Improving Care Options for Children in Ethiopia through Understanding Institutional Child Care and Factors Driving Institutionalization

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Cover photo: Children playing at a wash area at an institution in Addis Ababa. (Ren Kolka/FHI)

TABLE OF CONTENTS

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Without the support of the Ministry of Women's Affairs (MOWA), this study would not have been possible. The MOWA provided input into the design of the study protocol, ensured access to child care institutions, and contributed to the interpretation of the study findings. The MOWA further facilitated a consultative process to validate the study findings among stakeholders at the regional state level, including representatives of child care institutions, government oversight bodies, and community leaders, and obtained their feedback and recommendations on action steps to be undertaken.

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This document is dedicated to the more than 6,500 children residing in the child care institutions included in this study. May their voices be heard throughout this report, and may they continue to inspire us to make decisions in the best interests of children.

LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
BOJ	Bureau of Justice
BoLSA	Bureau of Labour and Social Affairs (regional level)
BOWA	Bureau of Women's Affairs (regional level)
CIFF	Child Investment Fund Foundation
CBO	Community-based organization
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
FGD	Focus group discussion
HIV	Human immunodeficiency virus
KII	Key informant interview
MOJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MOWA	Ministry of Women's Affairs
NGAC	National Guidelines for Alternative Care of Children
SNNPR	Southern Nations, Nationalities, and Peoples Region
UNICEF	United Nations Children's Fund

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Children in institutional care play cards in bed at an institution in Addis Ababa

GLOSSARY OF TERMS

Adoption: a social and legal process whereby a child is legally and permanently placed with a parent or parents other than their biological mother or father.

Alternative care: Article 20 (2) of the Convention on the Rights of the Child (CRC) accords children who are temporarily or permanently deprived of their family environment, or whose own best interests prohibit being allowed to remain with their family, the right to alternative care. Article 20 (3) of the CRC defines alternative care as—among other things—foster placement, *kafala*, adoption, or placement in suitable institutions for the care of children.[1] Alternative care may also be described as a formal or informal arrangement whereby a child is looked after outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents.[2]

Child: In the case of Ethiopia, a child is legally recognized as a male or female under the age of 18.

Child care institution: an establishment founded by a governmental, nongovernmental, or faith-based organization to give care to unaccompanied children. A child care institution may also be referred to as an orphanage, children's home, or children's village. A typical characteristic of an institution is that it is a group living arrangement with paid caregivers.

Children outside of parental care: children not living with at least one of their biological parents.

Community-based child care organization: a governmental and/or

1 United Nations Treaty Collection (1989). *Convention on the Rights of the Child.*

2 Save the Children UK (2007). *Child Protection and Care Related Definitions.*

nongovernmental body implementing a community-based child care program.

Community-based child care program: a program planned and implemented within the community to cater to the needs of children who are in especially difficult circumstances.

Domestic adoption: an adoption wherein the adoptive parents and the adopted child are of the same nationality and have the same country of residence.

Family-based care: a form of care arranged for a child that involves living with a family other than his/her birth parents. The term encompasses *fostering, kinship care, child-headed households*, and *adoption*.[3]

Family preservation: a range of support strategies meant to prevent the family from breaking up, and to protect children from abandonment.

Foster family: a family selected by an organization or government institution to temporarily provide an unaccompanied child with physical care, emotional support, and protection for a specified period of time.

Foster family care: a planned, goal-directed, alternative family care arrangement, where an unaccompanied child is temporarily placed until a permanent placement may be secured, including reunification with his/her biological parent, kinship care, or adoption.

Foster family care organization: an organization that is registered and licensed by the accredited governmental body to implement foster family care placement.

***Idir*:** traditional, sociocultural, community-based, mutual organizations established in Ethiopia to support its members with funeral needs and arrangements. Membership in *idirs* is family-based. The size of *idirs* varies from 500 to 3,000 member households each.

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3 Ibid.

Intercountry adoption: an adoption that involves adoptive parents from one country and an adopted child from another country.

***Kebele*:** a 'commune'; the smallest administrative unit in the Ethiopian government administration system

Kinship care: family-based care within the child's extended family or with close friends of the family known to the child. Kinship care may be formal or informal in nature.[4]

Orphan: a person under 18 years of age who has lost both parents. Reference is also made to paternal orphans (having lost their father) and maternal orphans (having lost their mother).

Permanency planning: the systematic process of carrying out (within a brief, limited timeframe) a set of goal-directed activities designed to help children live in permanent families. This process has the goal of providing the child continuity of relationships with nurturing parents or caregivers and the opportunity to establish lifetime family relationships.

Reunification: a rehabilitative intervention designed to facilitate the reunion of an unaccompanied child, or a child in alternative care, with his or her biological parents or member(s) of the extended family, restoring the family environment and providing a permanent living arrangement for the proper growth and development of the child.[5]

Reintegration: a rehabilitative intervention for children whose parents and extended families are untraceable, or for those who reach the maximum age limits in the institution, to facilitate their permanent placement in a community environment, either individually or in groups.[6]

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4 UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children (Draft, 2007).

5 MOLSA, *National Guidelines for the Alternative Care of Children* (2002).

6 Ibid.

Unaccompanied child: as used in this study, refers to a child who is fully orphaned (both parents have died); abandoned (both parents are untraceable); or whose parents are certified by the appropriate or accredited body as terminally ill.[7]

Vulnerable child: a child who has been orphaned by AIDS and/or affected by the HIV and AIDS pandemic, including children living with sick parents, children living in highly affected communities, and children living without adult care.[8]

7 Ibid.

8 Save the Children UK (2007). *Child Protection and Care Related Definitions*.

EXECUTIVE SUMMARY

Factors underlying the vulnerability of children and lack of appropriate parental care include HIV and AIDS, natural disasters, internal migration, and chronic poverty.[9] These factors have been documented as the main reasons children lack parental care on a global level and, more specifically, on the African continent.[10] The same paradigm may be applied to the situation in Ethiopia. With approximately five million orphaned and vulnerable children,[11] the need for alternative care options for vulnerable children is growing. The increase in the number of children requiring alternative care has contributed to the emergence of many new child care institutions. Ironically, this increase in institutional care has coincided with increasing awareness of and research into the negative effects of institutionalization on children's physical, emotional, and cognitive development.[12] Given this environment and the need to provide children with quality care, FHI, under the leadership of the Ministry of Women's Affairs (MOWA), in collaboration with the United Nations Children's Fund (UNICEF), and with funding from the Children's Investment Fund Foundation (CIFF), initiated a national study of child care institutions, institutionalized children, and factors driving institutionalization, titled *Improving Care Options for Children in Ethiopia through Understanding Institutional Child Care and Factors Driving Institutionalization*.

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9 Csaky, C., (2009). *Keeping Children Out of Harmful Institutions–Why we should be investing in family-based care*. London: Save the Children UK.

EveryChild (2009). *Missing: Children Without Parental Care in International Development Policy*. EveryChild, London. Retrieved December 23, 2009, from http://www.everychild.org.uk/docs/EvC_Missing_final.pdf.

10 Ibid.

11 Central Statistical Agency [Ethiopia] and ORC Macro (2005). *Ethiopia Demographic and Health Survey 2005*.

12 Cermak, S. & Groza, V. (1998); Johnson, D.E. (2002); Groza, V., Proctor, C., & Guo, S. (1998); Carter, R. (2005); Tolfree D. (2005); Browne, & Hamilton-Giachritsis (2006).

This study was developed through consultations between the MOWA, FHI, and UNICEF, and is the first of its kind to take an in-depth look at institutional care in Ethiopia. **The overall objective of this study is to understand the scope of the information on institutional care practices in Ethiopia, as well as the quality of this information and the gaps therein, with the purpose of informing efforts to improve the quality of alternative care—including institutional care—for children in Ethiopia**.

Specific objectives include the following:

- Assess the primary factors that leave children without parental care.
- Document the main reasons institutionalization is chosen as alternative care for children.
- Determine the scale of institutionalization and the number of child care institutions in Ethiopia.
- Assess current practices within child care institutions, including quality of care, in relation to nationally and internationally recognized standards of care.[13]
- Document good alternative care practices for children.

A task force chaired by the MOWA and involving FHI and UNICEF led the implementation of this study. The MOWA provided input into the design of the study protocol, ensured access to child care institutions, and contributed to the interpretation of the study findings. The MOWA further facilitated a consultative process to validate the study findings among stakeholders at the regional state level, including representatives of child care institutions, government oversight bodies, and community leaders and obtained their feedback and recommendations on action steps to be taken.

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13 Documents used include the *National Guidelines for the Alternative Care of Children* (Ethiopia, 2002) and UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children (2007, Draft).

Data collection took place over a period of five weeks, between early June and the first week of July 2008, and included both qualitative and quantitative data. Data collectors comprised three supervisors (from FHI program staff) and 15 enumerators (with a minimum of first degree in social sciences). Data collectors and supervisors were selected by considering their training and experience in qualitative and quantitative data collection methods. Methodologies used for data collection included interviews, focus group discussions (FGDs), checklists, documentation reviews, and site visits by team members. Interviews and FGDs were held with informants from eight regions of the country and included directors of child care institution; caregivers; representatives from government oversight bodies, including Women's Affairs (BOWA), Labour and Social Affairs Offices (BOLSA), and Justice (BOJ); community leaders; former institutionalized children; and parents of institutionalized children.

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A total of 87 child care institutions were involved in the study. At the request of the MOWA, institutions that care for children who will be placed in intercountry adoptions (commonly referred to as transition homes) were not included in this study. The 87 institutions involved in this study were located in seven main regions of the country:

- 33 (37.9%) from Addis Ababa
- 21 (24.1%) from Oromia
- 12 (13.8%) from SNNPR
- 10 (11.5%) from Amhara
- 6 (6.9%) from Tigray
- 3 (3.4%) from Harar
- 2 (2.3%) from Dire Dawa

At the time of the study, a total of 6,503 children, of which the majority (59 percent) was male, were residing in the 87 institutions.

Old bunk beds fill the bedroom of this child care institution

The qualitative data provided rich insights regarding views on institutionalization, quality of care, recommendations for improving institutional care and other alternative care options, adoption, and community responses to orphaned and vulnerable children. A total of 388 persons were interviewed or participated in FGDs during the qualitative data collection process.

Quantitative data were also collected, using a quality standard checklist based upon the *UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children*[14] and Ethiopia's *National Guidelines for the Alternative Care of Children* (NGAC).[15] This data were summarized using frequencies and percentages. Testing for an association between variables was based upon chi-square test results. The selected independent variables included type of ownership, address, and number of years an institution had been in operation.

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14 United Nations General Assembly/Human Rights Council. (June 2009).

15 As described in the National Guidelines for Alternative Care of Children (2002).

After the data were collected and the initial report was written, the MOWA and FHI conducted regional meetings to share the study findings with local stakeholders (representatives of government oversight bodies, child care institutions, and community leaders), validate the findings, and receive feedback and recommendations from stakeholders about next steps forward. The comments, suggestions, and recommendations were duly documented and are reflected in the conclusions and recommendations of this report.

Conclusions

Major findings of the study include the following:

- The main factors influencing the number of orphaned and/or unaccompanied children in Ethiopia are HIV and AIDS and related illnesses, and severe poverty.
- The development of new child care institutions (by nongovernmental and/or faith-based institutions) has been increasing over the past several years, but the development of other alternative care options has not been growing at the same pace.
- Little emphasis has been placed on developing other alternative care options, such as kinship care or foster care.
- Community members, child care management and staff, and some authorities have a positive perception of institutional care, and are not aware of the negative effects caused by institutionalization.
- There are limitations in supervision of child care institutions by authorities and minimal knowledge of and adherence to the minimum care standards outlined in the NGAC.
- There are limitations regarding uniform structures of accountability and oversight from the three main governmental institutions involved in the child protection system (MOWA, MOLSA, and MOJ).
- The government oversight bodies (mainly BOWA and BOLSA) do not have the financial and human resources to implement their

mandated responsibilities, and their relationship with child care institutions is mostly confined to reporting.

