REPUBLIC OF KENYA
Department of Children's Services

Caseworker's Guidebook

Case Management for Reintegration of Children into Family or Community Based Care
August 2019

The development of this *Guidebook* has been largely informed by the *National Child Protection Case Management and Referral Pathway Guidelines* in Kenya, *the Guidelines for the Alternative Family Care of Children in Kenya*, the case management model developed by 4Children [Coordinating Comprehensive Care for Children] Uganda's Keeping Children in Healthy and Protective Families project and the MWENDO [Making Well-Informed Efforts to Nurture Disadvantaged Orphans & Vulnerable Children] case management standard operating procedures for orphans and vulnerable children in Kenya.

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FOREWORD

A “guideline” helps determine the course of action and aims to streamline processes according to defined procedures. The same is true for this Case Management for Reintegration of Children into Family- or Community-based Care package. Much of its information is derived from guidance found in the 2018 Child Protection Case Management and Referral Guidelines in Kenya, Guidelines for Alternative Family-based Care of Children in Kenya (2014), and two global documents: the *United Nations Guidelines for the Alternative Care of Children* (2010), and the *Inter-Agency Group Guidelines on Children’s Reintegration* (2016).

Overall, this Case Management for Reintegration of Children into Family- or Community-based Care package consists of a Caseworker Guidebook, Caseworker Toolkit, Facilitator Guide, and Caseworker Training Presentation set. The package should be read together with the Guidelines on Child Protection Case Management and Referral and Guidelines for Alternative Care of Children in Kenya.

Children in Kenya form approximately 52 percent of the total population. They face diverse challenges that require guided course of actions to safeguard their rights and welfare. Approximately 3.6 million Kenyan children are orphans or otherwise classified as vulnerable. Of these, 646,887 are double orphans (i.e., they have lost both parents to AIDS or other causes, or one parent to AIDS and another to a non-AIDS related cause). An estimated 104,000 children are living with HIV. All children in Kenya are at risk of violence, exploitation, and abuse; however, some groups are more vulnerable than others due to their gender, social status, or geographical location. Children outside of parental care lack the protective environment and supervision that adult care normally provides. Fifty-four percent of maltreatment cases reported are of neglect (DCS CPIMS, 2020).

Kenya has over 830 residential care institutions—known as Charitable Children’s Institutions (CCI)—housing an estimated 45,000 children (the exact number is unknown and may be higher). These institutions were established to provide care, protection, and/or rehabilitation of children. Further, children make up an estimated four percent of the population in correctional facilities. Other children are made vulnerable due to poverty, harmful cultural practices, family breakdown, abandonment, natural disasters, ethnic and political conflict, and/or poor care arrangements. Communities in Kenya have traditionally responded to children without parental care by placing them informally into the care of extended family or community members. However, with increasing socio-economic pressures and weakening family structures, this kinship care mechanism is under threat and many children are at risk of maltreatment. The predominant, formal alternative care arrangements are placements into CCIs or other institutional care.

The number of children connected to the streets in Kenya is not known, but estimates are high, varying from 200,000–300,000. Urban areas have high numbers of children living on the street; countrywide, homeless families are prevalent.

These diverse situational cases require a standardized and harmonized approach to ensure the wellbeing of all children in Kenya. It is therefore envisaged that this Case Management for Reintegration of Children

into Family- or Community-based Care package—along with the Child Protection Case Management and Referral and Alternative Family Care Guidelines—will be used to direct and standardize the way state and non-state service providers promote family- and community-based care and protection for children outside of parental care. This will greatly improve service delivery to children and their families and as result, lead to sustained reintegration into families and communities.

The Kenyan Ministry of Labour and Social Protection is committed to the full implementation of these guidelines and will continue providing the necessary support and guidance throughout the processes that lead to sustainable reintegration.

Simon K. Chelugui, EGH
Cabinet Secretary
Ministry of Labour and Social Protection

PREAMBLE

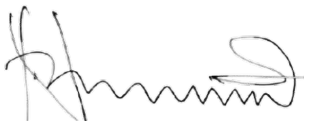
Protection of children from abuse, neglect, violence, and separation from families is a complex issue and therefore needs a multi-disciplinary approach. The Case Management for Reintegration of Children into Family- or Community-based Care package consists of standard operating procedures, job aids, tools, and training package (including facilitator guide and presentations) to aid practitioners in achieving successful reintegration of children into families or communities. The package has been developed in recognition of the increased emphasis and interest on comprehensive case management as part of a child protection system and as an evidence-based approach for promoting family- and community-based care of children in Kenya.

The application of case management in promoting family- and community-based care for children outside of parental care settings is quite recent. The intention in developing this package is to provide a general framework of agreed principles, considerations, steps, and procedures, along with a vital road map for effective case management that leads to successful reintegration of children back into families or communities. The package is also intended to offer a valuable tool for policy makers, program designers, and practitioners to help them acquire solid guidance for safe and effective reintegration of children.

This reintegration package has been developed in line with the guidelines on Child Protection Case Management (2018) and Alternative Family Care for Children in Kenya (2014), which uphold the principles enshrined in the Constitution of Kenya (2010) and the Children Act (2001) of a child's rights to family care, protection, and provision of basic needs.

While international instruments and national legal and policy framework recognize the importance of family care for all children, comprehensive guidance on what needs to be done—and how to do it—has been insufficient, leading to programming practice of varying quality and inadequate resources in reintegration work. This case management package is therefore a valuable and practical tool to help overcome these challenges and provide support to actualize the implementation of Guidelines for the Alternative Family Care for Children (2014) and the Guidelines on Child Protection Case Management and Referral (2018) for children without parental care or who are at risk of separation.

Effective and sustainable reintegration requires a solid framework along with an appropriate case management approach. This package speaks to those issues for anyone seeking to ensure family- and community-based care for children is enhanced and realized.



Nelson Marwa Sospeter, CBS
Principal Secretary
State Department for Social Protection

ACKNOWLEDGMENTS

Numerous organizations and individuals were involved in creating this Case Management for Reintegration of Children into Family- or Community-based Care package. Its development and production is in support for the rollout of care reform agenda, and is as a result of the collaborative efforts of many individuals, government departments, and civil society organizations—whose dedication and hard work is recognized and gratefully acknowledged by the Department of Children's Services.

In particular thanks, the department wishes to express its gratitude to the members of the technical working team involved in the development of this reintegration package representing Department of Children's Services, UNICEF Kenya, Changing the Way We Care (CTWWC), Stahili Foundation, SOS Children's Villages Kenya, Hope and Homes for Children, and Kenyan Society of Care Leavers.

Special thanks also go to the officers from the Department of Children's Services, led by Mr. Noah Sanganyi, the Director of Children's Services; Deputy Directors, Ms. Carren Ogoti and Mr. Justus Muthoka for their leadership in the entire process; the technical support team from our valued partner CTWWC, specifically Khadija Karama, Kelley Bunkers, Fredrick Mutinda and Anna Jolly; and the United Nations Children's Fund (UNICEF) Kenya team— especially Catherine Kimotho and Yoko Kobayashi. I also acknowledge the valuable contribution from other staff of the Department of Children's Services representing the various sections in the Department —namely, Alternative Family Care, Children Institution, Planning and Development, Strategic Interventions in Child Protection, Community Child Support Services, and Child Protection—as well as officers from various counties, especially Kisumu, Homabay, Migori, Siaya, Vihiga, Busia, Nyamira, Kiambu, and Kilifi, whose names are annexed in this report for their valuable contribution in the development of this package.

I urge all the personnel from government, civil society organizations, faith-based organizations, and charitable and statutory children's institutions to embrace and utilize this important package—along with the aforementioned guidelines—for the realization of successful reintegration of children.

Noah M.O Sanganyi, HSC
Director, Department of Children's Services

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ACRONYMS

AAC	Area Advisory Council
ACC	Alternative Care Committees
AFC	Alternative Family-Based Care
ARV	Antiretroviral
BID	Best Interest Determination
CBO	Community-based organizations
CBR	Community-based rehabilitation
CCO	County Children's Officer
CCI	Charitable Children's Institution
CGSDO	County Gender and Social Development Officer
CHV	Community Health Volunteer
CPIMS	Child Protection Information Management System
CPV	Child Protection Volunteer
CSO	Civil Society Organization
CTWWC	Changing the Way We Care
DCS	Department of Children's Services
DPOs	Disabled Persons Organizations
EARC	Education Assessment and Resource Center
ECD	Early Childhood Education
EGH	Elder of the Order of the Golden Heart of *Kenya*
FGD	Family Group Discussion
GOK	Government of Kenya
KEPI	Kenya Expanded Program for Immunization
KESCA	Kenyan Society of Care Leavers
MWENDO	Making Well-Informed Efforts to Nurture Disadvantaged Orphans and Vulnerable Children
NCCS	National Council for Children's Services
NCPWD	National Council for Persons with Disabilities
NGO	Non-governmental Organization
OVC	Orphans and Vulnerable Children
PWD	People With Disabilities
SCCO	Sub-County Children's Officer
SCI	Statutory Children's Institution
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
SOP	Standard Operating Procedure
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Conventions on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCO	Volunteer Children's Officer
WHO	World Health Organization

GLOSSARY OF KEY TERMS[1]

Adoption is the complete severance of the legal relationship between a child and his/her biological parent(s) and birth family, and the establishment of a new legal relationship between the child and his/her adoptive parent(s). Adoption is a permanent-care solution and because of its permanent nature is not considered as alternative care but a permanent solution for a child who cannot be with his/her biological parents. **Domestic (national) adoption** is adoption by a couple or individual who are Kenyan and where the child they are adopting is resident in Kenya. Applications for domestic adoption are initiated through a registered local adoption society. **Foreign resident adoption** is adoption by a couple or individual who are not Kenyan nationals but have lived in Kenya for over three years and adopt a child who is Kenyan.

Aftercare support/services is a process whereby a variety of services are offered to children after they leave alternative care and move on to independent living or are reunified with their families. Such services include supervision and provision of a toolkit, as appropriate.

Agency is a public or private body that offers services that organizes alternative care for children.[2]

Alternative care is a formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority 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.[3]

Alternative Care Committee (ACC) at the sub-county level is a subcommittee of the Area Advisory Committee (AAC) and therefore reports to the AAC. Its overall objective is to coordinate and strengthen family and alternative care services within the sub-county. Members include specialized professionals providing family strengthening and alternative care services in the sub-county. The AAC may co-opt people who are not members of ACC to provide expertise.

Assessment is the process of building an understanding of the problems, needs, and rights of a child and his/her family in the wider context of the community. It should cover physical, intellectual, emotional, and social needs/development of the child. There are various types of assessment, e.g., rapid, initial, risk, and comprehensive.

Attachment is a bond or tie between an individual and an important figure based on the need for safety, security, and protection.[4]

Best interests determination (BID) is a formal process with specific procedural safeguards and documentation requirements conducted for children, whereby a decision-maker is required to weigh and balance all the relevant factors of a particular case, giving appropriate weight to the rights and obligations recognized in the United Nations Convention on the Rights of the Child (UNCRC) and other human rights instruments such as United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD), so that a comprehensive decision can be made that best protects the rights of children.[5]

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[1] Unless otherwise noted definitions are from: Government of Kenya: Guidelines for the Alternative Family-based Care of Children in Kenya (2014) and the Guidelines for Child Protection Case Management and Referral in Kenya (2019).
[2] United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*, 2010. Retrieved from: https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf >.
[3] Ibid.
[4] Prior, V. and D. Glaser. (2006). Understanding attachment and attachment disorders: theory, evidence, and practice. London: Jessica Kingsley Publishers.
[5] Better Care Network (2019). *Toolkit Glossary of Key Terms* (webpage). Retrieved from: https://bettercarenetwork.org/toolkit/glossary-of-key-terms.

Best interest of the child is one of the guiding principles of the UNCRC, whereby Article 3 notes, "*In all actions concerning children...the best interests shall be a primary consideration.*"[6] The interests of children are different from adults, and therefore when adults make decisions that affect children they must think carefully about how their decisions will impact children. Additionally, the best interests of each child should not only be informed by globally recognized rights but also their individual strengths, needs, context, and situation.

Biological parents are the birth family into which a child is born. It can mean both parents if they are together, or only the mother, or only the father.

Caregiver/carer is a parent or guardian who is charged with the responsibility for a child's welfare.[7]

Care leaver is any person who spent time in care as a child. Such care could have been in foster care, institutional care (mainly children's homes), or other arrangements outside the immediate or extended family.[8]

Care reform are the changes to the systems and mechanisms that promote and strengthen the capacity of families and communities to care for their children, address the care and protection needs of vulnerable or at-risk children to prevent separation from their families, and ensure that appropriate family-based alternative care options are available.

Case closure is a process involving a series of meetings, discussions, and final case plan review with a child and his/her caregiver/family concerning documents in the case file to determine if the child and caregiver/family have achieved the case management objectives. It may include closure, so long as the goals of the case plan have been achieved and the reintegration is deemed to be safe and stable; it may include transfer, if continued monitoring is deemed appropriate by statutory authorities.

Case conference is a multi-disciplinary meeting consisting of child protection actors from different perspectives and disciplines who explore a child's/group of children's needs. A case conference can be called at case planning, implementation, or follow-up stage. Case conferences can be held at different levels including organization, sub-county, and AAC levels.

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

Case manager is the individual working the case who is responsible to provide technical support to and oversight of caseworkers and managing data flow.

Case plan is a written document which outlines how, when, and who will meet the child's developmental needs.[9]

[6] United Nations General Assembly, *Convention on the Rights of the Child*, (20 November 1989), Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.), article 3.

[7] National Council for Children's Services (2015). National Plan of Action for Children in Kenya 2015–2022. Retrieved from: http://www.childrenscouncil.go.ke/images/documents/Policy_Documents/National-Plan-of-Action-for-Children-in-Kenya-2015.pdf.

[8] University of the Highlands and Islands, 2019, *Care Leavers* (webpage). Retrieved from: https://www.uhi.ac.uk/en/students/support/care-leavers/.

[9] Better Care Network (2019). *Toolkit Glossary of Key Terms.*

Case review is a holistic process to evaluate the progress made toward reintegration. This is done by measuring progress against the case plan, and against objective "benchmarks" of sustainable reintegration. This is usually done every six months after reunification or placement.

Caseworker is the primary worker responsible for a case. This person maintains responsibility for the individual case management process from identification to case closure.

Case planning is the process of collaborating with the child and family to identify the goals to be reached with available assistance.

Charitable children's institution is an institution established by a person (corporate or noncorporate), religious organization, or non-governmental organization (NGO) which has been granted approval by the National Council for Children's Services (NCCS) to manage a program for the care, protection, rehabilitation, or control of children.

Child is any human being under the age of 18 years.[10]

Child abuse includes anything that causes physical, sexual, psychological, or mental injury to a child.[11] There are four types of child abuse: physical, neglect, sexual, and emotional. All four are more typically found in combination than alone.[12]

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

Child participation is the informed and willing involvement of children, including the most marginalized and those of different ages and abilities, in any matter or decision concerning them. Participation encompasses the opportunity to express a view, and to influence decision-making and achieving change.[13]

Children should be provided with relevant information in an age- and development-appropriate manner so they may participate effectively and their views given due consideration in accordance with their age and maturity. The General Comment Number 12 of the Committee on the Rights of the Child specifically mentions the need to introduce mechanisms to ensure that children in all forms of alternative care—including in institutions—are able to express their views and that those views be given due weight in matters of their placement, the regulations of care in foster families or homes, and their daily lives.

Child protection is the process of ensuring children are protected from all forms of harm through structures and measures to prevent and respond to abuse, neglect, exploitation, and violence, including putting into place the procedures necessary for handling situations or issues that may arise.[14]

Children without parental care all those not in the overnight care of at least one of their parents, for whatever reason and under whatever circumstances.[15] This excludes children in boarding schools and hospitals.

Community is composed of the individuals or groups of people, organizations, and institutions (formal

[10] Government of Kenya (2001). *Children Act.* Retrieved from: http://www.kenyalaw.org/lex/rest/db/kenyalex/Kenya/Legislation/English/Acts%20and%20Regulations/C/Children%20Act%20Cap.%20141%20-%20No.%208%20of%202001/docs/ChildrenAct8of2001.pdf.
[11] Ibid.
[12] Prevent Child Abuse America (2019). *Recognizing Child Abuse: What Parents Should Know* [webpage]. Retrieved from: https://preventchildabuse.org/resource/recognizing-child-abuse-what-parents-should-know/.
[13] Save the Children UK (2005). *Practice Standards in Children's Participation.* London, Save the Children UK.
[14] Better Care Network (2019). *Toolkit Glossary of Key Terms.*
[15] United Nations General Assembly 64/142, UN. *Guidelines for the Alternative Care of Children*.

and informal) where the child and family live.

Community-based care a range of approaches designed to enable children to remain with their own (or extended) family and prevent the need for separation, or to be placed with an alternative family within his/her community.[16] It may include care of a child during the day by a person other than the child's parent(s) or legal guardian, as an ongoing service during specific periods of time, such as the time when parents are at work. It can be provided in nurseries, crèches, or homes of the childcare provider.

Continuum of care reflects the contents of the UNCRC and the Guidelines for the Alternative Care of Children, and includes a range of care options for children who have been separated or are at risk of being separated from parental care. It includes family strengthening, alternative family- and community-based care/emergency, and short- and long-term placement in institutional care.[17]

In the Kenyan context, continuum of care describes a range of services and placement options for children, with the priority being family preservation or prevention of separation (i.e., all efforts to help a child to remain with one or two biological parents); where necessary to separate the child, other suitable care options are appropriately selected within this continuum such as, kinship care, temporary foster family care, long-term foster care, domestic adoption, monitored child-headed households, small group homes, inter-country adoption, high-quality residential care (including orphanages), and supported independent living. A continuum should represent a wide range of appropriate options.

