for sterilisation of bottles and water and the higher staff:child ratio demands.
- Finally, budgets based over a quarter, for example, may not be representative of the annual expenditure due to capital purchases or seasonal variations in any one quarter. Thus, where possible, calculations are more accurate if based on an annual budget which incorporates all expenditure expended or anticipated.

Steps of cost analysis

The following process is a simple way of calculating the cost of care for a child for one year.

Step One: Gather and enter financial information
Enter financial data (either actual expenditure or budget allocations) into the standardised format (Appendix 4). This format disaggregates the budget into categories of personnel, training and meetings, personal care, administration, and a miscellaneous section entitled 'Other'.

Step Two: Calculate annual expense per line item
Calculate the annual expense or budget for each category (personnel, personal care). If the financial information is quarterly, the figure should be multiplied by four to obtain an annual amount. If the information is for a six-month expense report, it should be multiplied by two for the annual figure.

Step Three: Calculate cost per child per year
Divide the annual cost by the average number of children assisted in the year. This results in the cost per child per year.

Cost comparisons between different countries will require costs to be converted to a common base (eg, US$).

Critical questions

Once you have calculated the expense/child/year for various categories, the following key questions should be asked:

- What percentage (or proportion) of the total cost is spent on personnel?
- Of the personnel cost, what percentage (or proportion) is spent on personnel providing direct care for children (care staff, community carers, social workers, community outreach workers)?
- Is this number of personnel sufficient to provide opportunities for one-to-one interaction, attachment, and bonding; or in the case of community outreach workers, sufficient to ensure children's care and protection needs are met?
- Do children directly benefit from the money spent on personal care? For example, many projects may have an annual budget for educational games or cultural drama costumes, which are actually locked away in a store, leaving children with no consistent access to these items.
- Do children have any say in decision-making processes about how budget allocations are spent?
- For line items with no budget allocation, it is important to question whether children are receiving this support or service from other sources (government or other agencies). For example, not all projects spend money on teachers, as children involved in the project may receive free education through a local school or separate agency.
- It is useful to explore which issues are covered for miscellaneous items under 'Others' as this may include items which have greater relevance to quality care then hitherto realised, eg, resources for cultural events.

Part Three: Case studies – applying the standards

This part of the report contains a series of seven case studies describing the process of applying the childcare quality standards within different agencies. Other childcare providers and agencies may wish to draw on the approaches and experiences documented and use these to benefit their own endeavours to improve the quality of care provided.

Each case study includes:

- background information on the agency
- details about how the standards were applied
- recommended changes in care provision arising from application of the standards
- a description of the impact on quality care.

The case study agencies

Nairobi Children's Home is a government institution established in Nairobi, Kenya in 1989. It offers temporary care and protection to children aged 0–10 years designated in need of special protection.

Gulu Support the Children Organisation (GUSCO) is an indigenous non-governmental organisation working with children affected by the armed conflict instigated by the Lord's Resistance Army (LRA), in northern Uganda. Established in 1994, GUSCO works both through a transit centre and in the community to provide (in partnership with Save the Children in Uganda) temporary care, rehabilitation and reintegration support for children affected by war.

Save the Children in Uganda (SCiU)[21] provides technical and financial support to a range of partner organisations promoting community-based child protection in northern Uganda (eg, developing community volunteer committees, child protection units within the Uganda People's Defence Force) to respond effectively to children affected by war.

Uganda Reach the Aged Association (URAA) is a non-governmental organisation working for the improved welfare of older people in Uganda. URAA is a member of the HelpAge International network. Its work includes a focus on vulnerable older women and men caring for orphans and dependent grandchildren.

HelpAge International (HAI) is a global network of over 60 not-for-profit organisations, working in 48 countries. HAI was established in October 1983 to work with and for disadvantaged older people to achieve a lasting improvement in the quality of their lives. Older people play a significant role in caring for children in communities in east and central Africa. Members of HAI aim to support older people in their caring role.

Save the Children UK in Democratic Republic of Congo works in Kinshasa (capital), Mbuji Muyi (Centre), and in Goma, Bukavu, Bunia and Ituri in the east. Working with local partners (government and non-government), programmes in Kinshasa and the west include care and protection initiatives to address the concerns of children accused of witchcraft. In Mbuji Muyi, the programme focuses on children's institutions, issues of children accused of witchcraft, and children living in the street. In the east, Save the Children UK is managing programmes to prevent the recruitment of child soldiers and promote the release and community reintegration of children associated with armed groups and forces.

Save the Children South Sudan works in collaboration with UNICEF and other partners to ensure identification, documentation, family tracing and reunification of abducted children, child soldiers and separated children in nine counties of South Sudan. Community-based care, protection and participation approaches are supported.

The timescale of the implementation process was from late September 2004 to mid-April 2005, which was less than seven months, with a substantial break for the winter holiday. As a result, many of the changes documented in the report are based on process indicators without evidence of longer-term outcomes or impact. Furthermore, as each context is different, the level, types of change and impact achieved also differ. However, despite these limitations, the somewhat limited evidence available to date does indicate substantial impact.

Case Study 1: Nairobi Children's Home

Background

The Nairobi Children's Home is a government institution working under the jurisdiction of the government of Kenya, Ministry of Home Affairs, through the Department of Children's Services. It was established in 1989 as a rescue centre and place of safety for children. The home is located in eight acres of ground in the west of Nairobi City.

The home offers temporary care and protection to children aged 0–6 years designated in need of special protection, and on occasion to older children up to ten years of age. The home was established with a maximum capacity of 60 children, and an initial staff complement of 20 'mothers' and 11 general staff. However, at the first point of contact with the Implementation Team, the home had 120 children, 12 'mothers' and five general staff. The increased number of children in the institution is largely attributed to the rising incidence of poverty, the impact of HIV and AIDS, and the breakdown of family support networks and social norms. The decline in staff numbers has been due to internal government transfers, voluntary retirement, retrenchment and natural attrition. Referrals to the home are made via Departmental Children's Officers from all areas of Kenya, the police, the courts, Provincial Children's Officers from Kenyatta National Hospital, and from members of the public.

The Nairobi Children's Home faces many of the problems endemic in government institutions, in that they have an ever-increasing number of children, low staff:child ratios and limited educational resources, further undermined by a declining budget allocation. In addition, few of the staff have any background or training in childcare or child development. Finally, children overstay in the home for extended periods because of a lack of effective collaboration and timely action by Provincial Children's Officers, the police and the judiciary. This situation is further exacerbated by the practice of interdepartmental transfers, which are enacted on the basis of grade, ie, 'mothers' (childcare staff) are classified as 'support staff' (equivalent to office cleaners in government departments) and as such can be transferred to work in children's homes having no experience or interest in childcare. While this is a standard practice within the civil service, serious concerns regarding this procedure are highlighted – in particular, the lack of any background checks for child protection purposes.

The Department of Children's Services is, however, constrained by a government moratorium on new appointments, declining budgets despite increased demand, and national limited capacity within care and protection personnel. Despite these constraints, it must be acknowledged that the department has been open and receptive to the work of the Implementation Team. Further, they must be commended in their efforts to improve the situation for children in Nairobi's Children Home throughout the period of the implementation process. Evidence of this openness included agreement to a formal assessment by the Implementation Team and support for the manager of the children's home to implement changes in practice.

Applying the standards

The challenges identified by the manager and staff of the children's home, and through the formal assessment by the Implementation Team, are shown in Table 5 opposite. These challenges are set out in accordance with the five areas of the quality standards.

Table 5. Challenges at the Nairobi Children's Home

Professional practice
No clear guidelines for government homes Children are not involved in decision-making No clear reporting structure in place – there is no organogram No child protection policy in place There is staff involvement in care planning, but due to poor staff:child ratios the task is overwhelming Staff handover is only verbal
Personal care
Congestion in home – high numbers of children in rooms Staffing ratios, currently 1:50 Abused children cared for by untrained staff Minimum standards for care or protection not met Child participation is not part of programme. Children's voices are not heard and unhealthy interactions continue unchecked Children are treated as a group not as individuals – eg, age, ability, privacy, choice, relationships and attachments are not considered Opportunities for building relationships are limited, due to time constraints and staff:child ratios Education is limited to nursery level, with only two teachers for all the children regardless of age and ability The first priority should be accorded to children, not the staff, as the home only exists for the children There was evidence of skin diseases and other ailments, such as diarrhoea and scabies There are limited drugs and medical supplies available; also the nurse is only available on a part-time basis Ventilation is poor and the refuse pit was full and close to the kitchen area. Kitchen practices are unhygienic Lack of water: Only a well which is subject to contamination by dust. Extra water needed for nappies and potties
Staffing and caregivers
Lack of trained personnel Overworked staff: Crisis management due to the limited number of staff. No extra staff to cover absent staff Volunteers should not be staff replacements Staff work for more than eight hours, eg, security guards work up to 24 hours Overtime claims are not considered No system in place to reward or motivate staff Staffing is gender imbalanced: out of a total of 24, only six are male Limited staff development plan Managers also need support; such as linking with peers with similar job descriptions who can offer lateral support Training and capacity building needs to be more frequent No access to regular supervision and support Staff selected on grading not ability, skills or interest to work with children Terms and conditions of service must be improved overall
Resources
Lack of adequate resources – financial as well as physical space Restructuring of home difficult due to government bureaucracy Ad hoc support from Friends of Nairobi Children's Home
Administration
Sole voice in care for young children Lack of flexibility in financial allocations No clear policy on confidentiality Children do not access their records There are no functioning systems for formal inspection

Recommendations

Following the assessment, a number of recommendations were provided to the home. These are set out in Table 6 in the same format as Table 5.

Table 6. Recommendations

Professional practice
An organogram should be drawn up Job descriptions should be streamlined, clearly indicating roles and responsibilities A child protection policy which covers confidentiality should be developed Children's home mandate should be strictly applied – no child should be accepted without a court order Care planning should be institutionalised Developing a working system to implement quality standards Staff should be held accountable by written as well as verbal accounts of their shift and regular review with manager
Personal care
Staff:child ratios must be improved – reduce numbers of children Future planning activities should be established Staff motivation should be increased through regular support and supervision Young children can talk and help in making decisions even at a minimal level, eg, what they would like to wear, choice in activities, which games or the type of play, etc Children's participation must be increased Write to the District Education Officer to request that children from NCH be allowed to attend the local schools Establish a closed water source, ie, a borehole can be drilled Improvements in the variety and supply of drugs. The home has a separate allocation for drugs but it is not adequate. An extra fridge should be added at the dispensary and all children should be fully vaccinated The home should be cleaned and disinfected frequently and hygiene rules established The dustbin and refuse pit should be relocated downwind and away from the kitchen The education provision should be improved by separating children according to age Teachers and teaching materials should be increased although relocation to local schools would be better Improvements in sanitation and washing facilities are necessary
Staffing and caregivers
Additional staff are required to ensure the system and care can run smoothly Management should mentor staff through giving guidance, supervision and support Social workers need to have access to training which supports capacity-building and motivates them Routine meetings should be held (and recorded) with each staff member to discuss work plans. Use for appraisals Management supervision can be resourced through having resource centres where senior staff can talk and link to other organisations for technical solutions Staff should be offered sabbaticals. Once trained, they should have to serve for a period of time before taking any new post Daily log records should be kept by staff on all shifts. These are important for analysing patterns of behaviour Qualifying certificates should be awarded and staff should be able to progress on a career scale in childcare Quality childcare implementation and experience should be recognised Induction then orientation for all staff and volunteers is crucial. Documentation of the ground rules, policies, procedures, expectations, etc is important because staff members can take their time in reading and understanding them

continued opposite

Table 6 *continued*

Resources
The current space is inadequate, with subdivision of rooms being inappropriate as there would be insufficient ventilation. Alternative 'small group home' accommodation should be sought
Administration
Government institutions often do not comply with their own rules and regulations. This is, in part, not rectified as there are no functioning systems for formal inspection. Government should establish rules and regulations for childcare services Care staff are designated as support staff in government pay scales. Thus, the nature of their posts and the skills required as childcarers must be recognised

Impact on quality

Following participation in the implementation workshops, the assessment visit and consultation with the Department of Children's Services, a number of improvements were made in Nairobi Children's Home. First, two additional staff members, a deputy manager and a house mistress, were transferred to the home. In addition, 50 children were moved from the home, either through reunification with their families or to alternative settings, ie, foster care or private institutions. The manager of the home negotiated small payments for four additional volunteers through the Friends of Nairobi Children's Home.

There is a lack of sufficient and clean water, and Friends of Nairobi Children's Home have been mobilised to raise funds for a borehole. In the interim, the home has renovated the bathing facilities, with the bathrooms now having shower curtains and doors. In terms of improved accommodation, a local agency, Our Kenya Kids (a branch of Care and Share, a Canadian non-governmental organisation) is looking at plans for a four-bedroom house to establish a small group home for some of the children.[22]

An introductory meeting for staff on quality childcare standards was facilitated by Save the Children, followed up by a second internal meeting on the implementation of a key worker system. Following this, job descriptions,[23] with clear roles and responsibilities, were developed for the key workers, childcare workers and volunteers. These are outlined in Table 7 overleaf.

While developing the strategy for the key worker system, a list of the resident children was drawn up with information on their age, capacity, abilities and any impairments, from which the grouping of children was decided. It was recognised that the system offered better opportunities for attachment and bonding than previously, even though the four groups were still too large, having 20 children in each group. The new system brings order and organisation, as well as greater opportunities for children to have a say.

In practice, the resources required for many of the changes have been minimal, yet the changes have made a significant difference to children's lives in the home. Management and staff have developed priority areas to improve the quality of care, and even within their limited resources, they have made some immediate changes. Further changes will need to be made over a longer period of time and planning is in place to achieve these. Table 8 on page 41 indicates activities undertaken to date and their current impact on the quality of childcare in Nairobi Children's Home.

Table 7. Different roles of key workers

Childcare staff	Volunteer care staff	Key workers
• Monitor children's activities • Feed younger children • Bathe children • Dress younger children • Tidy beds • Teach social skills • Take children to school • Play with children • Help with school work • Record responses in all areas, eg, social behaviour, interaction with other children, health, etc • Take preventive health measures for and with the children • Take care of children admitted to hospital	• Monitor children's activities • Feed younger children • Bathe children • Dress younger children • Tidy beds • Teach social skills • Take children to school • Play with children • Help with school work • Record responses in all areas, eg, social behaviour, interaction with other children, health, etc • Take preventive health measures for and with the children	• Spend the most time with children, leading a group of four other care workers • Bond with the children by dedicating their work time to them • Supervise other care staff

Children's views of the improvements

During discussions with the children, the children said they were happier with the new practices. For example, a nine-year-old boy who has been in the home for two years because of a medical condition said that the previous lack of privacy has now improved: *"I can now take my bath at any time without waiting for younger children, as the bathrooms have doors."* A ten-year-old girl who had been a domestic worker but had been rescued from her abusive employer, said: *"I was glad when I came in and Madam (the manager) explained why I was here and that they would do their best to trace my parents."* In addition, the children say they now feel more secure with their key workers. They can ask their key worker questions or go to them if they are upset. It is now the case that either the manager or the deputy explains the procedures to each child on admission, and key workers seek children's views. Thus, the children have greater access to information and more say in decisions affecting them.

Table 8. Activities and impact at Nairobi Children's Home

Activity	Direct impact on children	Policy and practice	Equity and inclusion	Involvement
Improving sanitation facilities (bathrooms and toilets)	Children's privacy is observed	Staff and children feel positively valued and respected	Boys and girls have access to facilities and privacy	Friends of Nairobi Children's Home involved
Reducing the numbers of children and increasing staff:child ratios	Children more relaxed and given more time and attention	Carers share more with children	Staff and children more relaxed – all children receive equal care	Headquarters, stakeholders and the community
Training of staff and older children on child rights	Children are aware of their rights and can now raise their concerns	Child participation valued and improved	All children are listened to and included in discussions appropriately	Headquarters, NGOs
Manager / Deputy have sole responsibility to admit the child and explain all aspects of their stay	Children are less anxious	Manager is the first contact with any child in the home	Staff and children	All staff
Staff sit with the children at meal times and play	Children's needs are noted early and action taken – bonding with staff and children	Carers assigned to specific children	Early responses to children's different needs are met	Headquarters, carers, administration
Liaison with local parish for primary education	Children can continue with education while at NCH	Children's right to education respected	All children gain access to appropriate education	Education Department, Headquarters, staff
Regular meetings with all staff – informal meetings with individual staff (between 08.00 and 18.00) and emergency meetings	Issues are detected and addressed as they arise	Regular support and supervision of carers	Children with difficulties get more focused attention	All staff
Critical element: Willingness of Kenya management to support quality childcare standards				

Case Study 2: Gulu Support the Children Organisation

Background

Gulu Support the Children Organisation (GUSCO) is an indigenous non-governmental organisation (NGO) working with children affected by the armed conflict instigated by the Lord's Resistance Army (LRA) in northern Uganda. The LRA has a record of abducting and using children as fighters, 'wives' and domestic slaves. GUSCO was established in 1994. Working in partnership with Save the Children in Uganda (SCiU), it provides temporary care, rehabilitation and reintegration support for war-affected children. Since the beginning of its work, GUSCO has reintegrated 6,889 children with their families and communities.

GUSCO runs a transit centre and undertakes community-based activities. Children are generally brought to the transit centre by members of the Child Protection Unit (CPU) established by the Uganda People's Defence Force (UPDF). This government Defence Force locates children during and after conflict involving the LRA. Some of the girls in the GUSCO transit centre have been used as 'wives' and have escaped from the LRA with their own young children, conceived and born in captivity; others have sustained injuries during the conflict, and some others show signs of psychological distress. After tracing and reunification of the child with his or her family, community work staff offer follow-up support to the child and the family for a designated period.

Working both in a centre and in the community, GUSCO offers a wide range of services. Within **centre-based rehabilitation**, the induction process involves children being received and debriefed, then medically examined and treated. They receive counselling and therapy and then are involved in structured activities. Family tracing, assessment, preparation and reunification activities are provided from the centre base.

Several different specialist teams work in **community-based rehabilitation**. An **education and training team** supports formerly abducted children (FAC) to re-enter formal schooling, and their teachers are offered training on psychosocial support; school feeding programmes and peace activities are run in schools. War-affected children are offered vocational skills training and tool kits to support these. For children under five years old, play centres are established and run, along with non-formal education centres.

A **community service team** conducts awareness-raising programmes on the needs of children affected by armed conflict, training community facilitators, establishing structured activities in the community, and conducting review meetings with local leaders, community members, children, community-based organisations (CBOs) and other stakeholders. Support is given to 'social interactive peace events' and community action plans to reintegrate children affected by conflict.

A **micro-finance scheme** provides start-up funds/seed money to support war-affected children and formerly abducted child mothers. CBOs and associations of concerned parents also have the opportunity to identify income-generation activities and receive training and revolving funds to implement these.

In support of all these activities, ongoing **advocacy, research and information** initiatives are undertaken that involve children as social actors – eg, child rights clubs, children's conferences and a quarterly newsletter.

In this war-torn context, the population faces endemic poverty and constant insecurity, resulting in a recent phenomenon of 'night commuters'. Initially, families would 'migrate' into Gulu town in the evening to avoid night attacks and abductions by the LRA. However, more recently, the increasing majority of 'night commuters' are children, whose parents remain at home to protect their homesteads. Nightly, tented camps of up to 3,000 children have been established. There is much debate about the appropriateness of this response. In addition, there is no clear response for the increasing numbers of orphans and separated children arising from the impact of the conflict and the ever-present HIV and AIDS.

Applying the standards

GUSCO initiated a collaborative workshop with three other agencies providing similar services, as a means of introducing the quality childcare standards. This was followed by a presentation of the standards solely to the GUSCO management and staff. Additionally, a short assessment visit was undertaken by the consultant and one of the facilitators. Table 9 shows the challenges that were identified during the course of these activities.

The Implementation Team member initiated a consultation with the children in the transit centre. Staff members summarised the standards during Family Talk sessions over two Sundays. Subsequently, centre residents (aged five to

Table 9

Professional practice
No child protection policy Recruitment based on personal contact – but with probation period. Children's views not considered Limited background checks for staff recruitment High numbers of inappropriate admissions – HIV- and AIDS-affected children, orphans, abandoned infants, etc Confusion re: numbers of children on books (112), compared to the number evident in the centre No care planning Children are not given a choice about entering the centre – many know where their parents are.
Personal care
Negative staff attitudes: eg, "nothing new in the standards" Minimum standards for care or protection not met High numbers of children in relation to capacity and quality care Staff:child ratios (1:133 /1:200) Escalating insecurity – no immediate evidence of emergency preparedness plans Limited child participation Limited diet: mainly beans and posho (cooked maize meal, a staple food in Uganda) Food preparation and storage poor Poor hygiene in toilets and showers: waste water running through the compound, toilets and showers smelly and in sight of main cooking and living areas Lack of adult supervision and involvement with the children – little evidence of specific activities
Staffing and caregivers
No stipend for community carers Lack of staff supervision Evident lack of interest in the children on the part of some staff Issues of staff retention
Resources
Fixed budget lines Lack of funds for wider dissemination in community Large tented accommodation inappropriate and with poor ventilation Overcrowded and standards re health and nutrition apparently not met
Administration
Top-heavy staffing, resources, building, comparatively lesser emphasis on, and quality of, service provision

25 years) were asked: **"What do you think GUSCO can do to achieve these standards?"** The responses are shown in the box below.

Initially, when asked the above question, the children and young people laughed, stating: *"If all the standards were being met in GUSCO, then there would be no need for us to go home!"* While it is crucial to establish quality care standards in centres, this statement highlights the importance of ensuring effective preparation and follow-up during the family reunification process, so that children are effectively cared for and protected in their own homes and communities. Wider community-based child rights monitoring and response initiatives need to be integral to this broader response.

