



BECAUSE WE CARE:
Programming Guidance for Children
Deprived of Parental Care

Prevent • Protect • Restore

BECAUSE WE CARE:

Programming Guidance for Children Deprived of Parental Care

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Series Editor: Bill Forbes



*World Vision International
Child Protection*

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Published by World Vision International, 800 West Chestnut Avenue, Monrovia, California 91016-3198 U.S.A.

Author: Elizabeth Oswald. Series Editor: Bill Forbes. Editor in chief: Edna Valdez. Production: Katie Klopman, Jim McAllister. Copyediting: Ted Vandelloo. Proofreading: Katie Klopman. Cover Design and Interior Layout: Rebekah Roose.



Acknowledgements

We would like to acknowledge the contributions of our colleagues who participated in informal interviews which informed both the content and direction of the paper and provided vital feedback during its drafting. A special thanks to the following contributors:

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Introduction

Purpose

World Vision prioritises the well-being of the world's most vulnerable children (*World Vision International's Integrated Focus*). Children without parental care have been deprived of the protection and guidance normally given by their parents as primary caregivers and duty-bearers, leaving them vulnerable to abuse, neglect and exploitation (Tolfree, 2005). These children may be found living on the streets, struggling to care for their siblings, trafficked and exploited for sex or labour, or languishing in large, impersonal institutions. World Vision's commitment to the most vulnerable children requires significant investment in determining appropriate responses to these difficult situations. Therefore, **the aim of this paper is to prompt discussion and discernment regarding best practices for models of care for children deprived of parental care (CDOPC).**

Background

Historically, orphanages and large residential institutions have served as the typical solution to the problem of children deprived of parental care (CDOPC). However, the detrimental impact of traditional forms of institutional care on the development of children is now recognised. The United Nations Convention on the Rights of the Child validated concerns about institutionalisation and declared the right of children who are deprived of their family environment to a standard of living adequate for the physical, mental, spiritual, moral and social development of the child; standards which most institutions are unable to meet (UN, 1989, articles 20 & 27). In addition, the *World Vision International Management Policy for Children Deprived of Parental Care* (WVI, 2007) states that:

As a Christian organization, World Vision values the family as the primary social unit and basis of civil society. Children grow and thrive best in a family-based environment, not in institutional care... World Vision responds to children deprived of parental care by strengthening families to care for children, reducing risk of separation from their immediate and extended family, strengthening systems that provide alternative community-based options to institutionalization, and supporting transition and deinstitutionalization processes... World Vision supports community-based care options for children. The primary focus should be to strengthen systems that allow the child to remain with family members. If remaining with the family is not in the best interest of the child, WV supports the family, community and local authorities to find community-based solutions.

Therefore, this paper assumes a preference for community and family-based care models over institutional models and seeks to analyse various models that can offer a conducive environment for the holistic development of children.

Recommendations

Improving care for CDOPC contributes to all aspects of a child's well-being, as it will help most vulnerable children to enjoy good health, be educated for life, love God and their neighbours, and especially contribute to children being cared for, protected and participating in spite of facing extremely difficult circumstances (WVI, 2009). As such, it is a critical area for World Vision programming. This paper sets forward the following general recommendations for consideration by World Vision and other relevant agencies:

- Community and family-based practices in alternative care models must be pursued, rather than institutional practices
- Any placement of children in alternative care must be based upon the best interests of the child

- A hierarchy of models is productive as a starting point for discussion and planning, but requires discernment in application based on the specific context and situation of each child
- The benefits and concerns of each model should be considered when deciding on a model of alternative care, and with every model measures must be taken to counter concerns with appropriate programming practices.

Structure

These general recommendations are explained and expanded upon in the two main sections of the paper: (1) general alternative care principles, and (2) analysis of alternative care models.

Section 1 includes principles and guidelines that can and should be applied to all alternative care interventions. These principles are divided into seven categories: developing foundations for alternative care, strengthening families, strengthening communities, engaging government, empowering children, supporting caregivers and developing professional practices.

Section 2 then analyses five models of alternative care in more detail: kinship care, foster care, children living independently, group homes and children's villages. Each section includes a list of benefits and concerns, programming suggestions for implementation and case studies to aid reflection on practical application. Section 2 has a modular structure. Each of the five models developed in this section can be read by itself, independent of the others, for those interested in only one or a few of the models. Therefore, there is repetition of important principles among models. Throughout the paper specific sections are identified as 'hot topics' for the purpose of encouraging discussion on a topic that is debated among sources.



Definitions

The meaning of terms, such as 'child,' 'orphan' and 'community care,' should not be assumed as common knowledge. Clarification of definitions is essential for productive dialogue, avoiding misconceptions that lead to false assumptions and eventually flawed programming. Below are discussions on the importance of defining specific terms on the topic of alternative care for CDOPC and the definitions that have been used for the purposes of this paper.

Adoption: Adoption is the placement of a child into a family in which the legal rights and responsibilities for the child are transferred to the adopting adults. It is generally a permanent living arrangement (Tolfree, 2006, p. 25). Adoption is not to be discussed as a model for alternative care in this paper because World Vision does not facilitate adoption, and instead leaves this responsibility to governmental agencies and other organisations with more capacity and experience in this area (WVI, 2007).

Alternative care: The term alternative care can be understood in relation to institutional care (see definition of institutional care below). It refers to care options for CDOPC designed to avoid an institutional atmosphere, ideally placement in a family-style unit that is monitored and supported by the community (Williamson, 2004, p. 12).

Child/children: Definitions of children vary between cultures and international organisations, differing on the designation of the age when childhood ends. This paper adopts the definition of a 'child' used by the United Nations (UN) *Convention on the Rights of the Child* (CRC) as males and females under the age of 18.

Children deprived of parental care: For the purpose of this paper, 'children deprived of parental care' (CDOPC) is defined broadly to address the range of contexts in which children around the world are temporarily or permanently living without, or separated from, their parents. These children have been deprived of the protection and guidance normally given by their parents as primary caregivers and duty-bearers (Tolfree, 2005). CDOPC can include, but are not limited to: orphans, as defined below; children who have been trafficked away from their original homes and families; children who have run away or been forced to leave home; children who have been abandoned by their families; and children who have been removed from their parents by government or child protection agencies. CDOPC who have been separated from their parents due to emergency situations are not included in the scope of this paper.

Child-headed household: There are many misconceptions about 'child-headed households' (CHH) and its definition can dramatically affect the shock value of statistics that are valuable to those seeking donor support. Loose definitions include homes where children live alone, but their grandparent or other guardian lives next door or homes where children are left alone when a parent leaves overnight for work (Hosegood, 2008, p. 44). Plan Finland suggests a more limited definition of a CHH in a high HIV/AIDS prevalence area. Plan defines CHH as a household of double orphans who are independent, adopting de facto adult/parent roles by providing leadership and major decision-making in the running of the household, responsible for feeding and maintaining the household, and caring for younger siblings (2005, p. 2). For the purpose of this paper, CHH is understood as a household of children who have the characteristics defined by Plan Finland, excluding the conditions that the children are double orphans or necessarily siblings. CHH will include children whose parents are living but perhaps have abandoned or been separated from their children, or single orphans who are not receiving support from their remaining parent.

Children's villages: For the purpose of this paper, children's villages are understood as the long and short-term placement of children into a small household of 4-12 children with at least one parental figure as a caregiver, living among and next to other similar small households, or as part of a network and support system set apart from the surrounding community.

Community-based care: Community-based care is a term often used to describe alternatives to institutional care, encompassing alternative efforts to avoid an institutional atmosphere and move toward family care that is monitored and supported by the surrounding community. In community-based care adults, youths and fellow children in the child's own community provide support within a family-like setting. Ideally, 'Community leaders or organizations take responsibility for children and oversee their care and well-being in all aspects' (Williamson, 2004, p. 12). Community-based care can also be referred to as 'family-based care.'

Family: The understanding of family should be culturally defined. While in the West family is usually defined as biological, other cultures have a far more expanded understanding. The Joint Learning Initiative on Children and HIV/AIDS has suggested a definition of family that will be used within this paper. Family is considered a social group connected by a variety of things, including kinship, marriage, adoption or choice. They elaborate further saying, 'Family members have clearly defined relationships, long-term commitments, mutual obligations and responsibilities, and a shared sense of togetherness. Families, in their many forms, are everywhere the primary providers of protection, support, and socialization for children and youth' (JLICA, 2009, p. 17).

Foster care: Foster care refers to care for children in a household apart from their family, as defined by the culture. It is usually understood to be a temporary arrangement for the child and if alive, the birth parents usually retain parental rights. However, foster care may become a permanent situation or perhaps lead to adoption. Informal forms of foster care take place when a child is taken into the care of a family without arrangements by a third-party. Formal or arranged foster care involves an outside agency or governmental entity (International Committee of the Red Cross, 2004, p. 43). The formal foster care model is what is most commonly referred to within this paper.

Group homes: For the purpose of this paper, group homes are defined as small family groupings of children. This includes long- and short-term placement of children into a home of 4-12 children with parental figures as caregivers, located in neighbourhoods among family households. Youth living together without a full-time, live-in caregiver, who receive supportive services or materials from an outside agency, will also be included under this definition.

Institutional care: Institutional and residential care are often used interchangeably and cover a wide array of care models. Because institutional care often carries a negative connotation, practitioners often avoid the term 'institutional' and use 'residential care' instead; this term describes both alternative models and large-scale orphanages or 'institutions.' It is a broader term which also includes models of care such as group homes, schools, hospital units or correctional facilities, along with orphanages and large institutions (Williamson, 2004, p.12). For the purpose of this paper however, institutional care will be defined as separate from residential care, understood as large-scale, group living arrangements for children with shifts of remunerated care providers.

Kinship care: This paper adopts the definition of kinship care as: 'The full-time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, step-parents, or any adult who has a kinship bond with a child' (UNICEF, 2006, p. 26). This definition however causes some confusion in western thinking between the terms kinship care and foster care because kinship bonds also include relationships among non-blood related family members, such as tribe members. Therefore, this paper respects the classification of 'relatives' or 'family' as flexible to the cultural definition.

Orphan: The definition of an 'orphan' can lead to misconceptions about the situation of children and inflated statistics. The term can be used to describe both 'single orphans,' children who have lost one parent, as well as 'double orphans,' children who have lost both parents. Also some children found in orphanages are considered 'social orphans,' children whose parents are still living, but have abandoned their children, usually due to poverty. For the purpose of clarity, this paper will use the term 'orphan' to refer to children whose biological parents have both died, unless otherwise specified as 'single orphans' or 'social orphans.'

Youth: Categorising older children and those in early adulthood as 'youth' provides the opportunity to discuss the unique characteristics, abilities, challenges and needs of this group. While acknowledging that the practical meaning of the term youth is culturally mediated, this paper follows the UN standards, defining 'youth' as males and females between the ages of 15 and 24.



General Alternative Care Principles

While each alternative care model needs to be analysed individually, general principles can and should be applied across all alternative care interventions. The challenge in defining general principles is accounting for the variety and range of contexts to which they are to be applied. This paper presents principles that must be adjusted to the varying capacity levels of the communities and governments in which they are to be applied. In each context, it must be determined who is responsible and able to provide quality alternative care for CDOPC, and the role of non-governmental organisations (NGOs) must be defined accordingly. The greatest responsibilities should default to national governments and community-based organisations. However, in some contexts NGOs may need to support government for a limited period of time, while the local capacity for care is increased. The general principles below provide guidance for alternative care as implemented by national governments, community-based organisations or NGOs.

The sources for alternative care principles are vast and targeted to a variety of audiences. This paper attempts to consolidate existing knowledge and reframe it to speak to the concerns of international NGOs, in order to improve the implementation of alternative care models.

The principles are separated into seven sections:

1. Foundations for alternative care
2. Strengthening families
3. Strengthening communities
4. Engaging government
5. Empowering children
6. Supporting caregivers
7. Developing professional practices.

I) Foundations for alternative care

- **Seek the best interests of the child**

The overriding guiding principle for all planning for alternative care interventions is the child's best interests. The 1989 United Nations Convention on the Rights of the Child (UNCRC) affirms the norm of the best interests of the child as the primary consideration of all actions affecting children. Because the UNCRC has been signed and ratified by 192 countries, this norm represents an international standard for all nations and agencies to observe (www.unicef.org). Regardless of the position of models upon any designated hierarchy of community-based care options, the decisions involving alternative care must ultimately be in the best interests of the child. Defining processes for determining the child's best interests must be a priority for every organisation involved in alternative care.

- **Seek family-like care environments**

A family-like environment provides the child with experience necessary for social and cultural development, and the ability to attain economic self-sufficiency as the child becomes an adult. Families model for children's social skills, teach them how to negotiate cultural aspects of life, and provide them with experience and knowledge of income-generating activities (Williamson, 2004, p. 4). Within their families, children absorb the values of their culture and develop the skills they will need in adulthood (Olson et. al., 2006, p. 4). In addition, psychological studies have provided insight into the importance

of a secure relationship with an adult caregiver for the healthy social and emotional development of a child. This has been referred to as the 'attachment theory' (Bowlby, 1999). World Vision believes that children grow and thrive best in a family-based environment (WVI, 2007). Whether in extended families, foster families, adoptive families, or family-like group homes, children should be given the protection, love and support they are entitled to within a family-like environment.

- **Utilise a child well-being approach within a rights-based framework**

Alternative care options should be implemented with a primary focus on child well-being, a concept well articulated in the UNCRC rights-based framework. The UNCRC challenges all duty-bearers to work towards the goal of child rights. This goal includes, among other things, seeking the best interests of the child, developing the child's capacities, and providing provision for and protection of the child. The UNCRC assigns accountability to the State when such rights are not achieved. Although the UNCRC provides a starting definition to child well-being, World Vision adds further language: Aside from child rights, child well-being includes the actual quality of the child's life and relationships. A child well-being approach, enabled by the child rights framework, allows for a holistic vision of 'life in all its fullness' for children (Stephenson, 'Integrated Programming Models project: Child focus research and learning project report: Towards sustained child well-being and fulfilment of children's rights within families and communities,' DRAFT).

- **Seek integration**

All forms of alternative care should keep the focus on preparing a child for integrating into society, whether through reunification with his or her original family, integration into a new family or family-style group in a community setting, or through independent living and adulthood. When possible, family reintegration should be the prime objective of alternative care (Cantwell, 2005, p. 14). When it is not in the best interests of the child to return to their original family, it is essential that children acquire the necessary social and life skills to live a productive life. A child needs to be supported in shaping his or her future towards becoming a self-reliant, self-sufficient and participating member of society (Parry-Williams, 2005, pp.15-16). Age appropriate education, life skills development and livelihood training along with value development are appropriate efforts toward this objective (International Foster Care Organization, SOS Kinderdorf International, FICE, 2007, p. 45). After-care support may also be needed in situations in which children leave care to assist them in the transition to an independent young adult life (Tolfree, 2005, p. 12). Alternative care arrangements and monitoring must revolve around the central goal of integrating the child into society.

