



MOVING TOWARDS FAMILY SOLUTIONS

An Immersive Simulation Experience

CAFO | OVC research



hope and homes
for children



MOVING TOWARDS FAMILY SOLUTIONS:

AN INTRODUCTION

Both Scripture and science affirm that children grow best in healthy families. For vulnerable children and at-risk families, a wide range of family support and care options together contribute to a robust “continuum of care” that can meet the unique needs of each child and maximize opportunities for children to grow up in nurturing families.

Organizations that currently provide residential care, such as orphanages and children's homes, are often well-positioned to reshape their programs to support care for children within families. These programs typically have competent staff, committed donors, and strong relationships in the communities where they serve, enabling them to make major contributions to family care.

PURPOSE:

Engaging with new models of care brings many unknowns. Will children be cared for well? How will donors and partners respond? Will we succeed? It can be a very uncertain time for a program.

To remove some of the mystery, the Christian Alliance for Orphans (CAFO), in partnership with Hope and Homes for Children and the Faith to Action Initiative, developed an experiential workshop centered around the fictional case study of an orphanage preparing

to move the children in their care to family care. This workshop was created to provide a safe and encouraging space for those involved in residential care to think through the process of a transition toward providing family-base care.

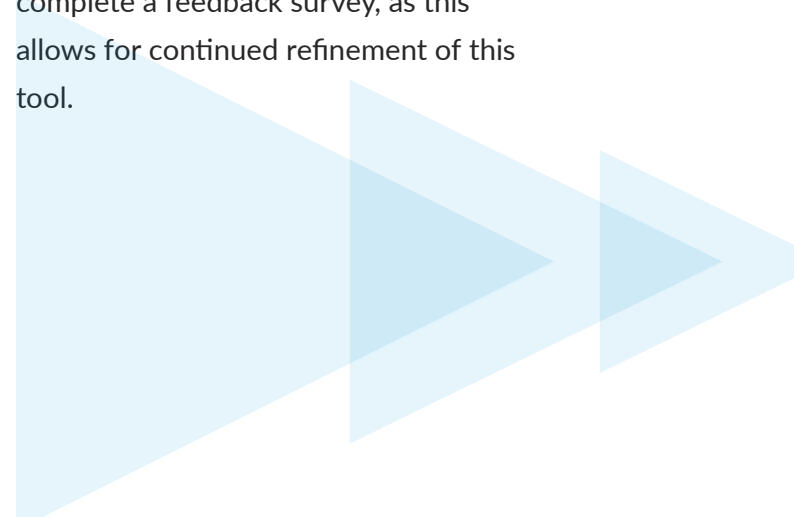
Workshop participants were guided through activities and discussions to plan and implement a transition for the fictional organization, Precious Children of Hope Children's Home (PCHCH). The material was adapted from workshop exercises created by Dr. Delia Pop.



Engaging with a fictional case study allows participants to explore the components of the transition process, while eliminating the need to immediately consider the emotional complexities that can come with imagining a reshaping of their program. They are able to learn, wrestle with, and adapt new information, and reflect on what is possible and helpful for children in their care. With the guidance of experienced group leaders, as well as group discussions, they are given the opportunity to create a plan for next steps in their program.

USING THIS RESOURCE:

This resource is free for use by organizations or individuals seeking to explore or learn more about expanding family care options for children. Users can translate or contextualize for cultural appropriateness, while leaving basic components intact. The workshop creators do request that participants complete a feedback survey, as this allows for continued refinement of this tool.





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MOVING TOWARDS FAMILY SOLUTIONS:

GUIDANCE FOR FACILITATORS

Thank you for facilitating Expanding Your Continuum of Care: A Simulation Lab for Moving Toward Family Solutions. The goal of this workshop is to create a safe and nurturing environment that allows individuals and organizations to consider the process of transitioning care for vulnerable children from a residential model to including family-based care.

CHOOSING GROUP LEADERS

Group leaders are vital to ensuring the success of this activity and, although helpful, do not need to have expertise in the area they are facilitating. If the group leader has less experience with their topic, ensure someone with solid experience is present at the workshop to offer support if necessary. If no one with technical expertise in a particular area is available in person, group leaders should collect all questions to ask someone with the required knowledge, and respond to the group members at a later date. Group leaders should read through the Case Study, Group Leaders Instructions, and Group description and discussion questions prior to the event in order to be well prepared to facilitate the discussion. Ensure group leaders understand their role of being a facilitator, focused on drawing out the insights of group members, rather than a teacher.

MATERIALS NEEDED:

Have printed copies of each of the following materials available. Additionally, it would be helpful to send an email containing these materials for participants to review prior to the event.

1. For All Participants and Group Leaders:
 - Copies of Case Study
 - Copies of Individual Reflection forms
 - Copies of Charts for each group
2. For Group Leaders
 - Copies of Group Assignments
 - Copies of Key Messaging
3. Projector with video/audio capabilities
4. Slideshow
5. Link or downloaded video
<https://tinyurl.com/yyddq5e9>

SUGGESTED FRAMING REMARKS

Thoughtful framing remarks for this workshop are critical to participant understanding and event success. Here are some topics to consider addressing in the opening remarks:

- *Welcome*
- *Acknowledge participants come from different perspectives*
- *Thank everyone for their role in caring for vulnerable children*
- *All of us want to make decisions based on the best interest of children that will allow them to fulfill their God-given potential*
- *Scripture and science affirm that the ideal environment to raise a child is in the context of a safe, nurturing, permanent family*
- *Although small group care may be the best fit in some situations, we often over-rely on this model and lack other options for children*
- *When you know better, you do better. We all have permission to change*
- *We are in this journey together*

SAMPLE SCHEDULES

The activities provided have been developed to be flexible to the time you have available to conduct the workshop.

3-HOUR SCHEDULE

0-10	Welcome and Framing Remarks (<i>see suggested</i>)
10-20	VIDEO: Story of Transition (https://tinyurl.com/yyddq5e9)
20-30	<p>Introduction to Simulation Activity- Facilitator</p> <p>Goal: Consider what the process of transitioning to family care looks like, using a fictional case study. Provide instructions to participants:</p> <ol style="list-style-type: none"> 1. Everyone quietly read the full case study provided 2. Separate into five groups, each focused on one area of the transition process <ul style="list-style-type: none"> • Engagement: Awareness-raising and engagement of key stakeholders • Case Management: Implement child-centered decisions to ensure the best fit for children • Families: Prepare and strengthen families for caring well for children • Resourcing Transition: Plan and implement new roles for caregivers, staff, and property • Measurement: Create an indicator table to ensure quality and sustainability • Fundraising: Transition current donors, and raise transition costs 3. Answer questions and do the tasks listed on group assignments sheet 4. Take notes in response to assignment 5. Reconvene with larger group on most important ideas <p><i>[Remind participants that they are reflecting on the case study for the time being, they will be allow to make application to the work they are personally involved in later.]</i></p>
30-35	Participants read case study individually
35-40	<p>Separate into groups to discuss questions provided</p> <p><i>[NOTE: Consider separating large groups so that each group has fewer than 10 people participating.]</i></p>
40-1:35	Group work session
1:35-1:45	Break
1:45-2:15	Groups share your most important insights with larger group
2:15-2:50	Apply lessons to own work. Working in groups of 3-4, complete and discuss reflection form. <i>[Group leaders roam from group to group to assist]</i>
2:50-3:00	Share link for survey- participants will receive resource toolkit when survey is complete. Final remarks and Prayer (Facilitator)