- Quality care is compromised in many child care institutions, due to limited financial resources, lack of supervision, and minimal awareness about child development issues.
- Children residing in institutions are subject to discrimination from community members, experience psychosocial problems, and are frequently subjected to physical, sexual, and psychological abuse and exploitation while in institutional care.
- Current procedures within institutions inhibit interaction between children and their families. This results in an increase in the likelihood of extended institutionalization and limits possible reunification.
- A significant number of child care institutions (62.1 percent did not have adequate documentation or case planning for each child. The limited emphasis on the temporary nature that institutionalization should have increases the likelihood that children will not be reintegrated or placed in a family-based care situation.
- Children who have left institutional care frequently feel they do not have the necessary skills to cope with life outside of the institution.
- Implementation of family preservation initiatives that combine parent education and family income strengthening appear to have positive effects on preventing institutionalization of children.
- Foster care strategies, whereby an institution identifies, trains, and supports a family willing to take in an unaccompanied child with regular financial and material support from the institution, is found to be an acceptable form of alternative care and readily fits into current cultural practices.
- There is a general lack of understanding of the relevance of domestic adoption (i.e., the relevance of legally formalizing the relationship between a caregiver and an unrelated child for whom they are caring on a permanent basis). Current domestic adoption

procedures also are perceived to be cumbersome and intimidating for Ethiopian families interested in national adoption.

- Efforts targeting the creation of a family-like atmosphere, through self-contained homes within the child care institutions, community integration of institutions and institutionalized children, training of institutional staff, and clear understanding of and adherence to minimal standards of care appear to have a more positive effect on children.

Recommendations

Based on the aforementioned findings, it is apparent that an effort to improve the quality of institutional care is an important beginning point. Given the well documented and widely known negative effects of institutional care, it is also important that this "transformation" of institutions be implemented jointly with the development and scaling-up of family-based alternatives, such as family preservation or reunification, kinship care, temporary foster care, and domestic adoption.[16] Article 22 of the Guidelines for the Alternative Care of Children, recently welcomed by the UN General Assembly,[17] promotes this view, stating that, "[W]here large child care institutions remain, alternatives should be actively developed in the context of an overall de-institutionalization strategy that will allow for their progressive elimination."[18]

Based on the study findings, specific recommendations within three categories—policy, care within institutions, and noninstitutional alternative care—should be set forth and should include the following:

Policy

Key government ministries should work collaboratively to develop protocols pertaining to specific processes and responsibilities, such as accreditation, supervision, and monitoring.

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16 Tolfree, D. (2005).

17 United Nations General Assembly/Human Rights Council. (June 2009). *Guidelines for the Alternative Care of Children*.

18 Ibid.

Accreditation standards and procedures should be developed to provide useful information and ensure that quality organizations are providing institutional care. The focus should be on promoting non-institutional alternative forms of care and improving current institutions, not creating new institutions.

Sufficient human and financial resources should be provided to the responsible government institution to facilitate timely supervisory visits to every institution operating in Ethiopia.

In the past year since the Institutional Care Study was conducted, the NGAC have been substantially revised, and MOWA endorsed and disseminated the revised version in September 2009. There is a need to ensure distribution of the revised guidelines and training of management and staff at child care institutions, other local institutions/organizations involved in alternative care or its facilitation (e.g., kebele, idir), and government oversight bodies in the application of the revised guidelines. As the revised guidelines are used, it is recommended to collect feedback from stakeholders involved in the implementation of alternative care services for vulnerable children and government oversight bodies, and possibly to obtain input from international experts, to ensure they are in accordance with current internationally recognized standards, use appropriate terminology, and reflect the desired emphasis on family-based care.

Care within institutions

- Appropriate and efficient database systems should be used by responsible government institutions, as well as all child care institutions. At a minimum, data should include name; date of birth; how, where, and why (i.e., reasons given for institutional care need) the child entered the protection system; family history; case plan; special needs (if appropriate); exit date; and follow-up.
- At a minimum, every child care institution must have a case plan for every child. A case plan should promote the temporary nature of institutionalization and include steps for reintegration and

placement in a family-like, permanent situation or an independent living arrangement.

- Those involved in institutional care, as well as community members and parents of vulnerable children, should be made aware of the negative effects of institutionalization via public awareness campaigns.
- Child care institutions should be encouraged to improve their level of care for children, based on internationally and nationally recognized standards. Such changes could include incorporating small homes or rooms suitable for groups; promoting linkages and participation in local communities; ensuring that a child protection policy and accompanying mechanisms are in place; providing appropriate psychosocial support, education, and developmentally appropriate care; and providing support and skills training to facilitate successful transitioning for children exiting care.

Noninstitutional alternative care options

In an effort to promote domestic adoption, information as to requirements and procedures should be readily accessible to nationals interested in adopting, as well as more understandable. Public awareness campaigns to promote domestic adoption should be conducted.

Minimum standards of care should be developed for each form of alternative care and should be based on the NGAC. The minimum standards should be distributed to all responsible government officials, child care institutions, and local organizations involved in alternative care. They should be translated into Amharic and other local languages, as needed, so as to be understandable by all.

SITUATION OF VULNERABLE CHILDREN IN ETHIOPIA

Ethiopia has a population of 77,812,236 (2007 Ethiopian census data, extrapolated to 2009, using a 2.6 percent growth rate), making it the second-most-populous country in Africa, after Nigeria. It has a total area of approximately 1 million square kilometers. About 84 percent of the population lives in rural areas. Administratively, the country is divided into nine regional states and two city administrations that are further divided into zones, *woredas* (districts), and *kebeles*.

In 2009, the Ethiopian Ministry of Health estimated that 1,116,216 adults—2.3 percent of the total adult population of Ethiopia are living with HIV or AIDS.[19] The final report for the Orphans and Vulnerable Children Rapid Assessment, Analysis, and Action Planning (RAAAP) Initiative, produced by UNAIDS, the World Food Program (WFP), UNICEF, USAID, and the Government of Ethiopia, referring to the 2000 Ethiopia Demographic Health Survey (EDHS), indicates an estimated 18 percent of all Ethiopian households are caring for at least one orphan.

Almost more startling is the number of Ethiopian children (ages 0-17) identified as one- or two-parent orphans, which in 2005 was determined to be more than 5 million.[20] This enormous number represents more than 6 percent of the overall population of Ethiopia. The reasons for this number are multifaceted, including loss of parents to HIV and AIDS and other diseases such as TB and malaria, high maternal mortality rate, extreme poverty, famine, and migration.

Ethiopia's age pyramid shows a very young population, with children under the age of 15 accounting for 48 percent of the total population.[21]

19 Ethiopian Ministry of Health and Federal HIV and AIDS Prevention and Control Office, 2008. *Single Point HIV Prevalence Estimate Document*, Addis Ababa, Ethiopia.

20 AIDS in Ethiopia, FMOH, 2005.

21 Central Statistical Agency [Ethiopia] and ORC Macro. 2006, DHS 2005, page 33.

Ren Kolka/FHI

Left: Children use bottle caps to play checkers at an institution in Addis Ababa

In Ethiopia, 73 percent of children under age 18 live with both parents, 12 percent live with their mother only, 4 percent live with their father only, and 10 percent live with neither parent. In 2005, Ethiopia was home to an estimated 77,000 unaccompanied child-headed households, second only to Zimbabwe in sub-Saharan Africa.[22] Rural children are more likely than urban children to live with both parents. The highest proportion of children living with both parents is in the Somali Region (79 percent), whereas the lowest proportion lives in Addis Ababa (49 percent).[23]

Ethiopia ratified the UN Convention on the Rights of the Child (CRC) in May 1991 and the African Charter on Rights and Welfare of the African Child in 2002. The child protection system and, more specifically, alternative care, is the responsibility of three government ministries: the MOWA, the MOJ, and the MoLSA. These three ministries are responsible for different components. The MOWA, as the main government ministry charged with children's issues, is responsible for general oversight, supervision, and ensuring that children placed in alternative living arrangements receive quality care. The MOJ has responsibility for the accreditation of institutions. The MoLSA is responsible for supervision at the regional level via its Bureaus of Labour and Social Affairs (BOLSA). In recent years, local government and community structures, such as kebeles and idirs, have taken a more proactive role in facilitating support, services, and referrals for orphaned and vulnerable children. This community-based response has been documented and appears to be responsive to the growing needs of Ethiopia's children.

22 Bequele, Assefa (2008). *REVERSED ROLES and STRESSED SOULS - Child Headed Households in Ethiopia.* Africa Child Policy Forum, www.africanchild.infor/chhreport.asp

23 Central Statistical Agency [Ethiopia] and ORC Macro. 2006, DHS 2005, page 15.

HISTORY OF INSTITUTIONAL CARE FOR CHILDREN IN ETHIOPIA

In Ethiopia, as in most traditional societies, a strong culture of caring for orphans, the sick, the disabled, and other needy members of the community by nuclear and extended family members, communities, churches, and mosques has existed for centuries. Based on cultural and religious beliefs, provision of care to orphaned, abandoned, and vulnerable children has been seen as the duty of the extended family system among most of the ethnic groups in the country.[24] Thus, child welfare services in Ethiopia emerged as a result of traditional practices among the various ethnic groups.

Fragmented historical records reveal that among the Oromo and Amhara ethnic groups, adoption has been exercised since the 15th century.[25] However, it was only in 1960 that the Ethiopian Government officially recognized adoption through Proclamation Number 165. The Amharic word for adoption is *madego*. It is also called *gudiffecha*, derived from the Oromo word *gudissa* (upbringing). Among the Oromo, adoption focused on the continuation of parental lineage, thus the emphasis was on the adopter and less on the adoptee. Since lineage is preserved through male descendents, the most widely adopted children tended to be males. In the traditional Oromo culture, families who do not have male offspring often adopt a son of an extended family member or member of the same clan. Daughters are also adopted (e.g. in the case of infertility).[26]

In addition to *madego*, the Amhara have two types of arrangements that provide orphans and neglected children with minimum protection. These are *yetut lij* ("breast child") and *yemar lij* ("honey child"). In this case, the adopted child, usually an orphan or the child of parents

24 Assefa, T. (1995).

25 Ibid.

26 Ibid.

who are not able to care for him/her, receives proper feeding and attention but does not receive the same treatment as biological children. In this instance, there is a religious connotation or motive behind taking in another child. The emphasis is on the salvation of the soul of the adoptive family; therefore, the fate of the adopted child is given less attention.[27]

The advent of urbanization, recurrent drought, famine, and HIV/AIDS has claimed a heavy toll on human life in Ethiopia during the past three decades. As a consequence, thousands of children have been left unaccompanied and in need of care. The severe drought of 1984-85 is recognized as the catalyst for the proliferation of institutional care in Ethiopia. Many child care institutions were established by both governmental and nongovernmental organizations in response to the drought. Prior to this period, very few institutions were initiated and these were mostly faith-based, supported by local elite philanthropists. In an effort to find an immediate solution to the growing numbers of unaccompanied children, institutional care was seen as a quick alternative to family-based care, particularly for those children who were left unaccompanied as a result of the death of their parents from famine and those who were put into temporary shelters. Approximately 31 percent of the institutions in operation today were started during this time.

Immediately after the 1984 famine, approximately 21,000 children in 106 institutions were cared for in institutional settings, a record number. This study revealed that, as of December 2008, there were 6,503 children in 87 institutions. It is important to note that these institutions only provided long-term child care. The study did not assess institutions for children whose permanent plan was intercountry adoption. Currently, as a result of the Ethiopian government's guidance to discourage institutionalization of children, there are only three government institutions operating in Ethiopia. In January 1986, the Relief and Rehabilitation Commission (RRC) created a directive aimed at

27 Alemtsehay, Z. (1988).

deinstitutionalizing children through reunification and reintegration. From 1986 to 1990, a large-scale reunification program took place, resulting in the decline in the number of residential child care institutions.[28] However, this guidance has not influenced nongovernmental and faith-based organizations, which continue to operate child care institutions and, in some cases, open new institutions.