Note: The continuum of care in the care reform context means a wide range of options to be carefully selected using the principle of necessity and suitability/appropriateness. Therefore, it does not necessarily mean that a child will move from one form of care to the other in a linear scale, but rather, the case conference will determine the most suitable/appropriate care for the child after assessment of needs.

Disability, according to the World Health Organization (WHO), is neither purely biological nor social, but the interaction between health conditions and environmental/personal factors. Disability includes any physical, sensory, mental, psychological, or other impairment, condition, or illness that has, or is perceived by significant sectors of the community to have, a substantial or long-term effect on an individual's ability to carry out ordinary day-to-day activities.[18] The Persons with Disability Act defines disability as physical, sensory, mental, or other impairment, including any visual, hearing, learning, or physical incapability which impacts adversely on social, economic, or environmental participation.[19] **People with disability,** according to UNCRPD is one who is prevented from participating fully in the society by a combination of their impairment and other barriers associated with it.[20]

Duty-bearer is any person or institution, including the State, with responsibility for the welfare of a child.

Family includes relatives of a child, including both immediate family (mother, father, stepparents, siblings, and grandparents) and extended family—also referred to as relatives or "kin" (aunts, uncles, and cousins).

[16] Tolfree, D. (2003). *Community-Based Care for Separated Children.* Retrieved from: https://resourcecentre.savethechildren.net/sites/default/files/documents/2704.pdf.

[17] Faith to Action (2019). *Continuum of Care and Child Placements* (webpage). Retrieved from: http://www.faithtoaction.org/family-care-toolkit/continuum-of-care/.

[18] The Constitution of Kenya, 2010.

[19] Persons with Disability Act No. 14 of 2003. National Councils for Persons with Disability. Retrieved from: http://ncpwd.go.ke/index.php/downloads/persons-with-disabilities-act.

[20] UNICEF (2019). *Disability Orientation* (online training). Retrieved from: https://agora.unicef.org/course/view.php?id=909.

Family-based care is the short- or long-term placement of a child in a family environment with one consistent caregiver and a nurturing environment where the child is part of a supportive family and the community.

Family group discussion is a process to bring together people who are supportive of a child/family, so that they can make decisions and commitments regarding the child's best interest.[21] They include both family members and non-family members.

Family of origin is the family where a child is/was originally living prior to separation. It is not necessarily biological parents or kin.

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

Family strengthening/family support services are a range of measures to ensure the support of children and families—similar to community-based support but may be provided by external agents, such as social workers and service providers. The services may include counseling, parent education, day-care facilities, material support, etc.

Family support is the process of enabling a family to support itself, including supporting all children, caregivers, and other members. Support may include training on parenting skills, psycho-social skills, and economic skills with the aim of increasing care-givers' ability and confidence to provide and care for their family.[22]

Family tracing includes activities undertaken by authorities, community members, relatives, or other agencies for the purpose of gathering information and locating the parents or extended family of the separated or lost child

Follow-up refers to contacting service providers and other stakeholders for the purpose of obtaining information on the child and family's progress on meeting their needs and fulfilling their case goals. It can also include checking on referrals made to services and post-reintegration contact with child and family.[23]

Formal care is provided in a family environment which has been ordered by a competent administrative body or judicial authority; and **all care** provided in an institutional environment, including in private facilities, whether or not as a result of administrative or judicial measures.[24] Examples include foster care, guardianship care, Kafaalah, etc.)

Foster care is placement of a child with a person who is not the child's parent, relative, or guardian and who is willing to undertake the care and maintenance of that child.[25]

Foster parent is an adult registered under the Children Act 2001 to receive and retain a child for the purpose of caring for and maintaining the child apart from the child's parents, guardians, or relatives.[26]

Gatekeeping is described as **policies, systematic procedures, services, and decision-making** which ensure that alternative care for children is used only when absolutely *necessary*, and that children receive the

[21] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children in Residential Care into Family Care.
[22] Ibid.
[23] Ibid.
[24] United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*.
[25] Government of Kenya (2001). *Children Act.*
[26] Ibid.

most *suitable* support and/or care to meet their unique individual needs, thereby upholding the best interests of the child.[27]

Guardian is a person appointed by the will or deed of a parent or by an order of the court to assume parental responsibility for a child upon the death of the child's parent. This is done alone, or in conjunction with the surviving parent, or with the father of a child born out of wedlock who has acquired parental responsibility of the child in accordance with the provisions of the Children Act, 2001.

Guardianship is a term used in three different ways:

1) a legal device for conferring parental rights and responsibilities to adults who are not the child's birth parents;
2) an informal relationship whereby one or more adults assume responsibility for the care of a child; or
3) a temporary arrangement whereby a child—who is the subject of judicial proceedings—is granted a guardian to look after his/her interests.[28]

Informal care is any private arrangement provided in a family environment whereby a child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents, or other person(s) without this arrangement having been ordered by an administrative/judicial authority or a duly accredited body.[29]

Integrated case management is an approach to delivering services and support by different actors (including case managers, social and health service providers, and informal actors—such as extended family members or community leaders) in a coordinated way to avoid gaps and overlaps and maximize benefit for the child.[30]

Institutional/residential care refers to orphanages, children's homes, and other group-living arrangements for children in which care is provided by paid adults who would not be regarded as traditional carers in wider society.

Kafaalah according to Islamic law, is the commitment by a person or family to voluntarily sponsor and care for an orphaned or abandoned child. The individual or family sponsors the child to meet his/her basic needs for health, education, protection, and maintenance. **Kafiil** refers to an individual who is providing kafaalah to a child as defined above. Normally, the kafiil is a Muslim.

Kinship care (informal) is a private arrangement within an extended family whereby a child is looked after on a temporary or long-term basis by his/her maternal or paternal extended family, without it being ordered by an administrative or judicial authority. Family members include grandparents, aunts, uncles, and older siblings.

Kinship care (formal) is an arrangement ordered by an external administrative or judicial authority, whereby a child is looked after on a temporary or long-term basis by his/her maternal or paternal extended family. Family members include grandparents, aunts, uncles, and older siblings.

Kinship or family adoption is adoption by adopters who are kin or relatives within the extended family of the child. Applications for kinship adoption are similar to domestic adoption.

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[27] Dumba-Nyanzi, I. and M. Li (2018). *Assessing Alternative Care for Children in Uganda.* Retrieved from: https://bettercarenetwork.org/sites/default/files/Assessing%20Alternative%20Care%20for%20Children%20in%20Uganda_FINAL_tr-18-250.pdf.

[28] Better Care Network (2019). Toolkit Glossary of Key Terms.

[29] United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*.

[30] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children.

Mentors are trusted adult community members who commit to work in support of vulnerable children. They have basic training on children's rights and laws protecting children, life skills, adolescent health, income-generating activities, active listening, and how to provide psychosocial support offered by organizations. Through their presence in the community and by making regular visits, the mentors encourage children to attend school, avoid risky behaviors, help them access basic services, and provide psychosocial support.[31]

Monitoring visits are regular home visits to the child and family to ensure that the reintegration process is serving the child's best interest, the child and family are meeting their needs and making progress on their case plan, and to provide any further referrals or psychosocial services. These visits may also involve interacting with neighbors, extended family members, or service providers.[32]

Necessity Principle is a key tenet of the United Nations (UN) Guidelines for the Alternative Care of Children. The principle asks the question whether placement or intervention is necessary for the healthy and full development of the child.[33]

Permanency involves family connections and placement options for a child that provide a lifetime of commitment, continuity of care, a sense of belonging, and legal/social status that goes beyond the child's temporary placement.

Permanency planning is an array of social work and legal efforts directed toward securing safe, nurturing, life-long families for children in alternative care.

Placement is a social work term for the arranged out-of-home accommodation provided for a child or young person on a short- or long-term basis.

Prevention includes a variety of approaches that support family life and helps diminish the need for a child to be separated from her/his immediate or extended family or other caregiver and be placed in alternative care.

Protective factors are conditions or attributes (skills, strengths, resources, supports, or coping strategies) in individuals, families, communities, etc. that help people deal more effectively with stressful events and mitigate or eliminate risk.[34]

Reintegration the process of a separated child making what is anticipated to be a permanent transition back to his/her immediate or extended family and the community (usually of origin) in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life.[35]

Referral is the process of recognizing a risk or concern about a child or household, deciding that action needs to be taken, and providing information about or referring the child or family to the identified service. Referrals include self-referral (e.g., calling to a helpline) or a referral from a service provider (e.g., a caseworker referring a family to the health clinic).

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[31] Better Care Network and Global Social Service Workforce Alliance (2015). *The Role of Social Service Workforce Strengthening in Care Reform.* Retrieved from: http://www.socialserviceworkforce.org/system/files/resource/files/The%20Role%20of%20Social%20Service%20Workforce%20Strengthening%20in%20Care%20Reforms_0.pdf.

[32] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children.

[33] Informed by Cantwell, N., J. Davidson, S. Elsley, I. Milligan, and N. Quinn (2012). Moving Forward: Implementing the "Guidelines for the Alternative Care of Children." Retrieved from: www.alternativecareguidelines.org.

[34] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children.

[35] Interagency Group on Children's Reintegration (2016). Guidelines on Children's Reintegration.

Referral mechanism is a collaborative framework whereby different service providers cooperate to fulfil their obligation of providing protection assistance to children and families. The framework should define each actor's roles, mandates, and the steps involved in referral process.

Reunification is the physical reuniting of a child and his/her family or previous caregiver with the objective of this placement becoming permanent.[36]

Risk factors are any attributes, characteristics, or exposures of an individual—including a child—that increases the likelihood of developing a disease, injury, or other form of harm to wellbeing.[37]

Social service workforce includes a broad range of governmental and nongovernmental professionals and paraprofessionals who work with children, youth, adults, older persons, families, and communities to ensure healthy development and wellbeing. The social service workforce focuses on preventative, responsive, and promotive services that are informed by the humanities and social sciences, indigenous knowledge, discipline-specific/interdisciplinary knowledge and skills, and ethical principles. Social service workers engage people, structures, and organizations to facilitate access to needed services; alleviate poverty; challenge and reduce discrimination; promote social justice and human rights; and prevent/respond to violence, abuse, exploitation, neglect, and family separation.[38]

Service provider is an individual employed or attached to a formal institution that provides professional care or services.

Statutory children's institutions in Kenya are children institutions established by the Government of Kenya for the purpose of 1) rescuing children who are in need of care and protection (rescue homes), 2) confining children in conflict with the law while their cases are being handled in court (remand homes), and 3) rehabilitating children who have been in conflict with the law (rehabilitation schools). The court commits a child into one of these institutions as appropriate. In Kenya, the statutory institutions include remand homes, rehabilitation schools, rescue homes, etc.

Strengths-based practice emphasizes people's self-determination and strengths. In social work, strengths-based practice is a philosophy and a way of viewing clients as resourceful and resilient in the face of adversity.[39]

Suitability Principle is another core tenet of the Guidelines for the Alternative Care of Children. The principle is used to help outline the conditions in which alternative care (formal and informal) are considered for a child, encouraging states to look at care options with regard to each child's specific and individual needs on a case-by-case basis, to ensure placement is suitable for the individual child.[40]

Supervision is a relationship that supports the caseworker's technical competence and practice, promotes wellbeing, and enables effective and supportive monitoring of casework.[41]

Supported independent living is where a young person is supported in her/his own home, group home, hostel, or other form of accommodation to become independent. Support/social workers are available as needed and at planned intervals to offer assistance and support but not to provide supervision. Assistance

[36] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration.
[37] Ibid.
[38] Global Social Service Workforce Alliance (2019). *Social Service Workforce Mapping Toolkit.* Retrieved from: http://www.socialserviceworkforce.org/resources/social-service-workforce-mapping-toolkit.
[39] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children.
[40] Cantwell, N., J. Davidson, S. Elsley, I. Milligan, and N. Quinn (2012). Op cit.
[41] Interagency Guidelines for Case Management in Child Protection. Retrieved from: http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf.

may include timekeeping, budgeting, cooking, job seeking, counseling, vocational training, and parenting.[42]

Transfer can occur when an organization is unable to continue offering services, or if the child has moved from one region to another before the case is closed; then the case should be transferred to another service provider. It is advisable that both the current and new caseworker conduct a consultative discussion session to introduce the new service provider to the child and the family.

Transition strategy is put in place when a child enters alternative care to ensure that he/she is either reintegrated with his/her family or placed in permanent family-based alternative care.

Violence against children includes emotional and physical abuse, neglect or negligent treatment, and sexual exploitation and abuse. It occurs in homes and families, schools, care and justice systems, workplaces, and communities. Perpetrators include parents, family members, teachers, caretakers, law enforcement authorities, and other children. Evidence is clear that violence can affect children's physical and mental health, impair their ability to learn and socialize, and undermine their development as functional adults and good parents later in life. In the most severe cases, violence against children leads to death.[43]

Vulnerability is being easily open or exposed to risks to wellbeing.[44]

Vulnerable adult is a person over the age of 18 who is at risk of harm or who lacks the most absolute basic life skills.

Vulnerable child is a child whose safety, wellbeing, and development are, for various reasons, threatened—including children who are emotionally deprived or traumatized.[45]

Young adult is a person between the ages of 15–24.

[42] Better Care Network (2019). Toolkit Glossary of Key Terms.
[43] UNICEF (2010). *Violence Against Children in Kenya: Findings From a 2010 National Survey*. Retrieved from: https://www.unicef.org/esaro/VAC_in_Kenya.pdf.
[44] Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures for Reintegration of Children.
[45] National Council for Children's Services (2015). National Plan of Action for Children in Kenya 2015–2022.

INTRODUCTION

Background Information

A **child protection system** is comprised of certain structures, functions, and capacities assembled to prevent and respond to violence, abuse, neglect, and exploitation of children,[46] including systems of care for children without adequate parental care. In many countries, formal care and protection responses within the child protection system have relied primarily on institutional care.[47] However, over the last 30 years there has been a growing understanding of the negative impact of institutional care on child development and wellbeing and recognition of the critical importance of the family to a child's development and social wellbeing.[48]

Research also shows that most children in institutional care are not placed there because they are without a caregiver, but rather because their families are facing a range of challenges in their capacity to provide and care for them. These challenges often result from poverty, lack of access to social services, discrimination, and social exclusion—and may also result from personal crises and emergencies affecting the household, including interpersonal and societal violence. Strengthening family care to prevent unnecessary separation of children from their families and developing alternative family- and community-based care options for children in need of protection are important entry points for reform of the childcare system but also of the broader child protection system.[49] In contexts where there has been a heavy reliance on institutions for children, **transforming institutional care and reintegration of children into family care** are core elements of care reform,[50] as well as putting interventions that support **families to prevent family separation**.

The United Nation Convention on the Rights of the Child (UNCRC),[51] the African Charter on the Rights and Welfare of the Child,[52] and Kenya's national legal and policy framework recognize the vital and irreplaceable role of a family environment for the growth, wellbeing, and protection of children. According to Article 45 of the Constitution of Kenya, *"The family is the natural and fundamental unit of society and the necessary basis of social order and shall enjoy the recognition and protection of the State."* These instruments, as well as the policy of the Government of Kenya (GOK), state clearly that all efforts should be directed toward keeping children in or returning them to their family and communities. This requires that interventions must be in the best interests of the child, they should facilitate the return of children to their families, and all placements must protect children and be subjected to periodic reviews.

The GOK has acknowledged the findings of the research and hinged the right of every child to parental care within the constitution,[53] and has also developed the Guidelines for the Alternative Family Care of Children in Kenya[54] to be in line with the United Nations (UN) Guidelines for the Alternative Care of

[46] Government of Kenya (2011). *Framework for The National Child Protection System for Kenya*. Retrieved from: http://www.socialserviceworkforce.org/system/files/resource/files/The%20Framework%20for%20the%20National%20Child%20Protection%20System%20for%20Kenya.pdf.
[47] Better Care Network and Global Social Service Workforce Alliance (2015). *The Role of Social Service Workforce Strengthening.*
[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] United Nations, Convention on the Rights of the Child, 1989. Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx.
[52] African Union, *The African Charter on the Rights and Welfare of the Child*, 1990, page 2. Retrieved from: https://www.unicef.org/esaro/African_Charter_articles_in_full.pdf.
[53] The Constitution of Kenya, 2010.
[54] Government of Kenya (2014). Guidelines for the Alternative Family Care of Children in Kenya, page 106. Retrieved from: https://bettercarenetwork.org/sites/default/files/Guidelines%20for%20the%20Alternative%20Family%20Care%20of%20Children%20in%20Kenya.pdf.

Children.[55] The GOK has disseminated the guidelines to several of its officers and to civil society organizations (CSOs) and encouraged their use. Beginning in 2018, the government—together with its partners—has been implementing the guidelines starting with four counties. This case management for reintegration package has been developed to provide appropriate knowledge and skills for all those supporting children without parental care (including those in residential care and on the streets) as well as children at risk of separation from family.

To support reintegration effectively, all child care and protection workers should have adequate knowledge on child development and the effects of residential institutional care on children, the push and pull factors that cause separation of children from families, and the effective approaches of supporting families and communities to care for their children. They also need to have the technical skills and tools for comprehensive assessment of children and families that will lead to interventions that ensure sustainable reintegration.

There is a need to ensure the right care placements and support for each individual child through proper assessment, case planning/preparation, and monitoring to ensure sustained reintegration. Moving children without properly preparing them and their families/placements can be harmful and detrimental to a child's wellbeing, putting them at high risk of trauma, abuse, and deprivation. The need to ensure that children and families are well prepared and supported before, during, and after reunification or placement is of paramount importance and can be achieved by having consistent guidelines, standard operating procedures (SOPs), job aids and tools, and by providing training for the use of these assorted documents.

The use of quality case management practices has been shown to improve decision-making and service delivery in childcare and protection by reducing violence against children, preventing unnecessary family separation, and improving child and family outcomes. The development of the case management for reintegration SOPs, training materials, job aids, and program guides are intended to support social service workforce using case management approaches to achieve successful and sustained reintegration and provide guidance on how case management works.