 FULL-DAY SCHEDULE

0-10	Welcome and Framing Remarks (see Suggested Framing Remarks above)
10-20	VIDEO: Story of Transition (https://tinyurl.com/yyddq5e9)
20-30	<p>Introduction to Simulation Activity (Facilitator)</p> <p>Goal: Consider what the process of transitioning to family care looks like, using a fictional case study. Provide instructions to participants:</p> <ol style="list-style-type: none"> 1. Everyone quietly read the full case study provided 2. Separate into six groups, each focused on one area of the transition process <ul style="list-style-type: none"> • Engagement: Awareness-raising and engagement of key stakeholders • Case Management: Implement child-centered decisions to ensure the best fit for children • Families: Prepare and strengthen families for caring well for children • Resourcing Transition: Plan and implement new roles for caregivers, staff, and property • Measurement: Create an indicator table to ensure quality and sustainability • Fundraising: Transition current donors, and raise transition costs 3. Answer questions and do the tasks listed on group assignments sheet 4. Take notes in response to assignment 5. Reconvene with larger group on most important ideas <p><i>[Remind participants that they are reflecting on the case study for the time being, they will be allow to make application to the work they are personally involved in later.]</i></p>
30-35	Participants read case study individually
35-40	<p>Separate into groups to discuss questions provided</p> <p><i>[NOTE: Consider separating large groups so that each group has fewer than 10 people participating.]</i></p>
40-1:20	Group session 1
1:20-1:30	Break
1:30-2:10	Group session 2
2:10-2:20	Break
2:20-3:00	Group session 3
3:00-3:10	Break
3:10-3:50	Group session 4
3:50-5:00	Lunch
5:00-5:40	Group session 5
5:40-5:50	Break
5:50-6:30	Group session 6
6:30-6:40	Break
6:40-7:00	Complete Reflection Form
7:00-7:30	Discuss Reflection Form responses with small group (3-5 individuals)
7:30-8:00	Ask individuals to share the ONE thing they learned from this exercise and will plan to implement. Share link for survey- participants will receive resource toolkit when survey is complete. Final remarks and Prayer (Facilitator)

MOVING TOWARDS FAMILY SOLUTIONS: GROUP LEADER INSTRUCTIONS

DEFINITION OF YOUR ROLE

- Your primary role is to draw out discussion, rather than to instruct.
- Please read and understand all materials prior to the event.
- Group leaders do not need to be experts in their group topic, but need to have enough understanding to guide their group well.
- Know where to direct your group for questions if you do not know the answers.
- Conversation may drift away from the case study. Feel free to highlight the next break as a good time to continue that discussion, and to direct the group back to the case study.
- NOTE: Group discussion is not for the purpose of debating the merits of different types of care, but rather for exploring the move toward family care solutions.
- If some questions elicit more discussion than others, feel free to focus on those.



KEY MESSAGING

As a facilitator please remember that this can be an emotional conversation for many participants. Here are some helpful tips for facilitating the conversation:

- Affirm the role of each practitioner and express gratitude for their commitment to care for vulnerable children.
- Cultivate empathy for organizations learning about transition. Help practitioners move from shame and guilt to education and action.
- Listen, learn, and respond sensitively- this will go a long way toward helping practitioners feel heard, known, and supported as they make big decisions.
- There is an abundance of evidence pointing to the need for children to be raised in loving, stable, secure families.
- Stories of successful transition- and even stories of mistakes or challenges during transition- can inspire and educate people and organizations in engaging ways.
- Help practitioners understand everyone has a learning curve, and encourage them in taking the first tiny step, then another and another. This is important to give them hope in their ability to transition.
- Recognize that every context is different, and there is no one-size-fits-all approach. Different programs in different settings will likely require different inputs or supports to allow for change.
- Timelines for transition are context-dependent, and we do not offer any one amount of time as a target, goal, or promise. Our aim is to get practitioners started on the journey and focused on the goal of moving toward children in families.
- We long for a world in which every child has a loving family, and we want to help organizations move toward that vision. However, we also recognize that for certain children, at certain times, in certain contexts, small, rehabilitative, family-like group care with a consistent caregiver may be the best available option.
- Group care is the beginning of the journey for many. Ensure participants know there are resources and tools to help them move toward family care.

TIME MANAGEMENT

The process of transition is extensive and complex, inspiring many questions and discussions. The purpose of this exercise is to provide a general overview of each topic, which means that complex questions from participants may need to be discussed at a different time. Encourage participants to use breaks and lunch to pursue answers to those questions, and to continue those conversations after the workshop has concluded. Additionally, please save 10 minutes at the end of each session to hear the biggest lesson each group member learned.



MOVING TOWARDS FAMILY SOLUTIONS: CASE STUDY

The following case study is fictional, but draws from multiple real-life situations in which children were cared for in residential settings. It is for the purpose of planning, imagining, discussing, and troubleshooting the process of transition from residential to family care.

HISTORY

Precious Children of Hope Children's Home (PCHCH) has been serving in an Eastern Africa country for 26 years. A missionary couple began caring for children whose parents had died during a cholera outbreak. It eventually became known as the place to bring children without parental care. This evolved into a home, and eventually a nonprofit organization.

HOME

The children's home compound contains a small school, a church, a main building, two girls homes, and two boys homes. There is a 2-acre garden used to feed the children, along with chickens for eggs and meat. In 2014, a church partner built a small cabin to house visitors on the property.

CHILDREN

PCHCH currently has 74 children in their care, ages 2-19. Most of the children were born locally. Some were placed in their care by the local government, and others were voluntarily placed by family or caregivers. Twenty-three of the children are being treated for HIV, and several have special needs related to mobility and learning ability. However, the majority of children are in good health.

The children are loved and well-cared for at PCHCH. It is safe, they are well-fed, and they have plenty of opportunities for learning and play. Nonetheless, when asked, the children say they long for a family to call their own. Once they reach adulthood and leave PCHCH, most of the youth have struggled to transition successfully into community life, and often return to PCHCH to seek assistance. Here are a few of the children under the care of PCHCH.

RUTH

Ruth (age 3) is a lively girl. She is meeting developmental milestones and is very sociable. She is attached to her older sister, Marcie, and likes to spend time with her. She rarely has accidents during the night and knows how to use the toilet. She doesn't attend kindergarten, but is educated by caregivers in the institution. Ruth likes cartoons and playing with dolls. Her mother separated from her father soon after their youngest sister Anna was born. The father was drinking heavily and very violent. The parents lived in town, in an apartment owned by the father. When the parents separated, the mother had no accommodations and no access to childcare. She brought the children to PCHCH and told staff she would return when her situation improved and when she secured accommodation. Since she placed her girls in the institution, she visited them twice in the following three months, but once she was under the influence of alcohol. The staff asked if she was drinking, but she refused to explain and became aggressive. After that incident, her visits stopped and her current whereabouts are unknown.