In 2001, in collaboration with international donors, the MOWA developed the first set of *National Guidelines for the Alternative Care of Children* (NGAC). Though the guidelines were not officially approved, nor widely distributed, this was a positive first step. In 2008-2009, the Italian Development Cooperation, in collaboration with the MOWA, revisited the national guidelines in an effort to bring them up to date with international standards, such as the Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care,[29] the CRC, and Ethiopian child protection laws. At the time of this study, the Revised Guidelines for Alternative Care were still in draft form and had not been officially approved by the MOWA. However, the revision of the NGAC was a priority to the MOWA, and in September 2009, the ministry officially released the new NGAC guidelines. The MOWA is currently working to translate the NGAC into local languages and begin a dissemination plan that includes all child care institutions, government oversight bodies, and organizations involved in the provision of alternative care services for children.

It is important for the context of this study to define what is meant when using the term "institutionalization," as well as to identify common elements of institutional care. Institutionalization refers to an establishment founded by a governmental, nongovernmental, or faith-based organization to give care for unaccompanied children. A child care institution may also be referred to as an orphanage, children's home, or residential care. Common aspects of institutionalization, as

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28 Alemtsehay, Z. (1988).

29 In 2007, the Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care were utilized. As of February 2010, those Guidelines have been officially welcomed by the UN General Assembly and are currently referred to as the *Guidelines for the Alternative Care of Children*.

defined by academicians, policy makers, and international organizations, include care by paidpersonnel living with non-related children, children clustered by age group, and a high child-to-caregiver ratio.[30] One of the most common characteristics of institutional life is the lack of stable, long-term relationships between a child and a caregiver.[31] Institutions may range in size from a small group to hundreds of children. In one study, "standard" institutional care was defined as more than 20 staff members caring for a large group of children, and typically a child-to-caregiver ratio of 10:1.[32]

OBJECTIVES AND SCOPE OF THE STUDY

The overall objective of the study was to understand the scope of the information on institutional care practices in Ethiopia, as well as the quality of this information and the gaps therein. Specific objectives include the following:

- Assess the primary factors that leave children without parental care.
- Document the main reasons institutionalization is chosen as alternative care for children.
  Determine the scale of institutionalization and the number of child care institutions in Ethiopia.
- Assess current practices within child care institutions, including quality of care, in relation to nationally and internationally recognized standards of care.[33]
- Document good alternative care practices for children.

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30 Rosas & McCall, 2009. Unpublished document, *Characteristics of Institutions, Interventions, and Resident Children's Development*, University of Pittsburgh.

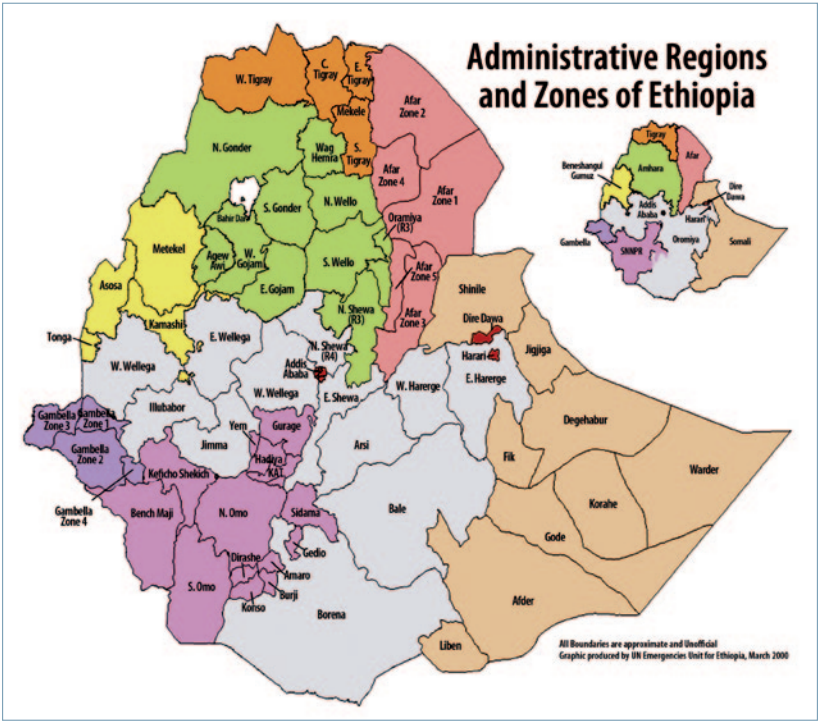
31 Dobrova-Krol, N.A., van Ijzendoorn, M.H., Bakermans-Kranenburg, M.J., Cyr, C., & Juffer, F. (2008), Rosas & McCall, 2009.

32 Smyke, A.T., Dumitrescu, A.B.A., & Zeanah, C. (2002).

33 Documents utilized include the National Guidelines for Alternative Care of Children(Ethiopia, 2002) and UN Guideline for the Appropriate Use and Conditions of Alternative Care for Children (2007, Draft).

The study includes both qualitative and quantitative information from a varied group of stakeholders and informants. including management and staff of institutions, government officials, community members, former institutionalized children, and their parents. Initial study findings were shared with representatives of government oversight bodies, child care institutions, and community leaders. After the findings were validated, feedback and recommendations were received about how to move forward.

It is important to mention, for transparency's sake, that this document reflects only the situation of the 87 institutions included in the study. Private institutions caring for children for whom intercountry adoption is the permanent plan were not included in this study, since they are considered by the MOWA to provide only temporary shelter. Therefore, this study only represents the situation of long-term child care institutions in Ethiopia and not all institutions with children in their care.



United Nations Emergencies Unit for Ethiopia, March 2000

Children sit in front of an institutional care center in Addis Ababa

METHODOLOGY

A total of 87 child care institutions located in seven main regions of the country were included in the survey. The largest group, located in the capital, Addis Ababa, included 33 institutions (38 percent). The second largest group consisted of 21 institutions (24 percent), and was drawn from Oromia regional state, the largest and most populous region in the country. The other locations were SNNPR, with 12 institutions (14 percent), and Amhara, with 10 (12 percent). Locations with significantly lower numbers of institutions included Tigray with six (7 percent), Harar with three (3 percent), and Dire Dawa with two (2 percent). Within the 87 institutions, there were a total of 6,503 children, with male children accounting for 59 percent, and female children making up the remaining 41 percent (see Appendix 1).

The methodology used to collect qualitative and quantitative data included interviews, FGDs, site visits, a checklist, and document reviews. Team members physically visited each of the 87 institutions during the data collection phase. A total of 388 persons participated in the study as informants (see Appendix 2). Additional information highlighting the distribution of data collected by region and type of informant is presented in Appendix 3.

Quantitative data were also collected using a quality standard checklist (see Appendix 4), based upon the UN Guideline for the Appropriate Use and Conditions of Alternative Care for Children[34] and the *2001* NGAC.[35] This data were summarized using frequencies and percentages. Testing for an association between variables was based upon chi-square test results. The selected independent variables included type of ownership, address, and number of years an institution had been in operation. Good practices in alternative care programs were documented using a self-administered, open-ended structured questionnaire (see Appendix 5). The heads of the institutions, or other delegates assigned by the institutions, were asked to complete the questionnaire with assistance from the data collectors.

Ren Kolka/FHI

A triangulation technique was used to generate valid and reliable information. The use of different qualitative and quantitative techniques and the inclusion of various groups of informants in the study were of great value, and enhanced data quality. An observation checklist was used to validate data reported by study respondents. Also, supervisors responsible for monitoring the data collection of the enumerators (data collectors) ensured that all collection, checking, and review processes were appropriate and ethical.

Prior to the commencement of the study, ethical clearance was obtained from the MOWA and FHI's Protection of Human Subjects Committee. The responsible government institutions at the regional level were officially informed in writing about the pending study, and

34 United Nations General Assembly/Human Rights Council. (February 2010).

35 National Guidelines for Alternative Care of Children (2001).

their collaboration was requested. Also, permission was obtained from the director of every participating institution. All interview and focus group respondents received a verbal explanation from the data collector, including the purpose of the study and confidentiality rules. Verbal consent was obtained from each informant. Specific respondent information (i.e., name, address) was not recorded during data collection, analysis, or in the study report. Region, town, child care institution, or pseudonyms were used to identify study participants.

FHI maintains stringent ethical regulations and requirements regarding research involving child informants, so it was decided that children currently residing in institutions would not be interviewed for this study. However, this initial absence of data was filled by including information from interviews with formerly institutionalized children, now adults, who could share their perspectives, concerns, and suggestions regarding their past experiences living within child care institutions.

After the data were collected and the initial report was written, FHI and the MOWA conducted regional meetings to share the study findings with local stakeholders (e.g., representatives of government oversight bodies, child care institutions, and community leaders), validate the findings, and receive feedback and recommendations from stakeholders about next steps forward. In total, three two-day regional meetings were held, two in Adama and one in Bahir Dar. Each meeting had 30 to 40 participants representing institutions, government ministries at the national, regional, and woreda levels, idirs, and other key stakeholders. The comments, suggestions, and recommendations were duly documented and are reflected in the conclusions and recommendations of this report.

QUANTITATIVE RESULTS

The quantitative results of the study were gathered using a Quality Standard Checklist, based on recognized standards of institutional care described in the UN Guideline for the Appropriate Use and Conditions of Alternative Care for Children[36] and the NGAC. Specific reference was made to the section of the 2001 NGAC pertaining to institutional care. The checklists were completed for each of the 87 institutions. The results of the Quality Checklist were significant. For the purpose of brevity, only key findings in specific areas are presented herein. Extensive information may be found in the complete report.[37] The quantitative data is compiled into four main categories: infrastructure and basic needs; supervision, monitoring, and reporting; staffing and policy; and case planning.

Infrastructure and basic needs

Identifying ownership of the child care institution was the first issue addressed in the Quality Checklist. Of the 85 institutions that responded to the question on ownership, the study found that 68 institutions (80 percent) were run by NGOs, 14 (16 percent) were operated by faith-based organizations, and 3 (3 percent) were run by the Ethiopian government. More than half of the institutions (48 of 87) had been established in the past 10 years; 21 of these were established fewer than five years ago. Fourteen institutions were established 11 to 19 years ago, and 24 institutions were established more than 20 years ago, coinciding with the great famine of 1984-85.

Most institutions (84, or 97 percent) reported that they provide basic necessities to the children in their care, meaning food, clothing, hygiene, health care, and play and recreation activities. Specific information related to these basic needs is explored below.

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36 United Nations General Assembly/Human Rights Council. (June 2009).

37 Family Health International, UNICEF, Ministry of Women's Affairs, & Child Investment Fund Foundation (January 2009).

Ren Kolka/FHI

Nothing is individualized in institutional care

Child care institutions have the obligation to make sure that children have ample, well prepared, nutritious food.[38] The vast majority of institutions (79, or 90 percent) have a feeding plan, but 9 percent lack such a plan. The food program was reported to include three meals per day in 77 institutions (89 percent). Snacks were less frequent, with only 26 institutions (30 percent) reporting that they provide a morning snack. Fifty-seven institutions reported that children are involved in meal preparation.

Results showed that all institutions provided clothing to the children in their care, varying frequency. Of the 75 institutions that responded to the question about frequency of clothing provision, 15 (17 percent) responded that they provide annually, 28 (32 percent) biannually, and 32 (37 percent) as necessary.

Seventy-six institutions confirmed that girls and boys have separate bedrooms. Thirty-seven institutions (49 percent) reported they had

38 *2001 National Guidelines for the Alternative Care of Children*. Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 8.2.2, page 17.

Ren Kolka/FHI

All institutions provide clothing to children in their care; these shoes belong to children in Addis Ababa

rules to prevent unsupervised visits between boys and girls. Twenty-six institutions (30 percent) reported that children (same gender and not) share beds (see Appendix 6). A significantly larger number of institutions in the capital, Addis Ababa, (42, or 48 percent), reported bed sharing versus 18 (20 percent) in other regions. Fifty-five institutions reported having separate bathrooms for boys and girls, and 73 institutions (83 percent) reported that caregivers had separate sleeping quarters.