- **Do no harm**

As external agents, international NGOs must recognise their ability to cause harm to communities, families and children. Organisations need to be conscious about how their methods for child care might compromise a child's safety, and implement protection mechanisms to avoid those risks. In addition, without a thorough understanding of the context, a NGO can unintentionally subvert community support for the most vulnerable. Resources given to one people-group over another can cause resentment and discrimination. External support can relieve a community from their own sense of responsibility, disrupt existing community actions, create dependency and halt traditional coping mechanisms (Grainger, Webb & Elliott, 2001). In every context, the risk of doing harm should be assessed prior to any programming and action must be taken to minimise any risk. All programmes should be organised and implemented to strengthen community mechanisms and local people. When a community is taking responsibility for the care of vulnerable children, an NGO is able to focus on programmes for raising awareness, training and capacity development, strengthening data collection and analysis, linking communities with resources, and advocacy (Richter, Manegold & Pather 2004, pp. 19-20). However, when social structures and services are broken or underdeveloped, international NGOs must ensure that vulnerable children are protected (ICRC, 2004, p. 2). NGOs can then develop

interventions to care for children in need, but present them as models for local agencies to duplicate. Financial or material support might be necessary for a limited period of time, but plans for financial independence should be developed and implemented. Every attempt must be made to develop local ownership and responsibility without jeopardising the safety and development of children.

- **Incorporate into community development**

Interventions for alternative care should be part of a larger community development effort that increases a community's own knowledge and ability to care for the most vulnerable individuals in their community. External interventions for one specific type of CDOPC without community input or support can cause problems. For example, providing exclusive services to child-headed households (CHHs) not only ignores the needs of other children who may need the services more, but can also cause resentment towards children in CHHs. Or, if special services are provided to children in group homes, impoverished extended relatives caring for CDOPC may be more motivated to hand the child over to a group home. The United Nations' (2001) *Declaration of Commitment on HIV/AIDS* recognises the importance of community development in reducing the vulnerability of HIV/AIDS orphans and suggests that services should not only focus on orphaned children or CDOPC, but target all of the most vulnerable children in the community through a participatory process. Community development and capacity building is essential to build community assets for and commitment to the long-term, sustainable care of CDOPC.

- **Seek an insider's perspective**

External agencies need to recognise their need for greater understanding of the local culture, context and community. In the article 'Orphan Care in Malawi: Current practices,' B. Beard (2005) states that the greatest resources of knowledge on how to help Africans are Africans:

Help begins by trying to understand African culture and not by imposing our Westernised culture. It starts... by listening to the children and the people of Africa as they tell us what they want to do and what we can do not for them but with them (p. 114).

An insider's perspective is invaluable and necessary for efficient and successful programming, especially in developing appropriate alternative care options for children deprived of parental care. External agencies must seek knowledge from the people to inform responsible actions (Olson, Knight & Foster, 2006, p. 7).

- **Avoid potential for discrimination and stigmatisation**

NGOs must take the appropriate measures to ensure that children in alternative care are not stigmatised, and to combat existing discrimination within the community. In *Save the Children's First Resort Series: Facing the Crisis*, David Tolfree (2005) describes how the term 'orphan' can carry connotations of misfortune and a loss of social status. Tolfree recognises that the stigma associated with orphanhood is often compounded by other factors, such as HIV and AIDS, disability, and gender. Tolfree also suggests that community members charged with caring for such children are not immune to these deep-seated cultural beliefs and therefore may be a threat to the healthy development of children (p. 3). Stigma and social exclusion can also be a problem for children who have had certain experiences such as living on the street, sexual exploitation, or children whose parents died of HIV and AIDS-related illnesses or who may be HIV-positive themselves. Social education, such as developing empathy or teaching the basics of HIV transmission and prevention, can reduce community ignorance and stigma (Mathambo & Richter, 2007, p. 77), and prepare households to provide community-based care for children from these difficult situations.

2) Strengthening families

- **Strengthen the capacity of families**

The family, both immediate and extended, is the natural support network in crisis situations. Efforts must focus on strengthening the capacity of families to care for their own, not only as a preventative measure to CDOPC, but also to reinforce kinship care. Family preservation is the preferred option to other forms of community care and therefore strengthening families must be a priority (George, 2003, p. 355). In *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, the United Nations Children's Fund (UNICEF) (2004) promotes strengthening the capacity of family as the first key strategy in caring for CDOPC and recommends providing economic, psychosocial and other support. Capacity building for families might also include: arranging access to savings and credit mechanisms through village banking programmes; vocational training of parents or youth; reducing demands on household members by assisting in household farming or access to potable water; freeing up time for parents to undertake income-generating activities by providing child care; or making arrangements for permanent child placement prior to parental death through writing of wills and conversations with the child (Hunter & Williamson, 2000, p. 7). The principle of strengthening family capacity refers to foster families or other community-based care arrangements as well, so that strong families are a feature of every community-based care arrangement for children.

- **Increasing social protection for families**

Social protection can be described as,

...All initiatives, both formal and informal, that provide: social assistance to extremely poor individuals and households; social services to groups who need special care or would otherwise be denied access to basic services; social insurance to protect people against the risks and consequences of livelihood shocks; and social equity to protect people against social risks such as discrimination or abuse (Devereux & Sabates-Wheeler, 2004).

World Vision has increasing interest and experience in social assistance for children, including family and child allowances, social pensions, and in-kind provisions. In a recent discussion paper, the organisation presented the rationale for 'child-focused social assistance,' arguing that social protection interventions must be structured so as to impact children and their families (Stephenson & Clarke, 2007). Social protection mechanisms have great potential for reducing poverty and empowering the poor, therefore strengthening poor families' ability to care for children. Vulnerable households which provide care for CDOPC (whether original or foster family) could often greatly benefit from social assistance schemes that help them build and maintain a margin for child protection and care.

- **Maintain contact with family**

The child's relationship with his or her family of origin should be encouraged, maintained and supported, if this is in the best interests of the child and if the child chooses to do so (IFCO et. al., 2007, p. 33; Richter et. al., 2004, p. 39). Contact with family can decrease a child's experience of trauma and distress, support the process of returning the child to the original family, and provide the child with a sense of identity and belonging. Even some children with very abusive histories report that they like meeting their parents, in monitored and controlled situations. However, the family situation must be thoroughly assessed to consider whether contact is in the best interests of the child. If unrestricted contact with the family is not considered to be in the best interests of the child, for example the family is not deemed safe due to past abuse or exploitation, then special consideration should be taken to facilitate interactions, such as supervised visitation at a neutral location. In the absence of family with whom to maintain contact the most proxy family contact arrangement based on local context might be encouraged.

3) Strengthening communities

- **Strengthen and support community-based responses**

External agencies must attempt to build on a community's existing strengths to ensure sustainability and community ownership (Tolfree, 2005, p. 20). In the HIV/AIDS context, UNICEF (2004) identifies mobilising and supporting community-based responses as the second key strategy for the protection, care, and support of orphans and vulnerable children (p. 14). The UNICEF strategy suggests several means for doing so, including: engaging local leaders to respond to the needs of vulnerable community members, organising and supporting activities that enable community members to talk about the issues, and organising cooperative support activities (p. 19). In 2002, 250 Eastern and Southern African representatives of governments, NGOs, UNICEF and others met to discuss the impact of HIV/AIDS on the regions' children and caregivers. In their meetings they recognised:

Communities are the starting point for planning and implementing services for children, and for prioritizing those children and households who should benefit from these services – particularly children without family care. Communities must be involved in lobbying politicians for action; monitoring and evaluating programmes; and supporting household income generation to ensure programmes are sustainable. Communities need money, information, skills, facilitation and opportunities to build their capacity (Loudon, 2002, p. 19).

World Vision has developed the Community Care Coalition (CCC) project model. This approach mobilises communities to care and support the most vulnerable children in a community by bringing together various entities within the community for decision-making, while utilising community volunteers for the identification, monitoring, support and protection of vulnerable children (Newsome, 2008). With the necessary adjustments, this model could be adapted to other situations of CDOPC, drawing on the community for the knowledge and resources necessary for alternative care models. NGOs must be willing to give up control to community stakeholders and become a facilitating agency, empowering the community to care for its own vulnerable members.

- **Create a supportive environment for children**

Not all communities are immediately open to care for vulnerable children due to cultural beliefs and stigmas. In such cases, it is therefore important that an external agency assist in creating an enabling environment through community awareness and education. Efforts might include changing public recognition of the problems of children from 'their problem' to 'our problem,' providing information on the child's situation and challenging myths (Hunter & Williamson, 2000, p. 10). By overcoming ignorance and discrimination, a community will become more inclined to support their children. Local advocacy for children's issues can transform attitudes. It is the most vulnerable children who are often overlooked by the community, especially children with disabilities in many communities. For example, in World Vision's Middle East and Eastern Europe region, children with disabilities were often placed in institutions to keep them 'away' from other children and society. Within this paradigm, institutional staff worked on the medical model of disability. That is, that they should work to 'fix' the problem that the child has in order for the child to become a member of society. If the 'problem cannot be fixed,' then the child is sequestered away from society. NGOs must work to encourage inclusive societies and systems that can adapt to the special needs of children (Interview with Jocelyn Penner, 27 February 2009).¹ By overcoming ignorance and discrimination, a community will become more inclined to supporting their children.

¹ - For all references throughout this publication regarding interviews, please refer to the 'Acknowledgements' page which includes a full list of names and titles.

- **Facilitate collaboration**

No single organisation can provide the necessary long-term holistic support needed for CDOPC. Therefore interventions require innovative partnerships, collaboration, and a referral network to meet health care, food, education, shelter, psychosocial, spiritual, legal, protection and economic needs (Wakhweya, Dirks & Yaboah, 2008, p. 26). A multi-sectoral approach should include all relevant government departments, NGOs, community-based organisations, religious bodies, schools, local businesses and others, as part of a continuum of care (Parry-Williams, 2005, pp. 15-16). Collaboration combines efforts to strengthen the community's capacity to care for vulnerable families and children.

- **Utilise community volunteers**

Children in alternative care should be given the opportunity to talk with someone outside of their placement who can ensure or monitor for adequate protection and care (Tolfree, 2005, p. 12). This role can be filled by a paid social worker, but trained community volunteers can provide the same support. These community volunteers serve as secondary caregivers to vulnerable children who need adult figures who they can trust and who can provide them with affection, supervision and stability (Richter et. al., 2004, p. 39). World Vision's CCC model relies on 'home visitors,' community volunteers who visit the children on a regular basis to monitor the child's well-being; to provide care for chronically ill and HIV-infected family members; to protect the child from abuse and neglect through advocacy, awareness raising and referrals; and to teach life skills (Newsome, 2008). Relying on community volunteers encourages neighbourly bonds, increases community members' child care skills and supports programme sustainability.

- **Place children within the community or a similar context**

Children should remain within their community, not only to decrease the child's distress in moving to a new community (Richter et. al., 2004, p. 39), but also to reinforce community responsibility, engage traditional coping mechanisms and strengthen the community's capacity to care for their children. However, there are exceptions where keeping children within their original communities is not preferred or possible, such as scenarios where there is danger of strong discrimination or of abuse from community members, or where the community cannot be identified. In these situations, efforts should be taken to place a child within a community that is a similar context to their original community, for example, placing children from a rural community into another rural community with similar cultural norms.

- **Integrate children into community**

Every community-based alternative care model must include activities that integrate children into their surrounding community to ensure the long-term growth and development of the child into a functioning member of society. Special care for social and cultural integration should be incorporated in the core programming of institutional models, such as children's villages (SOS- Kinderdorf International, 2005, section 4.7). A reciprocal benefit occurs for both children and communities when children participate as active citizens in community decision-making, as classmates in schools, as participants in cultural activities and as eventual contributors to the local economy.

4) Engaging government

- **Reinforce national governments' responsibilities**

All governments who have signed and ratified the UNCRC are obligated to respect and uphold the treaty's norms. NGOs can play a role to both encourage a government's responsibility to uphold these norms and to strengthen the government's ability to meet them. Governments must be encouraged to meet their obligations through advocacy initiatives that are linked to specific outcomes, reflect

credible and authoritative knowledge on the subject and target particular decision makers who have the power to change or implement those outcomes. NGOs who work in the child protection sector often have first-hand knowledge and credible evidence that verifies the failure of government to meet its obligations. However, NGOs must not only provide information on the failure of government, but also offer solutions and assistance to help the government meet its obligations; it is often the case that governments fail to meet their obligations because there is not sufficient capacity within government to successfully understand and fix the problems. NGOs can work with government to reform meta, meso and micro system change. At the national level, NGOs can suggest, draft or review legislative reform initiatives that align domestic law with international norms. At the regulatory level, NGOs can design or build the capacity of government to design regulatory mechanisms and implementation plans to execute the legislation and plan budgetary allocation. At the local level, NGOs can pilot or model services that align with regulatory systems and transfer these services to government control once they are running smoothly. By working within and for government systems, NGOs can build the needed structure and capacity of government to meet its obligations and thus, work to build a sustainable child welfare system. Without such action, NGOs are in danger of enabling government inaction while communities rely on NGO initiatives to care for its children. (Interview with Jocelyn Penner, 27 February 2009). Tolfree (2005) emphasises the national governments' responsibility for CDOPC:

Children who are outside of parental care – or who are at risk of placement in out-of-home care – have to be seen as the special responsibility of governments, not least because these children may lack the protection and care which is normally the immediate responsibility of parents as primary duty-bearers. It is therefore vital that governments make the care and protection of children a fundamental part of their activities and develop systematic responses to the range of children's protection and care needs. This requires a range of initiatives that will depend on the country context but might include the creation of an enabling legislative framework, policy development, resource allocation, co-ordination across government departments and partnership with service providers. (p. 19).

Many recommendations have been made as to which policies need the greatest attention in specific contexts. For example, in areas with a large number of child-headed households, the protection of property and inheritance rights are suggested priorities (ICRC, 2004, p. 51). In areas where deinstitutionalisation is needed, policies and regulatory frameworks that both promote community care and corral the necessary financial resources to implement such care models are essential. Whatever the context, NGOs must hold the national government accountable to meet their responsibility to care for CDOPC.

- **Support governments' responsibility for social protection**

National governments must be held accountable to their responsibility to provide social protection for their citizens and supported to ensure that social protection programmes directly benefit poor families and children. Article 9 of UNHCHR's *International Covenant of Social, Economic and Cultural Rights* (1966) recognises the right of social security and highlights the state's obligation. NGOs' roles include advocating for the establishment and implementation of effective social protection systems. In addition, NGOs also have a role in facilitating support of government programmes. For example, social cash transfers (SCTs) are one social protection mechanism that is gaining support among humanitarian organisations. It is vital that much thought is put into the decision of which form of SCTs is appropriate for a specific intervention's context and objectives: conditional or unconditional, vouchers or cash, 'cash for work', food aid or other forms (Bailey & Savage, 2008). NGOs can inform the decision of which form of SCTs the government should use and provide advice for the structure of the mechanism. NGOs also have an important role to play in making those SCTs effective for protection and support of vulnerable families and children. World Vision supports the use of government SCTs in the appropriate form and context, and promotes programme interventions that complement government programmes with community-based monitoring and support to ensure that children benefit from

the increased household income (Stephenson & Clarke, 2007). When communities and families are strengthened by government social protection and SCTs, they are better equipped to care for the needs of CDOPC. Households that take in orphans or other CDOPC can be greatly strengthened in their ability to care and protect these children through SCTs.

- **Facilitate involvement of local government officials**

Local government officials must be recognised and encouraged to be duty-of-care bearers for CDOPC. It is often the case that child protection services fall to local government agencies for operation, yet it is usually at the local level where capacity is most lacking. To hold local officials responsible for ensuring the protection and well-being of children within their own communities, NGOs must include local government as a key stakeholder in community mobilisation and capacity building activities. Local authorities should be thoroughly engaged in the development, implementation and monitoring of alternative care situations—with clearly described roles—to enable the transfer of alternative care services to local government at the appropriate time. Local officials' buy-in, support and involvement in all initiatives for CDOPC are vital for the success and sustainability of any alternative care model.