Purpose and Audience

This guide provides an overview of the principles and practices of case management for reunification and placement of children outside of parental care (e.g., children from Charitable Children's Institutions (CCIs) and Statutory Children's Institutions (SCIs), and street-connected children) into family- and community-based care. It details SOPs and provides associated relevant job aids. This *Guidebook* is further accompanied by the *Caseworker's Toolkit: Case Management for Reintegration of Children into Family- or Community-Based Care.* Together, the *Guidebook* and *Toolkit* provide comprehensive guidance and the practical tools needed to plan, implement, and monitor individual children placed into family- and community-based care, to ensure complete reintegration.

Audience members for this guide are caseworkers and case managers working directly with children and families for reintegration of children outside of parental care to family- or community-based care. The package aims to provide necessary information, tools, and the "how to" that will enable and support caseworkers and case managers to manage reintegration cases in a manner that reflects good practice and sound social work principles, to ensure that high-quality case management is provided until reintegration is achieved and that the safety and best interests of the child are upheld throughout the process.

[55] United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*.

Both the *Guidebook* and *Toolkit* rely heavily on the 2018 *Child Protection Case Management and Referral in Kenya* and the 2014 *Guidelines for the Alternative Family Care for Children in Kenya*. The intention of developing this package is to provide a general framework of agreed principles, considerations, steps, and procedures for effective child protection case management in line with the guidelines on child protection, case management, and alternative family care for children in Kenya developed in 2018 and 2014 respectively. It is therefore, recommended that this package is read and/or used with these guidelines.

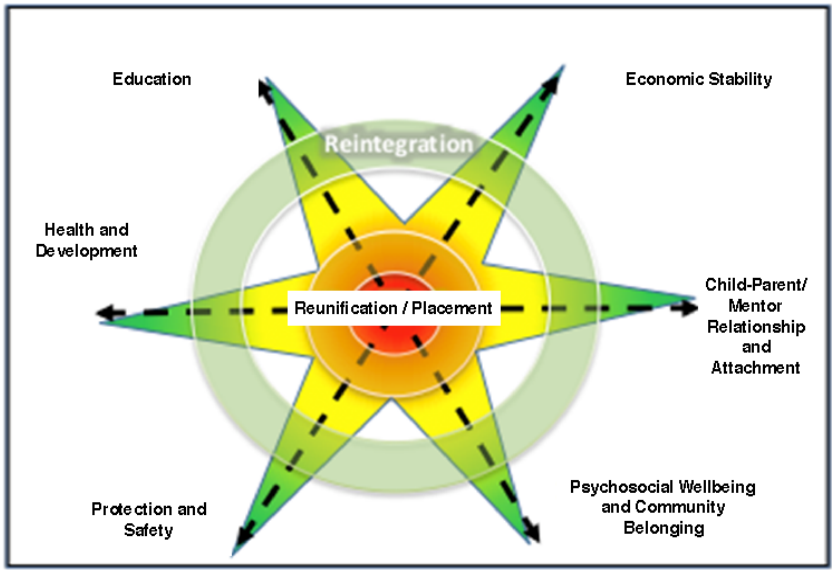
Content Overview

The *Caseworker's Guidebook for Case Management for Reintegration of Children into Family- or Community-Based Care* includes:

- glossary of key terms that will be used throughout the *Guidebook* and accompanying *Toolkit*;
- introduction to the reintegration model, including the methodology for reunification and reintegration of children from CCIs and SCIs into family- and community-based care;
- introduction to family-based care aligned with the Guidelines for the Alternative Family Care of Children in Kenya;
- guiding principles of case management, outcome goals, and functions of key players, including the role of caseworkers and how they are supported;
- SOPs for each step of reintegration case management, including the purpose, guiding principles, intended outcomes, and activities for each step; and
- additional supporting information and job aids.

Reintegration Model[56]

Figure 1: Reunification/Placement



The reintegration model used within this *Guidebook* and associated *Toolkit* aims to ensure the success of the reunification/placement and the longer-term safety and stability of the child's complete reintegration in family- or community-based care. The model's overall goal is to ensure that each child is receiving care and protection, has a sense of belonging/identity within a family environment, and feels a sense of purpose in life. The reintegration model has six wellbeing domains which are each considered critical to the process of reintegration of children. As seen in Figure 1, children should improve across *all domains* as they progress from reunification/placement (in the center of the star) to reintegration (at the outer points of the star). For the Kenyan context, the domain on Psychosocial Health and Development was combined with Social and Community Acceptance to read as Psychosocial Wellbeing and Community Belonging, with economic stability being the sixth domain as

[56] The six-point star reintegration model is originally based on Retrak's (https://www.retrak.org/about/) reintegration model. It was then adapted for the Keeping Children in Healthy and Protective Families project in Uganda, and finally readapted to suit the Kenyan context.

Table 1. These domains are similar to the Child Status Index domains as indicated in the 2014 Kenya alternative family-based care (AFC) guidelines: 1) food and nutrition, 2) shelter and care, 3) protection, 4) health, 5) psychosocial, and 6) education and skills training. Differences in this reintegration model is that it has included a child caregiver/mentor relationship and attachment along with community belonging.

Table 1: Domains

DOMAIN	DEFINITION
Health and development	This domain encompasses children's physical health in terms of malnutrition, access to healthcare, and food intake, as well as cognitive changes that characterize normative development, delayed development, or disability.
Psychosocial wellbeing and community belonging	This domain encompasses children's and their caregivers' psychological health and wellbeing, along with socio-emotional functioning, including self-esteem, resilience, and belonging. Additionally, this domain measures the child and caregiver's feelings of acceptance, welcome, inclusion, and support within their wider community.
Protection and safety	This domain encompasses children and caregivers' level of exposure to violence and exploitation, including both witnessing or experiencing violence and exploitation at home, at school, in the community, and online.
Child-caregiver/mentor relationship and attachment	This domain encompasses children's relationships with their caregivers/mentors, including spending dedicated time with each other, building connections, communication between the caregiver and child, and feeling loved. Caregivers must have knowledge and skills on providing nurturing care for children.
Economic stability	This domain encompasses the caregiver's ability to meet unexpected urgent and basic needs of the household members. It measures a caregiver's capacity around financial education and knowledge in regular saving.
Education	This domain includes children's access to school, including enrollment, attendance, progression, and inclusive education for children with disabilities. Skills training is required on economic stability to enable young adults and the caregivers.

Family-Based Care

Families are of critical importance to children's healthy growth and development, and years of global research has demonstrated that children who grow up in safe and nurturing families fare better than those in institutional care across all areas of development.[57] The UNCRC highlights the importance of family stating, *"The child, for the full and harmonious development of his/her personality, should grow up in a family environment, in an atmosphere of happiness, love, and understanding; the family being the fundamental group of society and the natural environment for the growth and wellbeing of all its members."*[58] The Guidelines for the Alternative Care of Children further emphasizes on the importance for family-based care by prioritizing preservation or re-establishment of the family unit through family support and reintegration as the first choice options for separated children.[59]

Family-based care can take on different forms and does not always involve a child's biological relatives. Within the Continuum of Care in the Guidelines for the Alternative Family Care of Children in Kenya, forms

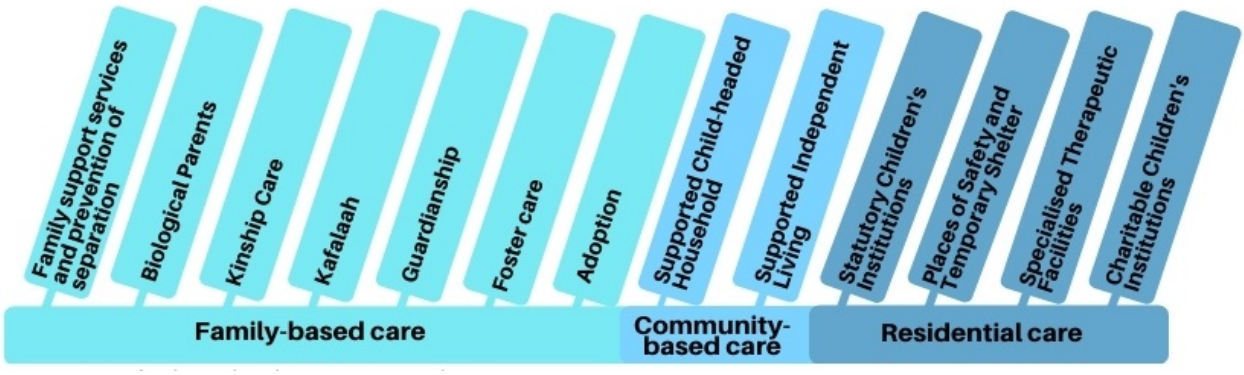
[57] A. E. Berens and C. A. Nelson (2015). The science of early adversity: is there a role for large institutions in the care of vulnerable children? *The Lancet, 386,* 388–398; C. Nelson, N. Fox, C. Zeanah, and D. Johnson (2007). *Caring for orphaned, abandoned, and maltreated children: Bucharest Early Intervention Project* (Power Point Presentation). Washington, DC, Better Care Network; and Browne, K. (2009). *The risk of harm to young children in institutional care.* Retrieved from: https://www.researchgate.net/publication/7436610_Young_Children_in_Institutional_Care_at_Risk_of_Harm.

[58] United Nations Convention on the Rights of the Child, 1989, page 1. Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx.

[59] United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*.

of family-based care include parental care, kinship care, kafaalah, guardianship, foster care, and adoption; as shown in Figure 2.

Figure 2: Care Options in Kenya (Credit: Michelle Oliel, Stahili Foundation)



Family-based care
Short- or long-term placement of a child in a family environment with at least one consistent caregiver and a nurturing environment where the child is part of a supportive family and the community.

Community-based care
A range of approaches designed to enable children to remain with their own (or extended) family and prevent the need for separation, or to be placed with an alternative family within his/her community.

Institutional-based care/residential care
Refers to orphanages, children's homes, and other group-living arrangements for children in which care is provided by paid adults who would not be regarded as traditional carers in wider society.

Where reintegration to family-based care is not possible, appropriate, or in the child's best interests, community-based care options should be explored. Community-based care options include a child-headed household or supported independent living.

Overall, Figure 2 essentially demonstrates the prioritization of care options in order from left to right. For example, reintegration to parental care should be the first priority. Where parental care is not possible, kinship care should be explored next, followed by kafaalah (where culturally and religious appropriate), guardianship, foster care, etc.

Necessity and suitability/appropriateness

The selection of the type of care in which a child should live should always be guided by the two key principles of the UN Guidelines for the Alternative Care of Children: necessity and suitability.

Necessity: Ensuring that children are not unnecessarily separated from their families and discouraging unwarranted recourse to alternative care.

Principle of suitability/appropriateness: A range of care services should be available to meet the unique needs of each child, and all care options should meet minimum standards. The care option for each child should be selected on a case-by-case basis, and provision should promote long-term solutions.

General principles in the provision of alternative family-based care

The *Guidelines for the Alternative Family Care of Children in Kenya* outlines key principles that should be followed in the provision of family-based care. These principles are critical in ensuring the four main principles of the UNCRC (the best interests of the child, non-discrimination, participation, survival, and development) and the two key principles of the UN Guidelines for the Alternative Care of Children are upheld. For example:

- Poverty should never be the driving factor or primary justification for removing a child from their family and placing in alternative care.
- All efforts need to be made to support families to fulfil their primary responsibility of caring for their child. This includes provision of family support, access to services, and tracing/reintegration.
- Where possible, all placements should aim to be as close as possible to the child's usual place of residence to enable continued contact with the family and to minimize disruption.
- The primary priority for all placements is provision of a stable, loving, and protective home for the child, with permanency as the long-term goal.
- Wherever possible, siblings should be kept together during placement.
- Use of institutional care should be limited, provided under strict standards and regulations, be as temporary as possible, and children under three years should always be in family-based care settings, not residential care.

Note. The full list of General Principles can be found in Section 4 of this *Guidebook*.

Determination of the most appropriate form of family-based care

The Guidelines for the Alternative Family Care of Children in Kenya and the gatekeeping guidelines being developed by the Department of Children's Services (DCS) will outline guidance on how to determine the most appropriate type of family-based care for children. This guidance is critical in ensuring the principle of suitability is upheld. For example:

- All decision-making should be carried out on a case-by-case basis and based on a thorough assessment which takes into account the child's wellbeing, safety, ethnic, religious, family, and community background, along with medical history, education, personal/development characteristics, and needs. The child and the family should be fully consulted throughout the process, in a manner consistent with their development and capacity.
- The paramount consideration during all decision-making is to ensure that decisions are based on the individual needs of each child and that care placement promotes stability and permanency.
- Authorities and alternative care providers should minimize frequent changes in care placements.
- Alternative care providers and authorities should conduct periodic reviews of the care placement, taking into consideration the child's wellbeing and personal development as well as his/her views. It is recommended that at minimum the reviews be conducted every three months.
- Every child outside parental care should be supported with aftercare services once he/she is reunified or placed with families or in the community.
- Case planning will be initiated at the earliest possible time and within one month of care placement.
- All siblings must be kept together unless it is in opposition to the best interests of a child.

Note. The complete guidance in determining the most appropriate form of care can be found in Section 4 of this *Guidebook*.

Gatekeeping: It is important to note that the ultimate decision regarding the necessity and suitability of a care placement for a child must be taken by a formal **gatekeeping mechanism**. The mechanism should be formally mandated to evaluate each child's case and make recommendations regarding how the child's interests can best be met. The gatekeeping mechanism should be comprised of multi-disciplinary professionals (with each member paying special attention to evaluating the elements of each child's assessment in which they hold expertise) and will ultimately decide of the different care options available to the child and which option is most suitable to meet the child's unique needs. The mechanism should provide formal documentation outlining the decision taken, the factors considered, and the weight given to each, as well as the specific conditions of the transfer of the child's care from one party to another (i.e., from where the child currently resides to their new care placement). This documentation should be retained within the child's file.

SECTION 1: Case Management with Children and Families[60]

Guiding Principles

Case management is grounded in a set of core principles informed by best practice, recognized social work values, and ethical standards. The following principles guide how caseworkers should approach the case management process and interactions with children and their families.

Child-centered and family-focused

All decisions, interventions, and plans should be made on an individualized basis, keeping the child's best interest and safety paramount. Adequate time should be spent getting to know and understand the child to ensure sufficient understanding of their unique needs and use this understanding to guide interventions and planning. Case management should progress at a pace that is comfortable for the child. Children should also be at the heart of reintegration efforts; they must be listened to, their input should be regularly and intentionally solicited, and they should be fully engaged in all case management processes. Work with children should be *trauma-informed*; that is, it should take an overarching approach that allows for individual experiences and history, which may include trauma (e.g., abandonment, abuse, or separation). When transitioning children, it is critical to consider their potential prior experiences with trauma to not re-traumatize them.

Families and their communities should also be a key focus of the reintegration process and involved in decision-making. Adequate time should be spent getting to know and understand each family's unique strengths and weaknesses, and use this understanding to guide appropriately targeted interventions and planning.

Implications for case management: Adequate time needs to be invested in getting to know and understand the child. Given the trauma many children in institutions have been through (at a minimum, all children living in institutions have been separated from their families, which can be both scary and sad for them), opening up may be harder for some children. The caseworker should move at a pace that is comfortable for each child, focusing first on building rapport and trust through play and/or age-appropriate activities. Caseworkers should pay close attention to children's non-verbal cues during this process. Getting the child to a place where they are able to trust the caseworker is essential for reintegration; this trust is the foundation for the child's full participation in the process. Getting to know the child well is also essential, so the caseworker is able to "read" if the child is demonstrating signs of discomfort throughout the case management process.

Do no harm

All reintegration processes should aim to benefit and avoid/prevent harm to children; prioritizing the prevention of abuse and all forms of violence, addressing stigma, ensuring informed assent, and respecting confidentiality. The assessment process should work to identify and mitigate against risks associated with reintegration for each child, without using the existence of some risk as an excuse not to reintegrate children if proper support can ensure safety and a chance for permanency. It is also vital that all caseworkers are trained in and agree to adhere to their organization's child safeguarding and protection policy.

[60] Adapted from Keeping Children in Healthy and Protective Families (2017). Standard Operating Procedures.

Implications for case management: Not all harm comes in the form of abuse or exploitation of children. Sometimes harm caused to children can be more subtle or intangible. For example, recognizing that many children in institutional care greatly miss and long for their families, harm could be caused unintentionally by a caseworker reassuring and promising the child that they will find their parents. If parents turn out to be lost, untraceable, have died, or are not willing to take a child back, the unfulfilled promise for reunification can be devastating to that child. Another example is that of breaking attachments formed at the institution. While the caseworker understands that family-based care is in the child's best interest, and while the child is demonstrating their excitement to return home, children can also experience emotional suffering if they are not adequately supported to transition from relationships they have built at the institution. Adequate time should be allocated to prepare children for the transition out of the institution, and to appropriately "close" their attachments there, to avoid re-traumatization.

Child participation and family self-determination

Caseworkers and case managers respect and promote people's rights to make their own choices and decisions, irrespective of their own values. There is an obligation to listen to children's views and to facilitate their participation throughout the process of reintegration. Children should be given relevant information in a manner appropriate for their age/development and encouraged/supported to participate in all matters concerning them with opportunities to express their views, hopes, fears, and wishes. Equally important is that their views be given due consideration in accordance with their age and level of maturity. It is important to note that children often express themselves very effectively in non-verbal ways (especially those who have experienced trauma, and who may not be willing to speak about sensitive topics), so caseworkers should be attentive to non-verbal cues.

Families have the right to be supported in making their own decisions, provided this does not threaten the rights of the child. The best interests of the child should always determine decisions within the reintegration process.

Caseworkers act as equal partners with the child and family and will take necessary measures to remove barriers which may make the family or child feel the caseworker has more authority than them (i.e., caseworkers will be active and intentional in minimalizing power dynamics.)