EMMA

Emma (age 17), was placed at PCHCH when she was six years old. Her mother brought her in saying that she could not afford to give Emma a future. Emma is attending the PCHCH school and wants to become a social worker. Emma is doing well academically and wants to apply to university after graduation. The staff in the institution likes her because she is responsible and hard working. Emma's family lives in a remote village in the same county where the institution is located. Emma spent time with her family over the summer school holidays when she was younger, but since attending high school she decided to remain in the institution over the summer to study.

GEORGE

George (age 8) was placed at PCHCH soon after his birth. He was diagnosed with Fetal Alcohol Syndrome. He is small for his age, has difficulties learning, and attends a special school. George has a short attention span, difficulties concentrating, and is impulsive when frustrated or unable to complete simple tasks. He doesn't know his mother, grandparents, or half-sister. George's mother used to live with her parents until they asked her to move out. They could no longer tolerate her disrespectful behavior, drunken friends, and abusive partners. He has never met his father. His mother's parents took responsibility for George's younger sister when his mother moved out and enjoy raising her. The grandfather is retired and receives a small pension and the grandmother works in local bakery. They own their house and have a small vegetable garden, chicken and hens, and are respected in their small community.

VINCENT

Vincent (age 4) is a quiet boy. He was placed at PCHCH at the age of 3 when his mother was hospitalized and soon died of AIDS. He is meeting developmental milestones and attends the PCHCH kindergarten; though if he could, he would spend all his time playing outdoors. Vincent doesn't have any known relatives. His father's location is unknown.

TIMOTHY

Timothy (age 19) spent his entire life at PCHCH. Timothy failed to complete high school but after he graduated 10th grade he enlisted in a vocational school where he is training to be a cook. He is talented and his teachers have only praise for him. Timothy blames his parents for abandoning him and he doesn't want anything to do with them. Timothy's family lives 140 miles away from the institution. They haven't been in contact with Timothy since he was 4, when they moved to a different village.

MARCIE

Marcie (age 5) has two siblings who were also placed at PCHCH: Anna (age 1) and Ruth (age 3). All three girls were placed in the at PCHCH a year ago. Marcie is walking, and while she doesn't talk, she is able to understand verbal commands. She is using sounds and gestures to show when she is hungry, when she is upset, when she wants to play with toys. Marcie is sociable and liked by the staff. She does not attend kindergarten and the caregivers say she does not know her siblings. Marcie is not visited by her parents or relatives. Her mother separated from the girls' father soon after Anna was born. The father drank heavily and was very violent toward their mother. Prior to separating, the parents lived in an apartment in town owned by the father. When the parents separated, the mother had no accommodations and no access to childcare. She brought the children to the institution and told staff she would return when her situation improved and when she secured housing. Since she left her girls in the institution, she has visited them twice in the following three months but once she was under the influence. After the staff questioned her about whether she was drinking, she refused to explain and became aggressive. After that incident her visits stopped and her current whereabouts are unknown.

ANDREW

Andrew (age 7), has a sibling in the institution, Ruby (age 5). He attends the PCHCH school and is in the 1st grade. Andrew likes school, where his performance is average. Andrew has friends at school and enjoys playing football. He is protective of his younger sister. Andrew knows his mother and grandmother and frequently asks about them. He is anxious and sometimes has accidents during the night. His mom is a single mother living with her mother and her older sister in a small village just outside the city where the PCHCH is located. His mother, aunt, and grandmother visit occasionally. His mother has been unemployed for several years. She used to work in a clothes factory, but when the business slowed down was laid off. The family survives through subsistence farming, unemployment allowances, and seasonal work in the village. The mother's older sister is employed. She also left her children in the institution when her husband left her. Andrew was 4 at the time.

FAMILIES

Approximately one third of the children living in the home have a surviving parent and around 80% of them have relatives living nearby. The primary reasons for placement include lack of funds for education, nutrition, or medical care, lack of childcare in single-parent families, poor health of parents, or placement by the government due to abuse or neglect. Most children stay with parents or relatives for holidays and school breaks.

STAFF

PCHCH boasts a skilled and committed local staff of 25. A missionary couple from the U.S. serve as Co-Directors, and there is a small U.S.-based staff and board. Two of the caregivers have been with the organization for more than 20 years.

Each of the boy's and girl's homes has three female caregivers, who rotate eight hour shifts. Each caregiver lives in the local village with her family. In addition to 12 total caregivers, PCHCH has a cook, an assistant cook, two maintenance staff, three teachers, two teaching assistants, two social workers, a nurse, and a staff trainer.

Local staff members have varying motivations and attachments to the current model of care. Several of the staff members were once children in the home. On the one hand, they recognize that children naturally thrive in healthy families and want these kids to have families, if at all possible. On the other hand, they worry about their livelihoods and their own families if the care center were to close. For some, like the two women who have worked with PCHCH for more than 20 years, the center is their family and they have anxiety about change.

FUNDING

The majority of funding comes from U.S.-based churches and some private donors. Major donors are deeply invested in PCHCH's work, with personal and emotional connections to the staff and children. Most have made multiple visits to the home and advocate for their work. About 25% of their annual budget comes from three major donors. Church partners engage financially, but also by sending short-term missions teams and sharing videos from PCHCH with their church congregation. They want a partnership that extends beyond finances and helps their congregants to be connected to what God is doing around the world to build the Kingdom. Most church partners have little to no expertise in caring for orphans and vulnerable children and are simply trusting PCHCH to guide their engagement. Approximately 60% of short-term mission sending churches make at least a one-time donation and often times team members become monthly donors. Each of the various buildings on the property has engraved bricks with names of church and individual sponsors.

PCHCH has a volunteer fundraiser in the U.S., but no hired staff specifically focused on development. Fundraising efforts include regular communication (monthly email newsletters and weekly social media posts), an annual gala in Dallas (which historically brings in around 15-20% of the annual budget), short-term mission trips, and personal relationships with staff. Communications with church partners also include membership on the monthly newsletter list and quarterly 2-3 minute videos that they can play during a church service, small group meeting, or Sunday school. Additionally, PCHCH works to get advocates to share about their ministry at as many partner churches as possible on Orphan Sunday every November.

COMMUNITY

PCHCH sits on the edge of the local town with a population of 18,000 people. Although the land is fertile, unemployment sits around 60%. Food is easily accessible, but clean water is harder to come by. The HIV/AIDS crisis has hit this community hard, with a 22% infection rate, leaving many children without living parents. Additionally, Cholera has been an intermittent problem over the years. Soccer and other sports are a popular pastime. The rate of chemical dependency is unknown, but seems more common than not. Education is free and compulsory to grade 7, and most community members are not educated beyond that.