5) Empowering children

- **Safeguard children's rights**

The protection of child rights defined in the UNCRC needs to be adapted and applied to the situation of CDOPC. The United Nations recently welcomed the Government of Brazil's *Guidelines for the alternative care of children* (2007). This document has recognised specific rights that are of special pertinence to the situation of a child without parental care, including access to education, health-care and other basic services; the right to an identity and language; and protection of property and inheritance rights. NGOs must promote the application of child rights to CDOPC, including ensuring that these children have birth registration so that they are protected by the rights and laws of their country.

- **Provide access to essential services or materials**

Children must be able to access essential services and materials throughout the placement and transition into alternative care. UNICEF's (2004) third strategy for the protection, care and support of orphans and vulnerable children ensures access to essential services, including education, health-care, birth registration and others. Children must receive essential services while developing the skills and tools to meet their own needs.

- **Increase the capacity of children to meet their own needs**

The focus of community-based interventions for CDOPC needs to be increasing the capacity of children and young people to meet their own needs and resilience at age-appropriate levels, through formal education, vocational development and life-skills training. Access to formal education leading to increased literacy, numeracy and social development is vital for empowering children. For child-headed households, free childcare for younger siblings and free meals at school can decrease the burden on heads of households, thus freeing them to attend school. Promoting policies which waive school fees and uniform requirements and provide free transportation eliminates prohibitive school expenses. Flexible school hours provide youth with time to assist with household chores and income-generating activities (Hunter & Williamson, 2000, p. 9). Vocational training through apprenticeships and skills training are effective for developing a child's ability financially to support him or herself (Olson et. al., 2006, p. 9). Children should be offered life-skills training to improve survival skills and define a better life for themselves and their community.

- **Facilitate child participation and respect children as citizens**

In addition to formal education, life-skills and vocational training, children must develop decision-making skills. Children and youth deprived of parental care should be empowered to participate in the decision-making process regarding their placement and care, given adequate information about his or her situation and encouraged to express his or her feelings. By taking a role in deciding how to meet his or her own needs, a child develops a sense of control over his or her own life. Child participation should be included in every stage of the process of alternative care, according to their life stage and development level (Hunter & Williamson 2000, p. 9; IFCO et. al., 2007, p. 21; Tolfree, 2005, p. 12).

- **Address psychosocial needs**

In the past, NGO provision of care and support for CDOPC tended to focus on material needs; however, children's social and emotional needs also require special attention (Olson et. al., 2006. pp. 18-19). Children must be given the opportunity to work through the psychological and social issues of living without their original parents in order to take control of their lives and transition into community-based alternatives of care (for resources see www.repssi.org). Those who have experienced high levels of trauma, such as being a victim of trafficking and violence, must be provided with needs-based, sustained, professionally designed and delivered services for the overall psychosocial well-being of the child (SARI, p. 8).

- **Do not separate siblings**

Siblings should not be separated by placement in alternative care unless it is in the children's best interests (Government of Brazil, 2007, p. 5; IFCO et. al., 2007, p. 24). Siblings provide life-long support for one another and provide a sense of family identity. Practitioners have discovered that keeping siblings together is often one of the best child protection and psychosocial care and support interventions (Interview with Stefan Germann, 2 March 2009).

- **Assist in maintaining a child's sense of identity**

It is important that a child maintains a sense of identity when placed in an alternative community-based care arrangement, especially when his or her parents have died. Children who lose their parents lose a connection to their history and heritage (Olson et. al., 2006, p. 15). A life story book or box with information, pictures and mementos of the family and child's life created by both the dying parent and the child can promote a child's self-identity (Government of Brazil, 2007, p. 16). Victims of trafficking should be helped to obtain necessary documents for establishing his or her identity, such as a birth certificate (SARI, p. 9).

- **Facilitate after-care support**

After the child has left an alternative care arrangement, he or she should have the opportunity to receive assistance and support so as to smooth the transition into the new living arrangement and not cause a major disruption in the child's or young adult's life. Contact with caregivers and peers from the former care arrangement should also continue, serving as an emotional support network (IFCO et. al., 2007, p. 55).

6) Supporting caregivers

- **Support income-generating activities for caregivers**

Poverty should not be a deciding factor in determining a family's ability to take in and care for a child in need. Community-based care models must help caregivers provide for children by strengthening their ability to earn livelihoods through income-generating activities, micro-finance loans, and small business training (Olson et. al., 2006, p. 8). When possible, income-generating assistance should be preferred

over allowances or payments which lead to dependence and decrease sustainability. However, regular monitoring is required to evaluate the effectiveness of the income-generating activity and the family's ability to care for the child.

- **Ease the burden**

Caregivers should be provided day-care and other supportive services that ease their burden and provide time for income generation, household chores or rest (Olson et. al., 2006, p. 18-19).

- **Train caregivers**

Caregivers should receive continuous training and professional support in developmentally-appropriate childcare and effective parenting practices in order to provide quality care and avoid potential for harmful or abusive parenting approaches (IFCO et. al., 2007, p. 35; Grainger et. al., 2001). Training should include health and nutrition screening, HIV/AIDS prevention, child protection monitoring, psychosocial support and enhancing the needs of children with disabilities and special needs.

- **Address psychosocial needs**

The psychosocial needs of caregivers are as important as they are for children, because caregivers must be healthy enough to be able to provide psychosocial support to the children. Support groups are effective for supporting the emotional and social needs of caregivers.

- **Acknowledge caregivers' efforts**

Caregivers need recognition and acknowledgement of their efforts and sacrifices for taking in children that are not their own (Mathambo & Richter, 2007, p. 77). Public recognition can be a more meaningful and sustainable reward than financial incentives. Communities should be involved in determining effective incentives or tokens of appreciation to motivate volunteer caregivers.

- **Contemplate financial assistance**

The option of financial assistance is debated and should be taken under careful consideration. There are often quality caregivers within communities who do not have the resources to take in and care for additional children. Communities, governments and NGOs must consider the benefits and concerns of providing financial assistance to caregivers. In addition to being considered unsustainable, financial allowances or incentives may cause caregivers to view their work as simply a job and lose the emotional connection between the child and caregiver (Richter et. al., 2004, p. 20). However, payment of caregivers can promote a professionalisation of caregiving which may lead to a higher quality of training, monitoring and support. Heather MacLeod, a technical specialist with World Vision International, suggests a cost-based approach to financial assistance that designates financial assistance for specific costs, such as food or education, or covering the financial burden of a specific child, instead of offering non-designated funds (Interview, 19 November 2008). In addition, social cash transfers have attained considerable credibility for impacting the well-being of children in vulnerable households. Debate revolves around whether SCTs should be targeted or universal. If the objective is to provide assistance to caregivers of CDOPC, targeted SCTs appear to be the obvious answer. However, targeting can divide people politically, cause isolation or stigma. While SCTs have proven potential for impacting the well-being of children, they should be implemented carefully and with intentionality in monitoring their impact (Stephenson & Clarke, 2007, pp. 17-18). Further discussions on the topic of financial assistance are found under the programming suggestions for kinship and foster care below.

- **Develop special assistance to older caregivers**

The duty to care for children often falls on grandparents or older caregivers. However, these older caregivers might lack the physical and economic ability or parenting skills to care for children. Governments should be held responsible to provide social security to meet the economic needs

of these vulnerable caregivers. Special supportive services allow older caregivers the opportunity to provide for children and allow children the opportunity to be raised in a supportive and loving household. Along with economic and physical support, older caregivers may also be in need of training and support in intergenerational parenting skills (Interview with Stefan Germann, 2 March 2009).

7) Developing professional practices

- **Develop a gate keeping process**

Gate keeping, a rigorous admission process, systematically assesses the individual situation of every child with the goal of matching the correct community-based care model and supportive services to the individual needs of the child. Supportive services should be provided only to those who meet tightly specified eligibility criteria to ensure that the most vulnerable are being cared for and that all possibilities of retaining children in their biological families have been explored (Gudbrandsson, 2004, p. 15; SOS Kinderdorf International, 2005, section 4.1).

- **Facilitate permanency planning**

Permanency planning is a process of planning which seeks a long-term placement, such as reconnection with a child's original family or placement within an adoptive family. Short-term alternative care options are only used as a step in the process toward permanency. A focus on the long-term placement ensures stability, continuity and a sense of belonging in a family. Permanency planning implies the need for case management and planning (UNICEF EAPRO, 2006, p. 15).

- **Implement a case management approach**

Case management must facilitate careful planning with the input of the child and comprehensive analysis of the child's needs in order to ensure the selected community-care option is the most appropriate match for meeting the needs, rights and best interests of the child (Tolfree, 2005, p. 17). Whether through a paid social worker or trained community volunteer, each child in a community-based care model should be monitored and supported by a case manager (UNICEF EAPRO, 2006, p.16). Case workers can use family group conferences as a tool for including the extended family in decision-making, so as to meet cultural traditions of group decision-making in many contexts (Gudbrandsson, 2004, p. 17).

- **Develop an individual care plan**

An individual care plan should be developed during a family meeting for each child, outlining the objectives of an alternative care arrangement and the long-term placement goal, defining the supportive services and resources that will be needed, clarifying each stakeholder's responsibilities, and creating a timeline for the process toward long-term placement. Children, at age-appropriate levels, should also participate in the development of the plan. A regular review process should be scheduled to re-evaluate the placement and address any needs or circumstances that have changed over time. Every decision during the process is guided by this plan (IFCO et. al., 2007, p. 27; Tolfree, 2005, p. 17).

- **Facilitate systems for monitoring and reporting**

Regular monitoring is vital for the protection and quality of care in community-based care. Systems for monitoring should include the child's development and progress according to his or her individual care plan (Tolfree, 2006, p. 12). The ultimate responsibility of ensuring monitoring falls upon the local government, but supporting agencies also have a responsibility to ensure effective monitoring. Community stakeholders should be empowered by the local government and supporting agencies to take leadership in developing systems and implementing monitoring and reporting. External agencies can assist by mobilising and building capacity of community members to do so, including development of effective reporting systems. Careful consideration of the specific contexts of each community must

be taken into consideration in developing the processes and systems for monitoring and reporting. In the context of high HIV/AIDS prevalence, World Vision's Community Care Coalitions (CCCs) provide a model for mobilising community members to serve as home visitors who not only provide support for children, but also serve as monitors of the child's well-being (Newsome, 2008). All monitors, whether community members, local authorities or NGO staff, must be trained to identify the signs of abuse and be educated in the process of reporting abuse.

- **Ensure child protection**

Every effort must be made to ensure children are protected from abuse, neglect, exploitation and other forms of violence. Organisations that are supporting alternative care should have strong child protection policies which address behaviour protocols, monitoring systems, communication about children, recruitment and selection, reporting/whistle-blowing, allegation management and programming issues, including discipline of children, monitoring and support of alternative care. An organisation's child protection policy should cover all individuals associated with the organisation, including members of the Boards of Directors, leadership, management, staff, volunteers, caregivers/home visitors, contractors, consultants, partners and visitors. Staff and volunteers should receive training on identifying, reporting, monitoring and addressing different child protection risks in their communities. In addition, self-protection knowledge and skills should be included in the child's education. Children need to be provided with mechanisms to report abuse, neglect or other concerns and each alternative care approach must include protocol for handling children's reports. These mechanisms should be developed in consultation with vulnerable children to ensure that they are appropriate.



Analysis of Alternative Care Models

Each model for alternative care has its own benefits and concerns depending on the context in which it is implemented. This section surveys the strengths and weaknesses of each model, suggests promising practices based on generally accepted principles, and provides a case study on the application of each approach.

The models of care of CDPC are presented in a hierarchy to prompt discussion and guide programming efforts. Kinship care is presented as the most preferred choice; followed by foster care; then child-headed households and children living independently, an option whose position in the hierarchy is debated; next is family-style group homes; and finally children's villages.

Kinship care

Before



Foster care

Before



Child-headed households

Before



Family-style group homes

Before



Children's villages

(Figure adapted from Germann, 2005, p. 383)

BECAUSE WE CARE: Programming Guidance for Children Deprived of Parental Care

The hierarchy is meant to guide decision-making, but should not be considered universally applicable for every child's situation. Nigel Cantwell (2007) warns against hierarchal ranking of care options in his paper, *Improving Protection for Children without Parental Care: Developing Internationally-accepted Standards*, for the Quality 4 Care organisations. He believes this approach is simplistic in its tendency to define family-based care as 'good' and residential care as 'bad' and instead promotes the view of alternative care as a range of options available for use based on a child's needs, characteristics, history and situation. He summarises his point:

My concern is simply that, in developing international standards, we remain constantly attentive to the dangers of blindly reflecting a black-and-white, good-bad view of care options that might not correspond to the realities – let alone the wishes – of each individual child, and to his or her circumstances and needs (p. 3).

In response, this paper attempts to identify the specific benefits and concerns of each model to provide insight into the placement decision-making process. The hierarchy is intended to provoke critical thinking and discussion on application in regards to the best interests of the child within specific situations, contexts and cultures. In all cases, careful attention must be given to the best interests of each specific child and situation with consideration of all the possible care options. Each child should be individually assessed to make a determination of the child's best interests. Also, the viability of each model of care will vary greatly between contexts and cultures. Finally, it must be mentioned that every model has the potential to be good or bad. It would be better to choose a model lower on the hierarchy with effective community-based programming practices, than to choose a model placed higher on the hierarchy with bad programming practices.

➔ Kinship care

Kinship care is the most prevalent and most indigenous model of alternative care throughout the world (Cantwell, 2005, p. 6). It most commonly occurs informally when private arrangements are made for a child to be taken care of by relatives. However, kinship care can also be formally recognised or authorised by an outside authoritative body or judicial authority. These arrangements usually involve an assessment of the family and ongoing support and monitoring (Broad, 2007, p. 2). Both types of kinship care have specific benefits and concerns in relation to other models.

Benefits:

- **Maintains and empowers local support systems**

Kinship care is an ancient tradition in child-rearing (Hegar & Scannapieco, 1999, p. 17). In times of crisis, communities throughout history and around the world have turned to the extended family to care for children who have lost their parents. A study in Zimbabwe found that a vast majority of orphans are cared for by relatives: 'This mode of care, derived from the deeply rooted extended family system, operates informally with decisions concerning the child's future being made by family elders without recourse to official government agencies' (UNICEF, 2004, p. 5). Tolfree (2006) recognises the opportunity and value of building on these cultural norms (p. 15). Working through natural, indigenous models that are non-intrusive encourages natural coping mechanisms.

- **Love and support**

It is commonly assumed that children who are raised by their relatives will be more likely to receive love and support by their caregivers due to kinship bonds and existing relationships. Compared to institutional forms of care, the family environment available in kinship care does generally provide much greater opportunities for the love and attention essential to a child's development and well-being (Olson et. al., 2006 p. 38). However, it should not be assumed that all kinship relationships are loving and supportive.

- **Preservation of family and community ties**

When children are placed with family members in the child's original community of origin they maintain their family relationships, social networks and contact with schools, places of worship, and other familiar places (Tolfree, 2006, p. 15).

- **Reinforcement of child's sense of identity**

Kinship care provides continuity of a child's personal and cultural identity (Tolfree, 2006, p. 15). Children preserve and continue to develop their personal identities as they interact with the familiar people who are caring for them. In addition, they are able to preserve and enhance their cultural identity as they maintain a sense of belonging to the larger community (Williamson, 2004, p. 4).