Recommendations

GUSCO aims to provide a fairly comprehensive service for children and their families in the context of ongoing conflict. However, in responding to the ongoing crisis, the original aim of providing care for former child soldiers and abducted children has become blurred, and without any clear admission and referral procedures, the majority of residents are now young women and children under five, as can be seen in Table 10 opposite.

The wide age range of children in GUSCO creates a challenge and demands that GUSCO varies its approaches. Many of the residents in the transit centre are adult women who were abducted (as children) and kept in captivity for up to ten years. Many of these

Children's concerns and their views on the efforts needed to achieve the standards

- GUSCO needs to improve accommodation for children. Sometimes it is very hot or very cold, the ventilation is not good. Maybe a permanent structure instead of tents would be better.
- GUSCO has failed to control visitors, and the children are tired of having visitors interrupt their activities.
- Too many children – there is overcrowding.
- Some staff are not friendly to children.
- GUSCO should improve the diet – we eat too many beans.
- GUSCO should employ more nurses; two nurses are not enough for all the children in the centre.
- Maybe GUSCO can share the quality childcare standards with parents: *"Some of our fathers are so cruel and do not bother giving us food or sending us to school."* Parents and relatives who come to visit the children should be taught about the quality standards.
- GUSCO should introduce the quality standards into schools. *"At school, teachers are fond of beating children and giving them heavy punishment."*
- The latrines are very dirty.
- Young babies and their mothers are treated better than us (adolescent boys). All children want the same treatment; for example, young mothers are given bags for the babies and the boys also want the bags.

Table 10. Age and gender of transit centre residents

Age	Female	Male	Total
0–5	40	40	80
6–10	7	13	20
11–17	24	38	62
18+	55	3	58
Total	**126**	**94**	**220**

women have their own children. Some of these young women will require this type of transit response, for example if they are rejected by their parents upon return to their homes. In such situations, GUSCO often provides vocational training and start-up money to enable the young women to generate their own income.

It was recommended (by the Implementation Team member) that GUSCO would be better placed to support most of these young women in the community, as they are capable of caring for themselves. There appears very little reason for these young women to be in the centre. If rejection is an issue, they could perhaps share a house in the community, and protection and support from GUSCO could be provided at that community level. Such a community response could also be useful for women in the community who have become pregnant through rape and abuse as a result of the conflict, but who were not adducted.

Furthermore, there is a heavy emphasis on the use of Western and traditional methods of psychological counselling and healing respectively, which is a principle reason given for the retention of children in the transit centre, even when families have been traced. Additionally, children are not given a choice about coming into the centre or being reunited immediately with their families. Research and best practice would suggest that children's healing would be best served with the earliest return to their families. It is, therefore, recommended that children should only enter the centre if there is no identifiable or accessible primary carer, or if there is no community-based care alternative, such as the model proposed for the young mothers. Psychosocial or traditional supports could then be provided through GUSCO's community-based services. This would benefit the children receiving early reunification and would also, because of reduced numbers, offer a better quality of care for those children who have to remain in the centre.

The GUSCO Implementation Team member lobbied within GUSCO and locally to stimulate commitment to the standards. The resulting recommendations included:

- Initiate staff capacity-building programme on the quality childcare standards.
- Identify specialist services for orphans and HIV- and AIDS-affected children. Seek support from TASO (HIV and AIDS specialist network organisation in Uganda) and others (generic services in communities for vulnerable children).
- Strengthen collaboration with stakeholders, especially district authorities.
- Make an organisational commitment to quality standards in all operational areas.
- Identify the maximum capacity of the GUSCO transit care centre.
- Bring child participation to a higher level.
- Review recruitment procedures.

- Ensure proper staff supervision.
- The quality childcare standards should be included in revised training manuals and in a stand-alone childcare training manual.

Impact on quality

Following all discussion and consultations, the following actions have been undertaken:

- Forums now exist for children to voice their concerns, including group discussions, Family Talk and separate boy/girl groups.
- Children participate in adult forums.
- The centre encourages people to do research by talking to the children rather than the staff. However, the children are now given a choice in this and the centre is drafting media guidelines for interviewers, researchers and journalists.
- There is improved supervision of care staff.
- Care staff are more aware of their roles.
- The standards were presented to the Uganda People's Defence Force and they are intending to adopt them in their work in the Child Protection Units.
- A measure for maximum capacity of children in the transit centre has been raised with the district authorities.
- A child protection policy is not yet in place but there is a commitment to take this forward through Uganda Child Rights NGO Network, which has a draft policy for member organisations.
- The management of community-based referral centres is committed to taking the standards forward in all its work.
- Organisational training manuals for the centre and the community-based work are currently being revised.
- District leaders of Pader, Gulu and Kitgum Districts will incorporate aspects of the standards as part of their working documents; for example, they will have a childcare plan to be used by organisations, community volunteer carers and community care advocates, in all community outreach activities.

Two additional comments were made by the GUSCO team members: children sometimes misuse the suggestion box to insult staff and some children do not participate in forums, yet end up complaining. This is common in the early stages of introducing more participative approaches, where children are still wary and do not yet know whether their views will be taken seriously. It is therefore important to manage participative processes carefully and encourage the children to take part.

At the time of publication, there was limited direct evidence of the impact of the recommendations and subsequent actions. Therefore, outcomes of the increased general awareness and the local advocacy undertaken should be reviewed over time. Regular consultation with the children would be a good way of assessing evidence of any changes in transit centre practices.

Case Study 3: Save the Children in Uganda

Background

Save the Children in Uganda (SCiU) is a consolidation of three Save the Children agencies, namely, Save the Children Denmark, Save the Children Norway and Save the Children UK, with Save the Children Norway being the lead agency. This consolidation is part of the International Save the Children Alliance global strategy.

In northern Uganda, Save the Children provides technical and financial support to a range of partner organisations. Such technical support includes building the capacity of the Uganda People's Defence Force (UPDF) and, more specifically, their Child Protection Unit (CPU), community volunteer committees (CVC), and local NGOs (including GUSCO) to strengthen an effective response to war-affected children. Training for UPDF staff has included child rights, protection, psychosocial support and HIV and AIDS.

Note: Unfortunately, the SCiU participant involved in the implementation process left the organisation for a new post prior to the conclusion of the process and, therefore, information in the following section is somewhat limited.

Applying the standards

Initial assessments and discussion in relation to the quality childcare standards were undertaken in collaboration with GUSCO, as many areas of work are interrelated. Thus, the information on the background context is as previously stated.

It was clear from the partner agencies that quality childcare standards were an entirely new concept in northern Uganda. As a first step to implementation, SCiU organised a series of capacity-building and training workshops for partner agencies, including the UPDF Child Protection Unit, Nutrition CVCs, and 'night commuter' volunteers and caregivers. Key weaknesses and challenges identified by these groups included:

- the rate and quality of implementation is affected by the lack of budget allocation to this area
- insecurity: some areas are inaccessible due to sporadic fighting
- massive transfers of trained staff within UPDF
- limited knowledge of childcare in the district.

Training components were tailored to the work of various partners; for example, UPDF training included application of the quality childcare standards in the CPU; the focus for nutrition CVCs was on the use of the standards and assessment formats when tracing, referring and handling cases of malnutrition; and for the 'night commuter' staff, the focus was on the role of caregivers and the translation of child rights into practical standards for the care of children. The notion of care planning was strongly emphasised with all these groups, with action plans being set up at the end of each training activity.

Impact on quality

SCiU is the lead agency for the Gulu District Psychosocial Core Team and it was planned that the quality childcare standards and the issue of maximum capacity for transit care would be raised as an agenda item at the next meeting.

Case Study 4: Uganda Reach the Aged Association (URAA)

Background

The Uganda Reach the Aged Association (URAA) is a not-for-profit non-governmental organisation, established to work for the improved welfare of older people in Uganda. URAA is a member of the HelpAge International (HAI) network and receives technical, capacity-building and financial support from HAI.

The HIV and AIDS pandemic has had an enormous impact on older people. Often, older people are the most vulnerable to endemic poverty and social change; they have little income-generating capacity, and in the majority of cases, they are the sole carers of their orphaned grandchildren. While such grandparents can provide attachment, a sense of identity and belonging, they often struggle to provide for the children's basic needs, such as sufficient food, shelter, clothing, medical care and education. In URAA's operational area, the average household consists of one elderly carer and six grandchildren.

These elderly carers face a number of additional challenges, other than the endemic poverty and unemployment common to the population in Uganda. As older people, they are unable to access loans generally available to other people in the community. In addition, even when they have land, their declining physical strength inhibits their ability to produce sufficient food for the family, never mind acquire profits for other needs. Furthermore, traditional social support networks, such as the extended family, are already overburdened by the impact of HIV and AIDS. Often, the elderly carer may be the only surviving adult in a family.

Through supporting elderly carers to care for their grandchildren, the burden on the carers is reduced and the lives of children improved. The aims of the URAA Intergenerational Care programme are to:

- improve the quality of life for vulnerable older women and men caring for AIDS orphans and other orphans in Uganda
- improve the welfare of older women and men, and their orphaned and dependent grandchildren.

To achieve this, URAA has the following strategies:

- advocacy programmes, including awareness-raising and sensitisation workshops, awareness in schools through drawing competitions, and production and dissemination of materials
- livelihood programmes to increase access to income through the provision of loans, cash, heifers, house construction and repair
- grants for blankets and seeds, start-up capital for member groups, help with school fees and educational materials, vocational training and walking aids for people with disabilities
- increasing awareness, skills and knowledge on HIV and AIDS care and prevention through the training of older people as home-based caregivers and counsellors.

Through this work, URAA provides support to 2,260 children in its areas of operation.

Applying the standards

Like other members of the Implementation Team, the URAA member first lobbied within URAA to gain the commitment of the management group and partner agencies to consider the quality childcare standards in their work. The greatest challenge to this was that children were only defined as secondary beneficiaries to the work of URAA. An additional challenge was the general lack of awareness by elderly carers of child rights. A third, but critical, challenge was the limited number of staff available to offer regular monitoring and follow-up visits to the families. Furthermore, concern was expressed in board meetings about the sustainability of programmes in relation to the children.

A second strategy was to introduce the quality childcare standards to all other stakeholders and to the URAA network members. This was achieved through:

- training for other staff, older people, children under the care of older people and child-headed households

- meetings with URAA partners in areas where implementation of the quality standards will be implemented and providing training on the standards, concluding with action planning exercises
- training for older people, specifically discussing the standards which will be implemented.

Following these training sessions, an assessment on the care given to children by older people was undertaken. The assessment was conducted in Bwaise, a slum area of Kampala City, and in the Namalemba area of Iganga District, which are peri-urban and rural areas respectively. Individual interviews were used and a questionnaire based on care standards was drawn up as a tool for collecting information. The selection of the homes to be assessed was done randomly to provide an overall picture. After each interview, the carer or older person was advised on how to provide better care for their grandchildren, within their means. This was monitored over time to assess changes in the standard of care provided. Findings of the assessment were disseminated during training workshops (on income-generation activity management) for older people. The findings are shown in the box overleaf.

Recommendations

Although grandparents provide ongoing attachments and love for children, which is very important, in many of the families visited the standards of care were low. This was initially attributed to the level of poverty in most households and the large number of children under the care of each older person. Older carers need information on how they can give their dependent grandchildren quality care within their limited means. For example, they should be given information on the nutritional values of locally and readily available, reasonably priced food items, and how to combine these to provide a good diet for their children. Furthermore, elderly carers should encourage children to make choices within these available options.

It was suggested by the Implementation Team that URAA may consider the value of exploring collective income-generation activities which would offer benefits to the children beyond income and food production. For example, relationships could develop between other elderly carers and children, and during periods of ill-health or the demise of one of the elderly carers, there could be a support network for children among the collective group, particularly in cases where children remained as part of a child-headed household.

In view of the lack of staff available to ensure regular follow-up and monitoring of these households, URAA has set up a system of 'nominees'. Nominees are generally close neighbours who volunteer to support the elderly carer and the children. They can offer regular support and assistance on a daily basis, and if the elderly carer becomes ill or incapacitated, the nominees offer invaluable support. Furthermore, nominees may offer a future alternative substitute or replacement carer for the children if the grandparent died or was no longer able to care. This transfer of care offers the children a sense of continuity with someone who already knows and understands them.

Impact on quality

Some very specific changes in practice have been noted in the quality of care provided to children as a result of the URAA activities. These are highlighted in the box on page 52.

Examples of changes in children's lives from children's perspective

- One boy, John, told URAA that he now makes choices about his clothes and sometimes about food. John said he used to go to the market from 7pm to 12pm, but now he delivers the food to the roadside, and his grandmother sits and sells the food. By 8pm, John is back at home and has enough time to play. When this subject was first discussed, John said he had to do it because he is the oldest. John also said his grandmother was now keeping health records for the children. Also, although there are many children in the house, the boys and girls now sleep separately. John said that his life at home has really changed and he feels much more free.

- A young girl called Grace reported: *"I am allowed to play and am only disciplined when I have done something wrong. We all still sleep on the floor, but we are able to sleep separately."*
- Ten-year-old Francis says his grandmother has no bathroom but now she takes him to his uncle's house to bathe.

Findings from the assessment

Child protection practice: Older people are not very sensitive to symptoms of child abuse or exploitation, Many of the children are involved in casual child labour and household tasks that have some negative impact on opportunities for study and play. Many girls are married young (eg, 15 years). Some people are aware of signs of sexual abuse among their grandchildren but have not addressed these concerns.

Core planning: Most children do not have care plans, but the majority of older people have made wills (re: property, land, houses and assets to pass on to their grandchildren). There is little continuity planning as to who will care for children when their grandparents die. Thus, children are often left in child-headed homes with the eldest as caretaker.

Diet and personal care: 85% of the orphans and OVCs under the care of older people live on two meals a day, with the major meal being dinner and the other tea with some of the left-over food. The diets are usually balanced. However, some cases of malnutrition have gone untreated due to lack of money. Children have little say in what food they eat, though older children are often engaged in preparing meals with their grandparents. Children and grandparents generally enjoy meal times together, as they talk, laugh and feel rested. For the older people in Bwaise (peri-urban), there was no access to clean safe water, and children were travelling long distances to collect water.

Health: All the children received some immunisations, but not all necessary treatment is affordable. Children generally do not have regular health checks. Only a few grandparents had health records for their grandchildren. Some health information is passed to children via stories from grandparents. Most of the orphaned children did not have birth certificates, and where these were available they were not given to the grandparents on the death of the parents. Sanitation facilities are generally available for children in urban areas, but in rural areas the majority of children (76%) have no latrines and/or have to walk some distance to a latrine.

Play and recreational activities: Children have some time to play at school. At home, children are given some time to play but spend most of the time working. Play at home is often restricted to a small area due to limited space.

Privacy: Most of the older people's homes are very small with no place for privacy. Homes have an average of two rooms shared between one grandparent and an average of six orphans plus other dependants. The bathrooms, latrines and rooms are all shared, though many of the homes had a different bedroom for boys and girls.

continued opposite

Findings from the assessment *continued*

Choice: Children do not have much say in preferred schools, clothes, food, etc. Choices are generally made by the adults as defined by their financial situation.

Dignity: Children's needs are known and older people try to meet each child's needs, subject to financial constraints.

Relationships and attachments: Generally, the relationship and attachments between the grandparents and children is very good. Children are cared for as individuals. Grandparents often offer a lot of love and emotional support and children are happy to live with them. However, children's rights are often violated, with many excuses made, ranging from ways of disciplining to lack of income to support children.

Children's sense of identity: Children are called by their family and given names, and their religion is respected. However, children are always called 'orphans', resulting in low self-esteem and discrimination. On the death of parents, children may be shared between relatives and seldom all get together.

Care, control and sanctions: Children are taught basic rules of social behaviour, that is, respect for property and one's elders. Any form of disrespectful behaviour or social deviation is punished. Children with unacceptable behaviour are advised and encouraged to change.

Children's voices: Children are traditionally trained not to answer back to elders and to appreciate whatever support is provided. Therefore, children do not air their views freely about the kind of care they are receiving. However, in many homes grandparents and children have kept personal secrets.

Children's views

In addition to the assessment undertaken with the adult carers, some consultations with children highlighted the following children's views.

- Children are not yet able to decide on food they want to eat. They decide within the range of food available, but they would really like to eat other things.
- Children stated that they do decide on which schools they want to attend.
- Children felt there was too much work.
- Grandparents spank and beat the children to discipline them.

Impact on quality

- Each child has a book for medical records and these are now being taken to government health centres.
- Older people have taken more interest in the way they care for grandchildren. Some have taken children back to school.
- Children choose from a range of schools that their older carers can afford.
- A number of families have made efforts to increase the allocation of space in their house for the children, especially for girls and boys to have more private sleeping areas.
- Girls are being escorted to the communal bathrooms.
- Children have more time to play and fewer children are going to the gardens to work before school.
- Older people have drawn up wills for their children, indicating their choices for alternative carers after their death.
- Grandparents still spank their children but have tried to turn to other ways of discipline, and children are responding to these alternative positive forms of discipline.
- Children can now choose their meals, and nutrition has improved.
- URAA and partners, including community leaders, are more aware of quality standards of care for children.
- More programmes are specifically including quality childcare standards in their projects.
- Vocational education for older children and school fees support for younger children are being provided.
- Radio programmes covering eight districts in eastern Uganda have broadcast programmes on quality childcare standards for children and older people's rights for a period of two weeks.
- Funding has been given by partners to improve the scope and range of training.

Case Study 5: HelpAge International

Background

HelpAge International (HAI) is a global network of over 60 not-for-profit organisations, working in 48 countries. HelpAge International was established in October 1983 with a mission to work with and for disadvantaged older people worldwide to achieve lasting improvements in the quality of their lives. HAI focuses on issues of ageing and development, poverty alleviation and human rights, working with and for disadvantaged older people.

HAI is aware of the positive contribution that older people make in keeping communities together in emergency situations. This is particularly the case in the current HIV and AIDS crisis, where older people are the primary carers for orphaned and abandoned children. Much of the focus of partners' interventions is on offering support such as access to healthcare, adequate food, clothing and shelter to the elderly. In some countries, they also support training initiatives on income-generation activities (IGA) for older people and older carers.

Applying the standards

The process of implementing quality childcare standards has meant HAI, in the region, has initiated more targeted work on children's issues. However, considering HAI's role as an international agency providing technical and financial support rather than direct services, opportunities for comprehensive application of the standards were lacking. Areas of focus were dictated by their appropriateness to current agency strategies and the limitations of programme funds. Yet, overall, the quality standards have provided a useful focus on children in HAI's ongoing programme and advocacy efforts. Issues which have been covered include the following:

- **Data** – Information on children and their needs was included in data collection systems.
- **Needs assessment** – Prior to programme development, planning now includes a section specifically on children, including their voices and views; and the quality childcare assessment format (see Appendix 2) is used to gather information on each child.
- **Programme development for six donors** – Programme funding applications have been submitted with a focus on quality care for children in order to access care resources and IGA activities.
- **Africa Programme** – This now has an advocacy component which includes childcare grants.
- **Training on child protection** – This is planned, although not yet funded.
- **Monitoring** systems are utilising some of the childcare standards[24] (such as an indicator on percentage and performance of children attending school) for HAI's HIV and AIDS programmes in eight African countries. Also, standards are used to monitor impact and change (eg, what are the issues for children and what do family members say).
- **Management support** has helped to identify new partners and promote implementation of the standards.
- **Research** – In partnership with Save the Children in east and central Africa, research regarding cash transfers in southern Africa is being carried out.
- **Partner culture** is changing in relation to children (URAA as a great example).
- **Children's views** – Children's voices are sought and heard.
- **Advocacy messages** are being developed and will be related to the welfare of the child with the main focus on education and healthcare. An article on the quality childcare standards was included in the regional newsletter.
- **Leverage of HAI work** – The ability to work with children widened our donor funding base to include those interested in intergenerational work; this also promoted a better image.

Impact on quality

As a regional and technical support agency, HAI has great potential for advocacy at different levels. While the evidence from the child-specific monitoring was not available at the time of publication, an increased focus on children's rights in these areas is evident.[25] In addition, the use of the assessment format and the inclusion of children in the assessment process will ensure that children's issues will, at least, be under discussion and, at best, be addressed through HAI partners and programmes. The additional funding applications will also contribute towards the realisation of quality standards.

Having clear indicators on quality childcare available through and promoted by HAI will prompt discussions on quality at all levels. Through the initiation of such dialogue, quality childcare will increasingly be on the agendas of other agencies and partners. Within the current regional HIV and AIDS programme being implemented in eight countries, HAI has increased the focus on support for orphans and vulnerable children using the standards as a good practice guide. All data collected on outcomes relate to the childcare and support, with new programmes under development in Uganda, Lesotho, and Swaziland.

Case Study 6: Save the Children UK – Democratic Republic of Congo programmes

Background

Save the Children UK works in three principle areas of the Democratic Republic of Congo (DRC): in Kinshasa (the capital city) in the west; in the centre, in Mbuji Muyi (the second largest city in the centre of DRC); and in the east, in Goma, Bukavu, Bunia and Ituri. This case study consists of two parts, describing how the quality childcare standards were applied in western DRC and in eastern DRC.

Background information: western DRC

In the western DRC, increasing numbers of children are being expelled from their families on the basis of accusations of witchcraft and poverty. The rise of this phenomenon appears to link directly with the extreme economic hardship and the increasing number of revivalist and evangelical churches. The abuse and violence meted out against these children is severe. Apart from the physical abuse delivered on the justification of cleansing the child, children are subjected to excessive emotional and psychological pressure to accept 'deliverance'. Such approaches often result in children being expelled from their family homes or sent to institutions or to the street. For example, Save the Children UK research shows that 70 per cent of street children in Kinshasa have been accused of witchcraft. In addition, since the end of the recent conflict thousands of former child soldiers are returning from the armed forces, either returning directly to their families or requiring support for tracing and reunification with their families.