GOVERNMENT

Historically, the government has relied on care for children in large children's homes. In the past three years, the government has declared a mandate for residential care centers to move toward family care and laws have gone into effect that make foster care a legal alternative. However, although alternative family care is legal, it is not common and there is limited government infrastructure and resources to support it. There are not enough government-employed child welfare workers to keep up with cases, and most social workers are not sufficiently trained in the process of moving toward family care. Government leaders have partnered with NGOs to provide case management and screening for foster families, as well as working to reintegrate children from a large institution that has historically had poor care practices.

TRANSITION

With increasing pressure from the government, the U.S. Director of PCHCH began exploring the concept of transitioning. He first spent time talking with another organization that made a similar transition. Hopeful, he is now leading PCHCH to explore the process of placing children in families. Most board members are open to learning more information. They have reviewed resources on transitioning, and see it as a possibility for PCHCH. They believe it may naturally solve some of the recurrent issues when their youth transition to adulthood, but have raised questions about the impact on funding and engaging short-term teams. The U.S. Director has not yet discussed transitioning with others outside of PCHCH's Board, sensing a need to be very sensitive and intentional in moving forward.

GROUP 1: ENGAGEMENT



GROUP 1

ENGAGEMENT

GOAL: Draft a plan for awareness- raising and engagement of key stakeholders for PCHCH.

INTRODUCTION

Collaboration is critical to the success of any program, and transitioning or expanding to a new model of care makes that truer than ever. Each stakeholder- from leadership, staff, and board members to donors, program partners, and the children and families themselves- need to be willing to work together in order to achieve the desired outcome. Developing thoughtful, actionable, achievable vision and strategy- and bringing others along to invest in it- is critical to the success of any transition.

Any changes will undoubtedly affect children and families most significantly, and it is critical they have a voice in the process. They know their assets, needs, and desires best.

Each stakeholder's response toward the move to family care will depend on a number of factors, including their role, focus, and

motivations. It is important to listen and seek to understand their perspective, meeting them where they are at, and walking with them to bring them along on the journey.

For many, the idea of shifting directions may elicit a strong emotional response. Feelings of regret, doubt, shame, guilt, anger, or grief may rise to the surface at different times, and it is vital to listen, affirm, and validate. Only then will stakeholders be able to truly consider the possibilities of moving toward family care.

GROUP 1

ENGAGEMENT

GROUP ACTIVITY

1. The group leader reads the introduction above to the members of the group.
2. The group works together to fill in the ENGAGEMENT table with their responses.

3. Discuss as a group:

What type of support, guidance, or resources are available for this step in the transition process?

4. Go around the group and have each participant share the thing that really stood out to them during this group time. Choose one participant to share one or two to of these “Ah-ha” moments with everyone.

SPECIAL NOTES FOR GROUP LEADERS:

If your group finishes the activity early, please ask group members to identify one key stakeholder in their own work who might be resistant to transitioning and share how they may approach that individual. This is a time for group members to help each other think through the process of engaging key stakeholders.

The U.S. Directors of PCHCH recently began exploring the process of placing children in families. As they have shared this idea with key stakeholders, they have gotten mixed results.

Children and families are the most important partners, as they are the people most impacted by the process, and are often best suited to identifying their own strengths, needs, and desires. Most children are interested but apprehensive. This would be new and different. For those from an unhealthy family situation, they would be meeting and living with a brand new family. They wonder about how they would see the children from PCHCH and if they can stay with their siblings. There is a lot of unknown. But ultimately, they want the belonging and security of parents uniquely committed to them.

Most of the local staff members have mixed feelings. On the one hand, they recognize that children naturally thrive in healthy families, and want these kids to have families if at all possible. On the other hand, they worry about their livelihoods and their own families if the care center were to close. For some- like the two women who have worked with PCHCH for more than 20 years- this is all they know.

Donors seem to represent both extremes. It was a group of donors that approached the directors with the idea to transition, as well as some supporting resources for the transition. They are ecstatic at the possibility of children being moved to families.

However, some of the other donors want to know what will become of the buildings they have sponsored and how the children's safety will be guaranteed. They question the stewardship of a change like this.

Most board members are open to learning more information. They have reviewed some resources and see it as a distinct possibility for PCHCH. They recognize that it may naturally solve some of the recurrent issues around helping youth transition to adulthood. The big question for them is how will this affect funding. Short-term teams are a major source of financial partnership- what do they do with a team if there is no home to visit?

Most of the families would love to have their children in their care, if only they had the material and social supports to care well for them. However, some worry about whether they can succeed in giving their children a good life. They may also feel intimidated about undergoing an assessment to see if their children can return home. The process feels invasive and they are afraid of failure.

As with many governments, national policies are typically tied to international standards and expectations but are not funded at the level necessary to have qualified staff and necessary support. Although the government is pushing a change in models of care, it will not be able to offer much assistance. However, the government is open to partnership with organizations that can prove their trustworthiness and are willing to give credit to the government.

GROUP 2: CASE MANAGEMENT



GROUP 2

CASE MANAGEMENT

GOAL: Outline next steps for implementing child-centered case management to support the best care setting for a child.

INTRODUCTION

The goal of case management is to match a child to the individualized placement and services that will allow him or her to thrive. Placement decisions are not made on the basis of a standard care plan, but instead are tailored to the individual, taking into consideration a child's needs, strengths, family, community, health, desires, and future. All domains of child development, including emotional, cognitive, emotional, physical, social, and spiritual, need to be attended to. Further, family and caregiver capacity need to be assessed and supported to ensure the health and longevity of the placement. Both short-term and long-term outcomes need to be considered from the beginning, as a successful temporary solution does not necessarily lead to long-term success.

Placing a child is a process- not an event- and may take months or years of carefully planned, attentive, intentional interaction.. Adequate assessment and follow-up is critical to ensuring desired outcomes are achieved, and to allowing opportunities to course-correct and make adjustments to the original plan. Case worker provide relational support and guidance to both children and families, and are critical to the health and success of any placement.

As a residential care facility pursues transitioning to family care, gatekeeping is an important step to consider and implement. Gatekeeping is the decision-making framework that decides whether a child should be removed from biological family care, and what type of care is best for him or her. The goal of gatekeeping is to prevent unnecessary

separation and inappropriate placements in alternative care settings.

A "Continuum of Care" refers to the types of placements and services available to care for vulnerable children and families in any given context. In order to make placements based on the best interest of the child, rather than being constrained by limited care options, it is critical to have access to a full continuum of care. A continuum of care can include:

- Family Strengthening and prevention of unnecessary separation
- Family Reintegration
- Kinship care
- Foster care
- Adoption
- Small group homes
- Independent living

Although many organizations provide more than one type of care, no organization can provide all services in all settings. In addition to expanding an organization's continuum of care by adding more services, partnership is critical to a complete continuum of care in each context. Multiple programs each focused on providing one or two types of placements or supports well may partner with others providing complimentary services, leading to a collaborative, robust, efficient model that provides for the needs of all families and children in a given location.

[See this graphic from Faith to Action Initiative for more information.]