- **Decrease trauma and distress**

Kinship care can decrease a child's experience of trauma, compared to moving in with a stranger in a completely new environment (International Social Services & UNICEF, 2004, p. 3).

- **Reduce the likelihood of multiple placements**

In comparison to foster care or group care models, children in kinship care are less likely to have multiple placements which often damage a child's ability to bond with a caregiver. However, in some circumstances children find themselves being 'passed around' the members of the extended family (ISS & UNICEF, 2004, p. 4).

- **Expand capacity for self-sufficiency**

The family environment of kinship care provides the child with experience valuable for social, cultural and economic self-sufficiency as the child becomes an adult. Families show the children how to get along in the world socially, teach them how to negotiate cultural aspects of life and provide them with experience and knowledge of income-generating activities (Williamson, 2004, p. 4). Within their families children absorb the values of their culture and develop the skills they will need in adulthood (Olson et. al., 2006, p. 4).

- **Ongoing support throughout life**

In kinship care, family relationships normally last into adulthood. Unlike other models of care where a child is expected to be completely independent at the age of 18 (or younger in some cultural contexts), kinship care cultivates long-lasting relationships and ongoing support (Loudon, 2002, p. 38).

- **Children and relatives provide mutual care and support**

Often, the relationship of support and encouragement is two-way; the kinship caregiver provides support to the child and the child is a source of emotional and physical support for the caregiver. For example, orphaned children and their grandparent caregivers rely on one another during a process of mourning. Children can also physically support grandparents by taking on the physically challenging household chores. In addition, children can later provide economic security for a grandparent as they increase in age (International HIV/AIDS Alliance & HelpAge International, 2004, p. 4).

Concerns:

- **Over-extension of families/households**

In situations of ongoing crises or chronic emergencies, such as HIV/AIDS or extended conflict, it has been suggested that families can become over-extended in their ability to care for CDOPC. Reporting on the 2002 Eastern and Southern Africa Regional Workshop on Children Affected by HIV/AIDS, Mark Loudon (2002) comments on the impact of HIV/AIDS in Africa, '...We have to kill the myth of the capacity of the African extended family. This family has been over-extended for quite some time now, and is no longer the coping mechanism that communities in sub-Saharan Africa [once relied on]' (p. 10). In some cases, a family has lost an entire generation to AIDS. Therefore, fewer relatives are available to care for the growing number of orphans. Grandparents who take on the responsibility of caregiver often suffer from health problems and because of their age, their time as caregivers is limited (Broad, 2007, p. 4). However, the argument of an over-extension of families should not be used as an excuse to pursue institutional forms of care. Community-based efforts to support families can strengthen this model's effectiveness. Loudon (2002) explains, '...This structure should not be regarded as having collapsed, but only as having cracked in places, and stakeholders should look for the cracks and find ways to seal them' (p. 19).

- **Lack of resources**

Because relatives often live in poverty and have fewer resources than caregivers in other models of care, kinship caregivers may not be able to provide adequately for the child. They may require more services and support from the government or external agencies (Broad, 2007, p. 7).

- **Lack of parenting skills**

Relatives who take in children may lack effective parenting practices and child communication skills. Caregivers may have difficulty dealing with behavioural and psychosocial issues of a child who has been deprived of parental care (Broad, 2007, p. 4).

- **Family conflict**

In kinship care there is a risk that children may be drawn into family conflict. Friction might arise over who should take care of the child, who has decision-making power, or the division of responsibilities for each family member. Children in kinship care can be discriminated against or be treated less well than the caregiver's own children. Children might be treated badly because of a conflict between the kinship caregiver and the biological parents (Tolfree, 2006, p. 15). Also, the relatives' negative feelings toward the child's birth parents might reduce the likelihood of the child's long-term reunification with his or her original family (Cantwell, 2005, p. 7). In some cases siblings are separated in order to ease the burden of one relative or because other relatives want to benefit from resources of labour that a child brings (Cantwell, 2005, p. 7).

- **Stigmas associated with a child's circumstances**

Social stigma about the circumstances of the child, such as sexual exploitation or HIV/AIDS, may cause a family to isolate, neglect or mistreat the child (Broad, 2007, p. 4).

- **Potential for unauthorised contact with biological parents**

Families may allow unauthorised or unsupervised contact with biological parents who are of great concern when the family poses a threat to the child, such as a history of abuse or exploitation. Relatives caring for the child may also refuse authorised contact with parents for personal reasons (Cantwell, 2005, p. 7).

- **Negative motives of caregivers**

Family members may not have good motives for agreeing to care for children. Poor families might look at the child as a resource. Families may be seeking to collect a child's property entitlements or other inheritance (Tolfree, 2006, p. 15; Loudon, 2002, p. 38). In a 2002 report on care and protection of children affected by HIV/AIDS in Malawi, Gillian Mann lists the reasons guardians in Malawi gave for why they chose to take in a child, including negative motives such as: because no one else would do it, they felt obligated, it was the wish of a dying family member and they feared that the deceased individual would come back to haunt them if they did not do so, to get a share of the deceased parents' wealth, to gain from the child's labour, to get registered for assistance or benefits, or to use a female child as a wife to a male guardian (pp. 29-31). The inherent dangers in these motives are obvious.

- **Potential for abuse, neglect or exploitation**

There is great potential for abuse by extended family members in the kinship care model. A kinship tie is not a guarantee that a child will be adequately cared for and protected (Tolfree, 2006, p. 15). Some children only receive food and resources after the needs of the caregiver's family have been satisfied first, and others serve the caregiver's family as an unpaid domestic worker (Cantwell, 2005, p. 7). In the situation in which a child is removed from their original family because of abuse or exploitation, the original perpetrator may have access to the child and abuse again. Abuse may also be a familial trait and the child may find his or herself being abused by another member of the extended family (International Social Services [ISS] & International Reference Center [IRC] for the Rights of Children Deprived of their Family, 2006, p. 1).

- **Lack of supportive services**

Children in kinship care may also be less likely to receive services because of the informal nature of the arrangement (ISS & IRC, 2006, p. 1). The lack of services offered to kinship caregivers can impact the family's willingness to care for children, instead placing the children in foster care or residential care facilities where children receive more support.

- **Lack of monitoring and evaluation**

Kinship care is often subject to much less supervision than other models of care. Even in formal kinship care, families are often left to care for the child as they wish, leaving the child vulnerable to abuse, neglect and exploitation (ISS & UNICEF, 2004, p. 2).

- **Cultural ideologies**

There are cultural beliefs that hinder the promotion of kinship care in certain contexts. For example, World Vision staff members in Eastern Europe recognise the difficulties in kinship care posed by post-communist ideology. Many families continue to look to the state for child care and lack a sense of personal responsibility (Interview with Nina Petre, 22 November 2008). Alternatively, in South East Asia the shared socio-cultural precedent for kinship care is based upon the common practice of wealthier families accepting the children of poorer relatives into their home on the understanding that they become the 'domestic home help' (Interview with Luke Bearup, 24 April 2009). In other cultures, families base their understanding of the best interests of a child on material and financial resources, rather than love and care. Therefore children in kinship care situations can be abandoned or coerced into situations that provide greater resources while children find themselves in environments that do not provide the love and security only a caring family can provide (Miles & Stephenson, 2001, p. 10). Efforts to overcome these cultural misconceptions are vital for developing the capacity of families to care for their own relatives.

- **Informal vs. formal kinship care**

There are benefits and concerns for both informal and formal kinship care. However, with informal kinship care there are greater risks of child maltreatment, child labour, child sexual exploitation and other forms of abuse, neglect, or exploitation. Formalising kinship care decreases the opportunities for caregivers to mistreat children because of an established monitoring mechanism. Formal kinship care models can also provide the material and psychosocial needs of children that would otherwise go unmet. However, the formalisation of kinship care can disrupt traditional coping mechanisms and family relationships. Financial incentives sometimes associated with formal kinship care can also serve as a disincentive for the return of children to their biological parents (ISS & UNICEF, 2004, pp. 4-5). Yet, in terms of the child's well-being, it seems that the benefits outweigh the concerns for the formalisation of kinship care. The process of formalising kinship care can prove difficult with many potential barriers, such as situations in which kinship care is informally selected by family members to avoid outside intervention or when families reject interference (Cantwell, 2007, p. 5).

Programming suggestions:

First choice

Kinship is the preferred option for alternative care, because of the major benefits of this approach. However, kinship care is not always the best option for a particular child. Child victims of sexual exploitation or children living on the streets may have a more difficult time returning to their communities of origin, and great effort must be taken to assess the risk of returning a child to his or her kin and community if there are likely to be issues of stigma. In addition, children who have been victims of abuse by their family, relatives or neighbours should be taken into special consideration when assessing whether kinship care is an option for the child.

HOT TOPIC

- **Formalise care**

The formalisation of kinship care can increase the protection and well-being of children living with their relatives. Most cases of kinship care are informal: children living with family members without outside intervention. By documenting these cases through a formal approach children and families will have access to supportive services and establish monitoring mechanisms of protection thus reducing the risk of abuse, exploitation and neglect. Formalisation of kinship care includes screening relatives for placement, training caregivers and ongoing monitoring of the child's well-being. However, formalisation

also brings with it concerns, such as decreasing the attempts of reunification of a child with biological parents and disrupting family and community coping strategies (ISS & UNICEF, 2004, pp. 4-5). The following are programming suggestions leading toward formalisation of kinship care, but the discussion of formal versus informal within a specific context should precede any programming decisions.

- **Facilitate family decision-making and child participation**

Every stakeholder should be consulted in the kinship care decision-making process, including the child, parents and all potential caregivers (Hegar & Scannapieco, 1999, pp. 78-9). Even in situations in which parents are terminally ill, they should be included in the decision-making process before death. Most importantly, a child must be given the opportunity of a safe environment to voice their opinion. In Mann's (2002) research in Malawi a major discrepancy was found between the views of adults and children. Adults focused on the material capacity of a family to care for a child, but children were most concerned about being cared for by an adult who loved them and respected their deceased parents (p. 3). This discrepancy highlights the importance of children's participation in the decision-making process. Joint family decision-making can decrease family conflict and help them to focus on the child's well-being rather than their own, therefore decreasing the chance that caregivers accept children based on negative motives, decreasing the potential for child abuse and stigmatisation while increasing the success of long-term placement. A child's participation requires that caregivers listen and respect children, empowering them in the decision-making process, according to the life-stage and development level of the child (IFCO et. al., 2007, p. 21).

- **Screen relatives for capacity to care for children**

In light of the potential for the over-extension of families, assessment of a family's capacity to care for a child is important. A recent study found considerable differences in the capacities and resources of extended family households to care for CDOPC, highlighting the importance of individually assessing families for kinship care (Abebe & Aasa, 2007, p. 2061). However, Amanda Cox, a community-based care consultant, warns against an outsider's judgment of a family's capacity, instead insisting that quality of care should be measured by community standards (Interview, 3 December 2008).

- **Ensure that repatriation or reunification of children is safe**

No rescued victim of trafficking or child associated with conflict should be sent back to his or her family without full confidence that the child shall not be re-trafficked, re-recruited, abused or stigmatised. In situations of reunification of child soldiers, despite initial joyful reunions, the family may be unable or unwilling to afford their child's long-term protection (Save the Children UK, 2005, p. 4). Prior to repatriation or reunification, the family of origin must be thoroughly investigated by trained staff and families who are found suitable must be prepared for the return of their child. Trafficked children and children associated with conflict must consent to the return and be adequately prepared for the return to his or her country of origin, including medical and psychosocial care and life-skills development. A minimum of monthly follow-up should monitor the child's well-being and safety for the first six months, followed by continued monitoring at an agreed-upon frequency (SARI, p. 19).

- **Develop an individual care plan**

Each child should have an individual care plan reflecting the feedback of all stakeholders for the long-term goals of the child's placement in kinship care. This plan helps set expectations for all parties which might decrease the potential for poor caring or family conflict. It also guides case management, regulates consistent monitoring and evaluation, and designates the needed supportive services, thus decreasing the burden on the family and reducing the potential for abuse and neglect (International Foster Care Organization, p. 5; IFCO et. al., 2007, p. 27).

- **Keep siblings together**

Every effort should be made to always keep siblings together in one household unless it is against the child's best interests. Keeping siblings together avoids the further experience of loss and trauma for the children while allowing brothers and sisters the opportunity to support one another (IFCO et. al., 2007, p. 24).

- **Facilitate community education**

World Vision staff member, Tamara Tutnjevic, has recognised the impact of community support, or the lack thereof, on the quality of care in kinship situations. Potential stigma can be reduced by educating surrounding community members on the challenges children have experienced, such as HIV/AIDS, sexual exploitation, child labour and disabilities (Interview, 11 November 2008).

- **Facilitate community support**

Community members are valuable assets for providing support to the child and family in kinship care, while also monitoring the child's well-being. World Vision's model of Community Care Coalitions (CCC) mobilises and strengthens community-based care and support for orphans, children living with HIV and other vulnerable children in high HIV/AIDS prevalence areas. However, the CCC model is applicable to other situations of CDOPC because of its focus on mobilising a community to support vulnerable children. CCCs begin by bringing together all stakeholders, including churches, faith communities, government officials, local businesses and other agencies to collaborate on how to support the community's vulnerable children. The group eventually recruits and trains volunteers to become 'home visitors', whose role it is to identify, monitor, assist and protect the children. The model attempts to build on existing resources and efforts by mobilising and strengthening the capacity of a community to care for children (Newsome, 2008). The use of community-trained volunteers to support kinship care situations can greatly increase a programme's quality and sustainability.

- **Address psychosocial needs**

Because of the lack of skills of most kinship caregivers, the psychosocial needs of children in kinship care should be taken into special consideration. Children who have lost or been separated from a parent, cared for and watched a sick parent die, experienced armed conflict, or suffered abuse or neglect are likely to have had experiences which have impacted their emotional and psychological well-being. Relatives, who may have experienced similar events, are often ill-equipped to care for the psychosocial needs of a child. Whether directly or through an established referral mechanism, external agencies should provide children and their families with support to process emotional, behavioural and relational issues (Tolfree, 2006, p. 15). Caregiver support groups and child play-groups have been developed for this purpose (Hegar & Scannapieco, 1999, p. 80; Tolfree, 2006, p. 20). Community volunteers and staff members who monitor kinship care should also be trained to provide psychosocial support. Community-based mechanisms such as religious or cultural rituals have also been successful in supporting children coping with the psychological impact of the atrocities that they have experienced, specifically for children associated with conflict (Save the Children UK, 2005, p. 8).

- **Provide economic strengthening programmes**

If there is concern over the family's ability to meet the financial and material needs of the child, efforts should be made to bolster the economic strength of the household (Williamson, 2004, p. 5). Livelihood programmes, micro-finance loans, and job training programmes develop financial sustainability of kinship households, avoiding the potential for dependency.