Over the last two years, Save the Children has been implementing social and legal protection projects in the urban areas in Kinshasa and Mbuji Muyi. The programme has developed significant expertise on child protection for children at risk in urban areas, and from this, it is initiating the following intervention strategies:

- **Research and monitoring**: Two major pieces of research have been completed on the causes of separation of children in Kinshasa and Mbuji Muyi. Surveys on the profile of separated children as well as ways to reintegrate them into their communities have also been completed. Monitoring of abuse has been achieved in residential homes, at community level and in revivalist churches that practise exorcism on children accused of witchcraft.
- **Promoting a legal framework and child protection policies**: The programme has been involved in supporting progressive legal reforms and developed a national consultation framework for a new Code of Protection for children.
- **Prevention of separation**: The programme is working with multiple sensitisation approaches in communities, including parental skills training, sensitisation programmes on child protection for religious leaders, and training programmes for local authorities at district and community level.
- **Transitional care in institutions**: The programme supports partners in the temporary care, tracing and reunification of separated children, former child soldiers and children expelled from their families because of accusations of witchcraft. Quality childcare standards are applied in these centres and communities.
- **Reunification and reintegration** are major areas of work, with some 1,800 children having been reunified after tracing and mediation processes. This area of work has also included the establishment of community child protection networks (RECOPE) which offer ongoing support and assistance to children and families in their own communities.

The programmes in Kinshasa[26] and Mbuji Muyi work with a range of government and non-government partners.

Applying the standards: western DRC

Save the Children used a participatory approach to promote ownership of the standards among all key partners involved in care provision for children in Kinshasa and Mbuji Muyi. Building on training

workshops on the quality standards, a series of activities was organised. Initially, partners shared information and experience, to ensure consistent and clear admission and referral policies in relation to care provision. The outcomes of these discussions were shared with local leaders and other relevant stakeholders to bring together a wide range of actors for advocacy work. It was proposed that the quality childcare standards should be included in the training of social workers, and incorporated into the ministerial level Code of Protection for Children. Furthermore, it was suggested that the standards could be used as the basis of criteria to determine which agencies and institutions can be authorised to care for children. Finally, all the participating partners were engaged in efforts to establish a system for accountability, follow-up and assistance to institutions in implementation of the standards.

Following these activities, government departments in Kinshasa and at provincial level (DIVAS) have informed institutions that they must comply with the standards, and local committees are being supported to follow up on institutions to assess levels of compliance in Mbuji Muyi. Government partners have stated that this type of inspection is what they must do to follow up on children. However, a number of constraints were identified through partner assessments which detracted from quality childcare (see box below).

Recommendations

It has been found that there is lack of information and carers do not know the law, and many training events are necessary to build awareness and promote implementation. Thus, a number of training events were undertaken in December 2004, January, April and September 2005. The training was run as part of a range of progressive activities; for example, childcare committees were established to support implementation, assessment and follow-up of quality childcare standards in institutions.

Constraints identified through partner assessments

- Lack of water in institutions in Mbuji Muyi.
- An expressed lack of means or ways for some partners to implement quality childcare standards.
- Numbers of children in institutions were increasing; thus, there are more children and less staff.
- Lack of engagement by partners in providing adequate care for children.
- Institutionalisation is accepted by the Ministry of Social Affairs as the main option for children deprived of parental care.
- Children are placed in institutions with no follow-up. Currently, Save the Children has nine partners in Mbuji Muyi who provide institutional care, but there are many more institutions. In Kinshasa, there are 12 partners, but the actual number of institutions is unknown; some estimates are as high as 1,500 institutions in total.
- In Kinshasa, the World Food Programme provides food to institutions with more than 20 children, and this prompts unscrupulous individuals to establish institutions, sell part of this food and only give the remainder of the rations to the children in their care.

Activities in relation to improving quality of childcare

- **Training on quality childcare** – 92 participants received training between December 2004 and March 2005.
- **Supported rehabilitation of infrastructures** provided within institutions caring for children (December).
- **Follow-up meeting** on standards was held with partners who had been trained (to review progress on partners' three-month action plan).
- **Additional support provided** – 25 representatives from NGOs and public institutions who had participated in quality standards training found that some institutions needed medicines and gave support to buy medicines for three children's homes.
- **Consultations with 18 children from six partner centres** were conducted (in February). Findings included children's wishes: to improve the education within the centre; to access clean, fresh water for improved health; and for carers and teachers to change their attitudes towards children.
- **A participation workshop with children in Kinshasa and Mbuji Muyi** was conducted in April for 30 participants, including 20 children. The children led discussions, requesting better application of particular standards.
- **Collaborative action** undertaken by DIVAS, networks and institutions which have been trained and have adopted the standards. In the process they have found that: 1) some of the institutional standards require development of administration and documentation systems; 2) some partners are setting a schedule of activities with the children; 3) supporting participation of children in the institutions also brings together workers to express themselves; and 4) children can be effectively involved in advocacy work through a Theatre for Development approach.[27]
- **Childcare committees** are able to follow up on the admission process and the placement of children, both for children already in the centres and for new admissions. National law prohibits moving children without following the admission policy. Setting up these structures and admission policies can have a much wider impact, as other institutions will be affected.
- **Additional training** was organised on the UNCRC, national law and the Organisation of African Unity (OAU) Charter. Increased efforts were made towards implementing national law in institutions and children's centres. Furthermore, partner agencies are advocating for additional training programmes for other institutions.

Impact on quality

Following this work in Kinshasa, a report was given to Minister of Justice based on the inspection of institutions. The government responded by requesting that training on the standards be given to all institutions, and then for appropriate sanctions for non-compliance to be introduced. In Mbuji Muyi, the 20 institutions that had participated in the training were allowed a specified time to comply with the standards (but not all are applying all the standards at the same time). The establishment of a government-supported system with follow-up mechanisms will ensure far broader impact on quality care developments, especially if sanctions are imposed for those institutions which do not comply with defined admission and referral processes.[28] This is critical, as it is far better not to admit a child inappropriately to an institution in the first instance, than to try to reunify a child after admission.

Background information: eastern DRC

Since 1999, Save the Children has been managing programmes in eastern DRC to prevent the recruitment of child soldiers, and promote the release and community reintegration of children associated with armed groups and forces. The number of child soldiers in DRC is unknown. Estimates are as high as 25,000, but many children who are associated with armed forces, particularly girls, have never been counted.

To date, programmes have supported the reintegration of over 1,800 children, mainly in North and South Kivu. While there is a formal peace agreement and a transitional government has been established, real peace has yet to come to the east of the country. Despite the recent agreement to a national plan for the demobilisation and reintegration of combatants, most children currently enter transit care either by escaping armed groups or through informal, ad hoc releases initiated by local commanders.

In addition to more than six years of armed conflict and displacement, the population of North and South Kivu has suffered nearly 30 years of economic neglect by the regime in Kinshasa. Because virtually all families suffer from extreme poverty, exacerbated by the conflict, efforts on behalf of especially vulnerable children have to carefully assess community realities. This is particularly the case in work to reunify street children and children accused of witchcraft who have been rejected by their families; many of these children are currently living in institutions.

Applying the standards: eastern DRC

From eastern DRC, the focus of the work documented in this report is specifically the work undertaken in relation to the transit care centres supported by Save the Children (UK) but managed by partner agencies. The standards were shared by the Implementation Team member (who works for Save the Children UK providing a technical support role) with staff from Save the Children UK and the partner agency who run the transit centre. Initial assessments highlighted a series of challenges in relation to improving the quality of care in the transit centres. See the box opposite.

Recommendations

In response to these challenges, and in consideration of the negative attitudes of staff and their resistance to change, the Implementation Team member developed a strategy to establish immediate material changes for children, combined with activities which demonstrated the skills, capacity and abilities of the children to the transit centre staff and managers.

Initially, activities focused on:

- creating awareness between parties of their activities and approaches, and of the quality childcare standards
- training other partners on quality childcare standards
- lobbying of provincial government partners.

See Table 11 on page 60.

Challenges faced in improving quality of care in the transit centres

- Lack of synergy between partners as an obstacle to implementation
- Partners lack of commitment to the children in their care
- Extreme lack of capacity in terms of childcare and development
- Poor recruitment processes. Staff are selected through a 'word of mouth' approach with limited, if any, checks on their background. No systematic assessment of suitability to work with children
- Induction, recording and documentation were poor
- Negative values and attitudes of the partner staff – task of care perceived as one of control
- Poor staff deployment
- Insufficient staff:child ratio
- Insufficient and inadequate accommodation
- Poor hygiene and sanitation
- Overall quality of sleeping and bathing arrangements inadequate
- Children had no choice in the centres
- Staff and management awareness and understanding of the child protection policy is very poor
- Sanctions were ad hoc
- Staff and management resistance to the changing system
- Despite training inputs, little evidence of any change in practice

Practical changes achieved have included:

- Child participation – fresh food, more varied meals, menus posted as a way to involve children
- Modules developed on Quality Child Care Standards for staff
- Dealing with conflict – ongoing work with the team on what sanctions exist, thereafter work with children on defining and agreeing acceptable sanctions
- Beds with mosquito nets in every centre
- Standardise facilities – eg, playgrounds, bedrooms
- Staff rotation and duty rosters are being implemented, although a way to deal with absenteeism is still being sought
- Employees' salaries have been increased to keep them in the centre longer
- Children have access to their personal records and confidentiality is observed

Table 11. Immediate activities undertaken and outcomes achieved

Activity	Outcomes	Support activities
Beds provided in every centre are limited to standards of quality	Reinforce child protection against abuse during the night, and the number of children in each bedroom arranged by age as far as possible	
Choice of fresh food in each	Increase child participation, with meals more varied and chosen by children; reinforce trust in relationships between children and adult transparency on question of expenditure	Guidelines developed for each transit centre team
Welcome children into the centres	Create a safe and open environment for children from the first day of arrival in centre; anticipate risks or conflict; staff prepared to answer questions from children and alleviate their worries	Module for staff based on observations and evaluations of conflict in centres
Dealing with difficult behaviours	Help staff identify responses to adapt in crisis situations	Module developed for staff on this theme
Develop varied creative activities (paints, drawing, sports, games, music, etc)	Various activities: increase understanding of adults of the importance of play, implementation of activity plan; reinforcement of the belief in children's capacities	Proposal for standard weekly activities plan
Job descriptions for transit centre staff developed	Staff have clear objectives on what they are supposed to do	Adopted in Ituri, North and South Kivu
Standardisation of kits for each arrival in centre	More appropriate content and avoidance of injustices in delay of distribution, items, quality, size, etc and to be more organised to meet emergencies	Guidelines developed for each transit centre team and for emergencies: adopted in Ituri, North and South Kivu
Complete full assessment in one transit centre	Internal investigation on allegations of abuse	
Theatre for Development with children in the transit centre and children reunified from the centre last year	Success of gathering all these children (from different armed factions) through recreational activity, advocacy with staff on the ability of ex-child soldiers to do something well	
Reinforcing the daily Save the Children presence in transit centres	Accountability possible on the implementation of standards in each transit centre; reinforce child protection daily	Official policy for the management in all east DRC transit centres
Moving one centre that was based in an insecure area	Centre relocated to a safe situation in the town to limit rebellions and the army presence in the compound	
Documentation by photographs – Polaroid	Increase reunifications after unpredicted demobilisations (400 children in three transit centres)	
Emergency welcome for 160 children in two days	Limited problems because of implementation of basic standards	

Children's request for application of standards in all transit centres

Children seeking 'asylum' have requested that all the centres could have the same standards. Thus, Save the Children's challenge is to advocate for quality childcare standards to be applied by all agencies running transit centres.

During a recent visit by a delegation from the French government to the transit centre, the Ambassador was impressed by the children and expressed his interest in advocating for wider application of the quality childcare standards in other agencies working with ex-child soldiers.

Impact on quality

A number of changes have occurred as a result of the activities undertaken. Some changes are immediately apparent in terms of the children's living environment, but others are more attitudinal and, as a result, behavioural on the part of both the adults and the children.

Regarding attitudinal and behavioural change, the use of Theatre for Development approaches to empower the children and support them to raise their concerns through drama and dialogue activities have improved communications and relationships between adults and children in the centre. Furthermore, the children's self-esteem, self-respect and sense of purpose have risen dramatically, as has their trust in each other and their adult carers. For example, a common feature of the transit centres, is 'revolt', or 'rebellion', on the part of children. Given their background, ie, former child soldiers, and the context in which they are placed, ie, poor institutional care with few activities or resources and often being treated with little respect, tensions and frustrations have built up. The most common outlet has been for the children to work collectively to challenge the staff, hence the 'rebellion'. However, since the changes brought about by the quality childcare standards activities, the atmosphere in the Save the Children transit centres has improved remarkably and children's participation has been encouraged through more positive outlets.

Case Study 7: South Sudan – Child protection and water and sanitation programmes

Background

The abduction of women and children from the south and their assimilation for purposes of reproduction and child exploitation in the north is a primary factor in the disruption of families, communities and South Sudanese society. Strategies for the return of such women and children have been in place for some years, and in recent years this reunification has been stimulated from both the north and the south, although abductions are still taking place.

In collaboration with UNICEF and other partners, Save the Children documents cases of abduction, child soldiers and separated children in nine counties of Aweil, Warab, Jonglei and Unity states in South Sudan. Basing their work on the UNCRC and good practice, the identification, documentation, family tracing and reunification of these children, using an established database, is the primary focus of the project. In addition, by supporting local coping mechanisms, traditional systems for reconciliation and retrieval of abducted women and children, and follow-up of returnees in their communities, the programme ensures that reintegration will be successful and sustainable. Providing support for community income-generation activities also underpins family reintegration.

The programme has established strong and durable responses for the returnees. Reunification is handled largely by the local community care committees, and as a result, the majority of returnees are reunified within a few days of return. For the few children whose families are more difficult to trace, small centres have been established where (usually) one or two children are cared for until they return to their families or are placed with a foster family.

As part of broader efforts to promote the realisation of children's rights, the programme has supported the development of 14 children's clubs over the geographic areas in which it works. Children's groups have received training in rights and responsibilities, and attended workshops to develop their understanding of how they can actively address their concerns in their community. The programme also provides training for project staff, partners, community-based child protection networks, local authorities and schools on relevant and contextually based aspects of child protection, including the quality childcare standards.

The programme also works in collaboration with others to advocate for children's and human rights at all levels, from the grassroots to the international – for example, to prevent the use of force in returns, or to advocate for the identification and release of abducted children. Furthermore, the programme is supporting local authorities and communities to discourage harmful traditional and cultural practices such as early and forced marriage through advocacy for legislative reform in the national constitution and traditional customary law. Further areas of interest include research and consultancies on child labour, children's issues in customary law, and protection and reintegration through education.

The focus of this case study is in two parts, efforts to apply the standards in the child protection programmes, and efforts to apply the standards in the water and sanitation programmes. The Water and Sanitation Programme in South Sudan focuses on developing community-managed water points to provide sustainable sources of clean drinking water, building of latrines, and providing hygiene education. The target groups for these efforts are returnees and host communities affected by abduction and conflict. As part of these efforts, relevant training on child rights and protection has been given to local leaders, water committees, hygiene motivators, village water management committees and school clubs. The

programme is not directly involved in providing childcare and for this reason offers a very interesting example of how the quality childcare standards may play a wider role in improving the lives of children.

There is limited access to water, particularly clean drinking water, for most of the population. Seasonal weather patterns result in long, hot dry periods, with extensive flooding during rainy seasons. Population movement for pastoralists and work patterns are affected by the climate and this has a direct impact on programme timetables for agencies operating in South Sudan. As the population is dispersed across large geographic areas, interventions are located in several communities separated by distance and often cultural diversity. However, agencies have tried, despite these constraints, to provide support to communities.

Applying the standards: Child Protection Programme

The application of the quality childcare standards is still at the elementary stage. The Save the Children programme staff initially provided training on the quality childcare standards to civil authorities, community-based organisations and care committees. However, as the training was limited to only two days, participants have asked for additional training on the standards.

Progress on the programme for this work was disrupted in late December by an influx of 5,000 women and children returning to the south, as the government of Sudan supported mass returns of 'abductees' from the north to the south to demonstrate to donors and other actors who have criticised their lack of action, that there were in fact activities underway. There are cases where some of these returnees have stated they have been forced to return; for example, children of southern origin have been rounded up in market areas, and women living independently have been taken from their children and put on trucks to the south. This clearly constitutes a violation of rights. As a result, UNICEF and Save the Children have used very strong advocacy to stop such 'forced' returns.

Community-based child protection networks were established and have taken part in the registration and documentation of several thousand people over a number of months in the dry season. These have proved to be effective community structures for co-ordinating tracing and reunification, and for advocating against the violation of returnees' rights. In January and February alone, 1,000 people were returned. Co-ordination and collaboration have been a huge challenge, but Save the Children insisted on women and children being reunified as soon as possible and not held in centres. Save the Children and the care committees reunified 911 children in less than two months. Those remaining in local county centres were still being traced at the time of writing.

Impact on quality

The mass returns of 'abductees' or spontaneous returns of displaced people to southern Sudan disrupted programme plans to fully implement the quality childcare standards and monitor their impact. However, initial training and advocacy was undertaken. Feedback from the training indicates an interest and enthusiasm for greater inputs on the subject matter of the standards. Furthermore, participants in the training found the quality childcare standards applicable to their own contexts and demonstrated this in the reunification processes.

Table 12 overleaf indicates key activities undertaken to date and the current impact on quality care for children.

Table 12. Key activities and impact

Activity	Direct impact on children	Policy and practice	Equity and inclusion	Participation	Constituencies of support
Training, community child protection networks, outreach workers and assistant project officers	Improvement for childcare and protection	Child protection policy and good practice in place	Equal treatment for all children	Children are consulted	Save the Children UK, chiefs, local authority recognition
Registration	Identification	Good practice in use of interagency forms	All children have a sense of belonging	Children have right to an identity	Save the Children UK and local authority
Tracing and reunification	Children are reunified with their parents, clans and extended families	Good practice, using verification and preparation for reunification	All children have the right to be with their parents	Best interests of the child	Save the Children UK and local authority
Follow-up	Ensure their well-being	Realisation of children rights	Reintegrate	Continuation of consultation with children	Save the Children UK and local authority
Reintegration support	Children's parents have to be supported	Ensuring their reintegration	Ensuring their equity in community environment	Children's clubs and education	Save the Children UK and local authority
Income-generation activity	300 returned children to benefit	Level of vulnerability is observed	All vulnerable children to be treated equally	New focus on small income-generation projects through children's groups	Save the Children UK and local authority
Children's clubs	Child participation	Advocacy	Inclusive of girls and children with disabilities	Develop leadership roles, raise awareness of issues affecting children	Save the Children UK and local authority

It is intended that the next training for the Community Child Protection Networks (CCPNs) will result in concrete actions being taken and strategies relevant to them being developed. The forthcoming plans for these CCPNs will also look at defining practice standards and procedures with each CCPN, devising a training programme for carers and potential carers, and equipping the CCPNs to keep confidential records, etc. Monitoring on application of the standards will be undertaken in future through the Child Protection Programme.

Applying the standards: Water and Sanitation Programme

As a first step, feedback was provided to the programme management and stakeholders through a community meeting. This was followed by the quality childcare standards being incorporated as a component in all elements of the Water and Sanitation Programme, as illustrated below.

- Eighty women and 120 men undergoing three-month training on hygiene were introduced to elements of the standards, where appropriate, as an aspect of the training.

- Annual teacher training incorporated introduction of the quality standards to teachers, through two-hourly sessions, every day for a week. The healthcare standards were the focus of most discussions. Teachers were positive and enthusiastic about the standards and some of the female teachers brought their children to the training centre.
- Clubs for children aged 0–12 were established to teach others about child-to-child approaches. A one-day meeting with children in three different locations provided training on children's rights and the quality childcare standards, particularly highlighting children's role in decisions affecting their lives.
- The programme staff met with local authorities to discuss the participation of women and children in decision-making. For example, when a well was being built, the children came to see the water source, which offered opportunities to talk with the children about their personal care.

Impact on quality

This programme works on a seasonal cycle and so there was limited time to assess the impact of the work on quality standards. For the longer-term work of the programme, it would be useful to establish monitoring mechanisms with indicators which inform how *actual practice* has changed as a result of the training. Despite the lack of evidence of impact at the time of writing, responses to the concept of the standards were positive and advocacy for the participation of women and children in decision-making is being undertaken.

Part Four: Learning and issues arising

This section of the report highlights a range of critical issues that were debated during the implementation process. From the beginning of the work on quality standards in east and central Africa, it was apparent that there were certain areas of the theory and practice in quality childcare which practitioners found challenging, including:

- management and recruitment
- staff supervision, training and motivation
- the best interests of the child
- children's participation
- children's resilience
- child protection policy and practice
- responding to AIDS orphans
- responding to challenging behaviour.

While this publication is not intended as a training manual, practitioners are encouraged to reflect upon their existing experience and practice, and to make use of what follows to promote the practical application of key good practice childcare principles.

Application of the standards to improve the quality of care provision needs to be localised, taking into account the views of children and adult stakeholders. Improvement in standards generally starts with a conceptual shift in thinking about the needs and rights of individual children, and the quality of care they receive. Thus, reflection and localised action planning, rather than an 'ABC' of how it should be applied, is needed in each context.

Additionally, childcare practitioners and agencies have a role to play in advocating for wider application of these quality standards by government agencies, and increased policy and practice support for family- and community-based care options. Thus, in moving forwards and recognising the scale of the care crisis the final section of this publication focuses on engaging in policy-level advocacy.