GROUP 2

CASE MANAGEMENT GROUP ACTIVITY

1. The group leader reads the introductions above to the members of the group.
2. Based on the examples of the children given in the case study, fill in the CASE MANAGEMENT table provided.
3. Develop a plan for PCHCH's gatekeeping procedures during the transition taking into consideration the policies and capacity of the government. What steps need to be taken?
4. Discuss as a group:
 - *How will you build capacity of PCHCH to perform the case work needed to support children and families through the transition process (i.e. staffing, partnering, training)?*
 - *What care options would need to be in place to support decisions for children?*
 - *How will PCHCH make decisions on what care options found within the continuum of care they can provide and where they need help from a partner?*
 - *What are some ideas and boundaries PCHCH should consider for child participation during the decision making process?*
5. Have each participant share one thing that stood out to them during this group activity. Choose one participant to share one or two of these "Ah-ha" moments with all the workshop participants.

SPECIAL NOTES FOR GROUP LEADERS:

As with considering any new idea, challenges may receive more attention than opportunities. Assist your group on focusing on potential solutions.

Please note that all assessment and preparation of family's needs to be under the supervision of trained social work professionals. This exercise is to help participants understand the process, but will not prepare them for the actual work discussed.

To help stimulate group discussion, here are some examples of steps to take in the gatekeeping, child placement and preparation processes.

GATEKEEPING

- Is overseen by professionals or trained paraprofessionals
- Is a group process, requiring input from those with knowledge of child protection, the local context, and the individual child?

WHEN DECIDING CHILD PLACEMENT, CONSIDER:

- Input from multiple parties (i.e. child, caregivers, teachers) as part of any assessment
- The best interest of all parties, including parents, siblings, and extended family
- The resources and services available to ensure a safe and nurturing home
- Reintegration with biological family, when possible
- Keeping sibling groups together, when it is in the best interest of all children
- Alternative family placements that offer the greatest chance for permanency and improved child wellbeing

PREPARE CHILDREN FOR TRANSITION BY:

- First contacting the parents or relatives through email, phone, video, or letter. This may need to be repeated several times prior to in-person contact.
- Scheduling short, in-person meetings supervised by a social worker, ideally at the child's location.
- Scheduling longer visits at the parents' home, supervised by a caseworker.
- Scheduling longer, unsupervised visits at the parents' home, only after supervised visits have been successful.

[Adapted from [Transitioning to Family Care for Children: A Guidance Manual \(Faith to Action Initiative\)](#).]

GROUP 3: FAMILIES



GROUP 3

FAMILIES

GOAL: Decide how PCHCH can prepare and strengthen families to care well for children.

INTRODUCTION

Scripture and science are both clear: children do best when raised in healthy families. Although most parents desire the best for their children, many are under-resourced, unprepared, or lacking in health, funds, support, or opportunities. As one of the most significant indicators of child well-being is caregiver health, these gaps can lead to poorer outcomes for children, and in some situations, to separation from parental care.

Although there are no comprehensive global numbers, we do know a significant number of children living in residential care have surviving parents, and even more have living relatives. Reasons for placement can vary widely, from poverty to illness to unsafe home life, and some parents may not be able to raise their children. However, for many parents and relatives, a modest investment of support can build their capacity and make them able to raise their children in a secure, loving, healthy family environment.

Although the ideal placement may look differently for different children, we know this: Children want to be in a loving, safe family.

Although the transition to family care often begins with family tracing, it is not enough to simply find parents or relatives willing to commit to raising a child. The process also needs to include thorough assessment of a family's strengths, needs, health, and fit for the child, the creation of a transition plan, capacity building, and thorough follow-up and evaluation. This process always requires the supervision of a trained social work professionals.

Supporting families begins with preventing separation wherever possible, often accomplished through Family Strengthening. Family strengthening includes the provision of any services that expand family capacity, including economic, psychosocial, physical, vocational supports, parenting skills training, daycare, or any other service or support that can help families be healthy and care well for their children.

The goal is not to close orphanages, but rather strengthen families to the point that large-scale residential care is no longer necessary, and can be reshaped into other family and community supports.

There are numerous options for family care, but all include a family environment and one consistent parent or caregiver. Although reintegration with the biological family is ideal when in the best interest of the child, other options can be utilized with great success. Those include:

- Family Strengthening and prevention of unnecessary separation
- Family Reintegration
- Kinship care
- Foster care
- Adoption
- Small group homes
- Independent living

One thing to keep in mind when assessing the best family fit for a child is the intangible benefits of being reintegrated with biological parents. At times, a substantially larger

INTRODUCTION CONTINUED

investment may be needed to prepare a biological family for reintegration than would be necessary to prepare a foster or adoptive family. However, there are immeasurable gains and healing that can come with a child being cared for by their family of origin. Of course, there are situations in which reintegration is simply not possible, and we should never place a child in an unsafe or unhealthy living environment. However, wherever possible, explore all options with the biological family before considering others.

Although many organizations provide more than one type of care, no organization can provide all services in all settings. In addition to expanding an organization's continuum of care by adding more services, partnership is

critical to a complete continuum of care in each context. Multiple programs each focused on providing one or two types of placements or supports well may partner with others providing complimentary services, leading to a collaborative, robust, efficient model that provides for the needs of all families and children in a given location.

[See this graphic from Faith to Action Initiative for more information.]

GROUP 3

FAMILIES

GROUP ACTIVITY

1. The group leader reads the introduction above to the members of the group.

2. Based on the child descriptions in the case study above:

- *What are some family strengthening supports that might be necessary for families in the community?*
- *How do we find out what community or government agencies are providing these services? How can PCHCH decide who to partner with? How can PCHCH decide which services it will provide?*
- *What resources, supports, or assets can biological family members provide their children without the support of PCHCH? What should PCHCH do or not do to avoid establishing dependence on their support?*

3. Discuss the following questions:

- *How should PCHCH assess family readiness for reintegration?*
- *What expectations of families should PCHCH hold on to, and what expectations might they need to release?*
- *What kind of supports should PCHCH provide to reintegrated families?*
- *How can PCHCH recruit families for alternative family placements?*
- *How can PCHCH assess, prepare, and support kinship, foster, and adoptive families for placement?*
- *Do any of the youth living at PCHCH require assisted independent living? If yes, what is the best way to provide assistance?*
- *Do any of PCHCH children or youth require therapeutic small group care? How does PCHCH provide that and determine for how long it will be necessary?*

4. Have each participant share one thing that stood out to them during this group activity time. Choose one participant to share one or two of these “ah-ha” moments with all workshop participants.

SPECIAL NOTES FOR GROUP LEADERS:

Please note that all assessment and preparation of family's needs to be under the supervision of trained social work professionals. This exercise is to help participants understand the process, but will not prepare them for the actual work discussed.