HOT TOPIC

• Contemplate provision of direct material or financial support

The prevalence of poverty among kinship caregivers causes concern regarding the family's ability to adequately care for children. Governments' obligation to meet this need must be recognised. NGOs therefore must adopt the role of advocating and guiding policy at the national level, while also building capacity and accountability at the community level. However, it is important to recognise that the effectiveness of direct material or financial support for impoverished kinship care providers is debated. Direct material or financial support can induce negative motivations of caregivers, develop dependence on outside support or create a disincentive for the return of children to their biological parents (Tolfree, 2006, p. 15; Broad, 2007, p. 6; Cantwell, 2005, p. 7). However, commitments to provide direct material or financial support that is designated for specific purposes, such as education expenses, health care and basic needs are generally accepted (Williamson, 2004, p. 5). The debate in the context of social cash transfers (SCTs) has resulted in productive decision-making tools and criteria. Most major humanitarian organisations have developed policies regarding when and how SCTs will be used in their programming. The discussion includes when it is appropriate to provide cash, vouchers, food aid, gifts-in-kind or work for cash models; conditional vs. unconditional grants; targeted vs. universal initiatives; and so on. Therefore, the decision is not only whether to provide or to not provide material or financial support, but what type of support is most effective and efficient. One example of a dilemma over which type of SCTs are most appropriate in the context of CDOPC might be whether or not SCTs should be targeted only for a specific form of care for CDOPC, such as child headed households. Targeting this group may create an incentive for a family to allow a child to live alone so they will qualify for this material or financial support, instead of taking them into their own homes where they will be better cared for. Another example is the decision on whether or not SCTs should be conditional, such as money designated only for the use of educational cost. At first glance, conditional SCTs may seem like the answer for impacting the well-being of children in especially difficult circumstances. However, there are important things to consider, including the extra cost of implementing conditional verses unconditional SCTs and in this example, the quality and access of education (Stephenson & Clarke, 2007). There is not an easy answer as to when and in what form material and financial support is appropriate. However, if there are social assistance programmes in existence, then NGOs or caregivers should ensure that households that have taken in CDOPC and CHH are accessing the benefits to which they are entitled. NGOs should continue to develop tools to aid governments and supportive agencies in these difficult decisions.

• Develop special assistance to older caregivers

Studies have shown that orphans often prefer to live with their grandparents after the death of their parents because the children feel that their grandparents provide more love and affection than other relatives (Mann, 2002). However, grandparents often lack the physical and economic ability to care for children and are often in need of special assistance. Special supportive services for grandparent caregivers can include economic strengthening to substitute for the loss of financial stability due to the death of the adult child who is traditionally responsible for the care of their parents (International HIV/AIDS Alliance & HelpAge, 2004, p. 5). Respite foster care, when a child leaves the grandparents' home to stay with another family for a short period of time, can also provide relief for an older caregiver (Mulheir, Browne & Georgopoulou, 2007, p. 65). Also, grandparent caregivers should not be over-looked for receiving psychological support, as they too are dealing with the grief and trauma of losing a child while attempting to meet the psychological needs of their grandchildren. Finally, governments must recognise the rights and needs of elderly caregivers and develop relevant policies, especially related to health care and flexible education services (International HIV/AIDS Alliance & HelpAge International 2004, pp. 7 & 20). Special supportive services such as these allow older caregivers the opportunity to provide for their grandchildren and allow children the opportunity to be raised in a supportive and loving household.

- **Monitoring**

Monitoring should include regular reviews by a volunteer or staff person, not directly involved in the child's care, and providing opportunities for the child to talk privately with someone outside the home (Tolfree, 2006, p. 30). Children should also be involved in choosing the person and method for giving their feedback. Monitoring should be triangulated, include unexpected visits, and whenever possible facilitated by community members. Whether community volunteers, NGO staff or local officials, monitors need to be trained in identifying the signs of abuse, measuring a child's well-being and reporting incidents.

Case study:

Luwero District Programme, Uganda

The Ugandan civil war has displaced millions of people and the HIV epidemic has hit the country hard. Orphans constitute more than ten per cent of the population in Luwero District, Uganda, and a third of them are cared for by elderly grandparents. Christian Aid partnered with community members to mobilise their community to ensure that orphans and their caregivers benefited from community and government services. The first step was to identify informal kinship care households and to survey their needs and the services that they were already receiving. Next, efforts were focused on community mobilisation. Christian Aid worked in partnership with the district, county, parish and village-level government officials to strengthen community awareness of the issue, identify the community's responsibilities, and ensure that activities for care of orphans were included in district plans and budgets. These efforts helped to reduce the stigmatisation of orphans by recognising their rights as equal to other members of society. The programme led to the recognition of the community and local government's responsibility to provide material support to orphans and their caregivers. Programmes for vocational training, loans, and income generation were then offered to kinship care households and school fees were provided to children in need. This project demonstrates the potential for improving support and protection of children with the formalisation of kinship care arrangements and community mobilisation. It also highlights the importance of working with local government to ensure sustainability of supportive services for kinship care (Bold, Henderson & Baggeley, 2006, p. 29).

Foster care

Foster care ranges from very short-term, emergency placement to remove a child from a dangerous situation overnight, to long-term agreements where children never return to their original family. In some situations, foster care is a pre-adoption arrangement to evaluate whether or not a prospective family is able to meet the needs of the child (Gudbrandsson, 2004, p. 26). The benefits and concerns listed here relate to the full range of foster care situations.

Benefits:

- **Supports child development**

The foster care model supports the development of children by providing a nurturing environment within an alternative family (Gudbrandsson, 2004, p. 25). Foster care offers interpersonal experiences that are not available in more institutional models of care (Barth, 2002, p. i). A family-type environment can ease emotional and psychological stress as children recover from traumatic experiences (Ansah-Koi, 2006, p. 561).

- **Safe and supportive environment while maintaining relationships with original family**

When in the child's best interests, a foster family can provide a safe and supportive environment for a child while the child and biological family work to overcome the problems that lead to their separation moving toward reunification (Gudbrandsson, 2004, p. 26).

- **Equips children for independent living**

Children in foster care are exposed to daily household tasks, such as cleaning, fetching water or cooking. When it comes time for a child to move out on their own they will bring with them the knowledge and skills to live independently (Barth, 2002, p. ii; Tolfree, 2003, p. 14).

- **Cost effective**

Foster care is usually less expensive than residential care and therefore more sustainable (Gudbrandsson, 2004, p. 25; Tolfree, 2003, p. 14; Barth, 2002, p. 11; Mulheir et al., 2007, p. 15). A child or children are placed into pre-existing, self-sustained households. The family's budget may be slightly increased to accommodate the new member of their family. However, expenses for formal foster care should not be underestimated; costs include the hiring and training of staff to screen and monitor families and children, supportive services, material support, and possibly some type of financial support. Caution should be taken in promoting the view of foster care as 'cheap' as it can translate to inadequate provision for support and supervision after a child is placed (Cantwell, 2007, p. 5).

Concerns:

- **Trauma of separation from family**

Even if a child is placed in another home within his or her community, the relocation into a different family can cause distress and the potential for trauma. Trauma can also be increased if children are separated from their siblings (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 40).

- **Potential for abuse**

The foster care model does entail a potential risk of maltreatment of children because of the fact that the caregiver does not have a kinship bond with the child. In addition, there are no family obligations or pressure to keep the caregiver accountable and there may be less monitoring mechanisms than utilised in residential care (Barth, 2002, p. i). There is also a danger that foster children are not treated as well as biological children (Ansah-Koi, 2006, p. 561).

- **Potential for ambiguous legal circumstances**

Temporary foster care can drift toward permanence and therefore lead to an ambiguous legal situation for the child (Tolfree, 1995, p. 197). A lack of regulation regarding parental rights creates confusion over the responsibilities of foster parents, biological parents, the government social worker and the state (Phiri & Web, 2002, p. 18). There are also issues related to inheritance; whether it is a foster family benefiting from the inheritance of a foster child or whether a foster child has the right to receive an inheritance from their foster parents (Ansah-Koi, 2006, p. 562).

- **Confusion about identity**

Foster children may develop anxiety and confusion about their identity (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 40). In some situations, a child is removed from their family, home, school, place of worship, and all that they have known with little or no contact with their original parents and relatives. If proper arrangements are not made, children whose original parents have died may lose all knowledge of their family history, traditions and cultural background. A child in foster care may not feel like they fully fit into their foster family or original family.

- **Causes shame to birth family**

Fostering may cause the birth family embarrassment and shame, publicly demonstrating their inability to care for their own children and resulting in strained relationships between the child, birth family and foster family (Tolfree, 1995, p. 203).

- **Negative motives of caregivers**

As with kinship care, caregivers in foster care may have wrong motives for taking in children. They may be seeking to profit from the child through financial incentives and child labour. For example, in Cambodia the socio-cultural milieu that forms a basis for understanding the foreign concept of foster care is based upon the precedent of wealthier families accepting the children of poorer relatives into their home on the understanding that they serve the family. For this reason, some NGOs in Cambodia refuse to place individual children in households, preferring to only place children in foster care in pairs (Interview with Luke Bearup, 24 April 2009).

- **Disruption of education**

Children who move to a foster home outside of their own community may need to switch schools. Foster care placement can disrupt a child's education as a child makes the transition and attempts to adjust to his or her new surroundings (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 40).

- **Cultural ideologies**

Certain cultural ideologies can inhibit the effectiveness of foster care. For example, World Vision's foster care programme in Romania has struggled to change mindsets against the post-communist passivism while promoting a citizen's responsibility to care for children (Interview with Nina Petre, 22 November 2008). Formal foster care is foreign to many cultures and sometimes rejected. In some African cultures, ancestral spirits are believed to watch over and protect family members while also avenging any wrongs with the family. Therefore, outsiders to the family are looked upon with suspicion and there is reluctance to care for children who are not from the family blood-line (Powell, 1999, p. 3).

- **Labour intensive**

The development and maintenance of a quality foster care system is time consuming and the case management is labour intensive (Lim Ah Ken, 2007, p. 15). It requires recruiting and screening families, along with monitoring and case management of children, both of which require a considerable amount of skill and time for volunteers or staff. Governments who intend to, or are already, running foster

care programmes may have difficulty developing political will needed to raise resources and develop sufficient policies and programmes.

- **Lack of willing foster families**

In some areas it is difficult to find families willing to take in a child for a variety of reasons. For example, some families fear facing delinquency or violence from disturbed youth (Lim Ah Ken, 2007, p. 15). Finding foster parents for the disabled is especially difficult.

Programming suggestions:

Second Choice

Foster care is second in the hierarchy of community-based models for alternative care. Because it attempts to provide a family environment, foster care is considered the second choice after kinship care. Foster care should only be pursued if all alternatives to keep the child in her or his original family have been explored and rejected (IFCO, p. 4; Williamson, 2004, p. 5). In efforts toward permanency planning, adoption would also be considered the second choice in situations in which it is absolutely clear that a child can never again be cared for by his or her birth family (Cantwell, 2007, p. 6). However, there are situations in which a child will never return to his or her birth family and long-term foster care might be more appropriate, such as with youth nearing adulthood, with large groups of siblings who might be split apart in adoption, or with children who may want to maintain relationships with their birth parents or extended family (Mulheir et. al., 2007, p. 65). In addition, it may not be the child's desire to be adopted (Cantwell, 2007, p. 6), and many governments do not have effective adoption systems. Therefore, adoption should be considered cautiously as it is a permanent division between a child and his or her original family. World Vision does not facilitate adoptions, but rather refers adoption to government or other organisations with greater capacity and expertise to facilitate adoption. The foster care model can provide a safe and nurturing family environment for short or long periods of time, either as the relationship between a child and his or her biological family is explored or as a permanent foster care arrangement.

- **Mobilise the community**

When there are no existing systems of foster care, international agencies must seek to mobilise the community to develop a local programme. No matter what the existing status of foster care programmes, the community should be considered a valuable asset for guiding, supporting and monitoring foster care programmes. The community can provide knowledge of the cultural norms that effect programming, allowing for targeted education of the community to overcome stigmas, to strengthen positive views of children, and to promote a strong sense of community responsibility for care and protection (Tolfree, 2003, p12). Community members are also the most qualified people to identify both vulnerable children and families willing to foster children, and to develop the criteria for selecting foster families (ICRC, 2004, p. 45). After placement, community members should be the main resource for monitoring children's safety and reporting mistreatment while also providing support to foster families and children (Bold, Henderson & Baggeley, 2006, p. 13). World Vision sectoral specialists have recognised the value of foster care within small community groups. For example, a church group that has several foster families facilitates a system of checks and balances for protection of children and also serves as a support group when challenges arise (Interview with Nicole Behnam, 18 November 2008). The CCC model described under kinship care also has potential to mobilise communities for foster care protection and support (Newsome, 2008).

- **Build the capacity of government and other agencies**

It is not the role of NGOs to run foster care systems. Instead these organisations must seek to build the capacity of all levels of government and local agencies. NGOs can develop models of care, perhaps funding the models for a short period of time, with the full intention and agreement of turning the programme over to the government or other locally sustained agencies. Budgeting for programmes should be done within the local agency's capacity to maintain.

- **Facilitate child participation**

It is vital that children understand their options and are given the opportunity to express their feelings throughout the placement, monitoring, assessment and evaluation of the foster care situation. The child's opinion should be documented and respected in the decision-making process according to his or her life stage and development level (Tolfree, 2003, p. 12; IFCO et. al., 2007, p. 21).

- **Place children with families in their community or similar contexts**

Allowing children to remain in their communities or a similar context helps the child retain a sense of belonging and identity (Tolfree, 2003, p. 14). When there are no present dangers, a child should stay within his or her original community, maintaining a sense of stability by keeping the same friends, school and faith congregation. However, in some cases the child's original community may not be the safest environment. For example, sexually exploited children should be removed from the red light areas to minimise the risk to their safety and facilitate rehabilitation (SARI, p. 5), or else in some cases people who have committed crimes against the child might seek revenge upon them. In such instances where returning a child to their original community is not in their best interests, efforts need to be made to place a child in a community with cultural norms that the child is familiar with and, if possible, within a family of the same ethnicity as the child.

- **Recruit caring local families**

Community members can be utilised to develop clear criteria and identify fellow community members who may be willing to foster children. Most believe it is possible to find local families who are willing to care for these children. Shanti George (2003), the author of 'Foster Care beyond the Crossroads: Lessons from an International Comparative Analysis,' believes one must be more creative in recruiting foster parents. George recommends seeking out people in the community who are already caring for these children in loose fostering relationships. For example, for a child living on the street one might contact the shopkeeper who allows the child to sleep on the doorstep of their shop or a café owner who keeps leftovers for the child (p. 349). Recruiting those who are already caring for children provides some assurance that the caregivers have the best interests of the children as motivation and avoids opportunistic motivations (Nicole Behnam, 18 November 2008). Faith-based and other community organisations are also good places to recruit foster families because these groups can provide screening and supporting resources (Gray, 2005, p. 41). However, the location of the foster placement must take into consideration the child's best interests and safety.

- **Ensure the safety of children**

When children are placed into foster homes after experiences of abuse and exploitation, careful consideration should be taken to ensure the safety of the facility. Foster homes are within a private home and therefore more difficult to inspect than residential facilities and children in foster families can be less able to complain about treatment (Cantwell, 2007, p. 5). In cases where the child has survived or witnessed crime, security measures may need to be taken to protect children from people who may want to harm them. Rigorous regulation and registration, screening of foster family members, and training and support of caregivers is critical to protect children from new sources of abuse or exploitation (SARI, p. 6; Cantwell, 2007, p. 5).

- **Keep siblings together**

As in kinship care, siblings should be placed together in the same foster home unless it is against the child's best interests (IFCO et. al, 2007: p. 24).

- **Develop an individual care plan**

As in kinship care, each child should have an individual care plan and foster care agreement defining the long-term objectives and goal of the child's placement in foster care. For some, the objectives might support the overall goal of reunification with the biological family; and for others, the objectives would support the child's development toward the goal of eventually living an independent, productive and self-sustained life. The individual care plan should specify the performance expectations for the foster family, the biological parents or relatives- if applicable, the case manager or volunteer, other community stakeholders such as local authorities and the child. The plan should be reviewed regularly by all parties to ensure that progress is being made toward each objective, guiding every decision during the process (IFCO et. al, 2007: p. 27). The individual care plan minimises confusion over identity, responsibility, legal rights and inheritance by keeping all parties accountable to the ultimate goals of the foster care.