Management and recruitment

The difficult and challenging task of childcare is consistently and demonstrably undervalued, in terms of the level of resources and funds allocated by governments, support agencies and donors. While the impact of the HIV and AIDS pandemic has drawn increasing attention and funding to the needs of children without primary carers, there is no corresponding increase in recognition of the skills, knowledge and abilities required to undertake the demanding role of providing alternative care for orphaned, abandoned and separated children. With children constituting an average of 50 per cent of the population of most African countries, and with an increasing demand for alternative non-family care, government allocations for departments of social welfare, and children and family services, are actually facing proportionally declining budgets, with an increasing reliance on voluntary subscriptions and external donor funding. By its nature, such funding is short term and focused on topical issues rather than core funding areas, such as personnel costs.

The lack of value placed on childcare, is reflected, first, in the ways childcare staff and volunteers are recruited and second, in how the fulfilment of childcare roles and responsibilities are managed and supported.

Recruitment processes of local partners and within some of the larger agencies were poor, without effective advertisement, job descriptions, reference checks or induction processes. Recruitment frequently took place without accurate job descriptions or person specifications. 'Recruitment' was often merely a 'word of mouth' process, or, in the case of government agencies, the transfer of an individual at the appropriate civil service grade. The repercussions of such approaches have meant, at best, that already vulnerable children are being 'cared for' by individuals

who may have no aptitude, skills or interest in working with children, and at worst, individuals who perceive children merely as the means to satisfy their own material or sexual needs. Partly due to the limitations of existing infrastructures, background checks on potential candidates were superficial or non-existent. The lack of child protection policies or codes of conduct further detract from ensuring that children in need of care, are protected from the excesses of the abusive, exploitative or perverse interests of some adults.

Sadly, it is the case that where most staff and volunteers are recruited with little regard to due procedure, even those individuals who are committed to, and skilled in, working with children will be forced to work at the lowest level of their capacity, due to the lack of a common purpose and motivation for the collective task of childcare.

The role of effective management is, therefore, crucial in establishing the basis upon which the quality childcare standards can be practised. The appointment of appropriate staff and carers with clear job descriptions appropriate to the tasks of childcare is required. Policies and procedures are essential to guide staff and hold them accountable, and to ensure that sufficient personnel are employed/deployed at any one time to allow for quality care of children. Such measures are all foundations upon which quality childcare should be developed.

An example of where such foundations were lacking was in the GUSCO transit care centre. Within the budget outline, there were six designated social workers, responsible for the care of the 200 children in the centre. In addition to their centre-based work, these workers were required to undertake numerous tasks, including the follow-up of reunified families and children which, in itself, is potentially a full-time role.

Similarly, during the Implementation Team's assessment of the Nairobi Children's Home, findings concerning standards relating to administration, staffing and professional practice, highlighted the following concerns:

- Staff have long working hours, largely due to limited numbers. Staff work for more than eight hours (eg, the security guard may work up to 24 hours in one shift if the other guard is ill; but in practice, a normal shift is 12 hours).
- Overtime is a frequent occurrence, but overtime claims are not considered.
- Caregivers are paid on the same government salary scale as office cleaners.
- Staffing is gender imbalanced. Out of a total of 24 staff, only six are male.
- No system is in place to reward or motivate staff.
- There are limited staff development plans.
- No clear reporting structure is in place, thus there are no clear measures of accountability.
- There is no child protection policy.
- Managers may need support in implementing changes, reporting structure, etc.

In most instances, salaries are constrained by budget resources. However, there is often a large disparity between salary levels for childcare staff who work directly with children, and salary levels for their line managers. In Uganda Reach the Aged Association, for example, in a staff team of five the salary of the executive officer and the programme officer were nearly five times and four times higher respectively than that of the two social workers. In the case of government employees, salary scales are generally set at a national level and posts are restricted to movement within a given point of such scales. Previous advantages which offset low salary levels for government childcare staff, such as pensions, rent controlled or free housing and permanent employment, are gradually being eroded by changes in government policy.

These findings illustrate issues which were also raised in other organisations. In repeated instances, staff motivation and the way in which staff were organised and treated was felt to have a major impact on the quality of childcare. Without giving value to childcare

workers and recognising the importance of their work, it is hard for them to value and give proper care to the children for whom they are responsible. Thus, improvements in areas of management, recruitment, staff support and motivation were frequently prioritised by organisations as they began to tackle implementation of the quality childcare standards.

Staff supervision, training, and motivation

One of the key mechanisms for motivating staff and holding each staff member to account is regular and documented support and supervision. Regular supervision provides opportunities to focus on the practice of individual staff members. When staff members are provided with a regular time to discuss their successes and concerns, to be provided with guidance and to agree amended approaches for their daily work, they feel more valued, committed and enthusiastic about the task in hand. Furthermore, through supervision meetings, managers gain an in-depth understanding about the individual capacities of their team and can identify and respond to problematic staff behaviours or attitudes at an early stage. In addition, regular recording of such discussions offers the potential for informed reflection preparatory to annual appraisals and planning.

Additional recommendations from the Implementation Team included:

- Terms of service, in general, must be improved, and staff and carers must be recognised for the job they do.
- Even if salaries cannot be improved (eg, government system and increment increases have a maximum that cannot be surpassed even with increasing years of service), motivation should be encouraged through training, supervision and empowerment. Years of experience and/or training should be recognised, staff should be able to move up the salary scale, and certificates of training should be awarded.
- Improvements to care staff:child ratios should be made through developing alternative models of care, in addition to increasing direct childcare staff members. For example, when discussing a 'small group home' model, one member of staff from a children's institution stated: *"When I come into work in the morning and see 120 children, I just cannot be responsible for them all. However, if I had six or ten children, I could be accountable – all those children would be properly washed, fed and clothed, and I would take the older ones to school."*
- Include childcare staff in future planning and work development.
- Reinforce management supervision by having a resource centre where staff can talk, have team meetings, have access to job training materials, and link with other organisations for technical solutions.
- Training sabbaticals and secondments could be explored. For example, in the Ethiopian system, government support staff are given professional training which the staff member then pays back by committing to work for a specified period before seeking any external employment.
- Link staff to counselling services.

Attitudinal change was considered by the Implementation Team to be a key factor in enabling the quality childcare standards to be applied. Negative attitudes and misunderstandings concerning children and their rights and the importance of quality care were some of the major constraints faced during the implementation process. If attitudinal change could be brought about among managers and care staff, ensuring a central focus on children, their holistic individual needs and rights, then other obstacles could be overcome.

Positive attitudinal change can be enhanced through efforts to respect staff and give them better support. All efforts at improved recruitment, management and support of staff will further the creation of positive care environment where children are valued, respected, involved in decision-making and effectively cared for.

The best interests of the child

Article 3: The best interests principle, United Nations Convention on the Rights of the Child (UNCRC)

"In all matters concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the children shall be a primary consideration."

The best interests principle should be considered in any decision that affects a child who is present in a particular country, including children who are refugees or asylum seekers. It applies to decisions that affect groups of children, as well as individuals. Sometimes the interests of the group can conflict with the interests of individual children within it.

Article 3 only requires that the best interests of children be of "primary consideration" – their interest does not automatically override all other societal considerations. For example, if a country has limited funds and makes a decision that, in the interests of society, economic development must take priority over healthcare in budget allocations such a perspective could be disputed. This brings us to the core of decisions on best interests.

The UNCRC does not tell us how to resolve conflicting interests or when to give priority to the best interests of a child or children. Thus, it is important to develop guidelines which will assist in determining how to define the best interests in each case and context. Being a "primary consideration" is a minimum standard and there are situations in which a child's interests will be given priority, eg, in adoption (UNCRC, Article 21).

Applying the best interests principle

There are certain times when the best interests principle is extremely useful.[29] These times include when:

- laws are silent (eg, in the case of early marriage, circumcision, etc)
- laws are unclear or contradictory (eg, when some outdated laws are revised but others are not)
- laws are against what is best for children (such as where laws promote custodial sentencing for children)
- conflicting laws (where more than one law may apply)
- different adults or institutions have different interests (eg, parents, police, social workers, owners of institutions)
- inflexible, unresponsive institutional approaches are applied (for example, all disabled children must attend 'special' schools)
- there are conflicts between children and adults (such as over cultural or generational issues)
- organisational approaches do not address the best interests principle and are not child-centred or child-sensitive
- short-term versus long-term interests are being considered.

The use of the best interest principle is common in the case of child custody issues following a divorce. In east and central Africa, as a result of gender inequity, women often have relatively less means than their male counterparts. In the following case example, the father is wealthy but has little interest or involvement in the child and is merely seeking custody of the child for reasons of tradition and control. The mother is poor but has a very sound and long-standing relationship with the child, and is very involved in supporting the child in school. Traditionally, in many African societies, male children go to live in the father's household after the age of seven years, as he can best provide for his material needs. However, both parents have a responsibility for the rearing and care of their children. In this case, it would be in the best interests of the child to remain with the parent with whom he or she has a good and long-standing relationship (ie, the mother), and the father should provide regular

maintenance (as agreed by a court) to ensure the material needs are met. Obviously, the child has a right to inform the court of his or her views prior to any decision being taken.

Positive progress is being made in relation to developing the necessary directions for the best interests principle with the UNHCR[30] and others working towards their own agency guidelines.

While the basis of these principles may conflict with current processes and practices, agencies are encouraged to consider how the above actions could be applied in their own cultural and agency context.

In summary, any best interests decision should take into account the entire range of the child's needs and rights (physical, psychological, social, cultural, spiritual, developmental, legal, etc), the outcome of any assessments, and the immediate and long-term implications of each possible alternative. Determining the best interests of each child requires consultation with the child and all key individuals, agencies and parties who know or are involved with the child and who have a contribution to make in

Guidelines to enable decision-making in children's best interests

- Decision-making should be individualised.
- An assessment of the child's situation should be undertaken.
- Make approaches more flexible and responsive (tailor the approach to children's needs and abilities).
- Ensure children have access to adequate and appropriate information to make informed decisions.
- Ask the child. Child participation is critical, but it does not mean the child always achieves the outcome he or she wants. Consider children's capacity to participate.
- Involve people around the child and consider their views.
- Consider children's needs and not just those of adults. Organise discussions between children and adults.
- Get advice or guidance from other sources (international best practice).
- Consider both long-term and short-term impact on children.
- Assess the potential impact on children of proposed decisions. Disaggregate potential impact by age, capacity and maturity.
- Recognise there is not always a 'best' or 'obvious' solution (in individual cases).
- Consider/offer other options – be creative.
- Consult local laws (legal advice).
- Go to court if appropriate (court decides).
- Consider child-centred and child-sensitive approaches (eg, in cases of court procedures for custody cases, for child abuse cases, for juvenile justice cases, etc).
- Go in stages – process is important for involving children and supporting them to understand the decision finally taken.

Example: Best interests and circumcision of a boy in care

An interesting example of conflict concerning the best interests principle was given by one of the Implementation Team who worked in a transit care centre.

A boy in the centre asked to be circumcised, which raised a number of conflicting views among the carers. One group of carers thought that the boy's wishes should be respected; another group said they did not have the responsibility to make such a decision. The second group felt this was not an essential medical intervention, but a cultural practice, and that the boy's parents should make this decision. However, some of the other carers were of the view that the boy could possibly be humiliated and excluded by his peers if he was not circumcised.

The Implementation Team reflected on this example and gave the following responses from each of their agency perspectives:

- For non-governmental organisations (NGOs) providing temporary care: The agency would not carry out the procedure as the parents should make the decision upon the child's return home.
- For government care providers: The government has a 'duty of care', and for children in long-term care they have a mandate to act *in loco parentis* (in the place of parents) in the child's best interests. If the child was only placed in the government's care temporarily, they would not allow the boy to be circumcised during this period. However, harmful cultural practices of any sort should not be undertaken in either short- or long-term care – eg, practices such as the removal of a child's first teeth (in some cultures, it is thought that if the teeth of a young child are not removed, the child will suffer diarrhoea and sickness).

terms of the child's future. Examples of these would include: extended family members, siblings, teachers, village chiefs, social workers, and agency staff caring for the child, representatives from placement agency, potential carers, etc. Any decision needs to be based on the child's long- and short-term best interests and not solely on immediate solutions. Decision-making should also take into account the protection and development of the child, and be firmly based on the rights of the child. However, the child's participation throughout the process should be ensured.

Children's participation

Children's participation in decision-making is a key principle of the UNCRC (Article 12) and is key to effective implementation of quality childcare standards. In addition, all girls and boys, including

Article 12: The child's opinion, UNCRC

1. State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of natural law.

children with disabilities, have rights: to information (Article 17), to freedom of thought, conscience and religion (Article 16), to form associations (Article 15), to play (Article 31), and to develop their potential and play a responsible role in the community (Article 23, 29).

During the Implementation Team workshops, participants explored various approaches to children's participation, as well as strategies to overcome key challenges enabling fair and meaningful participation. Different approaches to children's participation included:

- consultations with children using participatory methods to determine issues affecting them
- involving children in developing and maintaining the rules and regulations of the care centre
- suggestion boxes for children's views which are regularly viewed and responded to
- support of children's groups, in which children have their own regular space to raise and discuss issues affecting them
- use of Theatre for Development enabling children to identify their own agenda issues, develop theatre on these issues, and engage concerned adults in dialogue and action planning on these agenda issues
- 'Family Talk' events, where all staff and children come together, in a similar fashion to a cultural event
- involving children in recruitment and selection of staff members.

Discussions concerning the need for fair and meaningful participation focused on: processes which enable all children to participate (rather than a select few); protecting individual children who might be raising issues that adults may not want to hear; and the need to develop processes which enable children to influence the agenda, rather than being manipulated or led by adults. Strategies to overcome these concerns included:

- Enable all children to have regular time to meet without adults present, so that they are free to raise issues concerning them, and individuals are free to share their points of view without fear of adults' response. Children can then collectively develop strategies for sharing their agenda issues or concerns with adults (perhaps in a more anonymous way). Regular meetings between children (collectively and/or with their representatives) and adults can then be facilitated.
- Enable an external agency to facilitate child participation and to ensure the children's issues are brought to adult's attention. Self-advocacy by the children (individually and collectively) can be supported, or the agency can present the issues raised by taking on an advocacy role for children, both in individual cases and on collective issues. The external agency could also support broader capacity-building for participation by children and adults within the care setting or community, ensuring there are effective mechanisms for ongoing children's participation and accountable responses by adults.
- Ensure that adults are prepared to share information and power with children in genuine ways. Inform children about the limits of their power to influence decision-making processes (for example, when children are involved in processes to select or recruit staff, they should be aware of the limits of their influence).
- Support wider child-led initiatives such as Theatre for Development or support of children's associations that provide opportunities for children to express themselves in creative ways, to dialogue with adults and to develop action planning on issues affecting them.

Children's resilience

Supporting children's well-being does not just mean providing children with special protection. It requires that they have valid insights into their well-being, valid solutions to their problems and a valid role in implementing those solutions. Promotion of children's participation and engaging with children as social agents in their own right with the capacity to influence their situation in a positive way, also builds upon children's resilience. The term resilience refers to

Theatre for Development in Democratic Republic of Congo (DRC)

Theatre for Development was used as a tool in DRC to enable children to clearly define their own agenda, and to explore and present their concerns and power struggles in creative ways. Furthermore, by engaging community members and officials in dialogue following their theatre presentations, the children were able to directly advocate on issues affecting them. The children interviewed on their experiences of Theatre for Development clearly felt empowered by this approach and stated that adults were more respectful and responsive to them after the performances. Furthermore, adults interviewed were also impressed by children's potential. After one such performance, a local mayor, asked the agency to replicate Theatre for Development techniques in all sections of the district.

Sharing of different approaches to children's participation within the Team allowed team members to raise and clarify issues which may have previously acted as 'barriers' to the use of innovative approaches to children's participation in their own context.

Inner resources that are important protective factors for children's resilience include:[31]

- resourcefulness, ability to seek and get emotional support from others, a person or group, adult or peer, not necessarily over the whole childhood of the person
- ability to use imagination in interpersonal relations and also in mastering the environment in order to survive, by generating material resources
- sense of humour
- emotional range, ability to be in touch with a variety of emotions
- access to autobiographical memory; ability to recall positive relationships, moments of kindness, role models, personal achievements from past
- being grounded, rooted in home, nature, culture (present or past)
- sense of self in relationship to family, small group, community, nature, spirit
- general strength of family and community (present or past)
- ability to imagine a future
- having a goal for which to live, a 'why' to live for
- need and ability to help others, sense and experience of altruism
- a vision of a moral order, sense of justice
- curiosity
- thinking skills; capacity to understand crisis and find meaning in adversity
- physical health
- confidence in self and support of peers, caregivers
- sense of an internal locus of control

an individual's capacity to adapt and remain strong in the face of adversity. Resilience depends on both individual and group strengths, and is highly influenced by supportive elements in the wider environment. These positive reinforcements in children's lives are often described as 'protective factors' or 'protective processes'.

A fundamental element of the work on quality care was the acknowledgement of children's own resiliency;[32] several publications are available to the participants on this subject.[33] Children's resilience must be reinforced by focusing on their competencies and strengths. For example, children living on the street often develop their own 'protection networks' through peer groups, supportive adults or places that are 'safe'. Similarly, children who have been involved in and have survived conflict or war, and children who have been the head of sibling households or cared for parents prior to their death, will have gained skills to help their emotional and physical survival. For children returning to their own families or placed in substitute families or some form of community-based care, it is important that such learning and skills are recognised and harnessed, rather than their experiences being perceived as negative or denied.

Through participatory approaches, carers and practitioners can be encouraged to learn about children's own perspectives and understandings of adversity and their own ideas about coping and resilience. Moreover, it is critical that children's views and their own choices are recognised in any discussions as to the most appropriate form of care. In defining care options, children may be best able to say what support they need, who they would like to provide such care and how support and protection can best be given to them. Additionally, if children and young people contribute to the selection, design, management and monitoring of care options, more equitable responses to children, reflecting the diversity of their experiences, may be developed.

Promotion of community-based care rather than institutional care will also enhance these efforts, as community factors play an important role in limiting children's vulnerability and supporting their resilience. Neighbourhoods, schools and organised community groups and programmes can supplement protective factors at individual level by providing a supportive context for children. Participation in institutional and social settings that provide children with meaningful opportunities to contribute and to feel useful and supported helps to foster a sense of hope and purpose in children. By providing an enabling environment built on mutual respect and trust, these interventions aim to counteract rejection, exploitation and other negative past experiences.[34]

The Implementation Team was encouraged to explore opportunities for reviewing opportunities for engaging with children as social agents, the nature of care they provide, and opportunities for amending or adapting their services to offer a greater diversity of care options for each child.

Child protection policy and practice

There has been an increasing awareness of child protection and child abuse in the development community, and several organisations have developed child protection policies, codes of conduct and guidance documents for childcare agencies.[35] UNCRC Article 19 defines protection as including: *"States Parties shall protect the child from all forms of physical or mental violence, injury or abuse, neglect, maltreatment or exploitation, including sexual abuse."*

The Report of the UK National Commission of Inquiry into the Prevention of Child Abuse and Neglect, 1996, gives a broader definition: *"Child abuse consists of anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospect of safe and healthy development into adulthood."*

The safety and well-being of children form the core of childcare. It is never acceptable for a child to be abused, and childcare agencies/organisations, in

particular, must take steps to prevent abuse wherever they can, and respond to the needs of all children they come into contact with whenever it suspects they are being abused. It is important that everyone linked to the agency understands the problem of child abuse and their own role and responsibilities in protecting children and preventing abuse. This is the basis for the formulation of a child protection policy that focuses on working with children and managing issues of child abuse.

It is a sad fact that a significant proportion of the children we are in contact with will have experienced some form of abuse. Child protection policies recognise that child abuse is a global phenomenon and that organisations that work with children will have to respond to issues of child abuse in one form or another. This may involve alleged abuse of a child or children we are in contact with by parents, family members or other adults; or it may relate to a child or children we are not in contact with, but about whom concerns have been raised with our members of staff or others. It may also be that an employee of an organisation or another person involved in work with the agency is suspected of the alleged abuse. **It is fundamentally important that abuse is not perpetrated or compounded by the adults our agencies puts in contact with children and in whom children place their trust.**

A child protection policy sets out the responsibilities and activities undertaken to prevent or to stop children being abused or ill-treated, where abuse occurs at various levels (family, community,

The central elements of a child protection policy document are:

- a **Statement of Commitment**, which represents a public declaration of intent to safeguard children wherever it can
- a **Code of Conduct**, which details the standards of behaviour expected of its staff and others in their dealings with children
- a **Framework for Action**, which provides a clear process by which concerns regarding actual or likely abuse may be raised
- a **mandatory internal reporting requirement**, which means all concerns must be raised through the line management chain as described in the policy. Although this may sometimes feel like a difficult step to take, it is vital that all concerns regarding suspected or possible abuse are raised. To do otherwise may mean that abuse of a child continues unchecked. Also, any concerns that may have been around for some time, possibly relating to an ex-member of staff or a person no longer connected with your organisation, should still be raised, as there may be current child protection issues which stem from these concerns. A policy makes very clear the **responsibilities of staff and others** under this policy, and also highlights the fact that failure to act in accordance with the provisions set out in the policy may result in **disciplinary action** or whatever action is appropriate given the circumstances
- **local procedures** that translate the policy into a practical working document that fits the local context
- **guidance notes** also need to be available to assist in managing the implementation process overall and the particular role of managers needs to be clearly outlined.

institutions, etc), and occurs as: physical, sexual, emotional and psychological abuse. The degree of harm needs to be considered, as it relates to the child's growth and development.

The 'degree of harm' provides some guidance as to whether further or formal action needs to be taken in respect of a child. If a child comes to significant harm in terms of their health, safety or development then there is a basis for intervention. However, any level of abuse must be followed up; it is the nature or degree which informs the response and the intervention. The concept of the best interests of the child should always be the basis for any intervention.

If the above actions are achieved and implemented, the organisation can be identified as 'child safe', and will be seen to have undertaken the 12 steps, or processes, as shown in the box.