Upon a child's admission to an institution, the care facility has the obligation to provide health care, nutritional, and/or psychological rehabilitative services, according to the child's need.[39] The study found that in 53 institutions (60 percent), children receive rehabilitation services on admission. Type of rehabilitative service offered varies, with 46 (87 percent) of the 53 institutions reporting services offering health rehabilitation; 48 institutions (91 percent) providing nutritional rehabilitation services; and 43 (81 percent) providing psychological rehabilitation.

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39 *2001 National Guidelines for the Alternative Care of Children*. Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 7.6, page 15.

Laundry dries on the line at this institution in Addis Ababa

Child care institutions should ensure the medical needs of children under their care.[40] To accomplish this, 30 institutions have a medical clinic within their compound. Thirty-nine institutions (77 percent) reported they provide regular medical check-ups for children under one year of age. Furthermore, 46 percent of institutions provide biannual medical checkups for children six years old and older, while 23 institutions do not provide such medical care.

A child care institution has the obligation to provide sanitary materials to beneficiary children regularly.[41] According to the institutional guidelines, institutions are required to provide toothbrush, towel, and sanitary pads. Fifty-seven (66 percent) of the institutions said they provide these regularly, three (3 percent) said they provide them when available, and 22 (25 percent) said they provide them whenever they are requested.

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40 *2001 National Guidelines for the Alternative Care of Children.* Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 8.2.4, pages 18-19.

41 *2001 National Guidelines for the Alternative Care of Children.* Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 8.2.5, page 19-20.

A child care institution has the responsibility to provide educational opportunities for children, beginning in kindergarten and continuing through high school.[42] Eighty-three institutions (approximately 95 percent) confirmed that educational opportunities are provided to children in their care. The total number of children attending school from kindergarten through secondary school was reported to be 5,044, or 78 percent of all children. However, only 32 institutions (37 percent) confirmed the presence of a kindergarten within the institution. A total of 496 boys (8 percent of all male children) were reported as attending kindergarten, and a total of 362 girls (6 percent of all female children) were reported as attending. Specific ages of institutionalized children were not collected in the study; consequently the percentage of kindergarten-age children attending school cannot be determined.

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A child care institution should provide vocational training through their own organization or facilitate provision of training through other organizations for eligible children.[43] Results showed that 40 institutions (46 percent) had a life skills program; on average, 24 children participated at each of the institutions reporting having such a program. A total of 786 children (12 percent) were attending vocational schools, 472 males (60 percent) and 314 females (40 percent). As stated above, specific ages of children were not collected. Therefore, the percentage of children within the age limit for vocational school (13-17) cannot be determined; rather, only the percentage of the total number of children.

Supervision, monitoring, and reporting

Sixty institutions indicated they were accountable to the BOJ; 15 said they were accountable to their regional BOLSA; and only four institutions recognized the MOWA as the governmental institution responsible for oversight of child care institutions. It is important to note that only 19 institutions mentioned BOLSA and MOWA as their main governmental contacts, given that these two ministries are legally

42 *2001 National Guidelines for the Alternative Care of Children*. Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 8.2.6, page 20.

43 *2001 National Guidelines for the Alternative Care of Children*. Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 8.2.7, page 20-21.

Ren Kolka/FHI

These worn children's shoes have had several owners

mandated to oversee child welfare/protection issues and child care institutions. This highlights a significant need to improve relations with, exposure to, and knowledge of the roles and responsibilities of both BOLSA and MOWA. Conversely, the high proportion of institutions claiming to have a relationship with the BOJ should also be put in perspective. The BOJ is responsible for accreditation and registration of institutions. Therefore, one could extrapolate that a "relationship" with this ministry was a one-time incident during the initial stages of registration, and does not necessarily reflect an ongoing supervisory role.

> ***"There were only three caregivers for a population of 90 children when I was admitted to the institution. Before I left the institution the number of children had increased to 270 and yet, the number of caregivers was the same."***
>
> — Tesfaye, a young adult raised in institutional care

Ren Kolka/FHI

A caregiver looks after infants in institutional care

Approximately 84 percent of institutions said they had received at least one supervisory visit by a government official and 10 percent reported having had no supervisory visit by anyone from the government. For the 73 institutions that noted they had hosted supervisory visits by different government organizations, the majority indicated these visits were "sparse" and "irregular." In spite of the lack of supervisory visits, approximately 77 institutions (89 percent) advised they submit activity reports to government officials; 49 institutions (56 percent) report quarterly; 13 institutions (15 percent) report annually; and only nine institutions (10 percent) report on a monthly basis.

Staffing and policy

Eighty-four institutions (97 percent) reported having "caregivers" on staff, referring to staff that have direct interaction with and responsibility for children. Three institutions caring for a total of 64 children reported having no caregivers on staff. The child-to-caregiver ratio ranged from 0.33 to 125 children per caregiver. The former ratio is due to a very small institution with a high number of caregivers and few children.

Forty-three institutions (49 percent) responded that they use written recruitment and selection criteria for caregivers, although 47 (54 percent)

did not have documented criteria available. Those respondents that had criteria for recruiting caregivers said that typical selection criteria included education, experience in child care, discipline, love for children, medical status, age/maturity, gender, marital status, willingness to care for children, and social skills. Seventy-seven institutions (88 percent) reported that caregivers were subject to supervision, mostly by directors of the institutions.

When working with children, it is essential that an easy-to-understand child protection policy be in place at every institution. This is in accordance with minimum standards outlined by the UN Draft Guidelines, as well as national policy. A child protection policy outlines clear interventions when a child has been abused, exploited, or neglected, and provides clear information as to how to proceed (i.e., to report the abuse and prosecute the perpetrator). Also, the policy should specify reporting mechanisms for children to report abuse, exploitation, or neglect by a staff member of the institution or by another child. This study found that 66 percent of institutions report having a policy, while 31 percent do not. More than half (46) of institutions claimed to have a formal mechanism for caregivers that allows them to report child abuse and exploitation for investigation; 41 did not. Fifty-two institutions (60 percent) stated there was a complaint mechanism for children that allows them to report child abuse or neglect; 35 institutions (40 percent) did not have such a mechanism in place. Asked how the children report, 24 institutions (46 percent) of the 52 institutions responded that children report in person, 13 (25 percent) institutions said children report in writing, and the remaining 11 (21 percent) reported that children report via the director of the institution.

Case planning

It is good social work practice—and highlighted in other studies of institutional care[44]—to develop case plans for children with the goal of minimizing the amount of time a child spends in institutional care. This is especially critical for children under three years of age, who are most

44 Perez, L.M. (2008).

susceptible to the negative effects of institutionalization.[45] A case plan should include an assessment of the child and of the child's needs, a strategy for ensuring permanency planning, and the actions necessary to ensure that institutionalization is a temporary and not a permanent solution. Only 33 percent of the institutions reported having an individualized case plan for each child; 63 percent of institutions said they did not. Among institutions that do have case plans in place, approximately 66 percent (two-thirds) stated case plans are reviewed "periodically" either by directors, caregivers, or counselors.

> ***"I think it is good if institutions allow relatives to frequently visit the children. Children want to visit their relatives but the response from the administration was not encouraging. We used to feel disappointed when our request for a family visit was turned down."***
>
> — Tigist, a young adult raised in institutional care

A child care institution has the obligation to initiate reunification or placement in an alternative care program immediately after admission of the child.[46] Regarding efforts to promote reunification and alternative care placements outside of institutional care, 56 institutions (64 percent) reported placing children in alternative care and 31 (36 percent) indicated they did not. Of the alternative care options reported by institutions, foster care was used by 31 institutions (55 percent), whereas 36 (64 percent) supported family reintegration. Adoption was mentioned by 20 institutions (36 percent).

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45 Browne, K. (2009). The Risk of Harm to Young Children in Institutional Care, London: Save the Children as referenced in Csaky, C., (2009). *Keeping Children Out of Harmful Institutions–Why we should be investing in family-based care*. London: Save the Children UK.

46 *2001 National Guidelines for the Alternative Care of Children*. Ministry of Labour and Social Affairs, Guideline for Institutional Childcare, section 7.10, page 16

QUALITATIVE RESULTS

Interviews with formerly institutionalized children

Twenty-two in-depth interviews were held with children who were once institutionalized, but are now living independently. Most participants said that they did not feel that they possessed the necessary skills to smoothly transition from institutional care to independent life. A typical response was: "*I left the institution after the training was over. The administration told us that the institution would support us with a living allowance of Birr 250 per month for three months only. It was our responsibility to look for a job and establish our own independent life within the three-month period. This was impossible, because I couldn't get a job very soon. I was in complete misery for one year after the support had been terminated.*"

> ***"The problem of every child in the institution is when they try to assimilate with society. I was not happy with the way the leaders of the institution pushed us out of the institution. We were the first batch which was reintegrated in the society from our institution. At that time, there was no adequate preparation made to facilitate our reintegration to be as smooth as possible. I had thought that the institution would be my home forever. I was not ready to go out and live somewhere outside the institution."***
>
> — Mekonnen, a young adult raised in institutional care

Another common reflection shared by formerly institutionalized children was their recognition that, though their basic needs were met in institutional care, quality of life was severely limited, and family-based care was preferable. Several mentioned foster care as a good option, and most agreed that institutionalization should be considered only as a last resort. One respondent made the correlation between

receiving family love and socialization within family-based care: *"Things such as family love and social life are much better if one is brought up in the family environment. Instead of giving the child to an institution, it is good to give [him or her] to a volunteer family (preferably to a childless family) in foster care without any financial incentives."*

One respondent differed from the majority, stating that institutional care was better, but did qualify the statement by saying that it depended on the quality of care, stating, "*It is more advantageous to live in the child care institutions because children can get all the necessary facilities which they may not be able to get in the family. However, preference to institutional care depends on the quality of the services it provides to the children."*

Several respondents shared intimate, personal information regarding the negative effects of institutional care: *"I have unpleasant memories of life in the Gambella child care institution. I saw with my own eyes an adult (a staff member of the institution) rape a four-year-old friend of mine. Boys and girls also had to share rooms. Given all that I have seen, I do not trust men and have not had a good relationship with any man."*

Quotes from case studies of formerly institutionalized children reveal that even though many held a positive image and had fond memories of their own time in institutional care, most of them believe that *family-based care* is the best option to provide proper development and care of children. They largely emphasized that institutions should restrict their admission to orphans—children who do not have parents or any extended family. Most respondents said it is better to provide support to biological families, enabling them to keep their children at home instead of institutionalizing them. Interviewees also suggested introducing a more participatory approach to management and administration, increasing child-to-caregiver ratios to better meet the needs of children, and conducting an in-depth review and supervision of intercountry adoption practices.

Focus group discussions

Information reported in the FGDs provided significant insight into community members' views on the reasons for institutionalization, its

potential effects, and how to prevent negative outcomes. Informants were male and female, came from diverse occupations and economic levels, and represented several different faith communities, including Orthodox, Muslim, and Protestant. The main reasons mentioned by focus group members for the increasing number of unaccompanied children were HIV, famine, and extreme poverty. Several participants also mentioned that abandonment of children is on the rise due to unwanted pregnancies.