WHEN ASSESSING FAMILIES, CONSIDER:

- Basic biographical and location information, including all children and household members;
- Household income and employment;
- Education history of the parents and children in the household;
- Condition of the home and property;
- History of involvement with child protection services and involvement with community services;
- Observed quality of relationships, history of abuse, or domestic violence;
- Assessment of substance use or abuse;
- Previous contact with the child;
- Family health status and access to health services;
- Family strengths and any special needs (e.g., parental disability, housing, or parenting skills);
- Community and extended family connections
- Reputation in the local community

WHEN PREPARING FAMILIES:

- Share any background information about the child. Remind the caregiver that any sensitive information is confidential;

- Confirm that the child will have his or her own place to sleep and keep belongings in the home. Ensure expectations are appropriate;
- Make sure that the child's dietary, health, education, and other care requirements are well understood and work with the family to plan how these should be met;
- Discuss needed services for the child or family;
- Inform the family of expectations regarding communication of new or important information;
- Discuss future visits with the caregiver;
- Advise the caregiver of how to contact you and whom to contact if you cannot be reached;

WHEN PROVIDING FOLLOW-UP SUPPORT:

- Address the root causes of separation;
- Ensure access to health care, education, and other services that address the child's needs;
- Consider the place of respite care
- Work to build on child and family strengths
- Connect to therapeutic support.

[Adapted from Transitioning to Family Care for Children: A Guidance Manual (Faith to Action Initiative)].

GROUP 4: ASSET TRANSITION



GROUP 4

ASSET TRANSITION

GOAL: To prepare and implement the transition of caregivers, staff, and the physical property.

INTRODUCTION

Every organization has strengths and areas for growth, and those are sometimes highlighted during the transition process. The current assets of an organization- including relationships, staff, partners, property, and other physical capital can typically be re-purposed to support the reshaping of a program. Most assets that have allowed programs to serve children through group care can support children in families.

One of the greatest hesitations when transitioning programs is what will become of caregivers and on-field support staff. These leaders often have the motivation, cultural context, and useful practical skills to make them ideal supports to the newly-designed model. Some staff- such as teachers, social workers, or administrative professionals- may be able to transition quickly into a new role. Others may need additional education or training to prepare them for their new position, as with a caregiver who becomes a social work paraprofessional or foster parent. Each staff person will have a different mix of experiences, motivations, and emotions they bring to the transition, and it is critical to listen, validate, and work with them to mutually-beneficial solutions.

Partnerships and other community relationships are critical assets that need to be cared for in any transition. Discussing transition plans with local partners will allow for education, planning, and synergy, and may lead to the creation of a stronger continuum of care. No program can provide all services

independently, and collaboration is key to caring well for vulnerable children and families.

Physical assets may include buildings, home furnishings, equipment, supplies, or other property. Often, great thought, care, and expense have been invested in these items, and there may even be significant emotional attachment for children, staff, donors, volunteers, or others. Occasionally a program will choose to close its facilities and sell physical property. However, these assets can commonly be skillfully re-purposed to support the new model(s) of care. Not only can building be transitioned to emergency care, transition programs, or family shelters, but they can also be used for daycare or after school care, schools or vocational training, centers for business as mission, clinics, trauma-informed training, physical or psychological therapy, church programs, community centers, local event facilities. Options are limitless, and assessing the needs and assets of a community can provide direction for future movement.

GROUP 4

ASSET TRANSITION GROUP ACTIVITY

1. The group leader reads the introduction above to the members of the group.
2. List the assets that PCHCH currently has. What are some ways these assets can be re-purposed to support families (both biological and/or alternative families) to care for children?
3. Complete the included ASSET TRANSITION table based on the descriptions above.
4. Discuss:
 - *If PCHCH transitions- including tracing and screening families, placing children in safe families (both original and alternative) and supporting families- what assets are currently missing?*
 - *Who might PCHCH see to partner with to fill these gaps?*
 - *How might PCHCH consider offering some of its assets to other entities in the community to strengthen family services?*
5. Have each participant share one thing that stood out to them during this group activity time. Choose one participant to share one or two of these “ah-ha” moments with all workshop participants

SPECIAL NOTES FOR GROUP LEADERS:

ALTERNATIVE ROLES FOR CAREGIVERS AND STAFF:

- Social workers
- Social work para-professionals
- Adoptive or foster parents
- Teachers
- Community center staff
- Home visitors
- Daycare providers
- Nurses
- Respite care providers

ALTERNATIVE USES FOR PHYSICAL PROPERTY

- Community center
- Church
- Daycare
- Preschool
- Camp
- Clinic
- Therapeutic center
- Short-term emergency care for children awaiting placement

See next page for additional case study information.

Additional Case Study Information:

Anita (age 62) is a caregiver. She has been with the home since it first started. She sees her role there as a calling more than a source of employment. Anita works in one of the boys' homes and is known for being very strict but very loving. She does not give up on kids. She is a mentor to many of the other caregivers and has strong leadership abilities. Although Anita only has an 8th grade education, she has a learner's attitude and has attended countless trainings on how to care well for children. She is supportive of transitioning the program to family care, as she knows what research says about kids doing better in families.

Robert (age 45) is a cook. He has a heart for children and is married with four children himself. He works long days at the home and also serves as volunteer pastor of his church, shepherding a congregation of about 40. He has a heart to see the local community follow God's command to care for the fatherless by raising up and embracing orphans and vulnerable children as their own. To this point, he has strongly urged his congregants to be involved in PCHCH, but he would like to see children moving into loving families. He sees that the home is not the ideal solution, but doesn't know what to do instead. He is a great networker and is well-connected and well-respected in the community.

David (age 28) serves as maintenance staff. David moved to PCHCH at the age of 11, when both of his parents and aunt and uncle were killed in a house fire. The staff at PCHCH is the only family he and his siblings have. His sister, Josephine, is the nurse, and his sister, Kari, is a caregiver. They are all very committed to PCHCH. David is physically strong and works best with his hands. He has some learning disabilities and school was hard for him, but

he has found a great fit working with PCHCH. He is quiet, loyal, and hardworking, and happy to do what needs to be done. PCHCH is truly his home, and he treats it as such. Recently, Robert has been encouraging David to take on more of a mentorship role with some of the adolescent boys in the home, as they lack for male role models. David sees the need but feels ill-equipped. He is interested in investing more, but he doesn't know how. He is married to Claudine, who works as a teacher in a local school not affiliated with PCHCH. They have a happy relationship but are biologically unable to have children. Both David and Claudine volunteer with the children at PCHCH in their free time.

Christine (age 46) is a teacher. She has been working with PCHCH for 13 years and feels that it is her calling. She is honored to be able to provide a Christian quality education to children who might not otherwise be able to attend school. She teaches preschool through grade 6 and has one teaching assistant to help her. It is a challenging job, but she is extremely organized and has developed systems to help her manage extremely well. In college, Christine also pursued a fair amount of child development training. She has a heart for teaching parents and caregivers about how to optimize child development, educationally and beyond. She is undecided about the transition to family care, as she fears she will no longer be able to work with her students and worries about their wellbeing.