Implications for case management: The caseworker takes the time to create a safe non-judgmental environment and relationship that is conducive to the child's or family's self-expression, even if it does not align with the caseworker's opinion or values. Children's evolving capacities should be considered and development-appropriate engagement methodologies used to encourage more active and free participation (e.g., play, storytelling).

Caseworkers should endeavor to present themselves in a way that is comfortable and non-intimidating to children and families. For example, use the child and family's language of preference when speaking with them, do not overdress, physically come down to the child's level (i.e., make eye contact and sit on the floor when playing), etc.

Worth, dignity, and strength of child/family

Case management is based upon respect for the inherent worth and dignity of all people. Caseworkers should uphold and defend the physical, developmental, psychological, emotional, and spiritual integrity and wellbeing of every child and his/her family member. This should be reflected in all of the interactions with and decisions about each child and family member.[61] Caseworkers recognize that every person (child or adult) has peculiar strengths and works to identify and build upon them to promote empowerment and resiliency.

[61] International Federation of Social Workers (2019). Statement of Ethical Principles (webpage). Retrieved from: http://ifsw.org/policies/statement-of-ethical-principles/.

Implications for case management: Caseworkers understand that regardless of ethnic membership, educational level, development and disability status, or economic standing, each human being has a need to be recognized as a unique individual with special attributes and personality. Each person is respected and unconditionally regarded as having inherent worth and dignity, and this attitude is displayed in every interaction a caseworker has with a child or family. Caseworkers also recognize that every person has strengths to draw from, even if they are be small and may need significant support to identify and mobilize. Caseworkers who uphold the worth, dignity, and inherent value of the child and family take on these challenges and work with all family members and support systems to utilize or create resources for the family unit to reach its full potential. They know that each individual has inherent worth and can contribute to the holistic wellbeing of the family and community.

Rights-based

All children, regardless of age, gender, ability, or any other status, have the right to safety, protection, family, and to participate in all decisions that affect them. A child's best interests should be the primary driver all interventions, decisions, and plans.

Implications for case management: Caseworkers have an excellent understanding of relevant conventions, laws, policies, and frameworks and know that these supersede any personal values that might conflict with the rights of the child. They know they are required to act in the best interests of the child; this standard should guide them in all decision-making—especially if a child's safety is at risk—while respecting the legal and cultural authority of parents and caregivers.

Non-discrimination and respect for diversity

All individuals will be treated with equal respect by caseworkers. No distinctions will be made between children, adults, or communities on any grounds of status—including age, wealth, gender, race, color, ethnicity, national or social origin, sexual orientation, HIV status, language, religion, ability, health status, political, or other opinion. Caseworkers challenge all forms of discrimination and respect the diversity of families and communities.[62] Children and families should be given equal access to support services, appropriate to their needs.

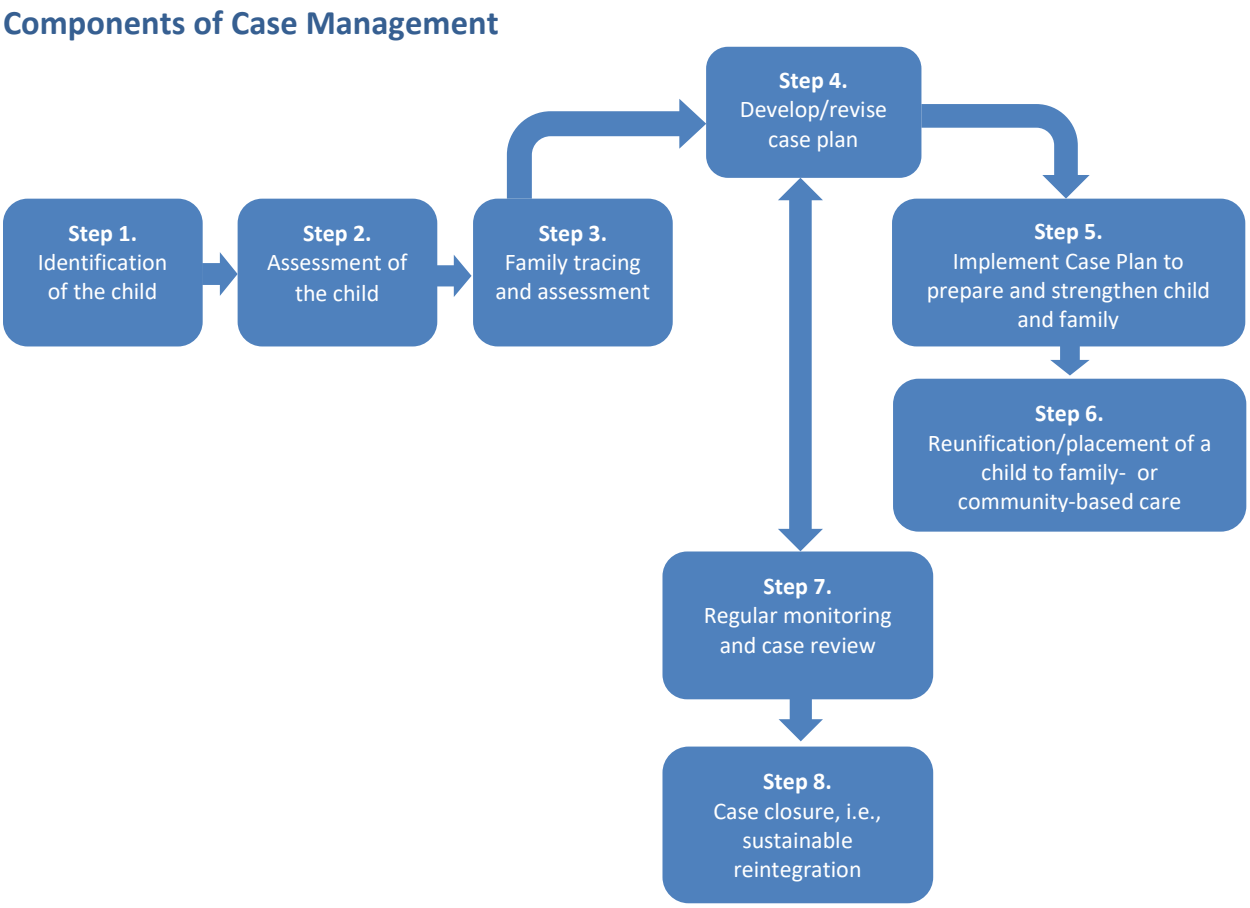
Implications for case management: Caseworkers must carefully and honestly assess their own biases and implicit prejudices for children and families possessing certain characteristics in order to avoid unknowingly letting these affect their interactions with families. Among the most prevalent attitudinal barriers to good practice are negative ethnic stereotypes, social class-bias, stigma, and discrimination related to disability, judgmental attitudes about HIV and AIDS, and religious differences.

Additionally, caseworkers should be sensitive to the experiences of children who have lived in Institutions for a long time. Sometimes children can develop behaviors that are different than those of children who have been living in family and community settings. Children may express themselves differently, have different behavioral patterns or habits, and different levels of abilities than children in communities (e.g., they may not have experience with "normal" household chores that their age mates in the community have). When children return home to their family, or to a new family and community, it is important that the caseworker helps the family and community understand the child's lived experience to help prevent stigma and discrimination.

Finally, caseworkers should be aware of how other children in the household view their relationship with the reunified child. Should the reunified child appear to be "favoured" by the caseworker, other children in the household may isolate the child or respond in other negative ways.

[62] Ibid.

Figure 3: Case Management



Case management is a process of organizing and working with children and families to address the individual needs of the child and family in an appropriate, systematic, and timely manner.[63] Case management helps ensure quality, consistency, and coordination of services, and is carried out in multiple steps.[64] It should be noted that case management processes are sequential, in that each process builds upon the previously completed process, and contributes to the subsequent process. It is therefore *essential* that all processes are completed, to ensure complete reintegration of children back into family-based care. Failure to complete all processes can lead to serious child protection risks.

Described below are the case management steps represented in Figure 3. More detailed descriptions are provided in Section 2: Standard Operating Procedures.

Step 1. Identification

This is a process of identifying children in need of family reunification/placement or a family at risk of separation and referring them for further eligibility verification and assessment. Children might be identified through specific services (e.g., CCIs) or by authorities and the community. The process used to identify children, their caregivers, and families must be well established, documented, and followed consistently. Having standard procedures, intake tools, and forms, etc. will help ensure fair and impartial criteria are used to identify appropriate children, rapidly assess their vulnerability, and determine if their

[63] Global Child Protection Working Group (2014). Interagency Guidelines for Case Management and Child Protection. Retrieved from: http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf.
[64] Adapted from: 4Children (2016). Case Management in OVC Programming.

cases would be appropriate to benefit from reintegration services. Identification usually takes place by community leaders, authorities, community-based organizations (CBOs), and institutions. Intake tools for CCIs can be found in the National Standards for Best Practice for CCIs.

Step 2. Child assessment

This is a systematic, holistic evaluation of the situation of a child, taking into consideration the specific needs of the child, risk/vulnerabilities, as well as the strengths of and resources available to the child. Child assessments explore issues related to development, disability, socio-economic status, health status, nutrition, shelter, psychosocial wellbeing, education, and protection that affect the child.

Step 3. Tracing and family assessment

Tracing: Efforts made to locate the child's parents and extended family to preliminarily evaluate their ability and willingness to receive the child.

Family assessment: A process for identifying the specific needs and strengths/resources of a family. Family assessments explore issues related to socio-economic status, health status, disability, nutrition, shelter, psychosocial wellbeing, education, and protection. It is important to assess individual children, as well as conditions affecting the primary caregiver and the entire household.

Step 4. Case planning

This is a process for developing a written plan that details how to improve the wellbeing, safety, and resilience of the child, caregiver, and household. It is informed by child, caregiver, and other individuals who are close to the child and family. The objective is to develop goals that support their successful reintegration. The case plan should include, at minimum:

- A summary and prioritization of needs, strengths, and resources;
- Goals and objectives that the child, family members, and caseworker hope to pursue together;
- A series of actions to be taken to address needs (building on strengths);
- The roles and responsibilities for all participants involved in implementing the case plan;
- A clear time frame for completing actions; and
- Indicators for determining when actions have been completed and when the goal has been accomplished.

Prior to reunification/placement, the case plan will focus on preparing the child and family for placement (e.g., ensuring the child has somewhere to sleep, is enrolled in school, feels connected to the family). Also, as part of the immediate reunification/placement goals, communities should be involved and prepared to accept the child back into the community. Preparing the community from the onset is critical as part of the family assessment in order to: 1) identify any protection concerns, 2) address stigma issues, and 3) increase community's sense of ownership for welcoming back the child and supporting the child and family throughout the reintegration process. Community acceptance is very critical for sustainability and successful reintegration.[65] After reunification/placement, the case plan will be focused on higher-level, long-term reintegration goals (e.g., community acceptance of the child, building of secure attachments between the child and family). Stimulating the community's responsibility for the returning child may occur in several ways, for example, use of local champions and/or community/religious leaders to speak on the importance of reintegration and peer support to families and children. Recognizing that stigma can be an important barrier to reintegration, it is therefore particularly important to engage communities in addressing this stigma, including disability stigma (e.g., become involved in organizing or participating in

[65]Inter-Agency Guidelines on Children's Reintegration. Retrieved from: https://bettercarenetwork.org/library/principles-of-good-care-practices/leaving-alternative-care-and-reintegration/guidelines-on-childrens-reintegration.

welcoming ceremonies).[66] When a child has been placed with a temporary alternative family, post-placement case planning should focus on developing plans for a long-term, more permanent family for the child.

> Within Kenya, the concept of case conferencing—although not referred to as such—has traditionally been applied at the community or clan level where key people within a community or clan meet and deliberate on issues affecting a child or household. This is an informal approach but has a similar intention and delivers results that reflect contemporary case conferencing. Even though this approach is used at the community's lowest level, it should not be considered the same as a structured case conference, since it does not typically include service providers or representatives of key line ministries. In instances where the solutions to a problem cannot be identified within the informal or traditional mechanisms, a case conference is an excellent way to engage a wide range of actors involved in child protection matters at the local level.
>
> Case conferencing can be called and done by caseworkers/case managers, other decision makers, or experts to solicit multi-disciplinary inputs without the child or family being present. A follow-up of the case should be done by the caseworker or case manager to assess progress.

Step 5. Case conference[67] and service provision or referrals

Case conference: In many settings, case conferences are called on behalf of a child or family to solicit multi-disciplinary input, problem solving, decision-making, and action-planning. Relevant stakeholders who know and/or work with the child/family are assembled to help develop possible ways forward when a case is facing significant challenges, risks, or bottlenecks. This is done to enhance reflective practice, strengthen problem solving, and support decision-making on important issues (e.g., best interests of child determinations). In some cases, the child and household members should be prepared to attend the conference in whole or in part.

Service provision or referrals: This is a process for ensuring that the child and family receive appropriate and timely services. Referrals can be made at any time throughout the case management process. Services may be provided by the caseworker, the caseworker's organization, or by another organization to which the child or family is referred by the caseworker (e.g., DCS or private sector service providers). Follow-up helps ensure that a referral has been accessed or received.

Step 6. Reunification/placement

Reunification is the process of bringing the child, family, or previous care-provider together for the purpose of establishing or re-establishing long-term care.[68] Placement is a social work term for arranged, out-of-home accommodation provided for a child or young person on a short- or long-term basis.[69]

Step 7. Monitoring and case review

Monitoring: This is a process that involves on-going follow-up with the child, caregiver, and other members of the household (e.g., via routine home visits), service providers, or others who regularly interact with the child or caregiver in the community to ensure that the child's best interests are still at the forefront and that needs are being met. Monitoring assesses if progress is being made toward successful long-term reintegration and permanency.

Case review: This is part of the monitoring process. It evaluates how the case plan is being implemented, checks progress on the case plan, and assesses the likelihood that reintegration will be achieved. Where inadequate progress against the case plan is found, adjustments are made to the case plan to ensure success.

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[66] Ibid.
[67] MWENDO OVC project Case Conference Standard Operating Procedure (2018).
[68] Better Care Network (2019). Toolkit Glossary of Key Terms.
[69] Ibid.

Step 8. Case transfer or case closure

A decision is made to **close** the case at a final review with the child and his/her caregiver, if reintegration has been achieved (as indicated by successful completion of the goals in the case plan and the placement being deemed to be safe and stable). If a child's placement is changed before the case is closed, the case may be transferred for continued monitoring by statutory authorities.

Roles and Responsibilities

Case management is an individualized and dynamic process with varying timeframes for each step of the process depending on and influenced by each child's and family's strengths, needs, context, and best interests. It requires well-trained staff; in this case the caseworker is the key person with responsibility for the child's case management from identification to case closure/transfer, even while many other people, both formal and informal, will come in to help with the success of the child's reintegration (e.g., extended family or community members, health workers, school teachers, or para social workers).

Caseworkers should receive frequent support from one, consistent case manager (preferably). For implementation in Kenya, caseworkers may be institution-based social workers, or social workers employed within other children-focused organizations. Case managers may be managers or directors employed by the institution, with additional support provided by children's officers employed by the DCS. To ensure full accountability and sustainability, only paid employees should hold the position of caseworker and/or case manager.

Caseworker and case manager roles and responsibilities are detailed in Table 2:[70]

Table 2: Caseworker and Case Manager Responsibilities

Responsibilities of Caseworkers	Responsibilities of Case Managers
Conduct child assessments, family tracing, and family assessments to determine which family may be most appropriate for the child.	Review assessments, supervise/support placement decision-making, and (where needed) convene and facilitate risk review meetings to ensure responsive case planning and implementation.
Develop case plans that respond to strengths and needs identified in assessments; facilitate child participation and family group conferencing.	Conduct regular supervision meetings, providing technical advice and support on individual cases and psychosocial support to caseworkers. Facilitate peer-to-peer support.
Prepare case summaries and present to the relevant sub-county children's officer (SCCO) in order to facilitate formal approval of the placement.	Review case summaries, and coordinate meetings with sub-county children's officer (SCCO) and ensure that caseworkers are supported to present cases.
Work to prepare children and families for reunification/placement, including making referrals to other services as needed.	Support individual cases (where required) and provide regular monitoring of all aspects of case management services.
Identify and connect with community actors who may have a role in protecting children and providing services to children and family members.	Identify and connect with community actors who may have a role in protecting children and providing services to children and family members.
Regularly monitor and support children and families through home visits, providing guidance, advice, emotional support, community mediation, and referrals.	Provide ongoing supportive supervision and support on-going in-service training needs of caseworkers.
Work with case managers and other caseworkers to arrange case conferences for complex cases and ensure children receive multi-disciplinary support.	Review staff caseloads to ensure they are manageable and share challenges with senior management and SCCOs.
Manage cases in line with SOPs, adhere to standard	Monitor timelines for response, decision-making,

[70] Adapted from: Global Child Protection Working Group (2014). Interagency Guidelines for Case Management and Child Protection.

Responsibilities of Caseworkers	Responsibilities of Case Managers
documentation processes, and follow best practice guidance.	placement, follow-up, and review; conduct case audits to check that SOPs and documentation standards are being followed.
Regularly document cases using relevant forms; update databases to ensure a comprehensive record of the case.	Ensure access to material, logistical, and technical support.
Ensure that data collection and storage respect data protection protocols and confidentiality principles.	Spot check to ensure safe storage of data and compliance with confidentiality principles.
Report and respond to child protection concerns.	Report and respond to child protection concerns.