Participants mentioned a correlation between institutionalization and negative effects on children's behavior and development. Several reported that they had witnessed the diverse physical and psychosocial consequences (negative) that result from institutionalization. One respondent noted: *"The first thing they lose is their parents' love. This has a major implication. What psychologically affects them is loss of parental love. Secondly, they do not behave like children who have been raised in a family atmosphere. As you observe them, their behavior is somewhat different."*

Ren Kolka/FHI

> ***"I adopted a child of my brother who died after begetting a girl child. I am now raising her. She is currently attending school."***
>
> — A participant in a focus group discussion with community members in Hawassa

Participants were also asked about alternative care options in their communities. Informants described the different procedures and stakeholders involved in various options. The most frequently reported forms of noninstitutional alternative child care included family income strengthening/family preservation, adoption, and foster care. With respect to national adoption, the most common type of domestic adoption is based on the tradition of extended family members volunteering to care for the child. Several participants mentioned their own "adoption" of relatives' children. While this is a positive development, it is also important to note that the legal situation of the child is not clear, as most of the presented cases appeared to be "informal

A child sits alone on her bed in this institution

adoptions", agreed upon by family members but not necessarily following a legal process. Unfortunately, many focus group members mentioned that children who are taken in or "fostered" by other families (related or unrelated) were frequently exploited for labor and/or abused. One participant mentioned that extended family members or foster families do not extend the same rights to foster children as they do to their own biological children. The idea that foster children are treated as second-class citizens was mentioned several times. Finally, family support/preservation programs and drop-in centers (also referred to as day care) were other alternative care options that people mentioned and typically referred to in a positive vein. Several respondents were familiar with sponsorship programs and could speak of the benefits of those programs in supporting families to stay together.

CONCLUSIONS

Based on the collected qualitative and quantitative data, several conclusions may be made, especially in the areas of standards of care, government oversight, attitudes about institutionalization, effects of institutionalization, and the prevalence of alternative care options. Major findings of the study include the following:

- The main factors influencing the number of orphaned and/or unaccompanied children in Ethiopia are HIV and AIDS and related illnesses, and severe poverty.
- The number of new child care institutions (by nongovernmental and/or faith-based organizations) has increased, while the development of other alternative care options has not grown at the same pace.
- Little emphasis has been placed on developing alternative care options, such as kinship care and foster care.
- Community members, child care management and staff, and some authorities have a positive perception of institutional care and are not aware of the negative effects of institutionalization.
- Supervision of child care institutions by governmental oversight bodies is very limited. Overall, there is minimal adherence to, or even knowledge of, the minimum care standards outlined in the NGAC.
- Uniform mechanisms for of accountability and oversight by the three main governmental institutions involved in the child protection system (MOWA, MOLSA, and MOJ) are limited.
- Regional oversight bodies (mainly BOLSA and BOWA) do not have adequate financial and human resources to carry out their mandated responsibilities, and their relationship with child care institutions is mostly confined to reporting.

- Quality care is compromised in many child care institutions due to limited financial resources, lack of supervision, and minimal awareness of child development issues.
- Children residing in institutions are subject to discrimination from community members, experience psychosocial problems, and are frequently subjected to exploitation and to physical, sexual, and psychological abuse while in institutional care.
- Current procedures within institutions inhibit interaction between children and their families and therefore increase the likelihood of extended institutionalization and limit possible reunification.
- A significant number of child care institutions (62.1 percent) had inadequate documentation or case planning for each child. The ideal of institutionalization as a *temporary* solution is not emphasized, increasing the likelihood that children will not be reintegrated or placed in family-based care.
- Children who have left institutional care frequently feel they do not possess the necessary skills to cope with life outside the institution.
- Implementation of family preservation initiatives that combine parent education and family income strengthening appear to have positive effects on preventing institutional care of children.
- Foster care strategies, whereby an institution identifies, trains, and supports a family willing to take in an unaccompanied child with regular financial and material support from the institution, is found to be an acceptable form of alternative care and readily fits into current cultural practices.
- There is a general lack of understanding of the relevance of legally formalizing the domestic adoption (i.e. the relationship between a caregiver and an unrelated child whom they are caring for on a permanent basis). Also, current domestic adoption procedures are perceived by study participants as cumbersome and intimidating for Ethiopian families interested in formal adoption.

- Creating a family-like atmosphere using self-contained homes in the child care institutions; integrating institutions and institutionalized children; training institutional staff; and promoting a clear understanding of and adherence to minimal standards of care appear to have more positive effects on children than does institutionalization.

RECOMMENDATIONS AND ACTION PLAN

Based on the study findings, it is apparent that improving the quality of institutional care is an important beginning point. Given the well documented and widely acknowledged negative effects of institutional care, it is also important that this "transformation" of institutions be implemented in conjunction with the development and scaling-up of family-based alternatives, such as family preservation or reunification, kinship care, temporary foster care, and domestic adoption.[47] Article 22 of the Guidelines for the Alternative Care of Children (2010) supports this view, stating: "*[W]here large child care institutions remain, alternatives should be actively developed in the context of an overall de-institutionalization strategy that will allow for their progressive elimination*."

Ren Kolka/FHI

Based on the conclusions of this study, specific recommendations include the following:

Policy

- Key governmental ministries should work collaboratively to develop protocols for specific processes and responsibilities, such as accreditation, supervision, and monitoring.
- Accreditation standards and procedures should be developed to ensure that quality organizations are providing institutional care. The focus should be on promoting noninstitutional alternative

47 Tolfree, D. (2005).

Young boys play in their bedroom in this Addis Ababa institution

forms of care and improving current institutions, not creating new institutions.

- Sufficient human and financial resources should be provided to the responsible government institution to facilitate timely supervisory visits to every institution operating in Ethiopia.
- In the past year since the Institutional Care Study was conducted, the NGAC have been substantially revised and the revised version was endorsed and disseminated by the MOWA in September 2009. There is a need to ensure distribution of the revised guidelines and to ensure training on their application for management and staff at child care institutions, and other local institutions/organizations involved in alternative care or its facilitation (e.g., kebele, idir) . Government oversight bodies should also be trained in the application of the revised guidelines. As the revised guidelines are implemented, it is recommended to collect feedback from stake-holders involved in alternative care services for vulnerable children

and from government oversight bodies. It may also be desirable to obtain input from international experts to ensure the new guidelines are in accordance with current internationally recognized standards, use appropriate terminology, and reflect the emphasis on family-based care.

Care within institutions

Appropriate and efficient database systems should be used by responsible governmental institutions as well as by child care institutions. At a minimum, data should include name; date of birth; how, where, and why the child entered the protection system; family history; specific reasons for entry into institutional care; case plan; special needs (if appropriate); exit date; and follow-up.

At a minimum, all child care institutions must have individual case plans for every child. A case plan should reflect the *temporary* nature of institutionalization and include steps for reintegration and placement in a permanent family-like situation or an independent living arrangement.

Those involved in institutional care, as well as community members and parents of vulnerable children, should be made aware of the negative effects of institutionalization via public awareness campaigns.

Child care institutions should be encouraged to improve their level of care, based on internationally and nationally recognized standards. Such changes could include incorporating small rooms or homes suitable for groups; promoting linkages and participation in local communities; ensuring that a child protection policy and accompanying mechanisms are in place; providing appropriate psychosocial support, education, and developmentally appropriate care; and providing support and skills training to facilitate successful transition for children exiting care.

Non-institutional alternative care options

In an effort to promote domestic adoption, information as to requirements and procedures should be readily accessible to nationals

interested in adopting, as well as more understandable. Public awareness campaigns to promote domestic adoption are also needed.

Minimum standards of care should be developed for each form of alternative care and should be based on the NGAC. The minimum standards should be distributed to all responsible government officials, child care institutions, and local organizations involved in alternative care. They should be translated into Amharic and other local languages, as needed, in order to be understandable by all.

Two-Year Action Plan

Phase I: Strengthening the Child Protection System and Related Tools

Action/Activity	Who Is Responsible	Timeframe
Translate NGAC into Amharic and/or other local languages of Ethiopia; publish and disseminate. Develop and implement training on the NGAC for key stakeholders.	MOWA in collaboration with MOLSA The Italian Development Cooperation to provide financial and technical support for the translation into Amharic Financial and technical support for translation into other Ethiopian languages from UNICEF and FHI	In process (end of 2009, beginning of 2010)
Develop tools for verification by government oversight bodies ofwhether an institution can be accredited, based on the NGAC (e.g., development of checklists and other tools to verify criteria/procedures/standards/processes).	MOJ in coordination with MOWA Technical support from UNICEF and FHI	4-8 months
Develop tools to guide implementation of specific alternative care options, based on the NGAC (e.g., manuals, training guides, checklists and other implementation tools to be used for enhancing care of children and for monitoring activities of institutions and other alternative care providers.	MOWA in coordination with MOLSA and DOJ Technical support from UNICEF, FHI, and possibly other NGOs/CBOs, AAU	1 year- 18 months

Action/Activity	Who Is Responsible	Timeframe
Develop protocols for accreditation, monitoring, evaluation, and supervision of alternative care providers (including institutional care)	MOWA in coordination with MOLSA and MOJ Technical support provided by UNICEF and FHI	3-8 months (this process could begin at the same time as the NGAC review process)
Develop a publicly accessible database on children in alternative care in Ethiopia, including children in institutions and adopted children (domestic and intercountry)	MOWA Financial and technical support provided by the Italian Development Cooperation	1 year

Phase II: Dissemination, Training, and Implementation of Systems and Related Tools

Action/Activity	Who Is Responsible	Timeframe
Disseminate revised NGAC to all collaborating government oversight bodies, management and staff of child care institutions, NGOs/CBOs implementing alternative care programs, and community groups, such as *idirs*.	MOWA, with possible assistance from UNICEF, FHI, BOLSA (regional level), BOWA, MOJ, and *idirs* The Italian Development Cooperation will support MOWA to launch the revised NGAC at the national level and to disseminate during the launch. Technical support for further promotion and dissemination, including at the regional level, from UNICEF, FHI, and other interested organizations	6-12 months
Create a training program for management and staff of child care institutions based on the NGAC and other best practice documentation pertaining to institutional care.	MOWA, with technical assistance from UNICEF and FHI	6-12 months
Implement training on the NGAC, minimum standards of care, and best institutional care practices for key government oversight bodies (all levels, including MOWA/MOLSA/MOJ), and for management and staff of child care institutions, NGOs, and CBOs working in the area of alternative care.	MOWA, with technical assistance from FHI, UNICEF, and other organizations; AAU	9-18 months

Phase III: Preventing Unnecessary Institutionalization and Promoting De-institutionalization through Alternative Care Options

Action/Activity	Who Is Responsible	Timeframe
Identify NGOs/CBOs and other community groups implementing family preservation/support programs and other alternative care options, such as foster care and support for child-headed households (CHH). Document best practices and lessons learned, and use to inform and promote local alternative care efforts, rather than institutionalization.	FHI, with support from UNICEF and oversight and coordination from MOWA and MOLSA	6-18 months
Develop and implement a cost analysis of the different elements of a continuum of alternative care—including institutional care as a last resort option—to inform further development of alternative care services in Ethiopia. This can be linked to the development of demonstration models of quality and comprehensive alternative care with a specific cost analysis element.	MOWA leading a collaborative effort of all stakeholders involved in alternative care, with technical assistance from a technical agency (e.g., UNICEF, FHI, and/or others)	3-5 years
Facilitate exchange programs to identified projects/sites for institutions/CBOs wanting to implement best practices in alternative care.	UNICEF, FHI in coordination with MOWA and MOLSA	9-18 months
Explore domestic adoption procedures and identify ways to facilitate local adoption as a means of avoiding institutionalization (e.g., public awareness campaign).	MOWA, in coordination with MOLSA and MOJ Technical support provided by FHI and UNICEF	9-18 months
Create a public awareness campaign promoting family-based alternative care options and bringing negative effects of institutionalization to light.	MOWA, with technical assistance from FHI and UNICEF	12-24 months

Note: Cross-cutting activities include development of logframes, monitoring and evaluation tools, quarterly meetings, and follow-up.