Peter (age 35) is a teacher. He has taught at PCHCH for five years. He is energetic and charismatic, and his students love him. He was originally a business professional, until he became a Christian. He sensed the Lord leading him to a career change and pursued



education. He now serves as the grade 7-12 teacher at PCHCH, making about 20% of what he used to make in business. But what he lacks in income is made up for in the satisfaction he receives from pursuing his calling. In addition to teaching, Peter works with kids from PCHCH and the local community to coach them through the college application process. He works toward a day in which every local child who would like to attend college has the opportunity to do so. He sees the promise in transitioning to family care, but also worries children will suffer educationally if their parents don't adequately prioritize learning.

Steven (age 52) is a social worker. He has been working with PCHCH for seven years. He obtained his master's degree in clinical social work and has a passion for counseling kids and families from hard places. Although that's what he originally signed on for, the other PCHCH social worker ended up transitioning to a new role, meaning Steven was left to handle all the case management, gatekeeping, and other necessary social work systems. This means he does very little counseling. He wants to see families reunited and empowered to raise their children. For years, Steven has been wanting to expand the reach of PCHCH to include prevention of unnecessary placement of children. He is very much on board with the transition and is willing and able to help think through implementation strategy. Steven could be described as focused, productive, yet very personable.

The physical compound of the home is near the local community, just on the edge of

town. The compound contains a small school, a church, a large main building containing a kitchen and dining area, two girls' homes, and two boys' homes. There is a two-acre garden used to teach gardening skills and to produce food to feed the children, along with chickens for eggs and meat. In 2014, a church partner built a small cabin to house visitors on the property.

GROUP 5: MEASUREMENT



GROUP 5

MEASUREMENT

GOAL: Create an indicator table for the project, to be used for ensuring quality and sustainability.

INTRODUCTION

Monitoring and evaluation exists to give programs an accurate picture of strengths, improve outcomes by uncovering gaps or weaknesses in services, and communicate with accuracy and integrity when reporting to partners and supporters. By encouraging thoughtful strategy prior to enacting new initiatives, it allows organizations to think through necessary steps, needs, and opportunities in advance. Monitoring and evaluating helps ensure programs are meeting the objectives and ensures proper care throughout the transition process.

Case monitoring plays an important role in identifying and responding to issues and challenges that arise during and after a child's transition to family care. It is also an opportunity to work with children and families to set realistic goals, recognize and build on strengths, and celebrate progress. Adjusting and settling into new routines takes time and case workers can help children and families through the critical steps of the process. Most families, when given appropriate support, will provide safe and loving care, giving children a sense of belonging and lasting connection that is important to healthy development.

GROUP 5

MEASUREMENT GROUP ACTIVITY

Group leader reads the introduction above to the members of the group.

1. Select 3-4 children within the case study from different circumstances. How would we define success for the child? Consider their health, education, family, social relationships, and living conditions. What are the indicators PCHCH can use to measure success? How should they collect data, and how often? Complete the MONITORING AND EVALUATION table with your responses.
2. Assume one of the children in the case study is reintegrated into his or her family. List the goals the family, child, and social worker might set for themselves. What would be considered a successful reintegration process? How would the social worker know when to close the case?
3. Discuss:
 - *How can PCHCH measure the success of the transition? What are the indicators of the success?*
 - *How can the data collected throughout the monitoring and evaluation process be used for the betterment of children and families in the future?*
4. Have each participant share one thing that stood out to them during this group activity time. Choose one participant to share one or two of these “ah-ha” moments with all workshop participants

SPECIAL NOTES FOR GROUP LEADERS:

CONSIDER DURING TRANSITION:

- Severe and persistent problems may be an indicator that a child is struggling with the placement. When in doubt, check it out.
- As children grow and develop, new challenges may appear. Both children and caregivers may need guidance in dealing with developmental and behavioral changes over time.
- Adjusting to a new situation after living in residential care can take time. Support the child and family in setting realistic goals and expectations, and remember to recognize and celebrate milestones and progress.
- Build on strengths whenever possible, but also look for signs that additional support is needed or that further intervention (including transferring to another family or service) may be necessary.
- Remember that the family is a part of a wider community. Seek to understand what sources of informal social support the family has access to. If this is lacking, then work with the family to identify and build supportive relationships in their community.
- The opinions of children, parents, caregivers, and other family members, as well as service providers and professionals, all matter. Together these different viewpoints help build a more complete picture.

CONSIDER DURING FOLLOW-UP VISITS:

- Are the goals of the child's care plan being worked on or met?
- Is the child showing signs of regression?
- Are the parents or caregivers showing signs of inappropriate behavior?
- What adjustments need to be made based on progress or challenges?

CASES CAN BE CLOSED WHEN:

- The goals and objectives of the care plan have been met and long-term wellbeing is assured.
- The child is in a permanent care situation with a family of origin or extended, adoptive, or long-term foster family.
- The child has reached an age of independence and is prepared for success in living independently.
- The case has been transferred to another organization or social worker.

[Adapted from Transitioning to Family Care for Children: A Guidance Manual (Faith to Action Initiative)].

GROUP 6: FUNDRISING



GROUP 6

FUNDRAISING

GOAL: Develop a fundraising plan for the transition to family care, as well as for supporting the new services.

INTRODUCTION

Financial partnership is about facilitating a mutually beneficial relationship in which programs provide an avenue for donors to fulfill their personal calling or vision to support work being done to serve others, and in which a donor provides financial support so that program can be successful and sustainable.

Adequate funding is critical to any program, ensuring care decisions can be based on the best interest of the child, rather than on limited financial capacity. Most programs are funded by donations from individuals, families, and churches, grants, corporate partnerships, government assistance, or a combination of these sources. These funders may bring with them diverse questions, backgrounds, motivations, or emotional responses. It is vital to listen well, work to understand their perspective, and seek to meet them where they are at with validation, information, stories, resources, contacts, and strategy.

One of the primary questions around the transition to family care is “How do we fund this?” There is good news and bad: The good news is that family care is typically far more financially efficient and sustainable long term. However, the bad news is that there may be initial “spike costs” as an organization maintains current programming while building capacity to move toward the new care model.

Financial partners may have key insights to making the transition process successful, and they may be willing to share business knowledge, strategic advisement, or other skills beyond

their financial involvement. Keeping financial partners informed and included goes a long way toward helping them be invested in the mission of the organization, and to see themselves as part of the transition. Further, sharing plans and success stories during the transition may attract new donors, whose partnership may absorb the initial spike costs associated with transition.

GROUP 6

FUNDRAISING GROUP ACTIVITY

1. The group leader reads the introduction above to the members of the group.
2. Complete the FUNDRAISING table with the information above.
3. Discuss as a group:
 - *What do PCHCH do if a donor threatens to withdraw support?*
 - *What parts of the current funding model would need to change to support family care? How might short-term missions look different?*
 - *What changes would you suggest to make the funding model more sustainable?*
4. Have each participant share one thing that stood out to them during this group activity time. Choose one participant to share one or two of these “ah-ha” moments with all workshop participants.