- **Focus on reunification or full integration**

It is important that foster care is focused and intentional. When the goal of the child's individual care plan is the return of the child to his or her original family, it is most effective when the biological family, foster family and child are all working together in partnership to achieve this goal within a specific timeframe (Tolfree, 2006, p. 18). It is therefore the responsibility of the foster family and foster care agency that a relationship between the child and his or her birth family is encouraged, maintained and supported through frequent visitations and communication, if this is in the best interests of the child (IFCO et. al, 2007: p. 33; IFCO, p. 5). However, when the goal of the child's individual care plan is eventual independence, the child should be fully integrated into the foster family and community, supporting the long-term development of the child.

- **Formalise case management**

Whether through government social workers or community volunteers, a formalised system of case management for foster care is vital for the protection and well-being of the children. The International Foster Care Organization (IFCO) guidelines state that foster care workers and family service workers should be qualified, trained and competent individuals (p. 6). The quality of care depends on these individuals' ability to screen, monitor, support and evaluate each individual foster care case. They must develop a system of assessing the suitability of prospective foster families and match the needs, characteristics and expressed wishes of the children with the skills, preferences and characteristics of a foster family. Continual monitoring by staff or volunteers should assess the progress of each foster situation and help each family and child make changes when needed (Tolfree, 2006, pp. 18-20). The IFCO also suggest an annual mutual review for all foster caregivers (IFCO, p. 6). The formalisation of case management should improve staff or volunteer skills and define standards and processes for ensuring the safety and well-being of children in foster care.

- **Arrange a phased transition**

To ease the fear and distress of the transition into foster care, a phased introduction of the child into the family should be arranged. It may begin with introductions and orientation before the child moves in with the family, to sensitise the foster family and prepare the child (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 50). Pre-placement meetings between the child and foster family will help them get to know each other in a safe and familiar setting (IFCO, p. 5). The placement might begin gradually with the child staying one night in the foster home, then a week, and so on. A formal foster agreement or public ceremony can mark the completion of the placement process (Tolfree, 2006, p. 20). The transition should be organised with the main purpose of ensuring the child's best interests and the well-being of all involved (IFCO et. al., 2007, p. 25).

- **Train and support caregivers**

It is important that foster caregivers are prepared for and encouraged in this undertaking. Prior to placement caregivers should be educated on issues such as potential difficulties, their role in respecting children's rights, positive discipline, and the involvement of their own children and the extended family (Tolfree, 2003, p. 12). However, foster families need continued support (IFCO et. al., 2007, p. 35). One example of this support is in Romania, where World Vision provides day-care and after-school centres to relieve foster families from their duties for a few hours each day. They also provide parent training classes, and counselling and support groups for both foster parents and children (Nina Petre, 22 November 2008). In Tolfree's (2006) report on positive care options for children, he suggests the development of associations of foster caregivers to provide peer support and peer monitoring (p. 20). These supportive services can be expensive and one author suggests coming to terms with the fact that the cost of quality foster care may be equivalent to the cost of institutional care, especially for children with difficult backgrounds (Cantwell, 2005, p. 9).

- **Address psychosocial needs**

As in kinship care, the psychosocial needs of children in foster care need to be addressed. Children who are placed in foster care have usually had severe and painful experiences that require care and support for healing. Psychosocial support should be provided on a case-by-case basis, providing opportunities for individual and group counselling (Tolfree, 2006, p. 15).

HOT TOPIC →

- **Contemplate the professionalisation of caregivers**

The 'professionalisation of caregivers' not only includes efforts to improve caregivers' skills, such as developing certification requirements and training courses, but also the payment of caregivers. The benefits and concerns of attempts to 'professionalise' foster care are debated. Some believe that caregivers have taken on an extra financial burden by taking in a child and are required to have a certain level of professional child-care skills, therefore they deserve compensation. Yet, others worry about opportunistic motivations that may lead to child exploitation or the loss of traditional community support systems. Shanti George (2003) suggests a trend that might change attitudes regarding the professionalisation of caregivers:

Earlier foster carers provided additional parenting, extending their efforts and attention to the new entrant to the family. A little kindness and support to a child bereft of its parents performed small miracles. Today, foster carers have to provide different parenting, and – in certain cases – provide expert support of caring for and treating children with alcohol and drug addiction, emotional and relational problems, criminal or delinquent behavior, AIDS and physical and mental disabilities (p. 353).

George goes on to recognise that the costs in fostering are not all economic and cannot be compensated for, while they may be seen as worthwhile for those caregivers who feel rewarded by the chance to make a social contribution. He writes:

While fostering should certainly not be a money-spinner, hardworking and dedicated foster carers should not bear the costs of ensuring the socialization of children who have to leave their birth homes. If other 'altruistic' professions are remunerated, why not foster care (p. 358).

George calls readers to support the professionalisation of foster care for higher quality care, deeper understanding of the issues, more experienced caregivers, better policies and access to richer networks of care (p. 358). However, the Venezuelan government argues from its experience against the payment of foster caregivers. At one time, the government in Venezuela paid foster families for looking after children, but found that foster care eventually subverted to a means of obtaining income rather than the opportunity and responsibility to provide affection, nourishment and education. The government returned to a voluntary foster care system (Levy & Kizer, 1997, p. 268). There is a middle road

regarding the professionalisation of foster families. Most believe that foster families should receive some financial compensation, such as money to cover education and medical expenses, food, and clothing. Economic strengthening of foster families finds wide support as an alternative to paying caregivers, helping these families earn some income to take care of the additional burden they have taken on (India HIV/AIDS & Tata Institute of Social Science, 2006, p. 42). Ultimately the decision of whether or not to pay foster care providers should be made on a case-by-case basis depending on the level of need of caregivers, requirements of caregivers, needs of children, cultural ideologies and so on. Tools and criteria developed for social cash transfers decision-making may be helpful in the context of foster care. In resource poor settings, some form of financial assistance is often an important component for ensuring good care is provided. However, monitoring mechanisms which ensure that the assistance is reaching the most vulnerable households, impacting the most vulnerable children, and adjusting to the changing context are key to their success.

- **Monitoring**

Tolfree (2006) recommends scheduling regular reviews by a volunteer or staff person not directly involved in the child's care, and providing opportunities for the child to talk privately with someone outside the home (p. 30). Children should also be involved in choosing the person and method for giving their feedback. Monitoring should be triangulated, include unexpected visits and whenever possible be facilitated by community members. Whether community volunteers, NGO staff or local officials, monitors need to be trained in identifying the signs of abuse, measuring a child's well-being, and reporting incidents.

Case Study:

Attachment to Families, Sudan

Short-term care arrangements have been exhausted for separated children in the Pignudo and Kakuma Refugee Camps in Sudan. Due to continued unrest and the fact that children were being raised within the camps, Save the Children sought out long-term community-care alternatives. A foster care programme was developed where children identified families with whom they wished to live. The child or a Save the Children staff member approached the family. If the family agreed, they would undergo preparations along with the child and build a small hut, called a *tukul*, next to the family's home. It is common in Southern Sudan for youth to live in a separate hut alongside their parents. The family supervises, provides advice and guidance for the child, monitors the child's health and education and provides discipline when needed. The nature of the relationship between the child and foster family is negotiated and flexible. Some youth prefer greater independence while others want a higher level of personal care and affection. Most children have become very attached to their foster parents, cooking together and enjoying conversation with one another. Youth are empowered throughout the process to make decisions about their own lives. Children in foster homes were also given the opportunity to learn about their heritage through songs, riddles, folk tales and cultural gatherings. Save the Children empowered children through a culturally adapted model of foster care that provided a nurturing family environment for healthy child development (Derib, 2002).

➔ Child-headed households

There is considerable debate regarding the position of child-headed households (CHH - children living with and caring for their siblings) in the hierarchy of community-based alternative care. Some suggest that an orphan living alone is an atrocity that must be corrected, while others recognise independent living as a viable option for children in certain situations depending on the age, developmental level and circumstances of each child. It is again important to remember that ultimately, the choice of alternative care must be based on the child's best interests in his or her situation and that all models have the potential to be both good and bad. With the inclusion of certain criteria, World Vision has taken the stance that if CHHs receive adequate, planned, resourced and monitored community support and care, CHHs can be an acceptable alternative care arrangement (WVI, 2007). Where CHHs fit in the hierarchy can be debated based on the benefits and concerns listed below in tandem with the context of each project.

The spread of CHH is also a contested issue, especially for high HIV/AIDS prevalence areas. Victoria Hosegood (2008), in a study of *Demographic evidence of family and household changes in response to the effects of HIV/AIDS in Southern Africa*, points to population-based data to clarify that despite the increase in orphans and adult mortality, CHH are extremely rare (p. 42). When they do exist, CHHs are often headed by an older sibling over the age of 18 or it is a temporary circumstance before the children are absorbed into the extended family (Wakhweya et. al., 2008, p. 25). With the understanding of CHH as a rarity rather than the norm, support for CHH as a viable model of alternative care may increase.

Benefits:

- **Siblings stay together**

CHH children are not separated from their siblings, therefore reducing their experience of loss (Loudon, 2002, p. 38).

- **Children do not need to move**

Children living in CHHs do not need to move away from their home, community or friends. They are able to maintain relationships that provide a natural support system (Loudon, 2002, p. 38).

- **Community support**

Because of their existing presence and relationships in the community, the CHH model provides greater opportunities for community commitment to supporting children who have been deprived of parental care (Loudon, 2002, p. 38). Studies have shown that support directly from international agencies can cause dependency and hinder coping mechanisms of CHHs (Luzze, 2002). Sectoral specialists recognise the importance of organisations letting go of control and instead building a community's capacity to support CHHs (Interview with John Williamson, 12 December 2008; Interview with Stefan Germann, 25 November 2008).

- **Cultural guidance**

The physical presence of the youth in the community and reliance on community members increases their cultural exposure (Loudon, 2002, p. 38).

- **Protection of property**

Children in a CHH are more easily able to guard their parents' property, houses and possessions, protected from extended family or others who might want to take advantage of the situation (Loudon, 2002, p. 37).

Concerns:

- **Hinders youth's development**

The development of youth can be hindered by their new role as head of the household. Youth are pushed into the role and responsibilities of an adult and can miss out on the formative experiences of adolescence (Loudon, 2002, p. 38).

- **Drop out of school**

Youth heading the household often drop out of school for work in order to provide income for the rest of the household members. While youth often make sure their siblings attend school, their priority is generating an income, growing crops for food and caring for the younger children (MacLellen, 2005, p. 10).

- **Dangerous income-generating activities**

The need to generate income is the most urgent priority of the head of the household. Working children are vulnerable to exploitation and abuse. Often income is sought out through informal means, sometimes including sex work (MacLellen, 2005, pp. 11-12).

- **Lack of protection**

Children living without a full-time caregiver lack protection and are more vulnerable to abuse, exploitation or theft (Loudon, 2002, p. 37).

- **Stigmatisation**

CHHs may suffer because of community stigmas about orphans or HIV/AIDS and therefore become victims of discrimination (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 24).

- **Lack of parental guidance**

The obvious lack of parental guidance can lead to the loss of intergenerational skills (Germann, 2005, p. 95). The lack of discipline normally enforced by parents can also lead to behavioural problems (Loudon, 2002, p. 37). In addition, an adult caregiver provides a recognised role in promoting the child's development in all domains: social, cognitive, physical, emotional and spiritual.

- **Risk of poor health**

Without needed support, CHHs can develop poor health due to a lack of nutritious food or a lack of access to appropriate health care (MacLellen, 2005, p. 13).

- **Struggle to survive**

Children in CHHs may have to struggle to survive more than children in other forms of alternative care, working to support one another financially, physically and emotionally. However, the struggle also provides opportunities to learn and grow, developing valuable life skills in the process (Loudon, 2002, pp. 37-38). There is a need for balance, not allowing children in CHHs to struggle so much as to be limited in their ability to reach their potential, but also allowing children the space to mature and learn through their experiences of struggle.

Programming suggestions:

A real option

Instead of viewing CHHs as problems, perhaps national and international agencies should begin evaluating the needed resources to make them an effective model. In his dissertation, Stefan Germann (2005) argues for international recognition of the CHH as an acceptable alternative care arrangement in high HIV/AIDS prevalence communities. In a hierarchy of alternative care models Germann places CHHs directly after kinship

care and foster care. Based on the World Vision International Management Policy on Children Deprived of Parental Care, World Vision is working to further develop the support interventions needed for CHHs. The policy states that CHHs are an acceptable care arrangement if children receive adequate, planned, resourced and monitored community support. However, the key factor to assess in deliberations over this model of care is the best interests of the child, considering his or her age and development capacity. When it is recognised as an option that could facilitate the best interests of the children involved, community supported CHHs should be taken into consideration as a real option for care of CDOPC.

- **Mobilise community support**

Community support is critical for ensuring that the needs of children living independently are met. Every member of society has a role in supporting CHH orphans. Community members should be mobilised to build sustainable community-based safety nets, including interventions broader in scope to help the whole community develop resources needed to support each other (Plan Finland, 2005, p. 5). UNICEF (2004) suggests voluntary support from neighbours and community members for CHH through mentoring, guidance and the provision of material resources (p. 6).

- **Facilitate child participation**

Children have a right to participate in the planning of programmes developed to address their needs. Children should be adequately informed of their situation, encouraged to express their views and to participate in the decision-making process according to their life stage and development level (IFCO et al., 2007, p. 21). The input of children from CHHs is particularly valuable for understanding their potential for self-sustainability. In addition, in designing programmes that promote psychosocial well-being, NGOs must build on positive coping strategies adopted by the children themselves rather than interjecting new methods that interrupt the process of learning life-skills and may lead to further dependence on the agency (Plan Finland, 2005, p. 5).

- **Facilitate mentorship**

Mentorship programmes further connect community volunteers with children in CHHs. Plan Finland (2005) recognises, 'Communities may not have material resources, but they are able to offer social and emotional support to orphaned children' (p. 5). Evaluations of World Vision Rwanda's mentorship programmes recognise the positive impacts of mentoring on children, including improving family dynamics, increasing emotional support, reducing risky behaviour, increasing social protection and community integration (Kalisa, 2006, p. 3; World Vision Rwanda, 2007, p. 10). Community volunteers need support and training to understand children's needs, including how to help them feel secure and how to provide supportive coaching. Volunteers should also be appreciated and recognised within the community for their efforts and commitment to the community's children (Plan Finland, 2005, p. 6).

- **Increase access to education**

Children living independently need assistance in gaining access to education. Schools can waive requirements for school uniforms and fees, or provide meal programmes. Community members can advocate for universal primary education as outlined in the Millennium Development Goals and many national policies (Bold, Henderson & Baggeley, 2006, p. 17). Teachers can support CHHs by showing understanding of their situation and encouraging children to stay in school. Creative and flexible education options for children living independently are critical. For example, a school can allow children to use land, grow plants in demonstration gardens and take food home to be eaten (Plan Finland, 2005, p. 6). Whatever the need, communities must find ways to overcome barriers to education for children living independently. For example, UNICEF has modelled an education alternative called Complementary Opportunities for Primary Education (COPE), where children study three hours a day, giving them time for managing their household (Luzze, 2002, p. 63).