Minimum Qualifications and Competencies

Caseworkers and case managers responsible for child reintegration will preferably be university or college trained, qualified social workers, or those within a related field. There are instances, however, when social workers may not have the relevant university diploma/degree but have significant work experience. If this is the case, the most important factor in determining whether someone has the skills and knowledge to be a successful caseworker is if they meet minimum competencies. The competencies (Table 3) required for a caseworker position (supported by the SOPs and training) include: [71, 72]

Table 3: Caseworker Competencies

Area	Competencies
Personal	▪ Self-knowledge, reflection, and questioning ▪ Management of stress and emotions ▪ Flexibility and openness to change and differences ▪ Critical thinking, creativity, and decision-making ▪ Accountability and integrity
Social	▪ Ability to negotiate ▪ Manage problems and conflicts ▪ Work and coordinate within a team ▪ Ability to work independently when required ▪ Show empathy, warmth, and genuineness ▪ Support and motivate a person/group ▪ Good communication and relationship skills ▪ Good networking and coordination skills
Methodological	▪ Promote participation and cooperation in case management ▪ Plan, implement, and review interventions ▪ Document relevant information in a timely fashion and store in a confidential manner
Technical	▪ Knowledge of the theoretical framework needed for reintegration ▪ Knowledge of the theoretical framework for work with children and families ▪ Basic knowledge of child development and family dynamics, counseling (in context of the culture), issues of disability, and child protection ▪ Purview of Kenyan child protection and safeguarding policy and Children Act ▪ Access to and ability to use specific tools for case management in reintegration ▪ Able to collect, report, and analyze information

Additional Skills, Qualities, and Approaches of Frontline Staff[73]

[71] Adapted from: Global Protection Cluster, European Commission and USAID (2014). Child Protection Case Management Training Manual for Caseworkers, Case Managers, and Workers.

[72] National Child Protection Case Management and Referral Guidelines.

[73] According to the Inter-Agency Guideline on Children's Reintegration those staff who work directly with children and families.

To support effective reintegration, staff need to have a range of technical skills and adopt appropriate approaches to reintegration. For example, staff will need to be able to do the following:

Acknowledge diversity: Children's experiences of separation and reintegration will vary substantially, depending on factors such as age, gender, ability, reasons for separation, experiences during separation (such as ethnic discrimination), and the family's current situation.

Develop a warm, professional relationship with the child: Knowing that they can rely on a caring adult who clearly values them and provides a sense of belonging enables children to assume their full role in the process and to raise any concerns. Trust and continuity are vital for forming this relationship.

Recognize the challenges that children and families face in the reintegration process: Children may be concerned about moving from a caring, well-resourced program to precarious support at home, leaving peers, or no longer earning money. Families may fear changing family dynamics due to the re-entry of the child into the household, or challenges feeding an additional person.

Help children speak out: Encourage children to voice any concerns and reassure them of their ability to make decisions and build a greater sense of power and control in their lives. Particularly in contexts where it may be dangerous to speak out publicly, caseworkers have a responsibility to create a safe and confidential space for children. Even very young children or those with a disability that affects their ability to express themselves should participate in decisions; managers will need to provide staff with more time and skills to support them.

Identify and build on strengths: Help children, families, and communities identify their own human and financial resources and develop a strategy to build on them.

Create local ownership: It is essential to stimulate the community's responsibility for the returning child. This may occur in several ways: e.g., local champions speaking on reintegration, peer support to particular families and children, and/or specific roles for community and religious leaders.

Act in a culturally knowledgeable way: It is important to identify solutions that leverage local methods of care and protection which are in line with children's, families' and communities' values and beliefs. Staff will need to be able to carefully negotiate solutions when the best interests of the child conflict with cultural values or practices.

In addition, staff will need certain qualities to work well with reintegrating children—including empathy, respect, patience, perseverance, and flexibility.

Caseload, Supervision, and Quality Assurance

Ideally, caseworkers should carry a caseload of approximately 10 cases at one time; however, this can vary depending on the complexity and level of effort needed for each case (i.e., the "weight" of a case and time required to manage it appropriately). The weight of a case can be determined by considering these factors:

- lengthy travel time is required to reach the household
- large number of family members in the household
- complex vulnerabilities within the family
- sibling group has been reunified/placed
- history or presence of violence, substance abuse, mental illness, chronic illness, disability, or child protection issues

Caseloads should be closely monitored by the case manager, and may need to be reduced to ensure adequate time/effort is given to each case.

Case managers should oversee no more than an average of 15 caseworkers in addition to supporting them directly on complex cases.

Case management is a collaborative process, and many hold the responsibility for the child's wellbeing (including the family, caseworker, case manager, organization, and relevant authorities). The case manager is responsible for providing direction and support to the caseworker, who applies theory, knowledge, skills, competency, and ethical content in practice.[74]

Deliberate focus on regular, reflective supervision should be made in order to enhance reflective practice, ensure caseworkers are guided, coached, mentored, and supported administratively, technically, and in self-care; that all are accountable and responsible in their work with children and families; and the work is of the highest quality.

Reflective practice in social work involves a questioning approach that examines the practitioner's thoughts, experiences, and actions, and seeks to improve skills as a result.[75] Reflective practice can be enhanced through supervision by reviewing caseworker's experiences and helping them be professional, accountable to themselves and others, and committed to improving and learning.

Supervision mechanisms act as checks and balances: for example, difficult cases may be discussed in individual or group supervision meetings or in reflective all-team meetings (case conferencing), leading to supportive suggestions and group decision-making to improve the quality of services. Supervision also plays a role in ensuring that caseworkers have the skills to deliver quality, competent services in accordance with the guidelines and SOPs. Supervision, both individual and group, can be a way of providing skills training and mentoring related to real case situations. Supervision provides opportunities to check on how caseworkers are doing, reflect on practice, deal with time management, identify where support is needed, and check on personal responses and coping mechanisms.

[74] National Association of Social Workers (2013). Best Practice Standards in Social Work Supervision.
[75] C. Knott and T. Scragg, eds. (2016, page 10). *Reflective practice in social work*. Learning Matters.

Table 4: Quality Assurance and Supervision Mechanisms within the Case Management Process

Supervision methodology	Frequency	Description
Reflective practice	On-going	Review caseworker's experiences, thought processes, etc. to increase professionalism, accountability to self and others, quality, and learning.
Case conferences	At certain key points in process and as needed	Multidisciplinary meeting of professionals known to and/or working with the child to discuss risk factors; care and protection needs; required supervision and support interventions with the child, family, and alternative caregivers; and the roles of the professionals involved.[76] This can include caseworker, case manager, institution staff, teachers/school, health workers, community leaders, SCCOs, etc. and is done at various points in the case management process. For key decisions, children and families will also be included in **family group conferencing**. The caseworker has a key role in supporting both conferencing processes.
Case reviews or group supervision	Monthly	Review of every child's case plan (when, how, progress, and blockages) managed by each case manager with his/her team of caseworkers.
Peer support	As needed	Individual peer-to-peer support and learning.
Mentoring, coaching, and shadowing	On-going	Individual support and learning through phone conversations, direct contact, and opportunities for peer-to-peer coaching between supervision sessions. Case managers may support during visits to child/family on an "as needed" basis and based on the caseworker's skill set and learning objectives.
All team meeting	Bi-weekly	Brings the team together (i.e., project workers, administrative staff, case managers, and caseworkers and parenting educators, as needed) to review challenges, organizational issues, discuss case studies, touch points for communication, and lessons being learned.
Individual supervision	Monthly	The case manager and caseworker look at the case load, identify progress, new actions, challenges, etc. The case manager should pay close attention to the workload. If a caseworker is allocated too many cases at one time, quality of practice will likely decrease, and children and families will not receive the level of time they require from their caseworker.
Safeguarding committee	As needed	Multi-level group for discussion of highly complex cases, to share the responsibility and enable group decision-making. Cases are identified in group or individual supervision. As the statutory authority, SCCOs may also be involved.
Regular training	As needed	During individual supervision, case managers may note trends of topics/themes where caseworkers require additional support. These should be addressed in formal trainings. Topics where caseworkers doing reintegration typically require additional support may include attachment theory, child-friendly techniques for working with children who have experienced trauma, child protection, disability, making home visits, making referrals, etc.

[76] Better Care Network (2019). Toolkit Glossary of Key Terms.

Working in Collaboration with Community Partners

The individuals and groups in the community where the child and family live also have an important role to play in the reintegration process. These actors can include government organizations, offices or workers, non-governmental and community-based organizations, schools, faith-based organizations, churches and mosques, and health and education institutions.

In order to ensure the safe and long-term reintegration of children to families, caseworkers will need to work closely with as many individuals and groups as possible who have a role in supporting families and protecting children. Caseworkers will work in partnership with children and families to identify which actors are best positioned to support them, and at which time.

Sub-county children's officers (SCCOs) are government officers at the sub-county level with statutory responsibilities to ensure appropriate care and protection of children. They will have responsibility for seeking official documentation so that children can be released from an institution and placed into family- or community-based care. Once cases have been closed, SCCOs also have responsibility to ensure that children remain safe in their families. By law, any concerns of child abuse, neglect, or exploitation must be reported to the SCCO.

Area Advisory Council (AAC) are structures that were formed through a Presidential Administrative Directive to address issues affecting children at the district level then to decentralize delivery of government services to *wananchi;* from the national to the district level with the understanding that local people more clearly understood their problems.[77] The composition and mandate of the AACs are intended to promote public and private partnerships in line with the composition of the National Council for Children Services (NCCS). It is known and appreciated that communities are in a position to best understand the issues affecting their children; therefore the need to decentralize services to county, sub-county, and local levels.

Alternative Care Committee (ACC) is a subcommittee of the AAC focused on coordinating and strengthening family and alternative care services within the sub-county. Members include multi-disciplinary, specialized professionals who provide family strengthening and alternative care services in the sub-county. The AAC may co-opt people who are not members of ACC to provide expertise. ACCs are mandated to evaluate children's cases who are being recommended for alternative care and to make recommendations regarding how children's interests can best be met (i.e., BIDs). When evaluating a case, each member pays special attention to evaluating the elements of the child's assessment in which they hold expertise (e.g., the health representative will closely evaluate the health status and health- related needs of the child). The committee then selects which option is most suitable to meet the child's unique holistic needs, depending on the different care options that are available. The committee should provide formal documentation outlining decisions taken, factors considered, the weight given to each, and the specific conditions of the transfer of the child's care from one party to another (i.e., from where the child currently resides to their new care placement). This documentation should be retained within the child's file.

Charitable Children's Institution (CCI) **directors, administrators, "house mothers/fathers," and other caregivers** will play an important supporting role to institution caseworkers in helping with identification, child assessments, leads for tracing, and preparing children for reunification/placement. House mothers/fathers often know the child very well; they have knowledge about the child's needs, strengths, and desires and can facilitate process of the caseworker building trust with the child (e.g., they can inform

[77] National Council for Children's Services (2015). *Guidelines for the formation and operation of the Area Advisory Councils*. Retrieved from: https://www.usaidassist.org › sites › default › files › aac-0.

caseworkers which activities might engage the child most or which friends to involve). Institution directors play a key role in deciding if support will be afforded to the child following reunification/placement (e.g., school fees). The caseworker should advocate on behalf of the child and family and their specific needs.

Community cadres—in the Kenyan context these include **Child Protection Volunteers** (CPVs) and **Community Health Volunteers** (CHVs)—who are community volunteers with a "watchdog" role, that is, they assist in the early identification of child protection issues, help families access available services and resources, and report serious issues up the chain of responsibility to sub-county children's officers (SCCOs), county children's officers (CCOs), or other officials (e.g., Chiefs or members of the AAC). Volunteer children's officers (VCOs) and/or CHVs also link the children and families to informal community mechanisms that can provide support in non-statutory but important ways, such as mobilizing neighborhood support. Community cadres are often referred to as front-line workers since they directly engage at the household or family level. Caseworkers will want to know who the community cadres are, what role they play in their community, and how they may watch out for and help the families in the reintegration program. Once a case is closed it will be important for a community cadre to know the families and children, and for children to know their local VCO or CHV.

School teachers and administrators also play a critical role in children's lives. Caseworkers will want to ensure that connections are made with schoolteachers and administrators to ensure access to schooling and successful community/school reintegration. Teachers are often the first to recognize any change in a child's behavior, so are good sources of information regarding whether or not the placement is progressing appropriately to complete reintegration.

Other service providers, including **health clinic staff, community health workers, community leaders, civil society, faith-based institutions,** and **community-based organizations** will provide important support to families—such as access to health services and linkages to community services (e.g., household economic strengthening, skills training, and more). Caseworkers will need to know what options exist and the best places to connect families/children based on their individual needs and case plans. SCCOs are a good initial point of contact to provide information on the type of services that exist around the child/family.

Information Management and Documentation

All case management work in reintegration will be documented in the child's case file using forms in the accompanying *Toolkit*. Each child to be reunified/placed into family-based care should have an individual case file; however, siblings who will be reunified/placed together should have a combined case file. As a case progresses, forms and notes should be accurately and thoroughly filled out and stored in the file.

Each case should be assigned a case file number, either the Child Protection Information Management System (CPIMS) ID or the unique number given to the child during admission for care or those identified to be at risk of separation. It is recommended to use this number for purposes of gathering data that are county-specific and to help determine the trend of reintegration. This information will be fed into the CPIMS for monthly reporting and analysis. In areas where the CPIMS has not been rolled out, the team will use manual data entry that will later be fed into the system.

Data Protection, Safety, and Confidentiality

Caseworkers should understand that all information learned, collected, and recorded about the child and family belongs to the child and family. With this in mind, it is only with their explicit consent and assent that this information can be shared with other actors (unless ordered by an authorized statutory entity such as a Children's Officer); this includes referral services. It should never be assumed that a child or

family approve a caseworker sharing their information—their permission should always be sought in advance. However, the caseworker should explain that confidentiality will not apply to such information as will affect protection/safety of the child him/herself and protection/safety of the receiving family. Also, in cases where family members are asked to sign a release of their information, the objective and implications of the release should be fully explained.

The National Standards for Best Practice in CCIs[78] requires that caseworkers be trained on confidentiality and sensitivity of information, and that management ensures safe storage and restricted access to information about children. Caseworkers should sign their organization's confidentiality agreement.

Caseworkers should also keep in mind that children have the right to access their files—at a level appropriate to their age and evolving capacity—even after reunification/placement. Caseworkers are required to submit a copy of all case files to the SCCO, and should also safely store the file for a minimum of seven years after the child is reunified/placed (archiving thereafter).[79] Case files should also be stored in a secure and confidential manner, with restricted access (such as a locked cabinet), and electronic data should be password protected.

[78] Government of Kenya (2013). *National Standards for Best Practices in Charitable Children's Institutions*. Retrieved from: https://bettercarenetwork.org/sites/default/files/National%20Standards%20for%20Best%20Practices%20in%20Charitable%20Children%27s%20Institutions.pdf.

[79] Ibid.

SECTION 2: Benchmarks for Case Management for Reintegration into Family- or Community-Based Care

The case management for reintegration benchmarks and case review (reintegration evaluation) tool will be used to help evaluate the status of the reintegration process, define and review the goals of the family and achievement, what areas the caseworker can help the household improve, and when to close the case. The reintegration benchmarks have six wellbeing domains which are each considered critical to the process of reintegration of children. As seen in the star model (Figure 1), children should improve across *all domains* as they progress from reunification/placement (in the center of the star) to reintegration (at the outer points of the star). This star model was readapted to suit Kenya's context, and it is from the six domains that Kenya came up with a total of 12 benchmarks to determine the reintegration progress, with each domain having a well-defined benchmark that will be used to measure progress of reintegration across the domains.

The following benchmarks reflect what are considered **successful outcomes** for reintegration. They represent the different criteria that could be used to measure achievement toward specific goals and related outcomes of the household's case plan. The benchmarks are aligned with the six domains encompassing the areas to measure successful and sustained reintegration: education, health and development, psychosocial wellbeing and community belonging, relationship and attachment, protection and safety, and economic stability:[80]

1. **Health and development.** This domain encompasses children's physical health in terms of malnutrition, access to healthcare, and food intake as well as cognitive changes that characterize normative and social development. Special considerations should be given to health and development needs of children, particularly those with identified developmental delays or disability. The domain has **three** benchmarks: **nourished, developing, and access**.
2. **Education.** This domain includes children's access to school, including school enrolment, attendance and transition, special developmental needs, and inclusive education for children with disability. This domain has **three** benchmarks: **accessing, attending/progressing, and inclusive.**
3. **Protection and safety.** This domain encompasses children and caregivers' level of safety and protection from violence, exploitation, and neglect (including both witnessing or experiencing violence and exploitation at home, at school, in the community, and online). This domain has **one** benchmark: **safe.**
4. **Psychosocial wellbeing and community belonging.** This domain encompasses children's and their caregivers' psychological health and wellbeing, socio-emotional functioning (including self-esteem, resilience, and belonging), and any special psychological needs. Additionally, this domain measures the child and caregiver's feelings of acceptance, welcome, inclusion, and support within their wider community. This domain has **three** benchmarks: **self-esteem/resilience, accessing social support services, and acceptance.**
5. **Relationship and attachment.** This domain encompasses children's relationship(s) and attachments(s) with their caregiver/mentor, including spending dedicated time with each other, building connections and communication between the caregiver and child, and feeling loved. This domain has **two** benchmarks: **quality time/positive communication and consistency**.
6. **Economic stability.** This domain encompasses the caregiver's ability to meet basic and any other unexpected needs of the household members. It measures the caregiver's capacity to save and financial literacy. This domain has **one** benchmark: **stable.**

[80] Benchmarks based on benchmarks originally developed by 4Children, MWENDO OVC project and the Retrak reintegration star model.

Table 5 includes the following:

- ***Name of benchmark and domain***—highlights which of the six domains the benchmark is composed.
- ***Sub-population***—refers to the person or persons that this benchmark refers to and who will be part of sharing the information to validate if the benchmark has been reached. This can include the caregiver, child(ren), adolescent girls and boys, and young adult(s).
- ***Definition of the benchmark***—includes a clear articulation of what this benchmark relates to and how it directly relates to areas that determine success of reintegration.
- ***How to verify achievement of the benchmark***—includes suggestions for how the caseworker or partner(s) will be able to verify whether or not the benchmark has been reached. There are various ways this can be done, and approaches or actions will differ depending on the benchmark.