SPECIAL NOTES FOR GROUP LEADERS:

- Funding to build organizational capacity for transition (e.g., staffing, training, outreach to families);
- Operating costs to cover the period when current services are still being offered as children are gradually being placed into families and family services are being coordinated and;
- Operating costs and capital investment requirements to create and sustain family support and any other services offered by an organization;
- Monetary value of any buildings, land, and other assets and whether to transition these to new services, sell, or transfer them to another organization;
- Current budget and funding arrangements, with an analysis of which funding sources can be transferred to the family care model; and
- Prospective sources for funding additional costs beyond the current budget.

[Adapted from Transitioning to Family Care for Children: A Guidance Manual (Faith to Action Initiative)].

See next page for additional background information.

Additional Background Information:

PCHCH has an annual operating budget of \$154,600.

The organization currently has assets of \$22,463.

Approximately 64% of funding comes from private donors.

Major Donor A is a 64-year-old male accountant who likes order and tradition, family, reading, golf, good food, and serving others. Ten percent of all funding comes from Major Donor A, whose father was a major donor at the beginning of PCHCH. The dining hall of the orphanage is named after Major Donor A's father, and their family sees funding PCHCH as part of their family legacy. Major Donor A has traveled with numerous family members to visit the home annually and calls the home his "favorite place on earth."

Major Donor B are a couple in their 30s who fund around 8 percent of the annual budget. They gained their wealth in the tech industry, and appreciate innovation, culture, and adventure. They have been giving partners for the past five years, since they stumbled upon the home while visiting the country to adopt their son. PCHCH is one of three organizations Major Donor B are deeply committed to. They have been learning about the need for family care and have begun to ask questions.

Major Donor C is a female business leader in her late 40s. She funds around 7% of the budget and is also a board member of PCHCH. She is a marathon runner, author, and frequent traveler. She became connected to the organization when a friend went on a short-term mission's trip and encouraged her to go, too. That was 10 years ago, and since then she has not only been a funding partner, but also an advocate for

PCHCH to local churches and donors. She sees her participation as the way God has called her to care for orphans and vulnerable children.

The other 39% of funding from private donors is approximately half monthly, quarterly, or annual committed support and half one-time gifts. Fundraising efforts include regular communication (monthly email newsletters and weekly social media posts), an annual gala in Dallas (which historically brings in around 15-20% of the annual budget), and short-term mission trips. Approximately 30% of short-term mission trips go on to make a one-time donation and some become monthly donors.

Approximately 36% of funding comes from 42 church partnerships.

Communication with church partners include membership on the monthly newsletter list and quarterly 2-3 minute videos that they can play during a church service, small group meeting, or Sunday school. Additionally, PCHCH works to get advocates to share about their ministry at as many partner churches as possible on Orphan Sunday every November.

Major Church Donor A is a non-denominational mega-church out of Texas. They fund around 6% of the PCHCH budget. They have an annual missions budget of more than \$250,000, and PCHCH is one of many partners they support. They were connected when the congregant went on an short-term missions' trip with PCHCH and began to advocate through them. They have sent one short-term missions team (including one youth pastor but no other church leadership) in the six years they have supported PCHCH. They are not able to share videos or other promotional material from PCHCH, as they have so many mission partners.



Major Church Donor B is a small-to-mid-sized church from Minnesota. They fund around 4% of the annual budget, and PCHCH is one of four mission partners they support. They were connected to the program when a friend of PCHCH founders became their pastor. They are deeply committed to PCHCH and have been funding partners for almost 20 years. In that time, they have sent dozens of short-term missions teams, special gifts, and have held campaigns to collect clothing, medicine, and school supplies for the children there. They show every quarterly video. Congregants see the kids at PCHCH as “our kids,” and the sentiment is returned. Some of the AwAnna kids even write back and forth to kids at PCHCH as pen pals.

Major Church Donor C is a church plant in a marginalized urban neighborhood. They were planted by Major Church Donor A and decided they wanted giving toward orphaned and vulnerable children ministries to be part of the church DNA. As their current congregation is quite small and under-resourced, they have been unable to commit to monthly giving. However, their occasional gifts have added up to be 4% of the overall PCHCH budget for the past two years. Their congregation is comprised primarily of singles and married couples in their 20s and 30s, as well as a handful of senior citizens who desire to be in a young church. They have not sent any teams but show the quarterly videos and encourage all of their congregants to sign up for the newsletter.

Many church partnerships were developed from the advocacy of short-term mission trip participants to their home churches. Around half of church partners have sent at least one short-term missions team, and some send multiple teams annually. They want a partnership that extends beyond financial donations and helps their congregants to be

connected to what God is doing around the world to build the Kingdom. Most church partners have little to no expertise in care for orphans and vulnerable children and are simply trusting PCHCH to guide their engagement.

PCHCH has a volunteer fundraiser in the U.S., but no hired staff specifically focused on development. Each of the various buildings on the property has engraved bricks with names of church and individual sponsors.

MOVING TOWARDS FAMILY SOLUTIONS:

ADDITIONAL RESOURCES

RESOURCES FOR RAISING AWARENESS AMONG KEY STAKEHOLDERS

Raising Awareness:

[Family Care for Children Toolkit \(Faith to Action Initiative\)](#)

Engaging Donors and Ministry Partners:

[Family Care Toolkit \(Faith to Action Initiative\)](#)

Engaging Donors and Ministry Partners:

[Changing Mindsets and Practice \(ACCI\)](#)

RESOURCES FOR CASE MANAGEMENT

[Guidelines on Determining the Best Interest of the Child \(UNHCR\)](#)

[Toolkit for Practitioners: Assessment Forms and Guidance \(Better Care Network\)](#)

[Family Care Toolkit- Gatekeeping \(Faith to Action Initiative\)](#)

RESOURCES FOR SUPPORTING FAMILIES

[Parenting Capacity Scale and Interventions Tool \(European Commission Daphne Program\)](#)

[Guidelines on Children's Reintegration \(Inter-Agency Group on Children's Reintegration\)](#)

[Webinar: Strategies for Transition to Family-Based Care \(CAFO & Faith to Action Initiative\)](#)

RESOURCES FOR TRANSITION SUPPORT

[*The Way We Care: A Guide for Managers of Programs Serving Vulnerable Children and Youth*](#) (FHI 360)

[*Transitioning to Family Care for Children: A Guidance Manual and Toolkit: Sustainability*](#) (Faith to Action Initiative)

Building Social Work Capacity [Webinar](#) and [Resource Guide](#) (CAFO)

RESOURCES FOR RESOURCE MANAGEMENT

[*Basic Principles of Monitoring and Evaluation Webinar , Resource Guide, and Worksheet*](#) (CAFO)

[*Child Status Index*](#) (PEPFAR)

[*Monitoring & Evaluation of Reintegration Toolkit*](#) (Rise Learning Network)

RESOURCES FOR FURTHER EXPLORATION

[*Changing Mindsets and Practice*](#) (ACCI)

[*The God Ask*](#) (Shadrach and Morton)

MOVING TOWARDS FAMILY SOLUTIONS

An Immersive Simulation Experience

*This resource was created in collaboration between Hope and Homes for
Children, Faith to Action Initiative,
and the CAFO | OVC Research Initiative*



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