12 steps to a child-safe organisation

1. Understand child abuse
2. Develop and maintain an open and aware culture
3. Identify and manage risks to children in your programmes
4. Develop a child protection policy
5. Create clear boundaries
6. Adopt best practice in recruitment and selection
7. Screen all staff and volunteers
8. Support and supervise staff and volunteers
9. Ensure there is a clear complaints procedure for reporting concerns
10. Know your legal responsibilities
11. Empower children and encourage their participation
12. Provide education and training to all participants

Important notes to consider

- Abused children usually become isolated and lose personal esteem. At some point (and this can be some time later) they will disclose the abuse to a significant person they decide they can trust.
- Do not force an abused child to repeat disclosure. Repeated disclosure, in turn, can become a form of abuse. In order to avoid this situation, tape recordings and video are used in some countries.
- Ninety per cent of abused children tell the truth.
- Perpetrators are not mentally ill but powerful and/or emotionally impaired people.
- Perpetrators/abusers may be identified by inappropriate touching, closing doors while talking to a child, or tempting with sweets and presents.

The table in Appendix 6 outlines the elements required for a child protection policy. It may be used to guide other agencies' efforts, and will enhance implementation of the quality childcare standards.

Limits of authority to intervene

The issue of authority was highlighted in relation to aspects of child protection policies, fulfilment of domestic laws and the child's best interests.

Different agencies have different responsibilities in relation to children's protection. For example, an agency with statutory powers, ie, a government ministry or its representative whose officers are delegated with specific legal mandates, has the authority to investigate concerns, remove children from their homes and place them in alternative care facilities if they believe the child is at risk. However, international or national non-government organisations have no such mandate, unless given delegated authority by the government. Without such delegated authority, an NGO which suspects a child is at risk must report their concerns directly to the local authorities, such as the police, the Department of Children's Services or a local leader or magistrate. Obviously, if by leaving the child alone the child's life

is in immediate danger, a removal is the wisest course, but in such an extreme instance the child must be taken directly to one of the above designated individuals or agencies.

However, the nature of risk may not always be clear. For example, some children living on the street may be at risk for a number of reasons, but, in fact, less at risk than in a sexually and physically abusive home environment. Former child soldiers may be at risk from re-recruitment but at greater risk of abuse in an overcrowded and understaffed institution. This particular issue is perhaps best illustrated by the conditions applied to children entering some transit care centres. In the first place, children might not be given a choice whether to return home straight away or to stay in the centre; second, there are often mandatory lengths of stay in such centres, eg, three weeks, six months or sometimes for longer periods; and third, children may not be allowed to leave of their own volition but solely on the basis of the views of centre managers. When such care providers were asked about their authority to admit and retain children in their institutions, few were supported by any legal authority for their actions. It was recommended that care providers should be clear as to their official mandate and seek agreement with the government, or its representative or substitute authority as to the limits and extent of their authority as care providers.

In the case of child abuse, a judgement should always be made as to the course of action that supports the best interests of the child. This issue was raised indirectly through a number of the role plays, but primarily where an older man (or woman) was having sexual relations with a girl (or boy) less than 18 years. The UNCRC (and sometimes domestic law) and most organisations follow the principle that any relationship between an adult and a 'child' (ie, anyone under the age of 18 years) must be investigated as possibly being abusive. While an investigation should occur, in some instances, prosecution may not be in the child's best interest, eg, where a boy of 18 years and a girl of 16 years are having consensual sex. Upon investigation, it may be found that such activity is part of the normal exploration of young people's sexual development or a mutual activity, which serves both young people equally. While some counselling and guidance may be appropriate in such cases, charging the young man with defilement or sexual abuse would serve little purpose. All cases must be investigated but not all would necessarily result in a formal charge being made or a prosecution being sought.

Responding to AIDS orphans

One issue which was frequently raised in discussions was that organisations are often challenged to respond to the growing number of children orphaned by the AIDS epidemic. This places increasing demands on the scarce human and material resources available to agencies. Team members were encouraged to stringently apply their admission criteria as a form of gate-keeping to ensure that only those children whose circumstances complied with the mandate of the agency would be admitted. For example, children are often admitted to non-family care services when the location of parents or family members is known. It has often been the case that adults may have admitted a child to a centre or institution on the assumption that the child would receive basic care and material goods which the parents or family members cannot provide, without recognising the proportionally greater negative impact of family separation on the child.

The implications of low staff:child ratios are clearly apparent, for both staff/carers and children. Increasing numbers of admissions merely detract from the quality of care given to children. While this is obvious, staff and carers are faced with emotional distress if they refuse care for a child, and the influence of this on admission rates cannot be underestimated.

It was therefore continually stressed in the workshops that no one agency can do everything and agencies should only undertake responses within their own area of expertise and within the limits of their available resources. For example, it would not be appropriate to attempt medical and care responses to HIV and AIDS

if this is not part of your mandate. Team members were therefore encouraged to seek support from others, to network with agencies that could provide complementary inputs and to draw upon specialist services where these exist, rather than to create parallel and duplicate responses. For example, GUSCO was able to seek support from The AIDS Support Organisation (TASO) and others to address specific issues of children infected and affected by AIDS. Networking and building referral systems between agencies is crucial if the best interests of each child are to be met. Where a lack of synergy occurs between childcare agencies, isolation and competitiveness becomes a barrier to quality of childcare. Such a situation was found in DRC, where the context of insecurity undermined the potential for collaboration.

Finally, the labelling of children as AIDS orphans or CABA (children affected by AIDS) or OVCs (orphans and vulnerable children), may create unnecessary divisions in terms of who will be supported and who will not. An effective response is needed that targets all vulnerable children within the community, with indicators of vulnerability being defined by the local community.

Responding to challenging behaviour[36]

Discussion and workshops on how to respond effectively to children exhibiting challenging behaviour were also undertaken with the Implementation Team. Children who are placed in any form of non-family care may have suffered some form of abuse or exploitation. They are likely to experience a range of emotions, including fear, sadness, anxiety and anger, and may display a range of reactions, eg, withdrawal or aggression. Such behaviours are often challenging to the staff or carers involved in the direct personal care of children. Staff and carers also have their own life history and each will find particular behaviours more challenging than others. Such behaviours could include a child ignoring the carer, aggression, disobedience, theft, inappropriate sexual behaviours and poor toileting behaviours.

It is important for carers to try to understand what children have been through and to be empathetic to unresolved issues and coping strategies that the children may have developed. As described in the earlier section, adults also need to build upon children's positive coping strategies, while guiding them to change negative coping behaviours.

Rather than responding with understanding and guidance, staff and carers often respond to children's challenging behaviour in a punitive and sometimes violent manner. This adult reaction may, in part, be due to stress and tiredness as a result of low staff:child ratios. More often, a punitive response arises because the beating of children is seen as culturally acceptable and a legitimate response to 'bad' behaviour. Thus, efforts are needed to transform the local culture so that in the place of beating, more positive alternative responses are resorted to by adult carers and staff.

Pre-explosion strategies

It has been stressed that prevention is always the first choice of intervention. In reducing challenging behaviour, a number of elements can be put in place which will reduce, avert or avoid the eruption of violent or disruptive behaviour by children. These elements were identified as:

- **Good programming** – There is no substitute for good programming. Through good programmes, one can provide sufficient structure to avoid idleness, allocate time to develop relationships and ensure positive surface behaviour management (ie, deal with small things before they become out of control).
- **Pre-explosion assessment** – Be prepared for misbehaviour through pre-explosion assessment. This means knowing the children; know what happens with the child who is coping or not coping, understand the child's history and 'triggers'. Also, it is really important to know yourself – your own strengths and weaknesses.
- **Set non-negotiable rules** – Involve children in defining rules which are non-negotiable. Such

rules should be limited to a few critical rules which are simple, easy to implement and relevant to children's day-to-day lives (eg, no physical violence towards other children or staff members). All staff and children should be made aware of all these essential rules.

- **Develop an intervention plan** – Define what you will do when certain behaviour occurs, have some policies in place, and ensure children and all staff are aware of the content and intent of these policies. Ensure all staff are aware and committed to these interventions and each clearly understands their roles and responsibilities.

The Crisis Cycle

When working with children and considering the types of behaviour prompted by a crisis, it can also be useful to consider the 'Crisis Cycle' (see Appendix 7). The Crisis Cycle depicts the moment-to-moment psychological process that occurs for human beings as they deal with stress and anxiety in problem-solving. The cycle indicates that coping events begin with a stimulus which immediately triggers a cognitive or thought response; these thoughts lead to an emotional trigger or feelings, which in turn results in behaviour or action. For every action there is a consequence, and the consequence itself very often becomes a new stimulus which in turn results in another cycle. An escalating event is a continual repetition of this cycle.

When using the Crisis Cycle it is important for staff to understand the replacement of the term 'stimulus' with that of the term 'invitation'. Staff should see the child's behaviour as an invitation to engage in professional intervention. Finally, it is important for staff to realise that they also engage in this psychological process. For staff, the child's or youth's behaviour becomes a stimulus for their own crisis cycle process.

Non-physical interventions

There are a number of ways to intervene in an escalating situation other than through matching strength or aggression. Some of these include:

- **non-verbal intervention** – active listening, genuine expression of concern, using 'I' statements as opposed to 'you' statements
- **verbal techniques** – planned ignoring, signals, proximity to the child and touch
- **para-verbal techniques** – volume, tone and rate of speech
- **door openers** – I'd like to hear more, tell me more about that.

In spoken communication during crisis situations, facial expression carries most of the meaning (55%), followed by tone of voice (38%) and lastly, the words that we actually say (7%).

'I ESCAPE' mnemonic for alternative responses to challenging behaviour

I	I share the conversation
E	Explore the child's point of view
S	Summarise the feelings and concerns
C	Connect the behaviour to feelings
A	Alternative behaviours discussed
P	Plan / develop / practise new behaviours
E	Enter the child back into the routine

Behaviour management techniques

As the immediate environment can have a stimulating, calming or distressing effect on children, there need to be activities and routines that satisfy the children, provide safety and meet their needs. The idea of 'life space' and how you conduct conversations, etc, is important (eg, moving others away from an upset child). In order to manage behaviour effectively, some techniques for consideration are listed below.

- **Managing the environment** – Is it loud and noisy, bright or dull; is it stressful or calming, safe or insecure for the child?
- **Prompting** – This is signalling to the child that it is time to stop or begin a desired behaviour, or stop an undesirable one. This can be done verbally or non-verbally. We can use gentle reminders such as 'Lights out in 15 minutes', or questions such as 'Do you realise how much noise you are making?'
- **Hypodermic affection** – This can be physical or verbal, such as saying 'You know how much I care about you', or showing spontaneous gestures of affection. Such actions or comments have to be sincere.
- **Hurdle help** – Rather than making demands or 'laying down the law' and insisting on co-operation, it is better to give the child a little help through the first steps of a task or stumbling block.
- **Redirecting** –Redirecting the child or a group is about changing an activity or interrupting behaviour with a distraction. This may be done simply by asking a question, such as 'How did you get on at school today?'
- **Proximity** – Teachers often use this in classrooms by moving closer to a child who is disruptive or acting as a buffer between two people in conflict with one another.
- **Time away** – This is not about isolating the child but giving them time alone away from stimulus to regain their control in an area where they can think. Younger children may simply need time alone to realise they are missing out on the fun. The emphasis should be on returning to the group as soon as possible.

Agencies are encouraged to use the above list as guidance for establishing rules for carers when they are responding to challenging behaviour. However, as stated at the beginning of this section, if the quality childcare standards are established as the basis for good programming, challenging behaviour will to a greater extent be prevented.

Good practice: acceptable and unacceptable controls and sanctions for use with children

Unacceptable

- No child should be physically punished or threatened with physical punishments.
- Food should not be withheld as a source of punishment.
- Medical care should not be withheld as a source of punishment.
- No child should be humiliated in front of others.
- No child should have communication, respect or support withdrawn.

Acceptable

- Express disapproval of unacceptable behaviour and make it clear it causes problems with good relationships and disturbs others.
- Restrict privileges, such as not allowing the child to participate in an enjoyable event or watch television.
- Allow the child time to regain self-control by separating him or her from the group and giving the child time to reflect on his or her behaviour.

Conclusion: Moving forward

As described at the outset of this report, the number of children with care needs is escalating as a result of the HIV pandemic, poverty, insecurity and conflicts. Ultimately, governments have a responsibility to provide adequate care and protection for children separated from their parents or deprived of parental care. Therefore, significant efforts are needed to engage in policy-level advocacy to ensure wider application of quality childcare standards in all care settings and greater support for family- and community-based care options.

Engaging in policy-level advocacy

Strategic efforts are required by local non-governmental organisations (NGOs), international NGOs (INGOs) and the UN to engage and work in partnership with governments to advocate for, and ensure effective application of, quality childcare standards. Quality standards need to be adopted by governments, reflected in government policy and implemented in key government structures and practices concerned with the care and protection of children.

NGOs are in a good position to demonstrate the value of the quality childcare standards, and can use their experience to advocate and build capacity for broader application within a range of care settings. Implementing small changes at a local level may gain the attention of the government, especially if influential persons from the community and authorities are actively involved in applying the standards.

Members of the Implementation Team found they were engaged in internal advocacy to convince their managers and co-workers of the need to increase their focus on the quality of care being provided for children. However, greater efforts were needed to engage in strategic external advocacy.

Before agencies embark on advocacy initiatives, it is important that they analyse their own strengths and weaknesses and seek solutions to problems of any gaps or capacities requiring development.

Key building blocks for developing an advocacy strategy are set out in Appendix 8. Additional information and practical tools to help advocacy efforts on quality care are available in Save the Children's *Advocacy Toolkit*.[38]

What is advocacy?

Save the Children's definition of advocacy is:

"To act with and on behalf of children, to influence the policies and actions of others and to improve the fulfilment of child rights."[37]

Broadly, advocacy is a way of influencing others to bring about changes in knowledge, attitudes, behaviour, policy and practice. Advocacy is also used to address differences in power relationships, to uphold children's rights, and to create a wider impact than what is possible through programming alone.

Example of local advocacy – Kinshasa, Democratic Republic of Congo

The Save the Children UK programme in Kinshasa used a two-stranded strategy to advocate for wider recognition and application of the quality childcare standards. First, the programme sought assistance from a network of NGOs, supported by CIMOS (an INGO), that has an established base in Kinshasa, thus strengthening the child rights constituency for advocacy efforts. Second, during the visit of UNCRC Committee member Mme Awa Ndèye Ouedraogo to Kinshasa, the NGO network lobbied for a change in the law pertaining to the protection of children.

Common barriers to effective advocacy

When agencies first consider embarking on advocacy activities, common barriers they experience include:

- no (or weak) forward planning and strategic view
- lack of capacity and skills (human and financial)
- inadequate or difficult communication to/from regional/head office
- lack of (or weak) sustained management support
- disjointed or isolated advocacy at regional or global level
- controversial issues to be addressed
- limited experience in research methodologies
- lack of technical support.

Key principles of advocacy

- Keep the strategy and messages simple.
- Put your 'frame' around the issue (highlight your perspective – eg, child focus).
- Know your audience.
- Use clear facts and numbers creatively.
- Allow your audience to reach their own conclusions.
- Present a solution, if possible.

Developing multiple strategies

Promotion of quality childcare standards in all care settings (institutional and community-based) is one vital strategy to improve the care situation of children. Efforts to improve the quality standards within institutional care may be an important starting point and they are crucial during the transition phase while children continue to live in institutions. However, multiple strategies are needed to work with governments and other agencies to accelerate the process of deinstitutionalisation, to reunify children with their care-givers and to increase policy and practice measures which prioritise family support and community-based care options.

Increasing efforts by governments, international agencies and NGOs have demonstrated the benefits, cost effectiveness and sustainability of new approaches to preventing family breakdown and ensuring family- or community-based care for those who cannot remain at home. These efforts need to be scaled up and incorporated into more systematic responses to children's care and protection needs at community, provincial or district, and national levels.

As part of the launch of Save the Children's First Resort series, which promotes positive care options for children, a call for action outlined the actions that governments and international organisations need to take to ensure they reach the many millions of children who need care and protection.

We encourage all practitioners working in care settings to make use of the guidance within this publication to engage in collaborative efforts to further implement the quality childcare standards, to support family- and community-based care efforts, and to advocate for the establishment of national and international childcare standards. Quality care of children in each and every one of our communities is vital and should receive maximum support from governments, donors, agencies and parents.

A Call for Action – The First Resort[39]

1. **Acceptance that care and protection of children is a fundamental role of government**: Government efforts might include creation of an enabling legislative framework, policy development, resource allocation, co-ordination across government departments and partnership with service providers.
2. **Prioritise family support and keep children in families wherever possible**: Adopt a strategic approach which mobilises existing resources within communities, provides basic services and develops more specific approaches for children and families in the greatest need.
3. **Empower children**: Promote the active participation and organisation of girls and boys in diverse care settings and local communities. Foster partnerships between children and key duty bearers to further children's care, protection and opportunities to develop as active, respected citizens.
4. **Build on existing community strengths but encourage innovation**: Build on existing traditional family and community structures that have the potential to provide good-quality care and protection. Also, be bold in creating a vision of what is possible and achievable, and encourage innovation by learning from other contexts.
5. **Support international standards for children deprived of parental care**: There needs to be a strong momentum to ensure that standards and good practice guides are translated into policy and everyday practices that improve the lives of children and families.
6. **Accelerate the process of deinstitutionalisation**: Governments have the ultimate responsibility for breaking the dependence on institutional care solutions by: closing unsatisfactory residential care provision; promoting prevention work and family-based care and protection; controlling the numbers and quality of care in residential homes provided by other organisations; and promoting better alternatives.
7. **Increase public awareness**: Encourage greater use of the media, drawing attention to the positive outcomes of family- and community-based forms of care, and the value of children's rights.
8. **Encourage funders to promote family-centred care**: Socially responsible funders and donors need to transfer their support from residential care options towards investment in programmes that support family integrity and develop family-based forms of care.
9. **Make knowledge available to all**: Support better knowledge management, practice exchange and information sharing.
10. **Fill the research gaps**: There is a need for participatory research with children to contribute to policy and practice debates; long-term studies that examine outcomes for children of different approaches; and detailed analysis regarding cost effectiveness of different protection options.

Appendix 1: Biographies of Implementation Team members

Robert Okenya, Programme Officer with **Gulu Support the Children Organisation** (**GUSCO**): Robert's post involved programme development, technical support and supervision of programme staff and reporting to donors and other stakeholders. Robert started work in GUSCO as a volunteer. After a year, he became a Field Officer for two years, until 2004, and he was also the Centre Administrator until 2005. He became the Programme Officer in February 2005.

Catherine Maina, Manager of the **Government of Kenya Nairobi Children's Home**: Catherine has overall management responsibility and liaises with other stakeholders in relation to the reintegration of children into their families and communities. Catherine also handles administration and financial matters in the children's home.

Teresia Mwongeli Mutava, Childcare Worker in the **Government of Kenya Nairobi Children's Home**: Teresia's role is to provide direct personal care for children. This involves day-to-day and night care for children including bathing, changing and feeding the children, and taking care of any children admitted to hospital. She also tidies beds, dispenses any prescribed drugs, and administers first aid. She monitors children's behaviour and activities, which includes recording the children's social interactions, well-being and any other issues pertaining to the children.

Kezia Mukasa, Projects Officer, **Uganda Reach the Aged Association** (**URAA**): Kezia has worked with URAA since May 2002. URAA works with the elderly currently caring for their grandchildren following the death of the children's parents. URAA's interventions include advocacy, livelihood projects, grants and training programmes. Kezia's role includes supervision and monitoring URAA programmes, needs assessments and subsequent project proposals, developing and delivering training for member groups and the elderly, raising awareness workshops and the production of donor reports.

Cecile Marchand, Field Co-ordinator/Child Protection Officer with **Save the Children UK in eastern Democratic Republic of Congo**: Cecile is responsible for developing work with Congolese partners in relation to transit care for former child soldiers.

Lexson Mabrouk, Water and Sanitation Officer with **Save the Children UK in South Sudan**: Lexson's role includes ensuring that clean drinking water is provided for children and families. This work involves training village hygiene motivators, the South Sudan Relief and Rehabilitation Commission Water Team, teachers and parent-teachers associations, village-level water management committees and water caretakers, as well as work with school clubs to improve hygiene in schools.

Bruce Luaba, Field Officer in Charge of Institutions and Reintegration in relation to separated children or those expelled from their families on the basis of accusations of forgery: Bruce works for **Save the Children UK, Mbuji Muyi, Democratic Republic of Congo**. He worked for five years with separated children in Kinshasa in relation to their care and protection and the training of child protection staff. In 2004, he began his work in Mbuji Muyi. His current role involves planning and promoting appropriate responses for reunification with agencies responsible for childcare. He undertakes follow-up with the institutional partners to ensure the children's protection and to ensure children's rights are met. He provides technical advice to partner agencies and documents the reunification processes.

Chol Changath Chol, Programme Manager for Child Protection for **Save the Children UK in South Sudan**: Chol's responsibilities as a manager and practitioner for the Child Protection Programme is overall management, programme monitoring and programme analysis. Chol has worked as a Senior Project Officer with Save the Children since January 1998, in various areas including research, Food Security and Livelihoods, until his currently role in Child Protection.

Dolline Olanga Busolo, Regional Programme Co-ordinator for **HelpAge International** based in Nairobi: Dolline's responsibilities include programme design, capacity-building, proposal writing, needs assessments, programme support, research, monitoring, and budget tracking and reporting. Dolline has worked with HAI for five years, following her initial appointment as a regional nutritionist.

Betty Kiden, Food Security and Livelihood Project Officer for **Save the Children UK in South Sudan**: Betty's responsibilities include acting as the link between Save the Children UK and local communities and authorities in Bahe el Ghazal, day-to-day implementation of Save the Children UK relief and food security projects, and assisting with the implementation of all other Save the Children UK projects in the area when necessary. Betty has worked with Save the Children since 1998.