Table 5: Benchmark Information

#	Benchmark	Sub-Population	Definition	How to Verify
Domain: Education				
1	**Accessing, attending, and progressing**	Children and young adults	The child or young adult has consistent access[81] to an appropriate education institution (early childhood, primary, secondary, or vocational), is regularly attending[82] an education program, and is progressing appropriately as compared to their performance prior to placement. The child values and enjoys their education program and feels included and respected by their peers and teachers. The child/young adult can safely move to and from the education institution and has the resources to complete education requirements (homework, extracurricular, etc.) outside of standard education hours.	▪ Observe travel distance for child to get to education institution and ask the child/young adult how they get there. Confirm access is safe. For children enrolled in early childhood education (ECD), ask caregivers how they take the child to/from the facility. ▪ Review enrollment receipt to confirm enrollment. ▪ Review school report card or school register to confirm regular attendance (i.e., not missing more than five days per month) and appropriate progression. ▪ Observe that the child/young adult has appropriate uniform, shoes, books, supplies/equipment,[83] etc. as required by the ministry of education. These should be items that are considered normal to the community where the child will be reintegrated, so they are consistent with their peers. ▪ Observe the education institution's hygiene facilities for adolescent girls; confirm with adolescent girl that menstruation does not present a barrier to attendance. ▪ Ask the children in the household about homework habits (i.e., when/ where are they able to complete homework and if a caregiver supports when needed); ask teachers about homework completeness. ▪ Ask the child/young adult how they feel about their performance. ▪ Ask the child/young adult to rank their enjoyment of education and visually observe them during their education program. ▪ Ask the child/young adult what they want to use their education for in the future. ▪ Ask teacher(s)/trainer(s) for progress of the child/young adult; obtain report card if it is not provided by the child and/or caregiver.

[81] E.g., geographic and economic access.
[82] Or has previously regularly attended, and now graduated.
[83] Inclusive of supplies/equipment needed to commence vocational training, e.g., cotton wool for salon towels or combs for a hairdressing course.

#	Benchmark	Sub-Population	Definition	How to Verify
2	**Inclusive**	All children and young adults—including those with disabilities or other special needs	Children and young adults living with disability/ies are attending an education institution which is inclusive and equipped to meet the unique needs of the child/young adult.	▪ Visit the education institution to confirm all children/young adults (including those with disability) have physical access to all areas of the facility (including classrooms, washrooms, recreational areas, etc.). ▪ Visit the education institution to confirm all children/young adults (including those with disabilities and with special needs) have access to specialized teachers and that inclusive teaching practices are used. ▪ Visit the education institution to confirm the child/young adult with disabilities does not have communication barriers in classroom. ▪ Confirm that the child's caregiver/mentor/teacher is aware of the child's special needs and its impact on education and that the caregiver/mentor/teacher has developed supportive strategies. ▪ Confirm that stigma does not present a barrier to the child/young adult attending school.
Domain: Protection and Safety				
3	**Safe**	Children, young adults, and caregivers—including those with disabilities	Children, young adults, and caregivers are not currently experiencing, nor in immediate danger of violence, exploitation, or exposure to violence at home, school, in the community, and online. Household is free from substance abuse. Children, young adults, and caregivers who have experienced violence have received appropriate and beneficial support services (e.g., health, protection, psychosocial, and/or legal).	▪ Evidence of completed referrals to relevant health, psychosocial, protection, or legal services is included in the case file (e.g., duplicate referral form, receipt, or service provider documentation), if violence has been an issue in the past. ▪ Evidence (or self-report[84]) that children, young adults, and caregivers know how to report and respond to violence and are aware of ways of protecting themselves against violence, including the ability to clearly articulate and give examples of how to 1) manage stress, 2) problem-solve in constructive ways, 3) positively communicate with caregivers, and 4) identify other means for decreasing violence. ▪ In the case where a child with a disability is unable to communicate, engage the caregiver to understand how they will respond and report violence and their knowledge of ways to protect their child(ren) against violence. ▪ Children can articulate their rights related to protection in accordance with their age and maturity and considering their evolving capacity.

[84] I.e., an individual gives personal detail about him/herself.

#	Benchmark	Sub-Population	Definition	How to Verify
				▪ Children and young adults can identify safe people and places in their community who they could go to for help if needed. ▪ It is observed and reported that the child receives positive reinforcement and that there are no harsh forms of punishment.[85]
Domain: Psychosocial Wellbeing and Community Belonging				
4	**Self-esteem and resilience**	Children, young adults, and caregivers	Children and young adults' express healthy self-esteem, self-worth, and an overall sense of positive identity. Children, young adults, and caregivers demonstrate confidence in problem-solving, use of positive coping strategies, and express hope for the future.	▪ Children and young adults can identify and express positive personal traits they are proud of, including skills/competencies. ▪ Mentors/neighbors report the young adults are not exhibiting risk behaviors,[86] and have positive peer relationships. ▪ Children and young adults display an overall positive demeanor, which is confirmed by caregiver, mentor, teachers/trainers, and/or neighbors, and do not exhibit 1) stress, 2) withdrawn behavior, 3) no interest in play or enjoyable activities, 4) change of appetite for food. ▪ Caregivers are not exhibiting signs of stress or are currently seeking support to manage their stress. ▪ Children and young adults can provide examples of how they have problem solved and/or learned from a mistake in the last 3 months. Teachers/trainers/mentors confirm that the child/young adult persisted in finding a solution (i.e., they were confident they could find a solution). ▪ Young adults and caregivers can provide examples of how they positively manage stress (including emotional support-seeking behaviors). ▪ Children, young adults, and caregivers can express a vision of and hope for their future life.
5	**Accessing social support services**	Children, young adults, and caregivers	Children, young adults, and caregivers have access to support services. All children have been registered with the department of Civil registration.	▪ Children and young adults have a birth certificate and/or national ID. ▪ Children, young adults, and caregivers can clearly articulate where they are able to access support services, and whether they have previously accessed support services (e.g., orphans and vulnerable children [OVC] cash transfers).

[85] E.g., physical punishment (beating the child, denial of basic needs, humiliation, and verbal abuse) and using abusive language. By comparison, positive reinforcement techniques teach and guide the child to correct their behavior, e.g., sending a child to "timeout" to calm down.

[86] E.g., including substance abuse.

#	Benchmark	Sub-Population	Definition	How to Verify
				▪ Case plan and referral documentation confirms services have been accessed and met their intended purpose.
6	**Accepted**	Children, young adults, and caregivers	Children, young adults, and caregivers participate and are included in daily activities. They regularly engage with caregivers, mentor, other adults, and peers within the community. They have a sense of shared identity with their community, a sense of belonging to the community, and can identify individuals or groups recognized as providing social and emotional support. Stigma is not a barrier to participation in family and community life.	▪ Child is observed to be treated equally, in terms of participation and resource allocation, to other children in the household. ▪ Ask children and young adults to identify at least one friend at school/vocational training/employment, and one friend in the community. Ask caregivers to identify at least one friend in the community. ▪ Ask child, young adults, and caregivers if they have participated in a community activity in the last 3 months (e.g., fundraising, wedding, funeral, religious function, baraza, or youth function). ▪ Ask children, young adults, and caregivers if they are a member of any community group (church/mosque, peer support group, women's group, disabled people's organization, child/adolescent club, savings groups, etc.). ▪ Children and young adults can identify adults they trust in their community who they could go to for help if needed, including a specific mentor (for young adults). ▪ Caregivers and young adults can identify someone who would take them to the doctor and care for them (e.g., cooking meals and completing daily chores) if they were sick, someone they can speak to about their problems who would understand them, and someone who makes them feel loved and important.
Domain: Health and Development				
7	**Nourished**	Children, young adults, and caregivers	The household was able to provide a minimum of two meals per day to all household members in the past 6 months that met the nutritional needs of the all members of the household.	▪ During monitoring visits to the household and case review, ask children, young adults, and caregivers regarding frequency, quantity, and composition of meals. ▪ Observe food storage and use of cooking equipment. ▪ Observe physical appearance to confirm there are no signs of malnutrition in the child(ren).[87]

[87] E.g., protruding stomach, gray hair, wrinkly/dry skin, and swollen ankles/feet.

#	Benchmark	Sub-Population	Definition	How to Verify
				▪ The nutritional needs of family members with specialized dietary needs are met, where relevant.
8	**Developing**	Children and young adults (adolescents)	Child or young adult is meeting physical and cognitive developmental milestones, or where these are not being met, is accessing appropriate services to support development.	▪ For children under-5, during the monitoring visits ask the caregiver if the child is walking, talking, and showing increasingly independent behaviors at a level similar to other children of his/her age in the community. Confirm via direct observation and interaction with child. ▪ Confirm adolescent girls and boys are aware of and can articulate the different developmental changes related to adolescents (e.g., menstruation, breast development, voice changes, self-worth, self-confidence, and engage/maintain positive friends). ▪ For children with disabilities—whose caregiver notes (via observation and interaction) developmental delays—review evidence of accessing appropriate support services (i.e., copy of receipt of services received and confirmation from service provider of services delivered) along with the caregiver's knowledge, attitude, and practice in relation to the child's delay/special needs. ▪ In absence of specialized services, ask caregivers to demonstrate their knowledge/competencies to support children with disabilities (e.g., caregiver is attending parenting skills training, checking for skills on home-based physiotherapy exercises, and feeding those skills).
9	**Accessing**	Children, young adults, and caregivers—including those with disabilities	Children, young adults, and caregivers have access to health information and services and can utilize services as required and without delay, to ensure maintenance of overall good physical health. Young adults and caregivers can meet the costs of any health-related expenses (including medicine, clinic fees, and	▪ Review referral forms on case file and review evidence of completed forms for individuals referred for treatment (e.g., returned referral slips, reports from children/young adult/caregiver/service providers on services received). ▪ Review copies of medical records on case file, including mother-child booklet (confirming full immunization) for children under-5. ▪ Children, young adults, and caregivers with disabilities have been assessed and registered by the National Council for Persons with Disability (NCWPD)[88] and have access to both general health services and the necessary disability-specific services.

[88] The National Council for Persons with Disabilities is a state corporation established by an Act of Parliament, the Persons with Disabilities Act No. 4 of 2003 and set up in November 2004. Retrieved from: http://ncpwd.go.ke.

#	Benchmark	Sub-Population	Definition	How to Verify
			transport), and have access to health insurance where available. Children under-5 are fully immunized as per the Kenya Expanded Program for Immunization (KEPI).	▪ Adolescent girls are using sanitary items. Adolescent girls and boys know where to access adolescent-friendly health services and are utilizing them. ▪ Where there is chronic illness, caregivers are conversant in treatment regimen. ▪ During case review, ask young adults and caregivers if they delayed accessing/supporting children's health or education services in the past 3 months due to financial constraints. ▪ Children, young adults, and caregivers have access to health information. ▪ Adolescents, young adults, and caregivers are aware of basic HIV prevention strategies, dangers of risky behavior, and can articulate risky sexual behaviors to the caseworker (e.g., provide examples of how they are protecting themselves and correctly describe the location of at least one place where they can receive sexual/reproductive health services and information).
Domain: Child–Caregiver/Mentor Relationship and Attachment				
10	**Quality time[89] and positive communication**	Children, young adults, caregivers, and mentor	Child spends consistent time with caregiver; young adult spends time with mentor that they value and enjoy. Communication between the child and caregiver is frequent and open and both feel understood and satisfied with the communication; communication between young adult and mentor is frequent and open and both feel understood and satisfied with the communication.	▪ During the case review, ask the child if they feel their caregiver knows a lot about them (e.g., do they know what the child likes/dislikes or what makes them happy/sad?). ▪ During the case review, ask children/young adults how they usually spend time with their caregiver/mentor, i.e., what do they do together and how frequently? ▪ Observe a child's/young adult's non-verbal cues, revealing if they enjoy spending time with their caregiver/mentor. ▪ During the case review, observe whether the caregiver/mentor generally speaks positively of the child/young adult. ▪ During the case review, ask young adults if they are satisfied with the frequency of time spent with their mentor.

[89] This is undivided attention given to a child/young adult for the purpose of strengthening the caregiver/mentor relationship, e.g., quality time spent talking and engaging in activities together. Quality time can be spent within or outside the household.

#	Benchmark	Sub-Population	Definition	How to Verify
				▪ During monitoring visits to the household, observe "serve and return"[90] between caregiver and infants and/or children who are non-verbal. ▪ During the case review, ask young adults how they usually spend time with others residing in the household, i.e., what do they do together and how frequently? Ask if they enjoy the time spent with those individuals. ▪ During monitoring visits to the household, observe communication between child and caregiver (or young adult and mentor) and other individuals residing in the household. Does the child/young adult express themselves freely with the caregiver/mentor, and is the child/young adult appropriately engaged in discussing decisions which affect them? ▪ Ask the child/young adult if they share exciting/good information with the caregiver/mentor, and if they can discuss personal problems with them.
11	**Consistency**	Children, young adults, caregivers, and mentor—including those with disabilities	There is consistency in the relationship between the child and caregiver (or young adult and mentor) in terms of level of supervision, responsiveness, boundaries, and discipline—leading to increasing trust.	▪ During monitoring visits to the household, observe caregiver's/mentor's response to the child's/young adult's cues for attention (including those with disabilities). Is the response timely and does it seek to meet the child's/young adult's needs? Note the serve and return engagement mentioned above. ▪ During monitoring visits to the household, observe the child's/young adult's response to stressors. Do they seek support and comfort from the caregiver/mentor? ▪ Observe if the caregiver/mentor responds appropriately to a child's/young adult's stressors. ▪ During the case review, ask the child/young adult if they were hurt or sick in the last 3 months and if their caregiver/mentor took care of them. ▪ During the case review, ask young adults if they needed help in the last 3 months and did they reach out to their mentor. Was their mentor able to provide useful/meaningful guidance and support?

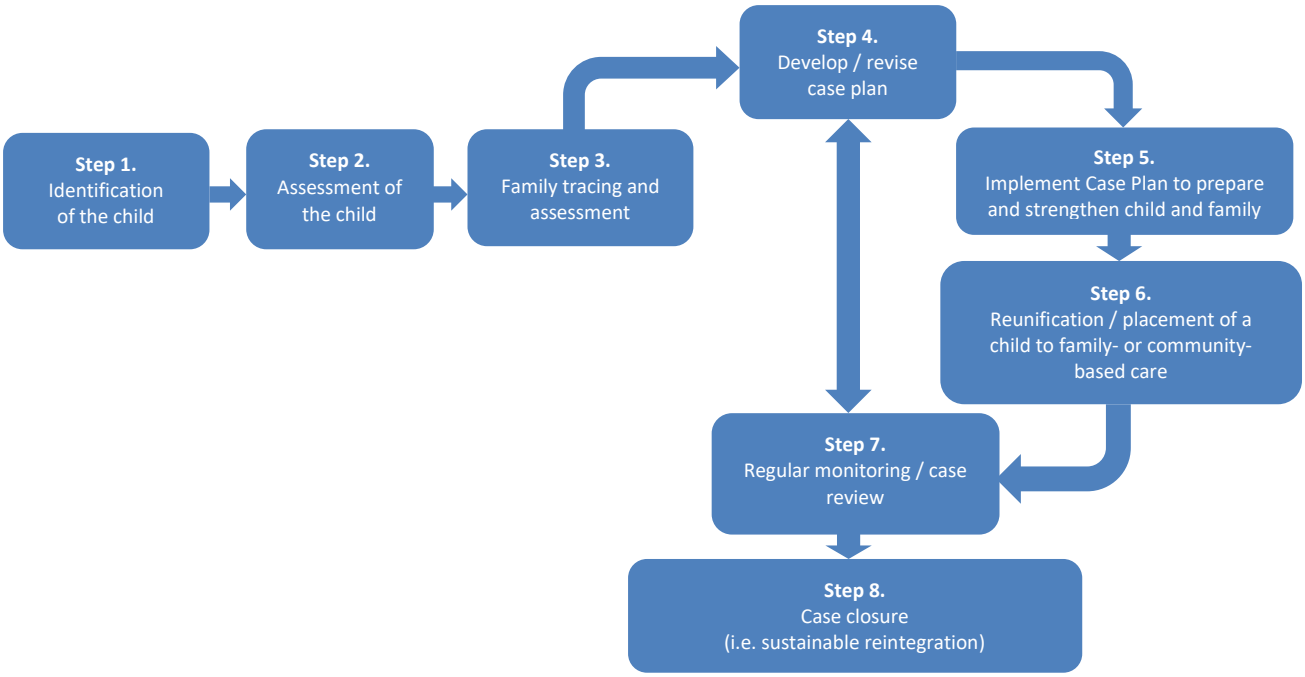
[90] A process whereby babies, young children, or those who are not able to express themselves verbally actively engage with, and get responses from, an adult or other person. When the infant/child gestures or cries, an adult acknowledges and responds appropriately with eye contact, words, or physical touch. This interaction supports brain development as well as social and communication skills.

#	Benchmark	Sub-Population	Definition	How to Verify
				▪ Confirm with the mentor any support the young adult needed during the last 3 months. ▪ During the case review, ask the child/young adult if they feel their caregiver/mentor knows where they are and what they are doing most of the time. ▪ During the case review, ask the child/young adult about the rules of the house, and consequences should the rules be broken. Where clear boundaries have been set, communicated, and consistently applied by the caregiver/mentor, children/young adults should be conversant in these. Confirm that rules and consequences are consistent for all children/young adults in the household.
Domain: Economic Stability				
12	**Stable**	Children, young adults, and caregiver	Caregivers have been able to meet the cost of children's basic needs, such as rent expenses, clothes, etc. over the last 6 months. Young adults who are working and being supported have been able to meet these costs for themselves. Caregivers and young adults have regular savings and basic financial literacy (e.g., planning, saving, budgeting, and responsible spending). Caregivers and young adults have been able to anticipate and meet emergency expenses in the last 6 months (e.g., medical expenses, drought, or flood) via savings or access to loan/credit.	▪ Evidence shown (or self-reports[91]) of sources of income (e.g., business, formal, informal, casual, and employment) and/or productive assets (e.g., livestock and poultry). ▪ Evidence shown of any payment receipts for rent. ▪ Observe if there have been any recent home repairs and home improvements, etc. ▪ In some cases, evidence shown of receipt of bursary or cash transfer. ▪ Confirm if there is any other external support (e.g., relative). ▪ Evidence (or self-report) shown of regular savings (e.g., active participation in saving and credit groups). ▪ The caregiver or young adult can provide examples of how they were able to meet emergency expenses in the last 3 months and can articulate plans how to meet future emergency expenses.