- **Increase opportunities for income generation**

Communities need to assist youth living independently or within CHHs in developing skills and tools for economic survival and independence. Programmes might include vocational training, apprenticeships, and small loan opportunities (Richter et. al., 2004, p. 17).

- **Provide life skills education**

Children in a CHH or living independently can be empowered through life skills education, learning to protect themselves from abuse, exploitation, pregnancy and sexually-transmitted diseases (Bold, Henderson & Baggeley, 2006, p. 18). Life skills education can also prepare children for independent living by teaching positive coping skills, communication skills, critical thinking skills, self assertiveness, negotiating skills, money management and decision-making (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 48).

- **Provide HIV/AIDS prevention training**

Because children living independently are at risk of engagement in sex work or vulnerable to exploitation, it is important that they receive HIV/AIDS prevention training (Germann, 2005, pp. 298-299).

- **Address psychosocial needs**

As in other models, children who live independently need psychosocial support as they deal with loss and painful experiences. Support groups for child-headed household members may give children a chance to talk freely and support one another (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006, p. 47).

- **Support childcare centres**

Childcare centres allow relief for youth who are caring for their younger siblings, giving them a chance to attend school or work. Childcare also provides younger children opportunities for educational, recreational and spiritual growth (Bold, Henderson & Baggeley, 2006, p. 16).

- **Provide for basic needs without singling out**

Measures must be taken to meet the basic needs of children through material support when necessary. However, communities must be careful not to stigmatise children in the process of helping them. Supportive services should be offered to all children that the community determines to be in greatest need, in an attempt to not single out orphans or CHH members (Bold, Henderson & Baggeley, 2006, p. 17).

- **Consider the impact on CHH coping strategies**

Every attempt to help CHHs or youth living independently needs to be considered for how it will impact the children, what is described as the 'the best interests of the child' in the UNCRC. In 2002, World Vision undertook a study to understand the impact that their supportive services were having on the coping strategies of CHHs in Uganda. The study suggested that direct services encouraged orphans to stay on their own, created dependency of CHHs, and had both positive and negative impacts on the coping strategies of CHHs. It is imperative that NGOs are conscious of their potential impact on service provision to CHHs. Fredrick Luzzo (2002), the study's author, lists some of the impacts an organisation must consider in programming. Communities must ensure that programmes for CHHs:

- Do not destroy vital positive coping strategies in CHHs
- Do not reinforce detrimental coping strategies
- Do not create unnecessary extra burdens on orphans in CHHs or on friendly volunteers

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- Do not elevate the quality of life of CHHs far beyond that of their neighbours, creating jealousy, which repels volunteers from the CHHs and also makes CHHs vulnerable to attacks from thieves
- Can be sustained by CHHs and community structures
- Cater for the needs of the different age groups in a CHH
- Embody the love of Christ in every intervention to CHHs
- Are long-term and phased to allow CHHs to gradually build capacity to handle new projects (p. 62).

All international organisations attempting to serve children in CHHs must ensure that their programmes cause no harm for these vulnerable children. Attention should focus on empowering and increasing the capability of the communities to care for CHHs and strengthen other community-based alternatives for CDOPC (Luzze, 2002, p. 63).

- **Monitoring**

Monitoring should include regular reviews by a volunteer or staff person not directly involved in the child's care, and providing opportunities for the child to talk privately with someone outside the home (Tolfree, 2006, p. 30). Children should also be involved in choosing the person and method for giving their feedback. Monitoring should be triangulated, include unexpected visits, and whenever possible be facilitated by community members. Whether community volunteers, NGO staff or local officials, monitors need to be trained in identifying the signs of abuse, measuring a child's well-being and reporting incidents.

Case study:

Khutsong After-school Centre, South Africa

The Khutsong After-school Centre has been serving children from CHHs since 2003. The centre provides a variety of activities to support the needs of these children, including assistance with homework, life skills training, support groups, counselling, meals, food to take home, clothing and toiletries. However, the after-school centre is also a place for children to play and forget their responsibilities and troubles. Every Friday children participate in drama and choir, and games are played all week. The centre serves a therapeutic role for children who often feel lost after losing their parents. Tolfree (2006) observes, 'The centre reassures [the children] that they are loved and it also gives them a home' (p. 11). Approximately 196 children from 27 CHHs benefit from the Khutsong After-school Centre. This intervention provides children with an opportunity to grow and learn in a safe and welcoming environment (Tolfree 2006, p. 11).

➔ Group homes

The model of group homes is considered within the category of institutional care by some. However, group homes can serve as a viable alternative to traditional orphanages when other care options are not in the best interests of the child, such as situations in which families are unwilling to take in children of a certain ethnicity or due to extreme trauma children are not able to transition directly into a family environment, or as a temporary arrangement while other care arrangements are being pursued. Group homes can take a variety of forms ranging from family-style homes to large orphanages. Another form of group homes that is included in this model is youth living independently, small groups of youth who live together without a full-time, in-house caregiver, but receive regular support from an agency. Caregivers in these arrangements are sometimes referred to as 'lead tenants,' individuals who help youth practice and transition to independent living.

Benefits:

- **Family-like environment**

Group homes have the potential to provide a family-like environment for a child when kinship and foster family care approaches are not in the best interests of the child. Family-style group homes should be small with children varying in age and at least one parental figure, ideally a married couple serving as house parents (Bagley, Ko & O'Brian, 1997, p. 105). Mimicking the function of a family, staff and peers can provide love, support, and supervision that aids the child's ability to heal and adapt to their new living arrangement. In group homes of youth living independently, youth can develop supportive relationships amongst each other and the part-time caregiver or mentor that will continue after a youth leaves the living arrangement.

- **Structured environment practitioner**

The group home model provides the structure needed for stability in a child's life while holding the child accountable to certain roles and responsibilities. Ghazal Keshavarzian, the Senior Coordinator for the Better Care Network recognises that adolescents with behavioural problems might benefit most from this type of consistent and structured environment provided by group homes (Interview, 5 December 2008).

- **Effective for transitioning to reunification or independent living**

The group care model is effective for short-term placement situations in which a child is expected to transition back into their original families, moving into foster care, or youth who are transitioning into independent living (Tolfree, 2005, p. 13 & 30). Group homes can provide a supportive setting for a child to heal, restore relationships, learn life skills or develop income-generating skills.

- **Effective in urban settings**

Practitioners recognise the difficulties of implementing community-based kinship or foster care in urban settings. World Vision staff member Luke Bearup recognises the potential of the group care and lead tenant model to be more effective in cities where community support can be lacking (Interview, 21 November 2008).

- **Effective for children who have difficulty returning to a family environment**

Group care is an important long-term option for children with specific needs for whom kinship or foster care are not options, such as some disabilities, psychological problems or other issues that a normal family environment might struggle to accommodate (Tolfree, 2006, p. 30).

- **Effective short-term option while other family-based models of care are developed**

Group homes can be effective in the context of large deinstitutionalisation and as a first step toward more family-based options, such as fostering or adoption (Tolfree, 2006 p.:30). This approach has been used in Georgia as the first step in reducing the number of children in institutional care while capacity was built to pursue the reunification of children with their families or place children in foster families (UNICEF Baltic States, 2000, p. 30).

- **Provides peer support**

Children are living with other children who have had similar experiences of trauma and abuse. Group homes therefore have the potential to serve as natural support groups. However, the collection of children with traumatic histories can also lead to peer-abuse and delinquency.

- **Opportunity to practice and develop life-skills**

In comparison to larger institutional care, group homes provide children with the opportunity to develop life-skills. When children are given individual roles and take on domestic routines, they learn personal and family responsibility, independent decision making, time management and skills that will allow them to one day transition into lives as productive and independent adults (Mulheir et. al., 2007, p. 67).

- **Opportunity for role modelling and mentoring**

Adult role models are also important in promoting all aspects of the child's development. The presence and support of consistent caregivers living in the group home can offer a child who may not be able to handle the family environment of kinship or foster care, an opportunity to develop relationships with adults. The caregivers can serve as mentors and role models to children who may not have had positive adult role models in the past.

- **Promotes integration into community**

Compared to the isolation of institutions, independent group homes located within the community increase a child's exposure to the social and cultural norms of their context. However, kinship homes, foster homes, and CHHs often have an existing place within the community. Therefore, group homes have to be more intentional about being integrated into the fabric of the community.

- **Greater control over quality of care**

The formal structure of group homes can offer greater regulation opportunities, therefore increasing the quality of care and protection of children. John Whan Yoon, a World Vision staff member with experience working with family-style group homes recognises control and protection as a benefit of the group home model. Caregivers can be screened and trained with greater rigour as they are accepting a formal task, rather than simply being asked to add another child to their private home, as in kinship and foster care (Interview, 21 November 2008).

- **More frequent monitoring**

Group homes can be more accessible to outside monitoring than private homes (Interview with John Whan Yoon, 21 November 2008).

Concerns:

- **Institutional tendencies**

If the standards are not developed and enforced, group homes can develop institutional characteristics that leave children isolated and without the individual care and trusting relationships needed for healthy development. For example, in Hong Kong, the Social Welfare Department has been known to convert an entire apartment block into over fifty 'group homes,' creating a large child care institution in all but name (O'Brian, 1995, p. 105).

- **Expensive**

The expense of maintaining group homes is relatively high considering that funding is needed for property, facilities, food, and household expenses in addition to caregivers' remuneration and the supportive services for each child.

- **Isolated from community**

Tolfree (2006) suggests that one of the challenges of group homes is integration into the local community (p. 30). Group homes have the risk of isolation if the house is located outside of normal neighbourhoods or if children are not included in the daily household chores that expose them to the surrounding community. Children who are isolated from the community cannot easily develop skills for practical living and social interaction, and may become stigmatised or develop dependence.

- **Risk of peer-abuse or delinquency**

It can be assumed that group homes that segregate children by age and gender can lead to greater risk of peer-abuse or delinquency, especially among adolescents. Placing a group of youth together who have had similar experiences of trauma and abuse leading to behavioural and relational problems in one home can lead to safety and protection issues.

- **Difficulty in youth's ability to move on**

The group home model has the risk of not providing an environment where children learn how to live on their own (Tolfree, 2006, p. 30). If group homes do not hold children accountable to certain responsibilities, if everything is provided for the child and if children are not active in the community, a child can form a dependency on the home, unable to understand how to function in society, and not be able or willing to move towards reunification or independent living.

- **Negative motives for caregivers**

As with kinship and foster care, there is a risk that group home staff may have opportunistic motivations. Paid caregivers can easily view their work as a job rather than a vocation or calling to care for and love children. Children are therefore in greater danger of abuse and exploitation.

- **Inconsistent caregivers**

Sectoral specialists warn against inconsistent caregivers. Staff of group homes can change frequently or children can be moved in and out of homes often, leading to the child being deprived of continuous loving relationships (Interview with Ghazal Keshavarzian, 5 December 2008; interview with Stefan Germann, 25 November 2008).

- **Lack of male figure**

Most group home arrangements rely on women as the main care providers and therefore lack male role models or father figures (Interview with Germann, 5 June 2009). Fatherhood studies show that such care arrangements have long-term negative impacts on children. Some studies suggest that the divorce rate for women and potential for violence for men are higher among those who did not have a positive father figure in their lives (Blankenhorn 1995).

Programming suggestions:

An option in special circumstances

If certain stipulations are met, group homes have the potential to provide quality care to children in the most difficult circumstances. However, group homes can easily develop the same problems associated with institutionalism. It is vital that certain standards are developed and enforced for group homes to avoid institutional tendencies and provide a positive environment for the growth and development of children in special circumstances. One of World Vision's partner organisations in Cambodia, Hagar International (Hagar), uses group care as one option in a continuum of care. Hagar serves children who have been trafficked for sexual exploitation. After a period in a recovery centre most children are integrated back into society through foster homes. However, due to cultural discrimination, it is not safe for Vietnamese girls to live within a foster care home. Instead these girls are placed in a home within the community, along with only six other children and one house mother. In these homes they are safe and surrounded by girls who can support them because of their similar experiences (Interview with Sue Taylor, 16 December 2008). Certainly, group homes can be considered as an option for children with special circumstances, such as these young women.

- **Allow culture to dictate group structure**

The structure and living standards of group homes should be dictated by the local culture so as to allow greater integration and discourage stigmatisation (WVI, 2005).

- **Develop from within the community or similar context**

To avoid disrupting the child's development and causing greater distress, group homes should be set up within the child's community of origin or a similar context (WVI, 2005). Group homes that are developed from within the community promote community engagement and empowerment, along with providing stability for the child. However, in situations where a community is not considered safe for a child or where children suffer from community stigmas, group homes should be developed in a community with similar social and cultural norms.

- **Integrate into the community**

Group homes must be embedded within the community among other homes and included within normal neighbourhood activities and relationships (Tolfree, 2006, p. 30). Children should go to local schools, participate in faith-based groups and conduct normal activities for children such as going to the market or fetching water, in order to maintain community ties.

- **Facilitate child participation**

As with any care model, children must understand their options and be given the opportunity to express their feelings throughout the placement by participating in the monitoring, assessment and evaluation of their group care situation according to their life stage and development level (Tolfree, 2003, p.12; IFCO et. al., 2007, p. 21).

- **Gate keeping**

Admission into group homes should be pursued only when all other options have been explored and rejected, with the focus on the child's best interests. Therefore a process of gate keeping should include a comprehensive child and family assessment and development of a child care plan to ensure that only those who meet tightly specified eligibility criteria are admitted into a group home (Gudbrandsson, 2004, p. 15).

- **Long-term individual care plan**

Individual care plans are particularly important for staff to have the ability to guide the support needed for each child. Children in group homes should be considered temporary and focused on preparing children for a more permanent care option. The individual care plan should be understood

as a guide to the overall development of the child. It describes the intended long-term goal with a timeline for reaching that goal and outlines of the steps that need to be taken in the process (IFCO et. al., 2007, p. 27).

- **Ensure the safety of children**

When children are placed into group homes after experiences of abuse and exploitation, careful consideration should be taken to ensure the safety of the facility. Security measures may need to be taken to protect children from those who may want to harm the children (SARI, p. 6).

- **Provide parental figures**

An important feature of the group home model is that it allows for close and continuous relationships between children and adults, substituting for the parent-child relationship (Tolfree, 2006, p. 30). Caregivers should be willing to make a long-term commitment to the household and children, ideally maintaining contact with children after they leave the home (Mulheir et. al., 2007, p. 67). Often a single woman or a married couple serving as the central caregivers within a small group home can fill the parent role (Tolfree, 2006, p. 30). However, it is important both a female and male figure are present in the lives of children in some capacity.

- **Train and support caregivers**

Caregivers should receive continuous training and professional support to ensure the overall development of children within the group home (IFCO et. al., 2007, p. 35).

- **Limit the number of children within household**

Group homes should be small, 4 to 12 children, allowing children to develop close relationships with their caregivers and peers. World Vision's position paper on CDOPC suggests the household size be determined by the traditional family (WVI, 2005). However, the World Health Organization set 12 as the maximum number of children in a single group home (Mulheir et. al., 2007, p. 67).

- **Implement strength-based approach to care**

Sectoral specialists suggest a child-centred strengths-based approach, where children's strengths are recognised and encouraged as children build their identity and confidence (Interview with Luke Bearup, 21 November 2008; interview with Livia Nano, 21 November 2008). Caregivers need to be trained in the principles and practical skills for this approach.

- **Keep siblings together**

As with every model of care, every effort should be made to keep siblings together for mutual support unless it is against the child's best interests (IFCO et. al., 2007, p. 24).