Grace Lamunu, **Save the Children in Uganda**

Appendix 2: Assessment format

1. Professional practice	Not met	Partly met	Met
1.1. Aims and objectives 1. Clear statement of aims and objectives 2. Philosophy developed with stakeholders 3. Carers and staff understand and agree to it 4. Best interests of the child underpin all			
1.2. Child protection policy 1. Written child protection policy, procedures and guidelines 2. Staff and carers know laws and procedures 3. Children have some awareness of policy			
1.3. Child protection practice 1. Reporting structure in place 2. Staff are sensitive to signs and symptoms of abuse and know how to respond 3. Arrangements reduce the likelihood of working in isolation with children 4. Carers have strategy for breaks and stress relief			
1.4. Referral to / admission to service 1. There is a process in place for admission to the service 2. Children being referred are provided with full information about the programme 3. Assessment is made, needs identified and possible response recorded 4. Child and others made aware of their rights/responsibilities re the law and the programme			
1.5. Care planning 1. All children have a care plan 2. Children are involved in making the care plan 3. Clear decisions taken and recorded detailing purpose and outcomes for child 4. Staff member held accountable for tasks 5. Actions or strategies are agreed in preparation for when the parent/carer dies, eg, inheritance, etc			
1.6. Review 1. Care plan regularly reviewed with relevant parties 2. Children involved in review 3. Reviewed plans recorded and timescale set 4. People held accountable for tasks			
1.7. Rehabilitation, throughcare and aftercare 1. Clear policy and procedures for planned/unplanned ending of care 2. Process acknowledges emotional impact of endings 3. Process is not prejudiced to children who leave, support is not withdrawn 4. Programme ensures nature, extent and provision of follow-up 5. Preparation for future, eg, life skills, independent living, etc is included in care planning			

2. Personal care	Not met	Partly met	Met
2.1. Diet 1. Sufficient and balanced food is provided regularly throughout the day 2. Staff understand how local foods contribute to nutritional needs of children at various ages 3. Good hygiene is practised in the storage, preparation and cooking 4. Children are involved in choice and preparation of meals 5. Mealtimes are relaxed and enjoyable, with interaction between adults and children 6. Special dietary needs are addressed 7. Clean water is accessed and available			
2.2. Health 1. Children have a health check on arrival and at regular intervals 2. Children receive immunisation and any necessary treatment 3. Health records are kept in child's file and regularly updated. Developmental milestones, illness and treatment, etc are recorded 4. Promotion of preventive health practices – eg, hygiene, safety and healthy attitudes 5. Health education is provided 6. Sexual health information and advice provided 7. Sanitation facilities are clean and disinfected 8. Carers know how to respond in cases of accidents or emergencies			
2.3. Play and recreational activities 1. Carers recognise the importance of play 2. Different stimulating activities are provided according to age, interest and ability 3. Time is made for spontaneous and planned activities – individual, large/small groups			
2.4. Privacy 1. Right to privacy promoted 2. Carers sensitive to wishes of the child for privacy 3. Carers sensitive and discreet about child's history/experiences 4. Lockable space available for toileting, bathing and dressing 5. Places to be alone 6. Private space to discuss child's affairs or for the child to meet visitors 7. Personal hygiene supplies can be accessed discreetly 8. Location of boys' and girls' latrines are separate and in well-lit places			
2.5. Choice 1. Children have choice in their daily lives 2. Carers make activity risk assessments according to age and development 3. Children are provided with information to make choices 4. Carers understand child's capacities and how able and willing the child is to make choices 5. Behaviour and conditions monitored to balance self-determination, risk and impact on others			
2.6. Dignity 1. Carers recognise that children are individuals and have different personal needs 2. Decisions taken *with* children not *for* them 3. Carers speak and record information in a way that signifies respect at all times 4. Children have access to information and can discuss this with carers 5. Carers understand the boundaries of privacy and confidentiality			

continued overleaf

2. Personal care	Not met	Partly met	Met
2.7. Relationships and attachments 1. Carers demonstrate the support for safe, positive and nurturing relationship 2. Children are comfortable and relaxed with carers 3. Children receive individual attention 4. Carers respond spontaneously when children are upset or unwell 5. Carers encourage children's ambitions and respond positively to hopes and fears 6. Child rights respected and responsibility encouraged 7. Children have a key worker 8. Key workers have responsibility for a small group of children			
2.8. Children's sense of identity 1. Children are supported to maintain a sense of identity 2. Children should be provided with any necessary identity papers, ie, birth certificate 3. Siblings are kept together 4. Family tracing and reunification are a priority 5. Children are called by their given and family names 6. Children's religion and culture are recognised and supported 7. Children have access to and can retain personal papers in a private space 8. Children are encouraged to have a positive view about themselves 9. Children are encouraged to participate in their cultural festivals and activities as long as they are not harmful 10. Mother tongue languages are encouraged			
2.9. Care, control and sanctions 1. Policy and practice defines acceptable sanctions for control 2. Children are aware of basic rules for behaviour – social skills, respect for property and respect for others 3. Unacceptable behaviour is seen as a child's need for greater support and guidance 4. Records are kept of sanctions used and ways in which these were avoided, including times and dates			
2.10. Children's voices 1. Mechanisms exist for children to express criticisms and views about their care or the programme 2. Discussion forums exist where children's views are valued and heard without judgement or fear of repercussions 3. Views and agreed responses are recorded 4. Carers encourage and assist children to make their views known 5. More reticent children are supported in voicing their views 6. Systems exist for confidential complaints			
2.11. Education 1. Appropriate quality education – formal, non-formal or vocational – is accessed 2. Education is flexible according to need and capacity 3. Carers support children in their education 4. Carers recognise the value of both academic and non-academic learning			
2.12. Babies and young children 1. Carers of young children are supported in the additional care needed 2. Appropriate food is available 3. Babies are not left unattended 4. Babies and young children are immunised			

3. Staffing	Not met	Partly met	Met
3.1. Recruitment and selection 1. Recruitment policies and practices exist for all staff, volunteers and trainees 2. Selection focuses on quality of carers to care for children and programme aims 3. Checks are made on applicant's character 4. Applicants are clear about the job tasks 5. Children are involved in selection 6. A formal probationary period exists			
3.2. Supervision and support 1. Staff and carers are supported by management to achieve the aims and objectives 2. Staff and carers receive regular individual and formal supervision 3. Supervision meetings are recorded and reviewed 4. Areas of weakness are supported and strengths recognised and valued 5. Staff have clear individual work plans			
3.3. Deployment 1. Sufficient number of care staff exist 2. Alternative cover is available in times of illness or absence 3. Children receive individual attention regularly beyond survival needs 4. Appropriate gender balance in carer group 5. Skills and abilities are recognised in staff deployment			
3.4. Professional development and training 1. Skills possessed and learning needs are identified and responded to through a range of options 2. The training provided reflects the complexity of needs presented by the children 3. Staff and carers are provided with regular training and mentoring 4. Training is viewed as a valuable aspect of the programme			

4. Resources	Not met	Partly met	Met
4.1. Location and design 1. Programme is located in community with community consultation 2. Community is aware of aims and objectives 3. There is positive interaction between the programme services and the community 4. Location is accessible to target group and other local resources			
4.2. Accommodation 1. Rooms are of adequate size for their purpose 2. There is adequate ventilation and heating 3. Fire and emergency action is defined and reviewed 4. Privacy and personal space is available and defined 5. Sanitation facilities are sufficient for the numbers of children, carers and staff 6. Sufficient materials for cleaning and personal hygiene are available 7. Protection issues are considered in location of facilities 8. Generally the accommodation is clean and tidy			

5. Administration	Not met	Partly met	Met
5.1. Records 1. Records for each child are compiled in sections 2. Records are available to children 3. (In collective childcare facilities only) Daily events records are compiled 4. Community contacts are recorded and evaluated 5. Personnel files are compiled for each member of staff 6. There are updated available records of policies and procedures 7. Financial/resource transactions are recorded			
5.2. Confidentiality 1. Clear policy on confidentiality exists 2. Records are securely locked away with limited access 3. Information is not passed on to other official parties unless necessary 4. Carers do not discuss or disclose information about a child 5. Children have access to their records 6. Information is only used with the informed consent of child			
5.3. Role of managers/owners 1. Managers and owners regularly oversee the work 2. Aims and objectives are regularly monitored, reviewed and evaluated 3. Quality is monitored, reviewed and evaluated 4. Independent evaluation is commissioned at critical points in the programme 5. Management promotes open dialogue with children and staff 6. There is transparency in decision-making and, where appropriate, with children's participation			

Appendix 3: Role plays and case studies

The scenarios for the role plays and case studies are set out in boxes, with facilitators' notes thereafter.

Role Play 1: Involving children in planning and review of placement

The child

You are Kato and are 14 years old. You were forced to join an armed group five years ago and have not returned home since. You were demobilised three months ago and want to go back to your home now, although it is in another district and you will find it difficult to return without support. You are sure your family will want you to return and you plan to help your father with the farm and managing the land.

You do not like the transit centre and think the staff do not listen to your idea for your return home, which is just to give you the money so you can go. However, you have begun to trust your key worker, Francis, who comes from the same district.

Other boys have already gone home but no one has told you what is happening in your case. You have a review in two days' time and you are very worried about what will happen. Francis has come to talk to you about it, and has said he will bring the centre manager with him as the manager will be chairing the review meeting. You do not like the manager because he is very harsh with all the boys.

The key worker: Francis

You have worked in the transit centre for a year and have been assigned to Kato as his key worker. A review of Kato's placement is scheduled in two days' time. Kato has been quite disruptive but you think his desire to return home immediately is unrealistic, as his behaviour remains aggressive, according to the other staff.

You feel you have started to build a good relationship with Kato and he often speaks to you about his father's farm. You know you need to be honest with him but you do not want to harm the relationship, and a recent tracing and resettlement exercise near Kato's home area has reported many villages burnt and destroyed with no signs of any people farming. You simply cannot bring yourself to tell this to Kato. You have not heard from your own family and are very worried.

The centre manager: Joseph

Francis is planning to have a chat with Kato about his review meeting in two days and has asked you to accompany him. Francis has worked in the centre for a year and is good with the boys but you feel that Francis is not honest or strict enough and wants to be friends with the boys rather than having a professional position as a support worker.

You have had some contact with Kato but mainly for the negative reasons of Kato's reported aggressive behaviour. The other staff are unhappy with the boy. Kato has repeatedly demanded to be let out of the transit centre and given money to return home. You are reluctant to consider this until his family has been traced.

A recent tracing and resettlement exercise near Kato's home area has reported many villages burnt and destroyed with no signs of any people farming. Francis has not heard from his own family who live in the same area as Kato's family. Francis is very worried and anxious about these reports.

Facilitator's notes for Role Play 1

Facilitators may wish to highlight:

- issues around the *relationship* and *engagement* between the key worker and the child
- concerns about both professional boundaries in the relationship and how that sensitivity is demonstrated
- issues around proxemics[40] and *appropriate touch* with children who are traumatised
- the contextual nature of the aggression demonstrated by the child and why such behaviour may be 'normal' given the circumstances
- the importance of good, clear communication and the need to be honest with young people about both information held and individual capacity as a carer
- if the child is seen as demanding and resolute in requests to the key worker, there needs to be debate on the *balance between care and control*. Adults need to maintain a degree of control in situations, thereby offering the child a *sense of safety* in the knowledge that the adult can manage difficult confrontations. Such action should not undermine the process of child participation
- if the child feels he or she is not being listened to, there may need to be a *child complaints procedure*.

Participants may give the role of the manager too little attention. However, mentioning this will allow discussion to focus on the *importance of staff being looked after and the relationship between the manager and the child*. Key points to highlight are:

- The relationship between the manager and the staff member is unequal. How do managers show compassion and understanding for staff? How should staff be supported in stressful situations? Staff need *supervision and support* if they are to offer an effective service to children.
- The conflicting relationship between the child and the manager may be more than meets the eye; there may well be some form of systematic abuse taking place.
- The child's pattern of anger and aggressive behaviour may be *symptomatic of abuse* which *is currently taking place as opposed to being a result of previous trauma*.

Role Play 2: Considering children's best interests in admission to a care facility

The girl

You are called Maria. You are 13 years old and live with your mother and her boyfriend. Your father died many years ago and you still miss him as he used to play with you and cuddle you. In the last few months your mother's new boyfriend has come to live at the house. Since then your mother has not shown you any affection or interest.

Your mother wants you to do all the housework. You do not mind doing housework but your mother does nothing and expects you to do everything. It is hard when you need to study for school and you are very tired.

Two nights ago when your mother had gone to the market, her boyfriend said he was sorry about what happened to you and put his arms round you and took you to your bedroom. He lay on the bed with you and kissed and cuddled you. He hurt you and then said it was alright. You did not like it but he was nice to you afterwards, although he said you must not tell anyone.

Today your mother has taken you into the city to a large office and has said she is going to send you away. You feel angry and confused but you want to be away from your mother as you are fed up being used to clean and wash and be shouted at.

The mother

You are 33 years old. You have worked in an office since your husband died some years ago. When you come home from work you are tired and feel that Maria has left the house in a mess. When you ask her to clean up, she refuses and this often ends in an argument. You are exhausted and cannot stand your daughter's continued disobedience and lack of respect.

Recently you met a very nice man who is the cousin of a neighbour and he has been very kind to you. He is very handsome and has promised to marry you. You have noticed that your daughter seems very friendly with him. This makes you angry because she is so insolent to you and he sometimes laughs when you are angry. You have decided to take Maria to the children's officer in hope that she will be placed in the government-run children's home.

The children's officer

Mrs Ndungu, 33 years old, arrives at your office with her 13-year-old daughter, Maria. Mrs Ndungu is very angry and agitated, as is her daughter. Mrs Ndungu has her daughter by the arm and is shaking her and throws her into a chair by your desk. You calm the situation down and ask what the problem is.

Facilitator's notes for Role Play 2

This particular role play raises issues around child protection and institutionalisation of children. Facilitators should highlight the following points.

- The focus for intervention in this role play should be the child and not the mother, who is merely seeking an alternative vis-à-vis her *parenting responsibilities*.
- Although the action may not specifically mention that sexual abuse of the girl was taking place, participants should be sensitive to the *underlying causes of behaviour change* – also look at the presenting behaviour of the mother.
- The issue of how one *addresses safety in the home* should be explored.
- This role play raises issues around *inappropriate institutionalisation* and the inappropriate message that may give the girl about her responsibility for the situation.
- Facilitators may wish to explore some of the *cultural norms and practices* in different contexts and how these should be addressed, to encourage a common understanding of abuse and child protection.
- It would be useful to explore issues of parental responsibility and *accountability* for the actions of the boyfriend – eg, what is the local law?
- Are there issues around the *mandate of the social worker* and the obligation to report an offence that has been committed, ie, the abuse of the girl?

Role Play 3: Working with sanctions for behaviour

Agnes

You are 15 years old. Both your parents died of AIDS a year ago and you have remained in the family house with your two younger brothers and a younger sister. Your uncles and aunts do not help you as they think you must also be infected. Your uncle has threatened to chase you off the land.

It has been a difficult year and you have not been coping well. Last week you went to the market with some vegetables from the garden in order to sell them, as you had no more money. You did not get as much for the vegetables as expected and when you had returned home, you put the money in a box inside the house.

The next day, you looked for the money to buy milk for the youngest child and some of the money was gone. Your ten-year-old brother was missing all afternoon and you discover that he had spent the money on going to a video parlour. You were very angry and felt he had to be punished. You held his hands over the fire to teach him not to steal. Later that night you realised his hands were very badly burned, although you had not intended to hurt him, so you ask your aunt about how to treat your brother.

The next day your uncle appears at the house with a person you do not know. Your uncle says this person is a children's officer who wants to speak to you about what you did to your brother.

The uncle

Your brother and his wife died last year and their children were left in the family house, which had five acres of land attached. The oldest child is a girl of 15 years who has remained at the house, caring for the other children. The girl grows some food and although she is struggling she has looked after the little ones reasonably well.

On returning home, your wife tells you that the oldest girl has burned her youngest brother's hands for stealing money. You have always felt that it would be easier for the children to be in a children's home, the eldest girl could be married and you would be able to farm the land, which is not fully cultivated.

The next morning you go to the children's officer in the district headquarters and tell her that the girl burned her younger brother's hands in a fire to discipline him, and that the children are not being fed. You accompany the children's officer to your niece's home.

The children's officer

A man has come to your office to complain that his niece, who looks her three siblings, has burned her brother's hands in a fire to discipline him. The man is very concerned about the children's welfare. You agree to accompany him to the house to see what has happened.

Facilitator's notes for Role Play 3

This role play focuses on child protection issues in the broadest sense. The facilitator may wish to explore the following issues:

- Who is the client in this investigation?
- Highlight the levels of *interview skills* sometimes necessary to gain a clear picture of the fundamental concerns of a given situation, particularly where a client is belligerent, threatening or taking a dogmatic position.
- How do staff members deal with threats in the course of their work? How could the children's officer *take control* of the interview in this situation and distance the uncle from the decision-making in respect of the girl and the other children?
- It is important to separate thoughts, opinions and facts in the process of investigating critical incidents. *Verifying information* is critical to ensure appropriate action is agreed.
- There may be concerns about the *motives* of the uncle. They may not necessarily be about the child's best interests, and his agenda may be about land grabbing or potential exploitation of the children.
- When visiting the girl and the children, should the children's officer have visited *with or without the uncle*? Which would have offered greater opportunities to assess the situation accurately?
- Were there others involved that the children's officer should visit?
- Considering the level of responsibilities carried by the girl, what available support structures could be used?
- How do cultural values conflict with child protection?
- What can be considered as appropriate or inappropriate *sanctions* in particular contexts? What alternatives could be suggested to discipline children?
- *How can a children's officer ensure future protection of all the children?*

Role Play 4: Using available resources

This role play involved all members of the Implementation Team and aimed to give them an opportunity to act out the types of decisions, negotiations, actions and constraints which many of them face on a daily basis in their own work. From this, they would be able to consider how and with whom such constraints may be overcome.

Background from workshop

The role play was intended to create a situation which team members met and dealt with in their work. The exercise was intended to represent 12 hours of one day and the facilitators timed this by ringing a bell every five minutes, with each five minutes representing one hour.

Each team member was given a large card stating their designated role, which was clearly visible to all other team members. The team members were placed in separate locations round the room, in an attempt to represent a rural setting. Each team member was given some background details, which were not shared with other team members. The one criteria stipulated was that children in need of care must be placed by nightfall. You begin the role play by instructing the two siblings, a 12-year-old with a two-year-old sister, to sit in the local chief's office (taken there by a neighbour) and instructing the eight-year-old boy to sell vegetables in the market.

Role Play 4: Using available resources

Time	Role	Background information
9.00	Police officer	A local trader has brought an eight-year-old boy to the police station. The boy was found wandering around and asking for small jobs.
12.00	Local chief	You are eating lunch and a farmer from outside the village has brought a 12-year-old boy and his two-year-old sister to your house. Apparently, the children's parents died the previous month with chest complaints, the children have no one to care for them, and there is no one in the village that is able to do so. The children have been identified as Muslims. The little girl clings to her brother.
Until 12.00	District children's officer	You are attending court this morning concerning a marital dispute. You return to your office by 12.00.
	Manager of institution at district headquarters	The institution is overcrowded and conditions are poor. The manager will only take older children to work in the fields and only accepts children of his evangelical faith.
	Couple with three children	The couple could look after one child but the husband only wants a girl – "They are easier to manage and can help in the house."
	Teacher	You feel sorry for the AIDS victims, but feel annoyed because you rely on fees for your salary – 'No Fees - No Salary'
	Community-based organisation	This CBO provides educational support for HIV-affected children, has a communal garden for members and sporadically provides food baskets for vulnerable households.
	Child	You are an eight-year-old boy. Your father left home after beating your mother. Your mother sent you to buy herbs at the market and when you returned home she was gone with all her belongings. After a week, you came to the market to look for work to get the fare to travel to your older sister in the city. You have some money but not enough.
	Two children	You are 12 years old and live with your two-year-old sister. Your parents died of chest complaints two months ago. You have sold vegetables to stay alive, but a farmer with the next plot comes to your house and takes you to the local chief, saying that you cannot be left alone. Your uncle lives nearby but he did not visit your parents.
	Uncle of the two children	You do not want to look after your niece and nephew. You believe their parents died as a punishment from God because they ran a kiosk selling alcohol.

Facilitator's notes for Role Play 4

Facilitators should highlight the following points.

- *Networking and co-operation* is crucial and should involve partners, local non-governmental and community-based organisations, police, children's institutions and the government. This should include identification and preparation of community carers. By identifying community carers, the children can be cared for in a safe environment, while the authorities investigate their situations, instead of hauling the children from office to office.
- *Children should be involved* in decisions that affect them – eg, be listened to and their views taken into account. Clearly the situation for each child was different, although some of the children had specific views regarding their own situation which could assist in their placement.
- Can the *roles, responsibilities and mandates* of the participants in the role play be defined? Each must know their own job. During the role play the children were shuffled from one office to another and often back to the office they just came from. This was largely due to the feeling that people did not know the remit of their jobs, or did not want to deal with the children.
- *Community preparation and response:* Awareness-raising is important to prevent stigma and provide information. Had this been done in the community, the extended family may have been more willing to look after the children and avoid the need for a formal placement and help from the formal Children's Services.
- *Care and protection mechanisms:* What mechanisms are in place to ensure children's care and protection? Where does responsibility lie and how should this be encouraged? What supports are there for vulnerable families and how could these have helped?
- *Accountability:* Clearly, some of the participants in the role play were overburdened. How can staff complements be increased to provide effective services for children?
- *Promote a continuum of care* through which the community can respond to children's various needs and wishes.
- Should children be institutionalised, and in what circumstances? The issue of children being in temporary care in their own communities is preferable; facilitators should prompt discussion on why this is so.