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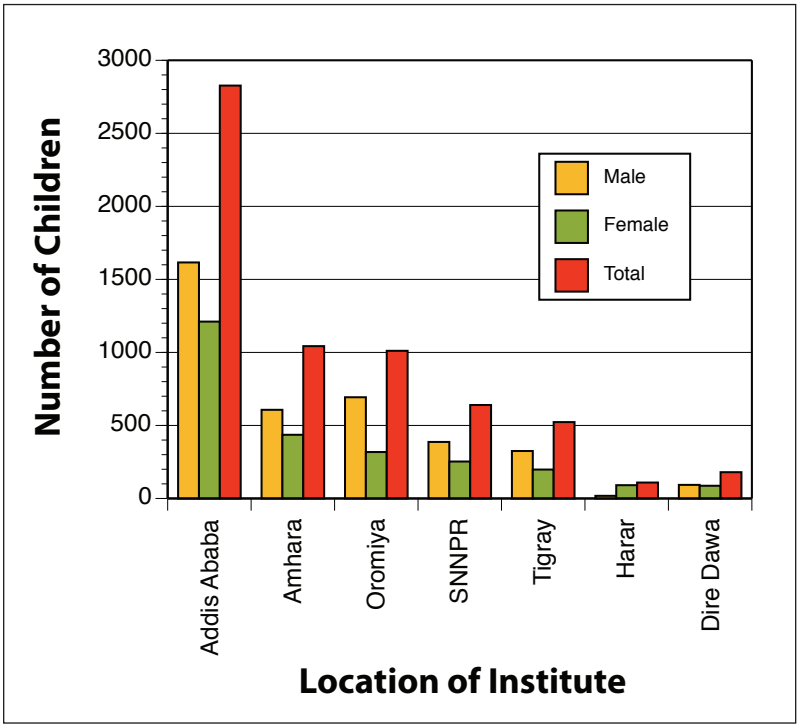
APPENDICES

Appendix 1: Distribution of children, by gender and location of institution



Appendix 2: Summary of informants and instruments used

Category of informants	Method of gathering information	Number of informants
Formerly institutionalized children	In-depth interview	22
Caregivers	Focus group discussion	49
Managers of institutions	Key informant interview	11
Community members	Focus group discussion	118
Parents/guardians who gave their children to institutions	In-depth interview	13
Officials of BoLSA	Key informant interview	11
Heads of institutions	Structured questionnaire	87
Heads of institutions/ organizations	Self-administered, semi-structured questionnaire on best practices	77
Total		**388**

Appendix 3: Distribution of data collected, by region

Method by which information was collected		Number of interviews, FGDs, etc., by region				Number of informants
		Addis Ababa	Amhara	Oromiya	SNNPR	
FGD	Community	4	4	2	4	118
	Caregivers	3	2	1	1	49
KII	MOWA/ BoLSA	1	4	2	4	11
	Managers/ heads of institutions	4	3	3	1	11
In-depth interview	Parents	1	4	5	3	13
	Formerly institutionalized children	8	4	5	5	22
Questionnaire		33	10	21	12	76
Semi-structured questionnaire on best practices		24	18	15	20	77
		Questionnaires collected from other regions				11
Total number of informants						**388**

Appendix 4: Structured questionnaire for institutions

Quality of care and current Institutional care practices in Ethiopia
Family Health International (FHI) – Ethiopia and United Nations Children Fund (UNICEF) in Collaboration with Federal Ministry of Women Affairs, Ethiopia **Quality Standard and Current Practice Assessment Tool** **APPROPRIATE RESPONDENT:** Head of the childcare institution

INTRODUCTION	
Questionnaire #	
Date of the interview	
Time interview started	
Time interview finalized	
Data collector's name and signature	

General information	
Name of institution (according to the license)	
Date of establishment	DATE MONTH YEAR
License number	
Type of institution/owner	1. Governmental 2. Non governmental 3. Faith based 77. Other (specify) _____

Address of institution/ organization	Region 1. AA 2. Amhara 3. Oromia 4. SNNPR 5. Tigray 6. Harar 7. Diredawa 8. Somali Zone /Sub-city _____ Woreda _____ Town _____ Kebele: _____ House # _____ Tel: _____ E-mail _____
Was the institution built for this purpose?	1. Yes 2. No
Position of the interviewee	

Checked by:
Supervisor's name:
Supervisor's signature:
Date:

Section 1: Working relation with government (1-12)			
	Questions	Response code	Skip
1.	Does the institution have a relationship with government body?	1. Yes 2. No 88. Don't know 99. No response	9
2.	To which government body/ bodies are you accountable?	1. BOLSA 2. Bureau of Justice 77. Other (specify) _____ 88. Don't know 99. No Response	
3.	What kind of relationship do you have with the above authority? (more than one answer is possible)	Supervisory Financial support Material support Reporting Other (specify) _____ 88. Don't know 99. No response	
4.	Do you report your activities to the aforementioned authority?	1. Yes 2. No 88. Don't know 99. No answer	6

5.	How often do you report your activities to the above government body?	Monthly Quarterly Biannually Yearly 77. Other (specify) _____ 88. Don't know 99. No response	
6.	Does the authority mentioned above (question 2) make supervisory visit (monitoring) your institution?	1. Yes 2. No 88. Don't know 99. No answer	9
7.	How often the authorities mentioned above (question 2) supervise (monitor) your institution?	1. Quarterly 2. Biannually 3. Yearly 4. Not regular (surprise) 77. Other (specify) _____ 88. Don't know 99. No response	
8.	If your answer for question number 7 is 4 (not regular), when was the last monitoring supervision you received from the above authority?	DD MM YY	
9.	Did any government body visit your institution during the past one year?	1. Yes 2. No 88. Don't know 99. No answer	13

10.	Which government body visited your institution last year?	1. MOWA 2. BOLSA/ MOLSA 3. MOJ/ BOJ 77. Other (specify) 88. Don't know 99. No Response	
11.	What was the purpose of the visit?	Supportive supervision Evaluation Problem solving Experience sharing 77. Other (specify) _____ 88. Don't know 99. No Response	
12.	If it was for supervision, have you received feedback?	1. Yes 2. No 88. Don't know 99. No response	
Section 2: Goals, objectives, and policies (13-25)			
13.	Does the institution have written objectives?	1. Yes (check document) 2. No 88. Don't know 99. No response	17

14.	Are objectives of the institution communicated to the staff?	1. Yes 2. No 88. Don't know 99. No response	
15.	Are the objectives of the institution communicated to the children?	1. Yes 2. No 88. Don't know 99. No response	
16.	How do you communicate the objectives? (Don't read out the options)	1. Posting on notice board 2. During meetings and different occasions 77. Other (specify) _____ 88. Don't know 99. No response	
17.	Does the institution have a child protection policy?	1. Yes (check document) 2. No 88. Don't know 99. No response	
18.	Do caregivers receive orientation about children's right?	1. Yes (check document) 2. No 88. Don't know 99. No response	22
19.	How often do you orient caregivers about the rights of children?	1. Regularly every _____ 2. Irregularly 77. Other (specify) _____ 88. Don't know 99. No response	

20.	If your answer to the above question is 1 (regular), who offers the orientation? (Circle all that apply)	MOJ MOWA BOLSA 77. Other (specify) 88. Don't know 99. No response	
21.	If your answer to the above question (question 19) is 2 (irregularly), when was the last orientation offered?	_____ (dd/mm/yy)	
22.	Do children receive orientation about their rights?	1. Yes 2. No 66. Not applicable 88. Don't know 99. No response	 26 26
23.	How often do children receive orientation about their rights?	1. Regularly every _____ 2. Irregularly 77. Other (specify) _____ 88. Don't know 99. Nor response	
24.	If your answer to question 23 is 1 (regularly), who offers the orientation?	1. MOJ 2. MOWA 3. The institution 77. Other (specify) _____ 88. Don't know 99. No response	
25.	If your answer to question 23 is 1 (irregularly), when was the last orientation offered?	_____ (dd/mm/yy)	

Section 3: Admission: (26 – 36)			
26.	Who refer children to the institution? (Circle all that apply)	1. MOJ 2. MOWA 3. MOLSA 3. Police 4. Kebele administration 3. Hospital 77. Other (specify) _____ 88. Don't know 99. No response	
27.	Does the institution have eligibility criteria for children who come to the institution?	1. Yes (check the document) 2. No 88. Don't know 99. No response	29
28.	What are the eligibility criteria for admission? (Circle all that apply)	1. Double orphan 2. Single orphan 3. Abandoned 4. Parents terminally ill 77. Other (specify) _____ 88. Don't know 99. No response	
29.	Does the institution undertake a pre-admission screening for children?	1. Yes 2. No 88. Don't know 99. No response	33

30.	If your answer for question 29 is 1 (yes), how many children received the pre-admission screening among the new enrolled children during the past year?	All children For some: M_____ F_____ 88. Don't know 99. No response	32
31.	If you are not undertaking the pre-admission screening for all children, what are the reasons?	_____ _____ _____ _____	
32.	What do you screen children for during a pre-admission screening?	1. Health status 2. Physical disability 3. History of abuse 77. Other (specify) 88. Don't know 99. No response	
33.	Who makes the final decision on admission?	1. Committee 2. Head of the institution 77. Other (specify) _____ 88. Don't know 99. No response	
34.	Do you have a register for all children admitted to the institution?	1. Yes (check the register) 2. No 88. Don't know 99. No response	

35.	Do you record baseline information for all children on admission?	1. Yes (check sample) 2. No 88. Don't know 99. No response	37
36.	If the answer is yes, which one of the following information is/are recorded?		
	(Circle all that apply)	1. Name	
		2. Age	
		3. Sex	
		4. Family name	
		5. Family history	
		6. Place and date of birth	
		7. Previous and current address	
		8. Religion	
		9. Education	
		10. Health status	
		11. Nutritional status	
		12. Physical disability (if any)	
		13. Psychological profile	
		14. History of abuse (if any)	
		15. Status of a child (e.g., orphan, abandoned child)	
		77. Other (specify)	
Section 4: Services: 4.A: On going care [through care] (37 – 55)			
37.	Is there a written care plan* for each child in the institution? (*a written document which outlines how, when and whom will meet the child's developmental needs)	1. Yes 2. No 88. Don't know 99. No response	43

38.	If the answer is yes, who participates in the care plan preparation? (Circle all that apply)	Managers Care givers Counselors Teachers Children Other (specify) _____ 88. Don't know 99. No response	
39.	How many care plans were developed in the past one year?	_____ _____	
40.	How frequently do you review care plans?	1. Every _____ 2. Irregularly 77. Other (specify) 88. Don't know 99. No response	
41.	Who is involved in the review of the care plans? (Circle all that apply)	Managers Care givers Counselors Teachers Children Other (specify) _____ 88. Don't know 99. No response	
42.	How many care plans were reviewed in the past three months of Miazia, Ginbot, Sene?	_____ _____ _____	

43.	Do you prepare a placement plan of children?	1. Yes 2. No 88. Don't know 99. No response	48
44.	Do you review children's placement status?	1. Yes 2. No 88. Don't know 99. No response	
45.	Who is involved in the review of the placement of children?	Managers Care givers Counselors Teachers Children 77. Other (specify) _____ 88. Don't know 99. No response	
46.	How many children's placement statuses were reviewed during the past year?	_____	
47.	Are there documented minutes of the review process?	1. Yes 2. No 88. Don't know 99. No response	
48.	Do children in the institution have a personal file?	1. Yes 2. No 88. Don't know 99. No response	50

49.	If yes, how many children have personal files?	_____	
50.	Is there a regular follow-up of children development status? (physical and mental)	1. Yes 2. No 88. Don't know 99. No response	
51.	Who is doing the follow-up? (Circle all that apply)	1. Health worker 2. Counselor 3. Caregiver 77. Other (specify) _____ 88. Don't know 99. No response	
52.	Is there periodic recording of the children's development follow-up?	1. Yes 2. No 88. Don't know 99. No response	

53.	Which service/s are you providing to children living in your institution?		
	(Circle all that apply) Read out options	1. Lodging	
		2. Food	
		3. Clothing	
		4. Health care	
		5. Sanitation (personal and environmental)	
		6. Academic education	
		7. Vocational training	
		8. Play and recreation service	
		9. Guidance and counseling	
		10. Reunification	
		11. Reintegration	
		12. Special care for children with disabilities	
		77. Other service (specify)	
54.	Do you provide a rehabilitation service to children on admission?	1. Yes 2. No 88. Don't know 99. No response	56
55..	What kind of rehabilitative service do you provide to children upon admission? (Circle all that apply)	1. Nutrition 2. Health 3. Psychological 77. Other (specify) _____ 88. Don't know 99. No response	