[91] Unverified information by other persons.

SECTION 3: Standard Operating Procedures of Case Management for Reintegration into Family- or Community-Based Care

Figure 4: Case Management Process for Reintegration into Family-based Care



As outlined in the introduction section, case management is sequential, in that each process builds on the previously completed process and contributes to the following process. It is therefore **essential** that all processes shown in Figure 4 are completed, to ensure complete reintegration of children back into family-based care. Failure to complete all processes can produce serious child protection risks.

Each case management process has key actions, specific principles, and expected outcomes. These are outlined in the SOPs below.

A toolkit of forms to support case management is provided. The SOPs below outline how to conduct the practice of each case management process, while information attained during each process will be recorded on the forms (i.e., the forms and SOPs are complementary and should be used together).

SOP 1: Identification

Purpose: The purpose of the identification step is to collect basic information of a child who is at risk of separation or outside of parental care. This is to ascertain whether interventions are needed to protect the child. It is a gatekeeping process to ensure that children and families are referred to appropriate services in order to prevent separation and ensure that placements are appropriate.

Guiding notes: Initial basic data on the child and/or family should be collected by the first point of contact with the vulnerable child (usually a statutory authority for child protection, e.g., children's officer or police). Basic information about the child should be attained through direct interaction with the child as well as other actors who may have information about the case, to determine if the child's reintegration into family/community-based care is necessary. This should be approached carefully, using child-friendly techniques and with *do no harm* principles in mind. It should be remembered that poverty should never be the driving factor or primary

justification for removing a child from his/her family and placing him/her in alternative care, and that all efforts should be made to trace the family and resettle the child. If temporary protective care is deemed necessary, the gatekeeper should follow the Continuum of Care to prioritize family-based and community-based care options, before considering referring the child to an institution. All alternative care placements should consider the importance of placing the child as close as possible to his/her usual place of residence. Other important principles to include are 1) strength-based, developmentally appropriate interviewing of children; 2) considerations for keeping siblings together; and 3) *General Principles in the Provision of Alternative Family Care* from the *Guidelines of the Alternative Family Care of Children in Kenya.*

Outcomes:

- Retrieval of biographical data on the vulnerable child to give support in the determination of need for reintegration to family/community-based care.
- Tracing and resettlement of the child, or referral of the child who needs temporary care and protection to family-based, community-based, or—as a last resort—residential care.

Actions: Initial biographical data should be collected by the first point of contact with the vulnerable child and attained through direct interaction with the child, along with other actors who may have information about the case. The child should be interviewed in a space that feels comfortable to him/her, using child-friendly techniques (e.g., drawing) focused on their strengths and sensitive to their gender, age, and evolving capacity. Siblings can be interviewed together if children seem more comfortable in each other's company. The interviewer must be open and non-judgmental in their attitude toward the child and what he or she may reveal. Areas to discuss with the child should include:

- Physical location of the family (as last known by the child)
- Names of caregivers and other significant relatives and any possible contact details
- Who was important to him/her; who looked after him/her?

People involved: Referring authority, alternative family care service providers, caseworker, institution administration, and child.

Documentation:

- Section 1 (Biographical information, *required*)
- Where applicable, the following: Section 2 (Details of Admission), Section 3 (Status of Family) on Child Identification and Assessment Form, and Section 4 (Medical history at admission)
- Copy of referral documentation (e.g., Care Order and police referral documentation)
- Case Notes Form (if extra space is needed)

SOP 2: Child Assessment

Purpose: The purpose of the child assessment step is to help determine the suitability and appropriateness of reunifying a child with his/her biological family or placing the child in family- and community-based care. It also helps attain initial information concerning the child's background, strengths, and needs; and information regarding the child's family, perceptions about his/her family, and any perceived barriers to reintegration, etc.

Guiding notes: Child assessment is an opportunity to ensure that *child(ren) participate* fully by providing them an opportunity to express their views and have their opinions heard. Of utmost importance is that the caseworker first builds rapport and trust with the child, to better get to know the child and understand their experiences, which will enable the caseworkers to support the child throughout the reintegration process. Considerations should first be made in the *child's best interest,* and also be *family-centered* with consideration of the family's ability and desire to provide care and protection for the child. A Child Assessment is **not an interview or "tick box"**

activity, but an **interactive conversation** with the child and supportive adults around the child. Adequate time should be invested in building rapport with the child before formal assessment begins. Caseworkers should be creative in designing activities that allow for children's full participation, appropriate to their age, any communication impairments, and evolving capacity (e.g., storytelling, drawing, games, or singing). Caseworkers should progress at a pace comfortable to children, paying attention to non-verbal cues. Allow children to guide the time and place where they are most comfortable to participate; they may also identify other individuals they want present (e.g., siblings or friends). Information collected on the child should be holistic, covering all aspects of a child's wellbeing. Always consider the child's best interests, child-centered decision-making, and child protection policies when interacting with children. *Do no harm* principles should be integrated when assessing a child along with *strength-based,* developmentally appropriate interviewing, potential peer group support (if appropriate for older children), possibility of *keeping siblings together*, and managing expectations. Avoid making promises to find the child's family unless it is known to be possible.

Outcomes: A completed child identification and assessment form will provide clues to support tracing, reunification, and placement. During case planning it will be used to inform goal setting and action development.

Actions: Caseworkers should review any documentation about the child that is available (e.g., health and school records) and add that information onto the child identification and assessment form. The caseworker will then engage the child and several stakeholders who know the child well, such as institution housemothers and other staff, schoolteachers, health workers, peers, and friends. This will provide a holistic picture of the child's health, development, education, rights, needs, behaviors, wishes, and concerns. Where there are gaps or inconsistencies in information, it can be helpful to engage additional stakeholders to triangulate.

At a minimum, two or three sessions with the child must be conducted in a comfortable and relaxed atmosphere, and in a space that is physically accessible for children with physical disabilities, with accommodation for any communication barriers. The length of the session should be sensitive to and dependent upon each individual child (e.g., age and evolving capacity), but usually not be longer than 45 minutes. The child should be encouraged (where possible) to identify where and when they are most comfortable participating. Child-friendly methodologies—like play and art—should be utilized to guide children to reflect on their family background and where they lived before coming to the institution, and how they feel about reunification without raising any expectations (see Engaging with Children job aid). The caseworker should use open-ended and follow-up questions.

People involved: Caseworker, CCI/SCI administration, child, child's friends/siblings (where appropriate), others who have worked with the child (e.g., teacher and healthcare professional).

Documentation (*Toolkit*): Child Identification and Assessment Form, Referral Form (to be used where immediate needs are identified), and Case Notes Form (if extra space needed).

Tools and resources: *Tips on Engaging with Children, Guidance for Determining Best Interests* (job aids), and *Disability Assessment Tool* (Toolkit).

If it is determined that the child requires temporary care, family- and community-based care options should be explored first. If appropriate family- and community-based care options have been exhausted, and referral to an institution is deemed necessary and appropriate, the information collected should be provided to the institution for admission, as well as a committal order through the children's court.

SOP 3: Tracing

Purpose: The primary purpose of tracing is to gather information and locate the child's parents and/or extended family (or legal guardian of a separated or lost child) and their willingness and ability to receive the child. If no family or extended family can be identified, the secondary purpose is to trace additional individuals connected to the child.

Guiding notes: Children should be aware that tracing is taking place and be involved at an age-appropriate level where necessary. The family should be treated without judgment and with respect for diversity.[92] Family tracing tends to include multiple visits to find as many family members as possible, to determine who may be best suited to care for the child and to make certain the caseworker is aware of the complete support network available to the child. In doing no harm, caution should be taken not to make promises regarding the return of the child or any other services.

Outcomes: Tracing will result in identification or contact of parents and various family members and give an initial indication of their willingness to care for the child, as well as issues that must be addressed before reunification/placement could be considered (e.g., where the child previously used to go to school).

Actions: Information contained in the Child Identification and Assessment will give initial leads for tracing. In the absence of initial tracing leads, tracing activities may include TV/radio/newspaper announcements or posters within the community. Once leads have been obtained, a tracing visit will be made by the caseworker to ascertain if the family can meet the needs of the child and is willing to receive the child. Children can be involved directly in tracing where safe and appropriate (e.g., some children may be able to recognize their home community and exact household if they are included in field visits). Caseworkers should aim to complement the meeting with the family with conversations with extended family members, community leaders, neighbors, non-governmental organizations (NGOs), CBOs, and others who know the family.

If no family can be traced despite considerable effort, the SCCO should be informed so alternative families can be explored for assessment with their guidance.

People involved: Caseworker, child, authorities, family, CCI/SCI administration, community leaders, and community members.

Documentation: Case Notes Form, Family Assessment Form, and Case Notes Form (if extra space is needed).

SOP 4: Family Assessment

Purpose: The purpose of family assessment is to gather in-depth information on the family structure, circumstances, strengths, needs, health/educational backgrounds, household income, livelihood skills, child protection risk factors (including root causes for child's separation if it is the family of origin being assessed), and views around reunification/placement. Family assessment includes members of the household and the wider family and community (i.e., anyone who is of influence or importance to the family and those who know the family). Full engagement and participation of the family as co-planners is required. The objective of Family assessment is to determine the family's capacity and willingness to provide care and protection for the child.

Guiding notes: Considerations should be made for the family's ability and desire to provide care and protection for the child while ensuring that families have information about the child and are given the opportunity to participate in decision-making for the child's best interests. The family should be treated with respect for both diversity and cultural differences. This information will be used to guide the determination of the most appropriate form of family- or community-based care. During assessments, the *General Principles in the Provision of Alternative Family Care* (in job aids) should be followed.[93]

Outcomes: The main outcome of family assessment is a determination of whether reunification/placement of the child with a particular family should be pursued, based on the family's ability and desire to care for and protect the individual child. The assessment will highlight issues that must be addressed before reunification/placement and the availability of services that can assist in both building on strengths and addressing needs.

[92] Include factors such as age, gender, ethnicity, religion, and culture.

[93] This apples to biological, extended, and alternative families.

A completed family profile, a completed child profile, and a case conference (involving at least the caseworker and case manager) will result in an initial decision of with whom the child will be reunified. This decision will be presented to the SCCO for formal approval.

Actions: Upon tracing the family, or having an alternative family identified by the SCCO, the caseworker will complete a family assessment to ascertain the family's willingness and ability to meet the needs of the child. The assessment will involve multiple visits to the home and conversations with people around the family who are considered important or influential, and who know the family (e.g., local authorities, community leaders, extended family, neighbors, health care staff, school staff, and NGOs). The family structure, circumstances, strengths, needs, health and educational backgrounds, household income and livelihood skills, child protection risk factors (including root causes for child's separation if it is the family of origin being assessed), and desires around reunification/placement will all be evaluated. This will help determine if placement is appropriate for the child and what supports may be needed to help ensure success. The family assessment must include the family's current capacity to protect and care for the child and identify any additional support from the community and public services that may be possible (e.g., schooling, health care, economic strengthening, and self-help groups).

Family group discussions (FGDs) can be useful tools for the family to make important decisions around the care of the child and ensure full family participation and ownership of the reintegration process. FGDs involve bringing family members together (and sometimes others of influence who are invited by the family) to make sustainable plans for how children can be brought into the family's care and receive ongoing protection (these plans are then included in the case plan). Sessions are planned in advance and can be coordinated by the caseworker (who supports with information as needed); final decisions will be determined by participants, to instill a sense of ownership over the reintegration process. When families feel they are fully in "the driver's seat" regarding planning for the child, they are more likely to remain invested in ensuring the plans are carried forward, and that the needs of the child are met.

Once it seems clear that the identified family is willing and able to provide for the child's care and protection, a case conference between at least the caseworker and case manager should take place. The conference should include review of any questions or risks that have been raised and generation of initial ideas for how the child and family will be supported. In complex cases, the conference might involve others, such as institution senior leadership, child protection focal people, or the SCCO.

People involved: Caseworker, case managers, family and extended family, neighbors/friends, community leaders, service providers, SCCOs, and family group case conferencing team.

Documentation: Family Assessment Form, Referral Form (where immediate needs are identified), Case Plan Form (for any goals set during Family Group Discussion), Disability Assessment Tool, Family Group Discussion Form, and Case Notes Form (if extra space is needed).

SOP 5: Case Planning

Purpose: The purpose of case planning is to ensure that children and/or young adults are returned and retained to family- or community-based care and to develop a clear plan of measurable goals and actions to strengthen the children and/or young adults and family's wellbeing/resilience.[94]

The case plan facilitates a smooth reunification/placement and ensures the child's safety and best interests throughout the reintegration process. It includes details on who will do what and when, based on the needs and strengths of the child and family and contains a plan for both reunification/placement (i.e., preparing the child and family and date of transition) and reintegration (i.e., longer-term goals that ensure the child and family are well-adjusted and settled) as well as building on the information collected during the child and family assessment.

[94] Resilience is the capacity to recover from difficulties or tough situations.

Guiding notes: The case plan is based upon the child's best interests. It is fully informed by the child assessment, family assessment and, as necessary, other individuals who are close to the child and family. The case plan is developed based on the principle that every family has strengths and resources which can be built upon while immediate and longer-term needs are also addressed. It is also built upon the Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) approach (described below).[95]

Outcomes: An agreed-upon Case Plan summarizes and prioritizes needs, strengths, and proposed action(s) to be implemented for successful placement or reintegration of a child in a family. The outcomes of a Case Plan include:

- Goals that the child, family, and caseworker will work on together; with each goal being SMART. Some goals will be shorter-term to prepare the child and family for placement, and some will be longer-term to focus on complete reintegration
- A series of actions or interventions to be taken to address needs, and/or the resources or services that will be needed
- The roles and responsibilities for each person
- The time frame for actions
- Indicators for determining when actions have been completed and when the goal has been accomplished

Actions: Several actions are involved in developing the case plan. The caseworker is responsible for coordinating and facilitating this process, including:

- Reviewing the child and family assessments and engaging the child and family in a discussion of priority needs and relevant strengths
- Consulting with the child on the plan for reunification/placement, their preparation for the move, what supports they will need, and identifying actions and points of monitoring to ensure the child feels safe and supported
- Checking the child's expectations and clarifying if they are realistic
- Ensuring that the case plan includes provisions to ensure all basic needs of the child are met, including but not limited to birth registration, education, life or job skills learning, leisure, play or recreational activities; serious consideration should be given to the psychosocial needs of the child, including the need to address issues of separation and trauma
- Writing SMART goals into the case plan, reviewing, and making sure applicable parties sign off on the plan
- Summarizing the case plan into the required document and presenting it to the Case Conference Chairperson to approve the proposed placement

Consultations with the family will include development of a plan for reunification/placement, their preparation, supports they will need, etc. The consultation is also an opportunity to clarify the family's realistic expectations around reintegration.

People involved: Caseworker, case managers, child, family and extended family members, Case Conference Chairperson.

Documentation: Case Plan Form (includes pre- and post-placement sections), Referral Form, Case Conference Reports (e.g., Family Group Discussion report, county, and sub-county), Case Notes Form (if extra space is needed).

Tools and resources: *Engaging with Children, Guidance for Knowing When a Child or Family Needs Greater Support, Essential Support for Young Adults Moving to Supported Independent Living,* and *Essential Preparation for Children with Limited Participation Capacity.*

[95] The SMART principle. Treadwell, J. et al. (2015). *Case Management and Care Coordination*. Springer Briefs in Child Health, DOI 10.1007/978-3-319-07224-1_2.

SOP 6: Preplacement Case Review and Approval

Purpose: The pre-placement/pre-reunification case review is the final determination of getting a child back to a family that has been assessed and determined to have the capacity to provide suitable care and protection. This information will be used to determine if the most appropriate form of family- community-based care (following the assessments and development of a case plan) is still appropriate. The review is based on information in the assessments, family group discussions, and outcomes on the case plan which demonstrate the roadmap for how reintegration will be achieved.

Guiding notes: The *child's rights and best interests* are at the core of the pre-placement case review; it is critical that all rights of the child are considered while evaluating the *necessity and suitability* of the child's placement into the assessed family, including ensuring that *siblings are not separated* unless it is in their best interests.

Outcomes: The pre-placement case review will result in approval of the placement for the child and family (or not, in which case additional families should be assessed, with guidance from the Alternative Care Committee and Department of Children's Services). When approving the placement, the Alternative Care Committee will issue formal documentation of transfer of placement and request revocation of any committal order that is in place.

Actions: There will be preparation of the case summary (including assessments and case plan) and its presentation to the Alternative Care Committee for review and approval. Caseworkers should be prepared to answer all questions that the Alternative Care Committee may ask; it is the Committee's role to do their due diligence in evaluating and verifying all details of the child's case to ensure that the child's needs will be met in the proposed placement. The Committee is multi-disciplinary, comprised of representatives of the Sub-county Children's Office, judiciary, police, healthcare providers, local administrators, and civil society representatives; each member will evaluate the case holistically and especially focus on the area(s) of the assessments and case plans in which they hold expertise. The Alternative Care Committee may ask:

- If the child is returning to their family of origin, how have the root causes of separation been addressed?
- What kinds of psychosocial support will be provided to the child (formal or informal)?
- How are specific identified risks or needs going to be addressed?
- What additional services will support the child or family?
- How often will you monitor the family and what will indicate the child is well cared for?
- When is the date of reunification/placement and is the family being provided any assistance to prepare?
- Do you have any concerns about the family?
- Was extensive tracing conducted to find the child's family of origin (if proposed placement is with an alternative family)? Why is it not in the child's best interests to be placed with their biological family at this time?
- Is this placement temporary or intended to be permanent? If temporary, what is the transition plan, and what is the plan for reintegration into a permanent family?
- If it is in the child's best interest, what is the plan for maintaining contact between the child and their biological family (if proposed placement is with an alternative family)?