Role Play 5: Convincing your boss (local advocacy)

One final role play was conducted during the last workshop. It was developed as a link to a workshop presentation on advocacy. Team members were given their respective roles and worked collaboratively to prepare the scenario for presentation the following day.

Although the role play demonstrated some good practice, and the outcome was positive in terms of refocusing the programme on children's issues and quality childcare standards, essentially the actors did not address some of the anticipated difficulties and conflicting demands which were clearly outlined in role play 4. It was felt that the role play as played out was not realistic in terms of such difficulties.

Role Play 5: Convincing your boss (local advocacy)

Participant in a training programme

You are the manager of a community support programme for vulnerable children. You have recently attended a workshop on quality childcare standards which you thought was really good. You consider it an obligation on the part of your organisation to ensure that children's rights are met, as far as possible, in your working context.

You work in Ukweli, a country affected by long-term drought, with increasing migration of people from the worst-hit areas. A large camp for internally displaced persons (IDP) has been established five kilometres from the largest town and your organisation is currently supplying emergency food drops to the camp and to vulnerable children and families in the community. Most of the people are surviving only through petty trading, and the nomadic tribes who keep livestock are increasingly concerned for their own survival. In addition, there is conflict in the two neighbouring countries, which makes Ukweli's borders unstable.

You have returned from the quality childcare standards workshop and want to promote the standards in all areas of work. Considering the context of Ukweli, you believe there is a growing crisis around future stability. In the communities you visit, there are large numbers of women with recurrent illnesses and the men are frustrated by lack of work opportunities. With increasing numbers of people arriving in the area because of the drought, people fear that existing resources will rapidly become depleted. A number of video parlours and drinking shops have opened up and are thriving in the increased population, growing numbers of children are seen loitering on the streets and markets and some boys and girls are openly offering sexual favours for food. Some babies and young children have already been separated from their families during the migration and many children are sleeping at night in the market areas. You would like to develop some work around children's protection and reunification, hopefully involving all the communities. In light of the reported increased prevalence rates of HIV and AIDS, you want to pre-empt a crisis by promoting, and basing future work on, the quality childcare standards. You speak to a colleague about the workshop to illicit their ideas and support before speaking to your line manager to get approval for your ideas.

Programme director

You are the programme director for a large programme, focused around emergency food aid and therapeutic feeding for under-5s in the IDP camp. Your work is in Ukweli, a country that has been affected by long-term drought, with increasing migration of people from the worst-hit areas. A large IDP camp has been established five kilometres from the largest town and your organisation is currently supplying emergency food

continued overleaf

Role Play 5 *continued*

drops to the camp and to vulnerable children and families in the community. Most people are surviving only through petty trading, and the nomadic tribes who keep livestock are increasingly concerned for their own survival. In addition, there is conflict in the two neighbouring countries, which makes Ukweli's borders unstable. Because of various traditional practices and the unprecedented movement of people, HIV and AIDS prevalence is apparently increasing, although no current statistics are available due to the low capacity and lack of functioning basic services.

You have management responsibility for all areas of work and are increasingly concerned about a 'reducing' budget – the original budget had not anticipated the scale of the migration and currently you are only able to provide one-third of the daily food requirements for half the people in the IDP camp. Most of the UN agencies are focusing on areas in the south of Ukweli, and do not see the IDP camp your programme is serving as a priority. According to recent reports, the conflict in neighbouring countries is moving across the borders of Ukweli and your priority is to develop some form of emergency preparedness plan in the event that there will need to be a mass evacuation of people from your area, including the IDP population. The local authorities are becoming concerned about apparent 'criminal' activities and 'bad elements' coming into the town from the IDP camp, they want the camp moved and are unwilling to look at any emergency preparedness plans until the IDP are 'eliminated' from their community.

Your programme manager, whose role is to support vulnerable children in the community, has asked to meet with you. The programme manager is a good worker, but, you feel, too caught up in theories rather than the practicalities of an emergency situation.

Project officer

You are a project officer and have been recently employed by this organisation. You live in the town and had worked for the government before coming to this post. You like your job but feel the organisation is too focused on the IDP camp; there is real poverty in your own community, particularly outside of town where people get no services. Ukweli is a country which has been affected by long-term drought, with increasing migration of people from the worst-hit areas. A large IDP camp has been established five kilometres from the largest town and your organisation is currently supplying emergency food drops to the camp and to vulnerable children and families in the community. Most people are surviving only through petty trading, and the nomadic tribes who keep livestock are increasingly concerned for their own survival. In addition, there is conflict in the two neighbouring countries, which makes Ukweli's borders unstable. Because of various traditional practices and the unprecedented movement of people, HIV and AIDS prevalence is apparently increasing, although no current statistics are available due to the low capacity and lack of functioning basic services.

You come from a rural area but you grew up in the capital city, and have a high level of education. Unfortunately, because of the political situation, you cannot find work in the city anymore. Many of the people you work with are illiterate and need to be told what to do. Neighbours have informed you that the IDPs coming into town are stealing things from the houses and the adolescent girls are selling sex for money in the market. You believe the programme manager is very nice but he does not really understand the community or the historical tribal conflicts which are fuelling some of the growing tensions.

Facilitator's notes for Role Play 5

Facilitators could highlight some of the following issues.

- When working with staff from a range of backgrounds there is often an *assumption of common values*, but this may not be the case. Does the team in the role play have a common understanding of the programme aims and objectives? Is there a *team identity*?
- How can different values undermine developments which promote equity and participation?
- What mechanisms could be put in place to improve *team cohesion*?
- How can the learning from the quality childcare standards training workshop be transferred to other team members? Getting other team members on board would help them to feel *ownership* of any strategies that are developed.
- When faced with *competing demands and declining budgets*, what information is required to prioritise children's issues? What strategies are necessary to influence others, and who should be targeted?
- Is it feasible to address quality child standards within an emergency programme?
- In order to gain an understanding of the existing care and protection mechanisms in the camp and the community, and current attitudes towards child care and protection issues, is a *situation analysis* required?
- Do additional aspects of the programme need to be developed and what resources would be required?

Case Study 1: Working with carers on quality standards in a community setting[41]

Errer Waldiya

Errer Waldiya is in the Harrar Zuria district of Harrar Regional State in eastern Ethiopia. It is a small rural town, accessed by gravel road, about 30km west of Harrar town. Errer Waldiya is a commercial centre for the people living in the surrounding Peasant Associations. The rural area west of Harrar is a fertile area with green hills, valleys and small rivers and is a tranquil place, especially for those coming from the big noisy towns.

Maate

Errer Waldiya is where Maate was born and spent her childhood, with three younger siblings. She was born into a family that is relatively well-off, mainly because of the shop they own in town, supported by a plot of land near the town growing cereals. Their shop is the most popular in the rural area, for it has everything that people want and customers often have to queue to be served. Maate is also known by the customers, since she spends time in the shop after school. Maate's father, as the villagers prefer to call him, is also a respected elder whom they consult on different issues. The family is a member of the Afosha, a traditional, community-based association established for mutual help. Despite her mother's death last year, Maate's life has been a happy and smooth one.

Maate's father has failing health

On many occasions, Maate has looked after her siblings and the shop while her father travelled to Harrar to replenish items in the store. In May 2004, when Maate turned 15 years old, Maate's father decided to spend a month in Harrar. His stay was not a pleasant one. He became sick after a few days and had to spend most of the time going to the hospital and in bed at his brother's home. After two months in Harrar, Maate's father insisted on going back home to rest and look after his children and the shop as best he could. He was looking forward to a warm welcome from the villagers and expected everyone to express their happiness on his recovery and return.

Maate's fear

The news of the father's sickness, weight loss and recovery was the talk of the town. Everyone was pleased that the respected elder had returned and many villagers stopped by the shop or the house to give their good wishes. Everyone was happy to see him, except for Maate.

Maate looked forward to managing the shop, but she had hopes and dreams of spending time in Harrar and attending college before taking over the store. She did not imagine that her father would grow old so quickly and rely on her to care for the three younger siblings (aged ten, six and four) and the shop, when she was only 15. As the eldest, this was expected of her. Over the coming months, Maate spent more and more time running the household, caring for her father, siblings and the shop. She barely had time to do her school lessons and the family plot of land was being neglected. Maate feared she would not be able to properly care for her family.

Teachers noticed that Maate was spending less and less time in school. Even though the younger siblings were consistently attending school, teachers noticed their social withdrawal and lack of motivation to participate in the classroom lessons. Many villagers also noticed the shop was closed more often and was running out of essential supplies. The village health worker visited Maate's father at least twice a week, but knew he would not live much longer.

Group question: What would you, as a member of the community, do to assist this family?

Facilitator's notes for Case Study 1

The Implementation Team split into two groups to discuss this exercise and both groups presented broadly similar responses. Facilitators could highlight the following points.

- Although education is seen as a priority, what other actions should take place to ensure the children's future well-being? Examples could include preparing the children for their father's death; activities such as a memory book may assist with this.
- How would one introduce *writing a will* to safeguard the property for the benefit of the children? This could lead on to discussion about *cultural practices* on succession of property.
- How would participants address *structural discrimination* against women in such practices?
- Because of cultural norms, it was suggested that someone of the same gender would be most appropriate to care for the father but concerns were expressed that a man who was not part of the family may abuse Maate. Is there a *danger of labelling and stigmatising men* as always having alternative motives when involved with children?
- What strategies would best respond to children's rights while still respecting local practice?
- Is there an assumption that the father had HIV and AIDS (this was not mentioned in the text)? Would such an assumption adversely affect the children during the father's final illness and after his death? How could an adverse response be minimised or prevented?

The participants were finally presented with the Afosha response (as below) that was actually put in place in this real-life scenario.

Afosha response

The meeting was started as usual with a blessing of the elders, followed by songs and drama. Then Maate's father started to speak of the years of service his family had given to the community, and the current suffering they have gone through in the village where they lived for generations. He acknowledged he could no longer care for his children as he wished. He emphasised that he had financial resources to provide food and pay for education fees, but he could no longer play with his children or teach them life's lessons. He also spoke about the additional burden his ageing and sickness was placing on Maate's emotions and social development.

Members of the Afosha then deliberated on this issue and decided to take the following options to the family:

- The nurse would visit the father three times a week to help Maate to provide healthcare for her ailing father.
- The neighbour's daughter would start working in the shop with Maate (some hours for pay and some hours for free).
- The headteacher would extend the school hours to run a drop-in centre for children both in and out of school. This would allow the younger siblings and Maate the opportunity to have fun and play with peers.

Case Study 2: Child protection issues

Mary, aged 14, and her siblings Faustus, 12, Emmanuel, 8, and Verity, 4, have lived with their elderly grandfather (age 65) since both of their parents died from cholera three-and-half years ago. Mary's grandfather is a well respected and influential elder in the local area. They live relatively near a small town but none of the children currently go to school. The children and their grandfather farm a plot for their basic food. Mary sells produce from the garden at the local market and both Faustus and Emmanuel look after the few goats and chickens. The land and livestock were acquired by Mary's grandfather when her parents died.

Mary's grandfather has decided that he will re-marry and arranges a marriage with Evelyn, a 16-year-old girl from a nearby village. Three months after the marriage Evelyn is really unhappy. She misses her family and takes her unhappiness out on the young children. She easily becomes irritated and beats the younger children as well as forcing them to do heavy work and chasing them out of the house. Mary complains to Evelyn who suggests it is time Mary was married as well. Mary's mother never arranged for Mary to be circumcised and Evelyn informs her that she will arrange for a woman to come to the house to carry this out.

Mary is extremely fearful and when she is in the market speaks to her friend Josephine, an older woman who has the stall next to her. Josephine advises her to go to a local non-governmental organisation (NGO) which provides child protection and advice.

What are the issues, and what actions should the NGO take? What are the likely challenges you may face as an employee of the NGO and what strategy would you adopt to ensure a level of care that is consistent with quality standards?

Facilitator's notes for Case Study 2

- Is the priority to 'prosecute' the grandfather for his marriage to Evelyn or to focus on the care of the children? Where is the focus on *child protection*?
- Team members felt it would probably be difficult in their own particular context to prosecute a *respected and influential elder*. Would such action be in the *children's best interests*?
- Where *cultural practices conflict* or harmonise with the law, should quality standards, cultural practice or the law take precedence in dealing with issues of early marriage? (NB The *highest standard* in respect of the child's best interests should prevail, whether this standard derives from law, cultural practice or, indeed, quality care practice standards.)
- What are the children's *immediate needs* and how might these be *best served*?
- What strategies could be put in place to *support Evelyn*?
- In terms of the *cultural values around circumcision*, what action is necessary to support Mary?

Case Study 3: The best interests of the child

The government of Ashonja has limited resources but is committed to providing education for all students up to year 12. Given these resource constraints, the government is preparing a senior school in Sawa to provide final-year education for all year 12 pupils (16–18-year-olds). It is estimated that there are 8,500 pupils who are able to graduate in the following academic year.

Sawa is located near, but is completely separate from, the military training camp for everyone undertaking the two-year mandatory conscription into the national army. The Ashonja government does not support child recruitment and will not conscript anyone under 18 years of age.

Parents want their children to have year 12 education, as they cannot graduate without it and will not be able to go to university. However, they do not want their children to be away from home. In particular, they are worried about their girls being in such a large school with young men and being near the military training camp; although they may send the boys, they will not send the girls.

Do participants agree or disagree as to whether the government decision is in the best interests of the child?

Facilitator's notes for Case Study 3:

Facilitators may wish to group participants according to whether they agree or disagree with the government position. Thereafter, the two groups could explain their position and then conduct a debate which raises some of the following key issues.

- There is an *apparent conflict between certain rights* – ie, the right to education and the right to be with parents. Does the children's *age* affect such conflict?
- Regardless of the setting, a boarding school is a form of institutional care. Is it possible to offer *care and protection* in such a large collective living situation? What would be required to ensure *adequate* care and protection?
- Are there *any conflicts* between children's best interests and the interests of others (parents, teachers, institution and government)?
- Concerns were raised about the *lack of potential qualified teachers* in the country.
- What will be the *impact* on other educational services?
- How can the *gender discrimination* be addressed?
- There are concerns about the relative proximity of the military training base, the government motives, potential abuse, HIV and AIDS and the *impact* on children.

Appendix 4: An example of a cost analysis comparison

This analysis compares the annual cost per child among various agencies and forms of provision. However, because the programmes were located in different countries, there is the complication of standardising costs to a common currency (in this case, pounds sterling). Ideally, different purchasing powers should be taken into account – ie, does one pound sterling (GBP) purchase a similar amount and quality of food in the programmes and countries compared.

From the budgets provided by the Implementation Team, three programmes shared a fairly similar core set of personnel and were selected for further analysis. These agencies were a transit care centre for the temporary care of former child soldiers, a government children's home and a community-based project supporting the elderly (many of whom care for their grandchildren, orphaned as a result of AIDS).

When comparing the budgets of the three agencies, common components (personnel, personal care items, etc) were identified, as in Table 4.1, below.

As can be seen in Table 4.2 (opposite), staffing arrangements varied significantly, due to different organisational structures and functions; for example, the transit care centre had two posts additional to the core team – a monitoring and evaluation officer (M&E) and an advocacy and information officer. It should also be noted that while the community-based project does not provide a direct salary payment to elderly carers, it does have personnel directly supporting such carers. It is evident, however, that if we include the information on staff:child ratios examined earlier, high unit costs for personnel do not necessarily translate into the provision of a low staff or carer:child ratio. Of course, such

Table 4.1: Basic items included in childcare budgets

Personnel	Personal care	Administration
Programme co-ordinator	Food	Communication (phone, postage)
Project officer	Health/medical supplies	Consumables (stationery)
Finance	Water, sanitation	Vehicle costs – fuel/repair
Accounts assistant	Clothing, blankets	
Administrator	Hygiene supplies	
Driver	Cleaning supplies	
Secretary	Education supplies	
Social workers/carers	Shelter (rent or rehabilitation)	
Domestic workers	Repairs, maintenance	
Security guards	Utilities	
Volunteer stipends		
Teachers		
Doctor/nurse		

Table 4.2: Staffing and personnel costs per child per year, equivalents in GBP

Transit care centre	Children's home	Community-based care
Programme co-ordinator	Programme co-ordinator	Programme co-ordinator
Finance/admin officer		Finance (accounts)
Programme officer		Programme officer
Accounts assistant		Accounts assistant
Driver	Driver	
Secretary		
Social workers	Social workers	Social workers
Administrator	Administrator	
	Domestic	
Others:	Security	Security
Monitoring and evaluation officer	Volunteers	Volunteers
Advocacy information officer	Teachers	
	Doctor/nurse	
234 GBP/child/year	**199 GBP/child/year**	**7 GBP/child/year**
1:133 care ratio	**1:40 care ratio**	**1:6 care ratio**

crude figures need to be treated with caution and should be analysed further before drawing final conclusions.

A similar comparison in relation to the cost of personal care items for children supported by these agencies shows a range of expenditure for personal care items per child varying from 30 GBP/child/year in a community-based programme to 190 GBP/child/year in an institutional setting (Table 4.3).

When the unit costs for childcare are combined with additional costs of training and administration (Table 4.4, overleaf), we gain a clearer perspective from which to review budget allocations.

Table 4.3: Expenditure for personal care items per child per year, equivalents in GBP

Transit care centre	Children's home	Community-based care
Food	Food	Food
Health care, medical	Health care, medical	
Water, sanitation	Water, sanitation	Water, sanitation
Clothing, blankets	Clothing, blankets	Clothing, blankets
Education supplies	Education supplies	
		Shelter
Repairs, maintenance	Repairs, maintenance	Repairs, maintenance
Utilities	Utilities	Utilities
Others:		*Others:*
Newborn baby supplies		Income-generating funds
47 GBP/ch/yr	**190 GBP/ch/yr**	**30 GBP/ch/yr**

Table 4.4: Training and administration costs

	Transit care centre	Children's home	Community-based care
Annual expenditure	£87,268	£57,333	£102,431
Number of children	200	120	2,260
Staff:child ratio	1:133	1:40	1:6
Cost	436 GBP/ch/yr	478 GBP/ch/yr	45 GBP/ch/yr
Breakdown of costs	76.4% personnel 11.5% personal care 3.4% admin 8.7% training	41.6% personnel 39.7% personal care 0.4% admin 18.3% training	15.6% personnel 66.7% personal care 4.4% admin 13.3% training

Improving budget and resource allocations

The Implementation Team reviewed the cost analysis and made recommendations as to how existing budgets could be reallocated to improve the quality of childcare provision within particular care settings.

The exercise highlighted the need for organisations to review the roles, responsibilities and job titles of staff on a regular basis in order to ensure a staff complement which could directly support children's development. Job titles should accurately capture the roles of the staff. However, the team members felt 'multi-tasking' might be essential in organisations with a relatively small number of staff.

Transit care centre

Critical issues arising from the budget analysis included:

- There are too many personnel doing similar, interrelated jobs.
- High overhead costs, rather than funding of direct personal care/care staff
- The budget allocation doesn't reflect the major points of intervention, eg, temporary care of children.
- The personal care budget is too small to fulfil education, health, food and shelter needs.

Recommendations for budget reallocation:

- Staff distribution should change. Remove some of the posts, especially the deputy managers and assistants, secretary and M&E officer. These duties could be performed by the project officer, project assistant and administrative assistant.
- Increase the number of social workers employed, funded from the above staff savings.
- Savings on staff costs could also be used to improve access to education, water and sanitation.
- Reduce the numbers of children to 150 through: establishing supported community accommodation for young mothers currently in the centre; reunifying children with families so they spend less time in the centre; implement better gatekeeping procedures so as to provide children with options prior to admission to the centre, including support for immediate reunification with their families.

Some childcare providers in resource-poor environments feel that quality care might not be possible due to resource constraints and budget limitations. Ongoing efforts are needed to advocate for increased and better allocation of resources for the most appropriate forms of care provision, such as family- and community-based care. However, the implementation process highlighted the fact that attitudinal change, rather than budget limitations, is often the key enabling factor – or constraint. If policy-makers and care-providers have a positive attitude and commitment towards the implementation of quality childcare standards, then creative use of existing budgets can often result in significant improvements in the quality of care provided for children.

In discussion, the team felt the URAA community programme relied heavily on volunteer support, including the 'nominees' (eg, close neighbours) for continuity of care. The Implementation Team felt the community-based project currently focused too much on direct material inputs and needed to reallocate some of the funds to more sustainable approaches to build longer-term capacity in the community, perhaps through networking more with other agencies to build capacity, such as training on income-generation activities. Finally, the programme would benefit from a longer-term strategy which recognised the needs of the children throughout their childhood. For example, the question was raised as to whether the organisation could continue to support the 'nominees' in the future care of children.

Community-based care programme

Critical issues identified from the budget analysis included:

- Most of the funds (66%) go towards direct household support. However, better monitoring for cost effectiveness for each activity could be undertaken if activities that support building sustainable community structures (ie, training of local leaders and teachers) were identified separately from the training of elderly carers.
- The salary gap between executive director and other workers is too high: the executive director receives four times more than a social worker.

Recommendations for budget reallocation:

- Invest in building community structures and capacity of the community carers, volunteers, etc.
- Undertake job evaluations to streamline salaries.
- Ensure there is ongoing training for carers and others involved in children's care and protection.
- Include monitoring and evaluation in the budget, establish an M&E system or employ an M&E officer. This was an interesting suggestion, given that the previous analysis suggested that this role could be undertaken by others.
- Conduct awareness-raising about child rights with the community.
- Motivate social workers through allowances for capacity-building training.
- Support older people and younger caregivers (depending on programme) through, for example, training on income-generation activities, childcare, child rights (eg, one to two training sessions per year per organisation per district).
- Meet with local leaders and older people (ie, one meeting for elderly carers per year per district and one meeting for leaders per year per district).
- Monitoring should be done continuously by the project officer, with periodic review and evaluation.