Section 4 B: Food and nutrition (56 - 69)			
56.	Is there a food program/ schedule for the children?	1. Yes (check the schedule) 2. No 88. Don't know 99. No response	
57.	Which of the following is included in the food program?	Breakfast Lunch Supper/Dinner Break snack Lunch snack 77. Other (specify) _____ 88. Don't know 99. No response	
58.	Do children take part in food preparation?	1. Yes 2. No 66. Not applicable 88. Don't know 99. No response	
59.	How frequently do you provide milk for children <4 months?	1. Every _____ 2. Not provided 66. Not applicable 88. Don't know 99. No response	

60.	How frequently do you provide milk and supplementary food for children between 4-12 months?	1. Every _____ 2. Not provided 66. Not applicable 88. Don't know 99. No response	
61.	How many meals do you provide to children from 1-7 years per day?	1. _____ meal / day 2. No different schedule (as requested) 77. Other (specify) _____ 88. Don't know 99. No response	
62.	How many meals do you provide children above 7 years?	1. _____ meal / day 2. No different schedule 77. Other (specify) _____ 88. Don't know 99. No response	
63.	Do you check the quality and quantity of food served?	1. Yes 2. No 88. Don't know 99. No response	
64.	What mechanism do you use to ensure the quality and quantity of food served?	_____ _____ _____ _____ _____	

65.	How often do you check the type, quality, and quantity of the food served?	1. Every _____ 77. Other (specify) _____ 88. Don't know 99. No response	
66.	Who supervises the food service? (Circle all that apply)	1. Health worker 2. Nutritionist 3. Counselor 4. Management of the institution 5. Committee 77. Other (specify) _____ 88. Don't know 99. No response	
67.	Is there a report about the type, quality, and quantity of the food served?	1. Yes 2. No 88. Don't know 99. No response	
68.	Do you have an adequate supply of water in the institution (enough for the children for their daily use and cleanliness)?	1. Yes 2. No 88. Don't know 99. No response	
69.	What is the source of drinking water in the institution? (More than one answer is possible)	1. Tap (piped) water 2. Protected well 3. Protected spring 77. Other (specify) _____ 88. Don't know 99. No response	

Section 4 C: Medical/ Health care (70 – 81)			
70.	Do children under 1 year of age have a regular medical check-up?	1. Yes 2. No 66. Not applicable 88. Don't know 99. No response	 73 73
71.	How often do children below 1 year receive a medical check-up?	1. Every _____ 77. Other (specify) _____ 88. Don't know 99. No response	
72.	How many children less than 1 year received a medical check-up service during the past year?	M _____ F _____ Total _____	
73.	Do children 6 years and above receive a biannual medical check-up?	1. Yes 2. No 88. Don't know 99. No response	 75
74.	How many children 6 years and above received the service past year?	M _____ F _____ Total _____	
75.	Do children under 5 years of age receive immunization?	1. Yes 2. No 66. Not applicable 88. Don't know 99. No response	 77 77

76.	How many children under 5 years of age get immunization past year?	M _____ F _____ Total _____	
77.	Do you have a clinic in the premises?	1. Yes 2. No 88. Don't know 99. No response	
78.	Do you have a referral system for medical/health care services?	1. Yes 2. No 88. Don't know 99. No response	80
79.	To which type of health facility do you refer children for medical reasons?	1. Hospital 2. Health center 3. Clinic 77. Other (specify) _____ 88. Don't know 99. No response	
80.	Do adolescents receive regular sexual education?	1. Yes 2. No 88. Don't know 99. No response	
81.	Do children receive regular education on the prevention of HIV?	1. Yes 2. No 88. Don't know 99. No response	

Section 4 D: Personal care (82 – 91)			
82.	Do you provide clothing to children?	1. Yes 2. No 88. Don't know 99. No response	
83.	If the answer is yes, how frequently do you provide clothing to children?	Annually Biannually As found necessary 77. Other (specify) _____ 88. Don't know 99. No response	
84.	Do you provide personal sanitary materials (e.g., tooth brush, towel, sanitary pads)?	1. Yes, regularly every _____ 2. Yes, as found available 3. As requested 4. Not provided 88. Don't know 99. No response	
85.	Do you provide laundry materials (soap, bleaches)?	1. Yes, regularly every _____ 2. Yes, as found available 3. As requested 4. Not provided 88. Don't know 99. No response	

86.	Do you provide sanitary materials to keep the compound clean (waste bin, broom, duster)?	1. Yes, regularly every _____ 2. Yes, as found available 3. As requested 4. Not provided 77. Other (specify) _____ 88. Don't know 99. No response	
87.	Are there waste disposal materials for the children (waste bin)?	1. Yes 2. No 77. Other (specify) _____ 88. Don't know 99. No response	
88.	Do institution staff supervise the cleanliness of the compound?	1. Yes, regularly every _____ 2. Yes, not regularly 3. Not supervised 88. Don't know 99. No response	
89.	Is there a check-up on children's personal hygiene?	1. Yes, regularly every _____ 2. Yes, not regularly 3. No check-up 88. Don't know 99. No response	

90.	Are children educated about personal hygiene?	1. Yes, regularly every _____ 2. Yes, but not regularly 3. No education 88. Don't know 99. No response	
Section 4 E: Play and recreation (91 – 93)			
91.	Are play and recreation facilities available on the compound?	1. Yes 2. No 88. Don't know 99. No response	94
92.	Are play materials appropriate for the needs of different age groups?	1. Yes 2. No 88. Don't know 99. No response	
93.	Is adequate time allocated for play and recreation for children?	1. Yes 2. No 88. Don't know 99. No response	
Section 4 F: Education and training (94 - 123)			
94.	Do all children have equal opportunity of education (male, female, handicapped)?	1. Yes 2. No 88. Don't know 99. No response	
95.	How many children ages 7 years and above are currently attending school within the community?	M _____ F _____ Total _____	

96.	Is there Kindergarten within the institution's premises?	1. Yes 2. No 88. Don't know 99. No response	
97.	How many children are attending Kindergarten currently?	M _____ F _____ Total _____	
98.	Does the institution support children who seek higher education?	1. Yes 2. No 88. Don't know 99. No response	100
99.	How many children under the support of the institution are attending higher education currently (university/college)?	M _____ F _____ Total _____	
100.	Is there a formal education facility (school) in the compound?	1. Yes 2. No 88. Don't know 99. No response	102
101.	Do other children (i.e., children living out of the institution) attend school in the compound?	1. Yes 2. No 88. Don't know 99. No response	

102.	Who provides school materials to children living in the institutions?	The institution Government Donors The community Other (specify) _____ 88. Don't know 99. No response	
103.	Do you provide supportive educational service to children who are in need of the support? (tutorial, additional class)	1. Yes 2. No 88. Don't know 99. No response	
104.	Do you follow children's educational development?	1. Yes 2. No 88. Don't know 99. No response	108
105.	How frequently do you follow children's educational development?	1. Every _____ 77. Other (specify) _____ 88. Don't know 99. No response	
106.	Who is doing the follow-up?	Counselor Teacher Committee 77. Other (specify) _____ 88. Don't know 99. No response	

107.	Is there a regular report on the children's educational development	1. Yes (check document) 2. No 88. Don't know 99. No response	
108.	Is there a reading room in the institution?	1. Yes (check) 2. No 88. Don't know 99. No response	110
109.	Are there relevant books for the children in the reading room (i.e., educational books for the level of the school)?	1. Yes. (check) 2. No 88. Don't know 99. No response	
110.	Do you have vocational training program for eligible groups of children?	1. Yes 2. No 88. Don't know 99. No response	124
111.	Do you have a vocational training school within the institution?	1. Yes 2. No 88. Don't know 99. No response	

112.	What are the eligibility criteria for a vocational training school? (Circle all that apply)	Age 12 years and above Has completed grade six Has interest to attend the training Failed to continue academic education 77. Other (specify) _____ 88. Don't know 99. No response	
113.	How many children are attending vocational training school?	M _____ F _____ Total _____	
114.	Who is covering the tuition fee for the children attending the vocational training?	1. The institution 2. Government 3. Donors 4. The school 5. The community 6. No payment 77. Other (specify) _____ 88. Don't know 99. No response	

115.	Who is providing teaching materials for the children attending the vocational training?	1. The institution 2. Government 3. Donors 4. The school 5. The community 77. Other (specify) _____ 88. Don't know 99. No response	
116.	Do you follow the educational development of children who are attending the vocational training?	1. Yes 2. No 88. Don't know 99. No response	120
117.	How frequently do you follow the vocational development of children?	1. Every _____ 77. Other (specify) _____ 88. Don't know 99. No response	
118.	Who is doing the follow-up?	1. Counselor 2. Teacher 3. Committee 77. Other (specify) _____ 88. Don't know 99. No response	
119.	Is there a report on the vocational training development of children?	1. Yes (check record) 2. No 88. Don't know 99. No response	

120.	Does the institution facilitate job opportunities to the children after they complete vocational training?	1. Yes 2. No 77. Other (specify) _____ 88. Don't know 99. No response	
121.	How many children graduated from vocational training so far?	M _____ F _____ Total _____	
122.	How many children have secured a job after the training so far?	M _____ F _____ Total _____	
Section 4 G: Lodging (123 – 128)			
123.	What is/are the type/s of lodging the institution uses? (Circle all that apply)	Self contained home Dormitory 77. Other (specify) _____ 88. Don't know 99. No response	
124.	Number of self-contained home in the institution	_____	
125.	Number of children living in a self-contained home	M _____ F _____ Total _____	
126.	Total number of dormitories in the institution	_____	
127.	Number of children residing in a dormitory	M _____ F _____ Total _____	
Section 4 H: Guidance and counseling (128 – 132)			
128.	Are there guidance and counseling services for the children?	1. Yes 2. No 88. Don't know 99. No response	133

129.	Which type of guidance and counseling do you offer to the children? (Circle all that apply)	1.Behavioral 2. Health 3. Educational 77. Other (specify) _____ 88. Don't know 99. No response	
130.	Who provides the counseling service? (Circle all that apply)	1. Counselor 2. Teachers 77. Other (specify) _____ 88. Don't know 99. No response	
131.	Is there documentation of the guidance and counseling services mentioned above?	1. Yes (Check the document) 2. No 88. Don't know 99. No response	
132.	How many children received guidance and counseling service past year?	M _____ F _____ Total _____	
Section 5: Gender related issues (133 – 136)			
133.	Are there separate bed rooms for boys and girls?	1. Yes 2. No 88. Don't know 99. No response	
134.	Do children share beds (including children of same sex)?	1. Yes 2. No 88. Don't know 99. No response	

135.	Are there separate toilet rooms for boys and girls?	1. Yes 2. No 88. Don't know 99. No response	
136.	Are there separate bath rooms for boys and girls?	1. Yes 2. No 88. Don't know 99. No response	
Section 6: Children participation and discipline (137 – 136)			
137.	Is there a separate bedroom for caretakers around the living rooms of the children?	1. Yes 2. No 88. Don't know 99. No response	
138.	Is there a regulation that forbids unsupervised visits between boys and girls?	1. Yes 2. No 88. Don't know 99. No response	
139.	Are children involved in making decisions on matters that affect their life (exit, placement, foster)?	1. Yes 2. No 88. Don't know 99. No response	
140.	Is there a written policy on methods of control, discipline, and sanctions?	1. Yes (check the document) 2. No 88. Don't know 99. No response	143

141.	Is there a mechanism to introduce the policy to the children?	1. Yes 2. No 88. Don't know 99. No response	 143
142.	How do you introduce the policy (mentioned above) to the children?	1. Regular orientation sessions 2. During meetings 3. Translating the doc in local language 4. Posting in the institution 77. Other (specify) _____ 88. Don't know 99. No response	
143.	How do you introduce the policy to the institution community (caregivers, teachers, guards, administrators)?	1. Regular orientation sessions 2. On meetings 3. Translating doc to local language 4. Posting in the institution 77. Other (specify) _____ 88. Don't know 99. No response	
144.	Is there a formal complaint appeal mechanism for caregivers that allows them to report child abuse and exploitation?	1. Yes 2. No 88. Don't know 99. No response	 145 145 145