- **Include a range of ages**

In an effort to mimic a family environment, a group home should be made up of children with a range of ages (WVI, 2005). However, group homes with youth living independently may be an exception to this principle.

- **Promote domestic routines**

In efforts to allow children to experience normal family life, children in group homes should participate in domestic routines, including chores and responsibilities that do not interfere with their education. Children must also be expected to participate in family/group activities (Mulheir et. al., 2007, p. 67).

- **Assist in transitions**

Group homes can be effective as a short-term transitional arrangement as a child prepares for reunification with their family or a youth prepares for independent living. It is vital that the time a child spends in the group home helps the child get ready for this transition. Group homes that specialise in reunification after institutionalisation must teach children how to function in the community and take care of themselves after years of isolation. Homes with children who have been victimised or traumatised must offer healing and relational skills before the transition. In some cases, a home can specialise in youth moving into adulthood and independent living (Tolfree, 2006, p. 30). These youth must not only be integrated into the social life of the community but also be trained in income-generating activities and independent decision-making. A group home should provide a safe environment for a child to learn, heal and fail.

- **Facilitate contact with original family**

To aid the transition of children back to their families of origin, group homes must make efforts to facilitate contact between the child and their families. The child's relationships with family members should be encouraged, maintained and supported if this is in the best interests of the child (IFCO et. al., 2007, p. 33). Possible relationship-building activities include visitations, writing letters, making phone calls, joint activities or open houses. However, the family situation must be thoroughly assessed to consider whether contact is in the best interests of the child. If contact with the family is not considered to be in the best interests of the child, for example the family is deemed unsafe due to past abuse or exploitation, special considerations should be taken to facilitate interaction, such as supervised visitation.

- **Screening, training and supporting caregivers**

Special attention should be given to the screening, training and monitoring of group home caregivers. Caregiver selection should seek out people who are willing to care for the children as their own and have the tools to provide the care a child needs.

- **Address psychosocial needs**

As in every situation in which a child is deprived of parental care, special attention should be given to the psychosocial needs of the child. Children in group homes may have more severe experiences and limited support, and therefore require even greater support through ongoing counselling, support groups and caring relationships (Tolfree, 2006, p. 15). Peer group discussions can be used to develop supportive relationships among the household and improve the day to day living environment (SARI, p.10).

- **Strengthen government and local agencies**

Again, it is not the role of an outside agency to run group home programmes. Instead these agencies should work to strengthen the capacity of government and local groups to care for children.

- **Monitoring**

Tolfree (2006) recommends scheduling regular reviews by a volunteer or staff person not directly involved in the child's care, and providing opportunities for the child to talk privately with someone outside the home (p. 30). Children should also be involved in choosing the person and method for giving their feedback. Monitoring should be triangulated, include unexpected visits, and whenever possible be facilitated by community members. Whether community volunteers, NGO staff or local officials, monitors need to be trained in identifying the signs of abuse, measuring a child's well-being and reporting incidents.

Case study:

World Vision, Georgia

Cultural ideologies about childcare and community responsibility from the communist era are still strong in Georgia. The institutionalisation of children is common practice as the people look to the state as the provider for the needs of their children. Parents place their children's physical needs before their social and emotional need for love and attention. World Vision Georgia (WVG) is involved in the vast undertaking of deinstitutionalisation with the goal of moving children and youth from institutions to stable, family environments. WVG was the first organisation to introduce the small group home model to Georgia in 2006. The organisation has always worked in partnership with Georgia's Ministry of Education and Science, which took over funding of the programme at the beginning of 2008 and is in the process of assuming full responsibility of all full operations of the homes. World Vision opened five small group homes in Akmeta and Samtredia, Georgia, with about eight children in each, ranging in age from 6 to 18 years old. The homes are run by host parents and try to mirror as closely as possible a 'regular' family environment. World Vision's Operation Manager, Tamuna Barkalaia, says that small group homes can serve as a model of effective alternative of care:

While prevention, reintegration and foster care are effective measures of care to replace institutions, there are a few critical cases that require assistance in temporary housing due to various reasons that do not allow reintegration into biological families or placement under foster care. Small group homes are a well-proven and effective alternative in these cases.

The organisation has had success with group homes. Giga, a 20-year-old young man who now lives independently and works at a gas station reflected on his time in one of World Vision's small group homes, 'This house made me feel different – I feel so much care from everyone. I know that if something goes wrong, I have people who I can count on in the future.' The relationships developed within the homes are long-term and provide life-long emotional support. World Vision Georgia is also involved in the child welfare reform process and is a long-term partner with the state in deinstitutionalisation, reunification and alternative care (Chkhaidze, 2008).

➔ Children's villages

Children's villages are a collection of group homes within a single campus or facility. The model for children's villages have similar benefits, concerns and programming issues as group homes, but those that are unique or most vital have been discussed again here. Children's villages are considered a last resort in the community-based alternative care hierarchy for the concerns listed below.

Benefits:

- **Family environment**

As an alternative to institutional care, children's villages attempt to create a family environment with small homes and house mothers who share everyday life with the child and attempt to develop lasting bonds with the children (SOS Kinderdorf International, 2005, sections 3.1-4.1).

- **Quality of care**

Children's villages often provide a higher quality of care by hiring skilled caregivers who receive intensive training and support (Senou, Turgeon-O'Brien, Ouedraogo & Desrosiers, 2008, p. 150). The villages also have specialised amenities such as clinics, schools and sometimes even pools and playgrounds (UNICEF, 2004, p. 9).

- **High level of monitoring**

The villages are generally well supervised and monitored, decreasing opportunities for abuse, neglect, or exploitation (Senou et. al., 2008, p. 150).

- **Peer support**

Children are surrounded by others who have had similar life experiences and form informal support groups through neighbourly relationships.

- **Support for child providers**

Children's villages provide a network of caregivers who are easily accessible to receive professional advice, counselling and other supportive services. The network also provides caregivers with peers who can provide informal support through care and friendships (SOS Kinderdorf International, 2005, section 4.1).

- **Marketable**

An efficient administration and aesthetically pleasing campus is appealing to overseas donors, making children's villages an effective fundraising model over other, less obtrusive alternatives (UNICEF, 2004, p. 9).

Concerns:

- **Isolated from communities**

Children's villages often contain children within the campus instead of integrating them into the surrounding community. This isolation limits the child's ability to develop cultural and social skills that would assist in a smooth transition to reunification with children's families or independent living (Bold, Henderson & Baggeley, 2006, p. 13; UNICEF, 2004, p. 9).

- **Institutional in all but name**

Many believe that children's villages do not go far enough in distancing themselves from institutional practices and consider them institutional in all but name (UNICEF, 2004, p. 9).

- **Not culturally appropriate**

Children's villages are often built in western architectural styles and with a quality that is superior to the housing available in the surrounding community. In the report, 'SOS in Africa: The need for a fresh approach,' G. Powell comments on this issue regarding the most well known children's villages, SOS Kinderdorf International, 'Children are nurtured in a setting which mirrors western, middle class suburbia. High quality housing set in landscaped gardens with excellent recreational and educational facilities attached. These facilities are bound to impress visitors and satisfy donors' (p. 5). UNICEF (2004) recognises that these living conditions disconnect children from their culture and community causing further stigmatisation, making a return to the community difficult (p. 9). Feedback at the Meeting on African Children without Family Care in Windhoek, Namibia, acknowledged some instances where children who had become used to television and swimming pools run back to the children's villages after reintegration (UNICEF/USAID/FHI, 2002, p. 14).

- **Creates stigmas**

Children in these villages are often perceived as privileged by the surrounding community and therefore resented and stigmatised (UNICEF, 2004, p. 9).

- **Expensive and unsustainable**

Children's villages are often the most expensive alternative care model and therefore sustainability is questionable (Powell, 1999, p. 4).

- **Difficulty in reintegration**

Isolation from the surrounding community, stigmatisation and the far superior physical environment make reintegration back into original families or communities difficult (Powell, 1999, p. 5).

- **Inequality of orphan care**

The disparity between CDOPC living within children's villages and those living in other care arrangements is vast. Powell recognises this injustice in Zimbabwe:

The 360 fortunate children who have been admitted to SOS homes in Zimbabwe comprise approximately 0.05% of Zimbabwe's predicted orphan population. The resources invested in them are infinitely greater than the resources available to the ordinary orphan (p. 5).

Programming suggestions:

The last resort

In terms of community-based alternatives to institutional care, children's villages are considered the last resort. However, if certain standards are developed and implemented, the children's village model has the potential to fulfil the development needs of vulnerable children in low-resource conditions. As a better form of institutional care, in situations of great need it can offer orphans a chance for survival (Senou et. al., 2008, p. 151).

- **Gatekeeping**

As with group homes, admission into children's villages should be pursued only when all other options have been explored and rejected, with the focus on the child's best interests. A gatekeeping process must be in place to ensure that only those who meet the criteria are admitted (Gudbrandsson, 2004, p. 15).

- **Facilitate child participation**

Children in children's villages must be listened to and respected in the decision-making process. The child should be adequately informed of his or her situation and encouraged to express his or her views, participating in the process according to the child's life stage and development level (IFCO et. al., 2007, p. 21).

- **Develop family-based care**

Traditional residential care must utilise a family-based care model, as children's villages have attempted to do. Children's villages must offer a family setting where children have a constant relationship with consistent parental figures, both female and male, and siblings of different ages and sexes. The family should follow cultural standards of roles and responsibilities, preparing food and eating together, and requiring children to take part in normal household chores (UNICEF, 2004, p. 9).

- **Reflect surrounding situation**

To reduce stigma, increase reintegration, and maintain children's connections to the community and culture, children's villages should reflect the living standards of the surrounding community (UNICEF/USAID/FHI, 2002, p. 14).

- **Scatter households among normal family households**

Community integration may be best achieved by distributing the children's villages, establishing individual homes sporadically throughout the community, while still utilising the network of support through supportive services and support groups (UNICEF, 2004, p. 9). In urban areas large apartment buildings can house these group homes integrated among normal households.

- **Integrate into surrounding community**

Children's villages should make every effort to be integrated into the surrounding community. There should be no signage or identifying features on the homes and children should be given freedom and activities similar to other children. Ideally, residents of these children's villages should be indistinguishable from other children in the community, attending the same schools, faith-based organisations and cultural events as everyone else (UNICEF, 2004, p. 9).

- **Develop an individual care plan**

Each child within a children's village should have an individual care plan so as to avoid a child's permanent placement within the village and guide the child's overall development. The plan should define the current developmental status of the child, set objectives of the care arrangements, and identify the supportive services and resources needed to achieve the objectives (IFCO et. al., 2007, p. 27).

- **Train and support caregivers**

Caregivers should receive continuous training and professional support to ensure the overall development of children within the village (IFCO et. al., 2007, p. 35).

- **Keep siblings together**

As always, siblings should be placed within the same household in children's villages unless it is against the children's best interests (IFCO et. al., 2007, p. 24).

- **Maintain contact with original family**

When original parents or relatives are identified, the child's relationships with them should be encouraged, maintained and supported if this is in the best interests of the child (IFCO et. al., 2007, p. 33; Senou et. al., 2008, p. 148). Interaction between the child and his or her original family can increase the potential for reunification, but if that is not possible, it can provide the child with a sense of identity and belonging. However, the family situation must be thoroughly assessed to consider whether contact is in the best interests of the child. If contact with the family is not considered to be in the best interests of the child, for example the family is deemed unsafe due to past abuse or exploitation, special considerations should be taken to facilitate interaction, such as supervised visitation.

- **Monitoring**

Tolfree (2006) recommends scheduling regular reviews by a volunteer or staff person not directly involved in the child's care, and providing opportunities for the child to talk privately with someone outside the home (p. 30). Children should also be involved in choosing the person and method for giving their feedback. Whether monitoring is done by community volunteers, NGO staff or local officials, they need to be trained in identifying the signs of abuse, measuring a child's well-being and reporting incidents.

Case study:

Cottage care, Myanmar

Family or cottage care has been developed as an alternative to institutional care in Southeast Asia. In Yangon, Myanmar, cottages are complex houses that accommodate no more than 10 children per house and are staffed by permanent caregivers who act as house 'mothers.' Children go to school outside the cottages so are therefore more integrated into the community. However, they are grouped by gender and age: one cottage for infants and young children, another for children aged three to five years, three cottages for boys aged six to sixteen, and one for girls aged six to sixteen. This arrangement might diminish the family-like environment, as children's contact with children of other ages is limited and children must move cottages and also caregivers when they reach a certain age. Another issue with cottage care is that men are not hired as caregivers so the children do not have a male role model in the household. The cottage complex is sustained through national support from the private sector and the Myanmar Department of Social Welfare. The cottage complex includes an office, library, clinic, staff quarters, a kitchen, a prayer and activity room, and a dining hall. It is clean, well-equipped and well-maintained. Children receive individualised care and attention that they would not otherwise receive within a large traditional style institution or orphanage. However, the facilities also separate children from normal interaction in the community and prevent experiences of normal family life, such as eating together as a family. Young children attend nursery classes at the complex, but older children attend government schools in the community in an attempt to find some means for integration. Unfortunately, the cottage care model involves many of the same concerns and deficits of large institutions, as children are isolated from the community and unable to develop practical life skills for reintegration back into society. In addition, children with disabilities or those who are affected by HIV/AIDS are not permitted to live in the cottage complex (UNICEF EAPRO, 2006, p. 33). While attempts to reform institutional care are a step in the right direction, greater consideration is required in developing the children's village model.



Conclusion

The aim of this paper is to prompt discussion and discernment regarding best practices for community-based care options for children who have been deprived of parental care. The vulnerability of CDOPC to abuse, neglect and exploitation implores national governments, NGOs and supporting agencies toward the continual pursuit of better care practices. This paper has presented general principles for alternative care to institutions, and the potential benefits and concerns of five major forms of community-based care with programming suggestions that can aid in overcoming the challenges of each individual model.

Institutionalisation is no longer the answer. It stifles the healthy development of children, hindering them from reaching their full potential. Efforts must be focused on improving alternative care interventions to develop a continuum of care to choose from in decisions regarding the best interests of a child who has been deprived of parental care. The effectiveness, sustainability and quality of alternative care are greatly affected by the involvement of the local community in developing, guiding, monitoring and supporting interventions. Community-based care has the potential to enable children to pursue a happy, healthy and productive life. However, practitioners must continually seek out promising practices and principles for community-based care. Practitioners in this field are responsible to consider carefully the complex issues raised in this paper, weigh the various models, apply the best practices and to ensure effective monitoring of the safety and well-being of children in community-based care situations. This paper intends to stimulate and focus the discussion of these issues as they apply to the variety of contexts where its readers reside.

While the subject is out the scope of this paper, the responsibility of World Vision in assisting the development and enforcement of standards for institutional care and reintegration of children within institutions cannot be ignored. Several tools currently exist for measuring standards of care within institutions, including the Better Care Network's *Manual for the Measurement of Indicators for Formal Care* (www.bettercarenetwork.org). Some forms of short term institutional care may be necessary and perhaps even in the best interests of a child in certain situations; even in situations where community-based care is the best option for CDOPC, some governments and non-governmental or faith-based organisations will continue to establish shelters. Therefore, while World Vision discourages institutionalisation and will not fund these long-term shelters, it must play a role in assisting governments and shelter service providers to meet minimal standards of care and protection, and to develop adequate processes for assessment, rehabilitation and reintegration. A focus on community-based care alternatives for CDOPC does not alleviate World Vision, or any other organisation, from the responsibility to seek and advocate for the protection and care of children within existing institutions.



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