Appendix 5: Job descriptions

The two job descriptions below show the possible range of duties for other staff members involved in the provision of childcare.

These draft job descriptions were developed within the framework of partnership agreements with organisations that manage transit care centres in east DRC. Save the Children drafted the outline job descriptions for staff members working in these centres so that staff could clarify the roles and functions of everyone to avoid confusion in the centres, especially for the children. In addition, finalised and agreed job descriptions will facilitate staff assessment in the centres as carried out by transit care centre (TCC) co-ordinators and Save the Children technical liaison officers.

Other similar and appropriate draft job descriptions were developed for the cook, security guards, storekeepers and the nurse. In addition, TCC procedures and a code of conduct were drafted for discussion with TCC staff.

Job description: Transit care centre manager/co-ordinator

General information about the post

The transit care centre (TCC) manager carries overall responsibility for the management and development of the TCC, including all aspects of policy development and implementing procedures, programmes, human and financial resources, and compliance with any binding agreements and memorandums of understanding with partner and funding agencies.

As such, the manager primarily ensures the welfare of and respect for children and compliance with agreed standards in all elements of the TCC work. He/she will co-ordinate the activities of the TCC Team, including the planning and co-ordination of work schedules and giving priority to the development of appropriate activities for the children. He/she will ensure an effective system of support and supervision so that staff are motivated and defined tasks are carried out on time and in the best interests of the children.

The TCC manager will ensure the above systems promote coherence and collaboration in the team, through the distribution and delegation of different responsibilities and duties in accordance with team members' field of activities. He/she will ensure that the work environment is conducive and that the team remains dynamic. He/she will co-ordinate a range of regular meetings, including daily team meetings, in order to enhance the work of the TCC.

In close collaboration with the Save the Children technical officer, the TCC manager will supervise all family-tracing activities and will have responsibility for the database, holding individual records of children and taking responsibility for the confidentiality of any information gathered. In addition, he/she will manage and supervise work carried out by trainers in the preparation for and reuniting of children and families.

Finally, the TCC manager will have responsibility for the timely production of financial and narrative reports to identified stakeholders for the purposes of accountability and the general documentation of the work of the TCC.

Responsibilities

The TCC manager respects and guarantees the objectives of Save the Children and any binding

continued opposite

Job description: Transit care centre manager/co-ordinator *continued*

memorandums of understanding and **is responsible for**:

1. the application of guidelines, standards and procedures as defined in the operational framework
2. the security and welfare of children and the presence of protection mechanisms in the TCC, strengthened through encouraging and promoting the participation of children in all TCC activities and in decision-making, in consultation with Save the Children
3. ensuring the presence of a sufficient number of trainers for the number of children in the TCC in harmony with established rules (one adult for a maximum of eight to ten children)
4. ensuring the quality and quantity of activities in the TCC (in accordance the minimum set standards): will organise and supervise the development of all TCC activities (educational, psychosocial, recreation, health, sport, games, etc) with the training team and in close collaboration with the Save the Children technical liaison officer
5. equitably planning and co-ordinating the staff work schedules at the TCC (facilitators, trainers in charge, nurses, guards), giving priority to the correct development of activities with the children
6. daily organisation and facilitation of review meetings with the training team regarding children's cases and also weekly meetings with the Save the Children technical liaison officer
7. ensuring continuity in family tracing for each child in the TCC: will supervise preparation for the reunification of children and families, ensuring children are placed in an alternative and appropriate placement if they are not reunited with their families within 90 days
8. ensuring appropriate record keeping: respect for and compliance with standards in documenting children's information in the TCC and in managing children's case files (medical files, documentation and follow-up), ensuring that children's records are kept up to date and available to the Save the Children technical liaison officer, ensuring proper maintenance of TCC staff records (CVs, appointment letters, job descriptions, employment application letters, etc) and documentation dealing with sickness leave and with absenteeism
9. ensuring the proper functioning of the TCC, including all aspects of the proper use, respect for and maintenance of the premises, hygiene standards, kitchen equipment, food storage and preparation, and teaching materials. In addition, ensuring regular purchase and provision of fresh foodstuff for children to meet their required daily nutritional intake
10. ensuring Save the Children is informed, within the shortest time possible, of any matter that may have an impact on the proper functioning of the TCC (thefts, problems with child protection, cases of adults admitted in the TCC)
11. ensuring that Save the Children staff are updated and informed of any information or changes concerning the TCC staff complement
12. forming links with actors in other programme activities: facilitates the work and collaborates with different members of the Save the Children office and other agencies working with Save the Children (eg, ICRC, UN Mission, partners)
13. preparing periodic narrative and statistical reports on the Centre for submission to partners (DIVAS (Government Departments in Kinshasa and at the Provincial level), the local NGO, etc) with a copy to Save the Children. Such reports should include the TCC's Statistical Data (number of children present, having gone through the TCC, or reunited with their families), and a narrative report on daily running of the TCC
14. managing any crisis or rebellion that may arise in the TCC; will inform partners (DIVAS, local NGO) in writing, with a copy to Save the Children, of any problem or event taking place at the TCC and refer the recommendations to the TCC technical liaison officer before making any official decision
15. ensuring appropriate interaction with the surrounding community and environment.

Job description: Trainer

General information about the post

The trainer is generally in charge of welcoming children to the TCC. He/she is responsible for implementing recreation and sports activities for children as they wait to be reunited with their families. The trainer is responsible for children's security and ensures that order and respect for rules of conduct are maintained both day and night. Particular attention is needed when admitting girls to the centre. He/she works under the direct supervision of the TCC manager/co-ordinator.

Tasks and responsibilities

Any trainer assigned specific responsibilities by the TCC co-ordinator shall be primarily responsible for the group of children he/she accompanies and for creating a friendly and family-like environment for them in the TCC.

The trainer is responsible for:

1. the daily welfare (food, hygiene, etc) of the children in his/her group: encourages and promotes children's participation in TCC activities, decision-making processes and collective tasks
2. ensuring that children in his/her group have daily opportunities to be listened to on an individual basis children
3. regularly updating the children in his/her group on any development in respect of family tracing
4. offering guidance to the children in his/her group, in collaboration with the Save the Children technical liaison officer and the TCC orientation team, on options for alternative and appropriate placements
5. actively participating in the daily review meetings with the orientation team concerning children's cases, and also the weekly meeting with the Save the Children technical liaison officer
6. developing recreation and sports activities adapted to the needs of children in his/her group; participating in their development, implementation and facilitation among the children and young people
7. regularly submitting proposals to the TCC co-ordinator for recreational, sports, educational, cultural and artistic activities according to his/her skills and capacities
8. submitting a specific weekly schedule of the proposed activities to the TCC co-ordinator
9. ensuring that children respect others and the TCC Code of Conduct
10. ensuring that girls and boys are under constant supervision, giving particular attention to prevention of abuse, especially during the night
11. if the TCC has no nurse, taking children to the health centre when necessary
12. informing Save the Children and partner agencies of any situation or circumstances that could affect the proper functioning of the TCC.

Appendix 6: The development of a child protection policy

Purpose of the policy
• Raising awareness of the problem of child abuse in general and the risks to children • Providing a framework for agencies working with children to effectively protect them from abuse • Outline clear actions to be undertaken when abuse is suspected within the membership
Be clear on
• Have an understanding of child abuse • The impact of abuse on a child • What makes children vulnerable • When to be concerned and suspect abuse of a child • Whether a child protection policy is necessary • How we should respond to disclosure (by children and colleagues) • How far we go with ethical principles such as confidentiality in cases where abuse is suspected
Practical measures
• Develop a policy that includes practical steps for implementation • Encourage partners to make formal commitment to adopt the policy and mainstream it within their organisational policy and practices • Ensure that staff exhibit high professional standards and conduct at all times when working with children
Issues for focus
Adherence: • Organisations need to understand that the policy exists and all staff should be signatories to it • They should understand how the policy will be monitored • Where abuse has occurred, action to be taken is clear
Professional conduct
The following people are aware of their roles and responsibilities in relation to the policy: • managers • staff • volunteers • consultants • funding agencies • partners • contractors

continued overleaf

What fears might we have as we implement the policy?
• What if the abuser is your manager? • What if I am mistaken? • What if I get victimised? • How do we handle issues of loyalty to colleagues and friends who may be suspected of abusing children?
Challenges
• How do we monitor the implementation of this policy and follow up the cases, especially if we have to take action? • How do we ensure its implementation outside the workplace (personal and professional conduct)? • What practical mechanisms should we put in place to ensure we act when abuse is suspected? • What do we do if the abusing or suspected agency is our donor partner, member organisation or volunteer? • What mechanisms should we put in place to allay these fears (implications of reporting)? • How do we handle a case that goes beyond an agency/organisation? Where do we seek support?

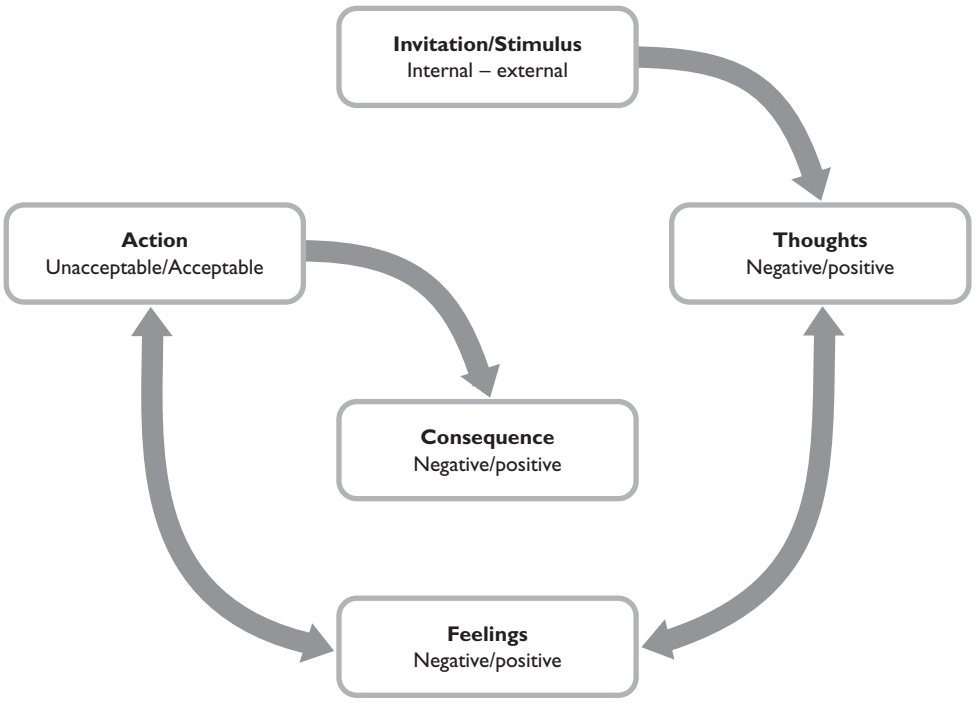
Appendix 7: The Crisis Cycle

When working with children and considering the types of behaviour prompted by a crisis, it is useful to look at a model called the Crisis Cycle. It must be noted that often behaviour which 'challenges' adults is also an 'invitation', on the part of the child, to stimulate communication.

The Crisis Cycle depicts the moment-to-moment psychological process that occurs for human beings as they deal with stress and anxiety in problem-solving. The cycle indicates that coping events begin with a stimulus which immediately triggers a *cognitive* or *thought* response; these thoughts lead to an emotional trigger or feelings which, in turn, result in behaviour or action. For every action there is a consequence; the consequence itself very often becomes a new stimulus which, in turn, results in another cycle. An escalating event is a continual repetition of this cycle.

When using the Crisis Cycle it is important for staff to understand the replacement of the term 'stimulus' with that of the term 'invitation'. Staff should see the child's behaviour as an invitation to engage in professional intervention. Finally, it is important for staff to realise that they themselves engage in this psychological process. For staff, the child's or youth's behaviour becomes a stimulus for their own crisis cycle process.

The Crisis Cycle



Appendix 8: Advocacy building blocks[42]

The building blocks below offer a useful process to follow when planning an advocacy strategy.

Problem analysis

- **Underlying causes** – Explore the underlying causes of the problem and not merely the symptoms arising from such causes. A 'problem tree' model can help with this.
- **Political analysis** – Agencies should understand the external environment, eg, whether there is the 'will' to change, and where the 'power' to change a situation is located.
- **Likelihood of change** – Agencies should ensure that they target their energies in areas where they *can* achieve change and should have realistic expectations. Some more ambitious changes, however, can be achieved progressively over time.

Change objectives

If 'advocacy' means influencing to bring about change in policy and practice then the changes we want to bring about are our '**change objectives**'. Change objectives should:

- be Specific, Measurable, Achievable, Realistic and Time-bound (**SMART**)
- be both **long-term and short-term**
- consider the different **dimensions of change** (local, district, national, international) and take these into account
- first consider the **capacity of the organisation** to engage in advocacy.

Stakeholder analysis[43]

The stakeholder analysis should identify all **targets, allies, opponents and those who may have influence** over the proposed change. This analysis should:

- identify people/groups interested in the problem/solution
- improve understanding of their interests and attitudes
- identify potential opportunities/allies and threats/opponents
- identify the overall approach with key targets (eg, change their attitude, reduce influence)
- assess which individuals/groups should be involved/targeted at different stages to achieve objective.

How is this information analysed?

Brainstorm stakeholder groups:

- who can make or block the change (targets)
- who can have influence over stakeholders (influentials).

For each stakeholder, identify:

- their attitudes (anti, neutral, pro)
- the importance of the issue to them
- their level of influence
- what they really care about
- what change you require of them.

Core messages

It is important to define:

- what you want to achieve
- why you want to achieve it
- how you propose to achieve it (solution)
- what action you want the audience to take.

In identifying your core messages, it is also important to **tailor your messages** to a particular audience or target. Questions to ask yourself include: what is most *persuasive* for that audience; what information does that audience need to hear; what specific action do you want that audience to take.

Approaches

Different approaches can be used for each area of the advocacy campaign. These may be:

- lobbying
- public campaigning
- mobilising others, ensuring their participation
- building alliances and networks
- developing appropriate materials, communications and documentation.

Managing implementation

It is important to manage your advocacy. Components for effective management include:

- develop an advocacy plan
- mainstream (make it part of all related work) and resource the plan
- implement the planned activities
- monitor and evaluate progress regularly
- have a clear exit strategy.

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Endnotes

[1] 'First Resort' is the name of a series of Save the Children publications that seek to promote policies and practices that support quality family- and community-based care options and children's participation in positive care options.

[2] Save the Children, *A Last Resort: The growing concern about children in residential care*, Save the Children Alliance, 2003

[3] This section draws from *A family is 'for life': A discussion of the need for family care for children impacted by HIV/AIDS*, prepared by Jan Williamson, LCSW, for USAID and the Synergy Project, 25 April 2003.

[4] See D Tolfree, *Facing the Crisis: Supporting children through positive care options*, First Resort series, Save the Children, London, 2005.

[5] *ibid*

[6] UNAIDS, UNICEF, USAID, *Children on the Brink 2004: A joint report on orphan estimates and a framework for action*, USAID, 2004

[7] See Joint Working Paper by ISS and UNICEF, *Improving Protection for Children without Parental Care: A call for international standards*, August 2004.

[8] The 'First Resort' series was launched by Save the Children in 2005 as a learning series to promote policies and practices which support quality family- and community-based care options and children's participation in positive care options.

[9] See note 2.

[10] Save the Children UK's work in Kenya has recently stopped.

[11] Save the Children UK's DRC and South Sudan programmes, HelpAge International Regional Office, Uganda Reach the Aged Association, Gulu Support the Children Organisation in Uganda, Save the Children in Uganda, and the Nairobi Children's Home.

[12] UNICEF, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, 2004

[13] These are examples of some of the issues raised by workshop participants for inclusion in the standards.

[14] A range of information materials was produced by the Implementation Team. While it has not been possible to include all the materials in this publication, full transcripts from the Implementation Team workshops and related PowerPoint presentations are available from scukesa@ethionet.et

[15] While initial drafts of a guide were developed in May 2005, the final stages of producing this document took longer, resulting in delayed publication and dissemination.

[16] See Appendix 1 for participants' names and backgrounds.

[17] Adapted from Save the Children UK Ethiopia Programme, HIV/AIDS Prevention, Care and Support Project Feature Report, January 2004, Internal report.

[18] S Laws, C Harper and R Marcus, *Research for Development: A practical guide*, Save the Children UK and Sage Publications, London, 2003, ISBN 0 7619 7323 5

[19] While childcarers or volunteer carers may not be acknowledged as 'staff' in the context of the provision of a childcare service, be it institutional care or community-based care, they are undertaking a job which merits professional recognition, training, development opportunities and support. It is for this reason that they are designated generically as 'staff' rather than 'volunteers', 'community carers' or 'foster carers'.

[20] In a participative assessment of children's views on the quality of their care, children clearly stated that they received love and attention from their grandparents and were happy to stay with them. See D Tolfree, *Facing the Crisis: Supporting children through positive care options*, First Resort Series, Save the Children, London, 2005. When discussing this option with the care staff, one childcare worker stated, "When I come in to my shift, I see these 120 children and just cannot take responsibility for them all, but if I had ten children of my own to care for, I would be responsible and ensure all their needs were attended to, including taking them to the local school!"

[21] Save the Children in Uganda is a consolidation of three Save the Children agencies, namely, Save the Children Denmark, Save the Children Norway and Save the Children UK, with Save the Children Norway being the lead agency.

[22] Their interest in the small group home model was stimulated during a recent visit where the quality childcare standards were discussed.

[23] It was recommended that the job descriptions developed for the transit centres by one of the Implementation Team would serve as a good model for others, and these are in Appendix 5.

[24] Standards [numbering as in *Raising the Standards*] included as part of the needs assessments by HAI included: diet (2.1.1–2.1.7); sense of identity (2.8.1–2.8.7; 2.8.10); babies and young children (2.12.1–2.12.4); choice (2.5.1–2.5.5); accommodation general (4.2.1–4.2.8).

[25] More concrete examples on the impact of standards on children's lives are available through one of HAI's partners, Uganda Reach the Aged Association (URAA).

[26] Non-government partners include RECOPE, the Network for Youth and Street Children and the Central African Training Centre for Social Education. The principle government partners are the Ministry of Social Affairs through its technical divisions (DISPE, DIVAS, and DAS) of the Ministry of Welfare, Women and Families.

[27] Theatre for Development empowers children to raise their own issues and to discuss these issues with the audience.

[28] This has been shown to be effective in Uganda, where a survey in the early 1990s showed that 95 per cent of children in institutions had known relatives and basically had no reason to be in institutional care. In response, the government established the Children and Babies Homes Rules and created a government Inspector of Homes post, which provided training, inspection and sanctions for non-compliance. Those institutions which did not meet the Homes Rules were closed down and children were reunified with their family or extended family. In 1993, there were 76 children's homes; after the introduction of a parallel reunification programme there were only 43, all of which complied with the Homes Rules. However, due to restructuring the Inspector of Homes post was discontinued in 2000, but by 2003 there were 88 homes. It is unclear how many of these complied with the Homes Rules. In 2004, the relevant Minister went to a conference in Stockholm where this history was presented, and on her return to Uganda she reinstated the Inspector of Homes post.

[29] Joachim Theis, *Tools for Child Rights Programming: A training manual*, Save the Children UK, South East Asia and Pacific Regional Office, 2001

[30] United Nations High Commissioner for Refugees, *UNHCR Guidelines on the Formal Determination of the Best Interests Determination*, May 2006, http://www.unhcr.org/cgi-bin/texis/vtx/home/opendoc.pdf?tbl=RSDLEGAL&id=447d5bf24

[31] J Boyden and G Mann, *Resilience, vulnerability and coping in children affected by extreme adversity*, background paper for the Refugee Studies Centre, Oxford and Centre for Child-Focused Anthropological Research, *Consultation on Children in Adversity*, Oxford, September 2000, http://www.sagepub.com/upm-data/5336_Ungar_I_Proof_Chapter_1.pdf

[32] Catholic AIDS Action Namibia, *Building Resilience in Children Affected by HIV/AIDS* (2nd ed.), Maskew Miller Longman, Cape Town, South Africa, 2003, ISBN 99916 1 274 2

[33] Edith Grotberg, *A Guide to Promoting Resilience in Children: Strengthening the human spirit*, Early Childhood Development Practice and Reflections Number 8, Bernard van Leer Foundation, The Hague, 1995, ISBN 90 6195 038 4

[34] See note 30.

[35] Tearfund and NSPCC, *Setting the Standard: A common approach to child protection for international NGOs*, 2003, 2003. These standards were developed by a steering group comprised of Christian Aid, MSPCC, Save the Children, People In Aid, EveryChild, Tearfund. http://www.peopleinaid.org/download/Setting%20The%20Standards.pdf

[36] This section is based on a workshop presentation given to the Implementation Team by the consultant, Neil McMillan. Further details of the workshop materials can be obtained from scukesa@ethionet.et

[37] Costanza de Toma and Louisa Gosling, *Advocacy Toolkit: A collection of tools to help plan, implement, monitor and evaluate advocacy*, London, Save the Children UK, 2005

[38] *ibid*

[39] See note 4, D Tolfree, *op cit*

[40] Proxemics is the study of the nature, degree and effect of the spatial separation individuals naturally maintain (as in various social and interpersonal situations) and of how this separation relates to environmental and cultural factors.

[41] Adapted from Save the Children UK Ethiopia Programme, HIV/AIDS Prevention, Care and Support Project Feature Report, January 2004. Internal document.

[42] See note 37, Costanza de Toma and Louisa Gosling, *op cit*

[43] Some tips for the stakeholders analysis: go beyond those that you already work with; think where the power *really* lies; be as specific as possible (eg, think about individuals and departments rather than whole ministries); produce a 'question and answer' sheet to summarise your views and your position on the main issues.