145.	If yes, where do they report? (Circle all that apply)	1. To the principal 2. To the counselor 3. To legal body (police) 77. Other (specify) _____ 88. Don't know 99. No response	
146.	Is there a formal complaint mechanism for children that allows them to report child abuse and exploitation?	1. Yes 2. No 88. Don't know 99. No response	148
147.	How do they report abuse? (Circle all that apply)	In person In writing Through the caregivers 77. Other (specify) 88. Don't know 99. No response	
148.	Where do they report abuse? (Circle all that apply)	1. To the principal /head of institution 2. To the counselor 3. To legal body 4. To caregiver 5. Other (specify) _____ 88. Don't know 99. Nor response	

149.	Were there reports of complaints about child abuse and exploitations in your institution in the past year?	1. Yes 2. No 88. Don't know 99. No response	154
150.	Now many such reports were received?	_____	
151.	Who reported the complaints? (Circle all that apply)	1. Children 2. Caregivers 4. Other members of the institution 77. Other (specify) _____ 88. Don't know 99. No response	
152.	What were the commonest forms of abuses and exploitation reported? (Circle all that apply)	1. Sexual 2. Labor 3. Psychological 77. Other (specify) _____ 88. Don't know 99. No response	
153.	Who were involved in the actions mentioned above?	Teachers Students (their mates/peers) Caregivers 77. Other (specify) _____ 88. Don't know 99. No response	

154.	What actions were taken?	1.. legal action 2. Reprimand 3.. Disciplinary action 77. Other (specify) _____ 88. Don't know 99. No response	
Section 7: Alternative forms of care (155 – 165)			
155.	Do you place children in other alternative care (other than institution) programs?	1. Yes 2. No 88. Don't know 99. No response	160
156.	If the answer is yes, what type of alternative care services are provided to children? (More than one answer is possible)	1. Foster care 2. Adoption 3. Family reintegration 4. Reunification 77. Other (specify) _____ 88. Don't know 99. No response	
157.	How many children were put in foster care during the past year?	M _____ F _____ Total _____	
158.	How many children were put in adoption care during the past year?	M _____ F _____ Total _____	
159.	How many children were reintegrated during the past year?	M _____ F _____ Total _____	
160.	How many children were reunified during the past year?	M _____ F _____ Total _____	

161.	Do you have disabled children in your institution?	1. Yes 2. No 88. Don't know 99. No response	164
162.	How many disabled children do you have in your institution?	1. M _____ F _____ Total ____ 77. Other (specify) _____ 88. Don't know 99. No response	
163.	What type of services do you provide to children with disabilities?	Brail training Prosthesis Wheel chair Skills training Sign language No service for disabled children 77. Other (specify) _____ 88. Don't know 99. No response	
164.	How many children with disabilities have received any of the above services during the past year?	1. M_____F _____ Total _____ 88. Don't know 99. No response	

Section 8: Human resources (165 – 175)				
	Which of the following staff are in the institution?	Availability and number	Education [1: read and write, 2: 1-8, 3: 9-10, 4: 11-12, 5: college and university]	
165.	1. Manager	1. Available # ____ 0. NA		
	2. Secretary	1. Available # ____ 0. NA		
	3. Finance officer	1. Available # ____ 0. NA		
	4. Purchaser	1. Available # ____ 0. NA		
	5. Store keeper	1. Available # ____ 0. NA		
	6. Cashier	1. Available # ____ 0. NA		
	7. Security guards	1. Available # ____ 0. NA		
	8. Sanitary personnel	1. Available # ____ 0. NA		
	9. Health assistant	1. Available # ____ 0. NA		
	10. Counselor	1. Available # ____ 0. NA		
	11. Caregivers	1. Available # ____ 0. NA		
	12. record keeping person	1. Available # ____ 0. NA		
	77. Other (specify)			

166.	Are there a written recruitment and selection criteria for caregivers?	1. Yes (check the document) 2. No 88. Don't know 99. No response	167
167.	What are the major criteria ?		
168.	Among the existing caregivers, how many of them have received basic child care training for three months?	M _____ F _____ Total _____	
169.	Do you have on-site job supervision of caregivers?	1. Yes 2. No 88. Don't know 99. No response	171
170.	Who does the on-site supervision?	The principal Committee 77. Other (specify) _____ 88. Don't know 99. No response	
171.	If yes, how frequently do you supervise caregivers who are on duty?	1. Every _____ 77. Other (specify) _____ 88. Don't know 99. No response	
172.	Do you conduct performance review meetings with the caregivers?	1. Yes 2. No 88. Don't know 99. No response	173

173.	How frequently do you conduct performance review meetings of caregivers?	1. Every _____ 2. Following the meetings 3. As found convenient 77. Other (specify) _____ 88. Don't know 99. No response	
Section 9: Exit (termination of services) (174 – 192)			
174.	Is there a written exit procedure for children?	1. Yes (check document) 2. No 88. Don't know 99. No response	
175.	Do you review the exit procedure with the children?	1. Yes 2. No 77. Other (specify) _____ 88. Don't know 99. No response	179
176.	At what age do you communicate the information to the children?	At age _____	
177.	When do you inform children before service termination?	_____	

178.	Do you officially notify the government about service termination?	1. Yes, officially in writing (check letter) 2. Yes, but not officially (not in writing) 3. No 77. Other (specify) _____ 88. Don't know 99. No response	180
179.	If the answer is yes, whom do you inform? (More than one answer is possible)	1. BOLSA 2. MOJ 3. MOWA 4.. Local administration 7. Other (specify) _____ 88. Don't know 99. No response	
180.	When do you inform the above authority about the service termination?	_____ time duration before exit 88. Don't know 99. No response	
181.	Do you facilitate a smooth transition of children from the institution to the community?	1. Yes 2. No 88. Don't know 99. No response	186

182.	How?	1.. Discussion with local leaders 2. Finding job opportunity 3. Regular follow up after exit 77. Other (specify) _____ 88. Don't know 99. No response	
183.	How many children have you exited past one year?	# _____ M _____ F _____	
184.	Do you have a follow-up mechanism for children after exit?	1. Yes 2. No 88. Don't know 99. No response	186
185.	If the answer is yes, what are the mechanisms you are using?	_____	
186.	For how long do you maintain your contact with the child after exit?	< 1 year 1-5 years > 5 years 77. Other (specify) _____ 88. Don't know 99. No response	
187.	Do children interact with the community?	1. Yes 2. No 88. Don't know 99. No response	189
188.	How?	_____ _____	

189.	Does the community interact with the children?	1. Yes 2. No 88. Don't know 99. No response	
190.	Are there efforts by the institutions to secure the collaboration of the community?	1. Yes 2. No 88. Don't know 99. No response	Question ends
191.	What are the efforts?	_____	

Appendix 5: Alternative care questionnaire

Questionnaire for Documenting Best Practices in Alternative Forms of Care *To be filled out for all institutions by the heads or delegates of the institutions and community-based service providers*
Institution description **1. General description** **Name**: **Location:** Region Zone Town **Location of Main Office (if different from above):** Region Zone Town
Objective of the institution:
Timeline:
When was the institution established? Date _____ Month _____ Year _____
Ending (if applicable): Date _____ Month _____ Year _____

Target groups:
Catchments population:
Catchments Region/Zone/Woreda:
2. Service provision
Enrollment statistics for the past five years

A. Number of new enrollment and cumulative numbers of children served during 1999 E.C.

Age	New admission during 1999			Existing number of children		
	Male	Female	Total	Male	Female	Total
< 1						
1-4						
5-9						
10-14						
15-18						
Unrecorded						
Total						

B. Trend of new enrollment during the past five years

Age group	Single orphan		Double orphan		Parents terminally ill		Parents not traceable		Other causes of admission		
	M	F	M	F	M	F	M	F	M	F	
1999											
1998											
1997											

1996											
1995											
1994											
Total											

C. Age of children and reasons for admission during the past year										
Age group	Single orphan		Double orphan		Parents terminally ill		Other causes of admission		Total	
	M	F	M	F	M	F	M	F	M	F
< 1										
1-4										
5-9										
10-14										
15-18										
Unre-corded										
Total										

Indicate reasons:

D. Number of children under the support of the institution but not living within the institution (other forms of care) You may attach a separate sheet to give detail.						
	New for the year (1999)			Total during the year (cumulative)		
Year	Male	Female	Total	Male	Female	Total
< 1						
1-4						
5-9						
10-14						
15-18						
Unre-corded						
Total						

Is there any activity that involves other stakeholders (for example, the community, government, CBO) in your service? Please specify the activity and the participants/partners.

1. Stakeholder_____

2. Stakeholder_____

3. Stakeholder_____

4. Stakeholder_____

5. Stakeholder_____

Explain how the specified groups participate in the service.

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have alternative forms of care program?

Yes _____ Continue with the next section

No _____Quit the question

Best Practices in Specific Intervention Areas

In the following section, please indicate which of the listed interventions (A-C below) you are undertaking by circling one or more. Then, go to the page indicated for each intervention and give your answers to the questions. Give a brief description of the activities you are implementing.

Thank you.

In which of the following activities does your institution work? Circle and then go to the page corresponding to each selection.

A. Transition of large institutions to smaller community-monitored facilities, Page XX

B. Foster care, kinship care, and guardianship care, Page XX

C. Family preservation services, Page XX

D. Other services

A. Transition of large institutions to smaller community-monitored facilities

1. Do you have a plan of further involving the community in the program design, management, monitoring, and support?
Yes No

(If yes, please briefly explain your plan.)

2. Have you started the process of involving the community in the program stated above?
Yes No

(If yes, explain how it is going.)

3. If you have started already, what is the response from the community?

4. What is the benefit of the initiative for your institution? How do you benefit from the activity?

5. What is the benefit of the initiative to the community?

6. What is the benefit to the children?

7. For what type of environment are these interventions suitable?

8. What did not work as planned or expected? Were you able to resolve this? If yes, how?

9. What recommendations would you give to others who would like to repeat similar interventions?

B. Foster care, kinship care, and guardianship care

1. What have you done to support foster care, guardianship, and kinship programs within the community? Describe briefly what you have done **in each area** and when this was started.

2. Do you feel you have accomplished your objectives? Are you satisfied?

3. What do you think is the best practice out of this intervention?

4. What is the benefit of the initiative for your institution? How do you benefit from the activity?

5. What is the benefit of the initiative to the community?

6. What is the benefit to the children?

7. What are your plans for this program?

8. What recommendations would you give to others who would like to repeat similar interventions?

9. What did not work as planned or expected? Were you able to resolve it? If yes, how?

C. Family preservation services (Family preservation refers to a systematic determination of those families in which children could remain in their homes or be returned home safely, and provision of the services needed to ensure that safety.)

1. What have you done to preserve the family (keep children with difficult circumstances home under the care of their family)?

2. Why did you start this service?

3. Do you feel you have accomplished your objectives? Are you satisfied?

4. What is the best practice out of this intervention? Why do you consider it the best practice?

5. What is the benefit of the initiative for your institution? How do you benefit from the activity?

6. What is the benefit of the initiative to the community?

7. What is the benefit to the children?

8. What is your plan for the future of this program?

9. What recommendations would you give to others who would like to repeat similar interventions?

10. What did not work as planned or expected? Why do you think it did not work? Is the issue still relevant? If yes, how do you think it could be resolved?

11. What are the challenges in implementing this program? How do you overcome these challenges?

_____

_____

Contact details

Who provided this information?

Name _____

Address (office) _____

Position in the institution: _____

_____

_____

Contact address _____

_____

Telephone (office)_____

E-mail _____

Appendix 6: Children sharing beds and location of institutions

Children sharing beds	Location of institution		
	Addis Ababa	**Other regions**	**Total**
Yes	15	11	26
	48.4%	20.4%	30.6%
No	16	43	59
	51.6%	79.6%	69.4%
Total	31	54	85
	100.0%	**100.0%**	**100.0%**

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