People involved: Child, biological family, prospective placement family, caseworker, case managers, SCCO, Alternative Care Committee.

Documentation: Summary of Child Assessment and Family Assessment, Case Plan, Case Conferencing Report, case file checklist, child assent, and family consent.

SOP 7: Child Preparation

Purpose: The purpose is to support the child in considering the various aspects of transitioning to the family and into community life (both pros and cons; their hopes and fears), to help the child prepare for the

reunification/placement and set realistic expectations. This step will further explore the child's feelings toward the reunification/placement and make necessary adjustments.

Guiding notes: The child's unique evolving ability, capacities, needs, and strengths should be considered throughout the process to ensure the child is able to fully participate. In order for the child to look forward to the next step, it is important they feel empowered and that they are being heard. It is also important to allow a child's curiosity to lead the process. The time needed to prepare a child will vary greatly based on their unique capacities and needs, but in general, younger children and babies require shorter and more intense programs, and older children and children with disabilities require longer programs. Considerations for the child's individuality will include age, maturity, developmental capacity, gender, their relationship with the family they will be placed with, their feelings about the change (including separation from current friends and caregivers), and length of time in institution/away from family and community, among others). Adequate time should be dedicated to preparing the child, allowing the child to move at a pace comfortable for them. Caseworkers should intentionally and actively solicit the child's feelings to ensure that they are still comfortable with the reintegration plan. Adjustments can be made to the reunification/placement plan when appropriate and in their *best interests* (e.g., if the child expresses they would like change the proposed date to allow more time to attain a sense of closure at the institution). Children may simultaneously express excitement and sadness about the transition; sadness is normal and children should be encouraged to express it and be supported through it, but this should not be seen as a justification for not reunifying the child.

Outcomes: The outcomes of the child's preparation will be that the child feels confident that they can make a healthy and safe transition to the family and expresses a desire for family reintegration. The child is also assured that the family and the surrounding environment are prepared, safe, and ready to receive the child.

Actions: The caseworker will first provide as much information as possible to the child about the family and the plan for their reintegration, in accordance with developmental capacity. This will include information about:

- Family structure, who lives in the home, gender, and ages of family members
- Family's daily routine (waking-up time, morning preparations, mealtimes, types of food, how children get to school, where the school is located, after-school activities, bedtime, sleeping arrangements, church/mosque attendance, etc.)
- Expectations the family has (e.g., helping with household chores), rules and values of the household, and discipline methods
- How any disability/developmental needs will be addressed
- What the family knows about the child
- What steps have been put in place to address the child's needs (e.g., school enrollment, access to required medications, and accessibility considerations for any disability)
- What the child will take with them (personal effects) from the current form of care (e.g., photo book, special toy, and clothes)
- Plans for the child and former caretakers to visit each other after reunification/placement
- Arrangement for the child to pre-visit the family where they are going before final placement/reunification

The child should have opportunities to talk about what they look forward to, what they are worried about, and anything they would like their family to know before the reunification. The child should be engaged one-to-one with the caseworker, the case manager, and the family. First discussions between the family and child can take place in the current care environment if the child expresses this is most comfortable for them; subsequent visits should take place at the home so the child is able to see and understand the environment further (increasing frequency and length of visits over time). These visits should be noted as actions in the case plan.

Prior to home visits: The caseworker should make a plan with the family and contacts persons,[96] and agree on some key objectives for the visit (e.g., if the child has expressed nervousness about not knowing how to do the expected chores, perhaps an objective of the visit could be for the siblings to practice doing some of the chores together; if they have expressed concern about dignity related to menstruation, perhaps privacy measures can be shown; or is the child is disabled, examine accessibility and safety concerns in the home). The caseworkers should then brief the child on what to expect of the visit (who will be there, any planned activities, how long the visit will be, that the caseworker will accompany them, etc.).

During home visits: Caseworkers should observe the interaction between the child and family members to evaluate how each may be feeling about the upcoming transition. Young children, who may not be able to verbally express concerns, can be observed for bonding (noting that—depending on the history of the relationship—strong bonding may not be expected at this point, but a observed desire to interact and build a relationship is essential). Caseworkers should support the interactions between the child and the family, emphasizing the child's best interests, needs, and desires. Children should also be involved in setting up their place in the new home so they feel ownership. During the visits, children and caregivers can talk about the child's likes and dislikes, etc. Some children will also benefit from opportunities to connect with the wider community (perhaps being given a chance to make friends by meeting/playing with neighboring children; adolescents could explore the types of recreational activities that are available in the community), visit their new school/vocational training and meet their new teachers/trainers/employers, attend church/mosque, meet their new doctor if there are ongoing health management needs, etc. This helps the child see they will have a strong support network during the reintegration process.

After home visits: The caseworker should allocate time to debrief with the child and discuss the pros and cons of the visit, allowing the child to express themselves. The caseworker should listen for cues for next steps and future visits. It is important to monitor and counsel the child to ensure that they are still positive about returning home. A good indication of a child who is ready to return home is when she/he frequently talks and asks about going home with a sense of excitement and anticipation (introverted children or those with past trauma may not do so). It is important that the child's behavior is conducive to a return home, so caseworkers should prepare children for any expectations at home such as house rules, discipline, and respect for elders. The caseworker should also debrief with the family following home visits to ensure they also continue to feel positive about the upcoming reunification/placement.

Children should have the opportunity to take personal items, clothing, etc. home with them from the institution. For younger children, transitional objects (such as a blanket or toy) can provide a sense of familiarity and security. For older children and adolescents who have lived in the institution a long time, they may wish to take photos of the institution and their friends, or a copy of their case file. For some, this is the only record they have of their childhood and personal history, and it should therefore be provided to them. Children of all ages may also want to understand how/when they can visit their friends at the institution or other ways to keep in touch.

For **supported independent living and child-headed households**: The caseworker will first provide as much information as possible to the young adult about the plan for their reintegration, in accordance with their evolving capacity. This will include information about:

- Where they are going to live (i.e., initial process of identifying the place of stay and the environment they are going to settle in)

[96] Contact persons are people identified by the child or family who act as first-hand resources in the community to support the child and the family. They usually play an important role in the life of the child or family, have frequent interactions with the child or family, and can provide day-to-day updates on the child or family in addition to the caseworkers—whose visits are structured. These may include religious leaders where the family attend services, class teachers, village elders, etc.

- How they are going to identify their mentor
- How the mentor will be involved in supporting their living arrangement
- How the mentor will support achievement of the goals and action in the case plan
- How/who to contact if they need to communicate any problems

The child/young adult should be fully informed about the plan for the day of reunification/placement, as well as what they can expect for monitoring visits from the caseworker once they are home. The child/young adult should be aware that arrangements have been made for them to access services. Give time for the child to ask questions or express concerns.

People involved: Caseworker, family members, child, community members, and occasionally specialists or other professionals (psychologist, schoolteacher, or health clinic).

Documentation: Child Assessment, Case Plan, Case Notes Form with information from peers.

Tools and resources: *Life Story Book, Essential Preparation for Children with Limited Participation Capacity,* and *Essential Support for Supported Independent Living.*

SOP 8: Family Preparation

Purpose: This is to help prepare the family and household members to receive the child, while considering the various aspects of reintegration (with permanency as the end goal) and setting realistic expectations.

Guiding notes: Every family is unique and will need different types of support to be best prepared for the reintegration. Considerations will be given to those who live in the household, home conditions, health or other needs of family members, how long the child has been separated, etc. Preparation should be based on the plan outlined in the case plan and, while being *family-centered*, keep the *child's best interests* at the forefront. The family's views, concerns, expectations, and perceptions should be given due weight in preparations. The dignity of the family is to be *respected* and information shared should be maintained in *confidence.*

Family preparation may include supporting home visits, helping them utilize support to address immediate needs and obtain access to needed services, and providing counseling on certain topics (such as the child's need for attachment and bonding, possible trauma-related or institutionalized behaviors, positive parenting, home hygiene, basic health, etc.).

Outcomes: The outcomes of family preparation ensure the immediate household concerns regarding child protection and care are addressed, the family feels confident to receive a child, and the conditions necessary for a healthy and safe initial reunification/placement are in place.

Actions: Initial meetings between the family and child can be held at the former place of care if the child expresses this is most comfortable for them; these visits can also help the family to better understand the conditions of the former care and lived experience of the child.

In preparation for the reunification/placement, the caseworker will work with the family to understand their child and prepare for welcoming them home by:

- Sharing information about the child that is relevant and that the child has agreed to have shared, reminding the family members that any sensitive information is confidential
- Helping the family understand that although reintegration is a happy opportunity for the child, they will still experience loss and separation from friends and caregivers at the institution
- Sharing information about the child's routine and daily life at the institution, that the child may not know how to do many household chores (such as washing clothes or making food, etc.) and will need to be taught with patience

- Highlighting ways to support any personal hygiene and sanitation needs, especially in the case of adolescent girls
- Confirming the date and time of the child's arrival and helping the family prepare a welcome for the child, such as a special meal or household gathering (where culturally appropriate, community members may also be involved to demonstrate to the child that the whole community is welcoming them)
- Explaining any dietary, health, disability, and education and care requirements that the child may have; working with the family to plan how these should be met
- Together with the family, ensuring that arrangements are being made for the child to access school/ vocational training and/or services and explain what is required of them to support the child to access these, including helping plan for any accommodations that will need to be made to make the home environment accessible for the child with disability
- Ensuring that the family is told what information has been shared with the child about the household, and their expectations
- Making sure the family knows that they should apprise their child's caseworker of any new information, any challenges or issues that come up, etc. and let them know how often visits will be; the family will need to know how/who to contact if emergencies or needs arise
- Helping the family share their placement/reunification plans with their neighbors and significant community members and be prepared for how to handle any questions or potential discrimination by members of the family or community

Home visits to the family help household members prepare and clarify responsibilities and future support plans. The caseworker plans for and conducts these visits (with or without the child). These visits, together with the case plan, will identify the support needed before the child can return. Family strengthening support may be available locally, from the community or local authorities, or may need to be provided directly. The caseworker should communicate with local authorities, faith communities, community leaders, service providers, and other groups (as necessary) to ensure that the family has access to any available support; they should then let the family know what has been put in place and who they can contact; support may need to include some or all of the following:

- Guidance or training on basic positive parenting skills, including the facilitation of mutual bonding and attachment, understanding and supporting the child's need to deal with loss and trauma of separation, supporting peer relationships, positive discipline methods, child protection issues (with emphasis on preventing physical and sexual abuse, neglect and violence—especially for children and young adults with disabilities), health (including HIV if relevant), nutrition, and education
- Psychosocial support through counseling and guidance as needed, especially to create the opportunity to express any concerns or expectations
- Any necessary health services, referrals, or on-going health needs should be provided or planned for before the placement; caseworkers should help the family understand the child's health status (if the child has special needs due to a long-term illness or disability, extra steps should be taken to ensure supports are in place and that the family can access)
- Families in need of economic strengthening should be linked to savings and loans group and/or government social protection programs (e.g., OVC/elderly caregiver or disability cash transfer program
- Household preparation support ensuring the child has a place to sleep and keep their belongings, addressing any home hygiene questions, etc.
- Community preparation support ensuring that the child will feel welcomed back into the community, including at school and at church (if applicable) and with peers.

People involved: Caseworker, family members, and community members.

Documentation: Assessment Form, Case Plan, and Case Notes Form (if extra space is needed).

SOP 9: Referrals to Services

Purpose: Referrals are to ensure that children and families access appropriate and timely services to support the reunification/placement and reintegration process as stipulated on the case plan.

Guiding notes: Referrals to services should be done in alignment with the *child's best interests* and ensure that the child's rights are being upheld. Referrals are made according to the objectives and actions outlined in the case plan, or because a new need has arisen, or any time the service need cannot be met within the organization. Children and families should be supported to follow through on referrals to make certain that resources and services are accessed.

Outcomes: The outcome is that the child and family are supported by a wide range of services that meet their needs and strengthen their resilience; the outcome is not the referral itself but the impact of the referral.

Actions: The caseworker should be aware of community services and resources that are accessible in the family's community, including a wide range of both public (government) and private (non-governmental) services. Services could include government social protection programs, child protection, parenting or other skills training, household economic strengthening or income generation, support groups, youth groups and kids' clubs, faith-based groups, disabled people's organizations (DPOs), education services, disability or other specialized services, day care centers, early childhood services, health services (prevention and treatment), counseling, etc.

Supporting children and families for referral to services can include:

- Using the child and family assessments to identify services that will be needed
- Conducting community mapping to be informed of existing services to meet those needs
- Working with others to identify community resources and services (SCCOs and the Area Advisory Council have a wealth of knowledge about which services are available)
- Alerting the receiving organization that a referral is being sent
- Accompanying the child or family to the service
- Following up with the service provider and/or following up with the family

People involved: Caseworker, family members, SCCOs, and community service providers.

Documentation: Department of Children's Services Referral Form and Case Notes Form (if extra space is needed).

SOP 10: Reunification/Placement

Purpose: Reunification/placement is the physical reuniting of the child with a family; it is the day the child/young adult transitions from the current form of care to family- or community-based care.

Guiding notes: Children/young adults and families should be fully supported leading up to and during the move. Children should have time to say goodbye to friends and caregivers before reuniting/placing them to the new care; this can be done through celebrations, escorting the child, and a celebration at the new form of care (family or community celebrations). The child/young adult should have opportunities to ask questions and participate. Considerations for the child's individuality will include age, developmental capacity, gender, their relationship history with the family they will be placed with, their current feelings about the change, and length of time in current form of care. *Every child and every family are unique—and their feelings and needs at reunification will also be unique.*

Outcomes: A successful transition of the child/young adult from the current form of care to a new family/community.

Actions: The date of placement/reunification should be outlined in case plan, accompanied by the actions needed to ensure that the resources and support needed throughout the reintegration process are in place. The date of

placement/reunification may shift based on how the child and family preparations progress. The best interests of the child should be the driving factor.

The caseworker(s) and other professional staff (such as counselors) should accompany the child on reunification/placement day. The caseworker should encourage the current form of care to have a farewell celebration for the child to demonstrate their excitement about their transition to the family; this is important for a sense of closure and comfort for the child, showing that reunification/placement is a good thing for the child. The caseworker should also encourage the family to have a welcoming celebration in a manner appropriate to the family, culture, and community to make the child feel welcome and supported. In addition, the caseworker should support the family to hold a FGD that include other significant family members and a community resource person during the reunification/placement. This meeting will help the family identify strengths and weaknesses, and make decisions/commitments to ensure successful and sustained reintegration.

Schedule the first monitoring visit and make sure the family/mentor and child/young adult know how/who to contact in case of any concerns. It should be clear to the family and child when the caseworker can be expected to return.

People involved: Caseworker, family members, child/young adult, mentor, and other community members.

Documentation: Case Plan (which has date and actions for placement/reunification day), Placement Form, and Case Notes Form (if extra space is needed).

Tools and resources: *Essential Preparation for Children with Limited Participation Capacity,* and *Essential Support for Supported Independent Living.*

SOP 11: Monitoring

Purpose: Monitoring provides on-going support and assessment to ensure that the reunification/placement is still in the child's best interests and their needs are being met. Monitoring also provides a chance to strengthen the capacity of the family and sustainability of various activities in the case plan.

Guiding notes: It should be recognized that reintegration is a process of adjustment for the child and family. Many children need time to adapt to living in a family/community situation again and to let go of behaviors they learned away from home (if those are not harmonious with living in the family). Similarly, the family will need to take time and put in effort to get to know the child who is (re)joining their family/community. The frequency of post-placement visits and interventions should be determined on an individual basis; however, visits should be most frequent immediately after family assessment (depending on the risk), reunification, or placement (during the phase of most rapid learning and adapting for both child and family) and then decrease in frequency over time as the case progresses towards permanency. Monitoring interventions are best done in person by visiting the family and community; the caseworker can attain holistic information about the child and family's wellbeing, as well as physically verify the information. This interaction with a wide range of family and community members ensures ongoing support to the child. Additionally, monitoring visits allow the caseworker to build a trusting relationship and puts the family at ease since they are in their own environment. Visits should work to fully *engage both children and family members* in the process of reviewing goals, objectives, actions, and revisions to the plan; the success of the reintegration depends on their sense of "owning" the process. When the placement is temporary, plans for permanency should be developed.

All areas of a child's and family's wellbeing should be monitored, as well as the progress made on the case plan and any new issues that may have risen since the last visit (which can be addressed with new goals and actions added to the case plan).

Outcomes: Monitoring visits ensure that the child is well cared for and settled at home and assess whether the reunification/placement is still in the child's best interests. It also helps in establishing new strengths and needs

of the family for further action. Where monitoring reveals otherwise, actions should be taken to improve the situation. When the placement is temporary, plans for a more permanent placement must be developed with the child and family (with necessary guidance from the SCCO) and included in the case plan.

Actions: Table 6 shows the recommended schedule for monitoring children reunified/placed into family- and community-based care.

Table 6: Recommended Schedule

First post-placement visit	Identify and address any immediate challenges and safeguarding issues.	2 weeks post reunification/placement[97]
Regular post-placement visits	Every 2 weeks thereafter, until the end of the second month (i.e., 4 visits in 2 months), the caseworker visits the child and family to ensure that the child is settling in well, checks on the child's/family's overall wellbeing, and monitors progress against the case plan.	Months 1 and 2
	Thereafter, home visits reduce to monthly to check the child's/family's overall wellbeing and to monitor progress against the case plan.	From month 3 to month 12
Formal case reviews	Bi-annual holistic case reviews are held to determine if the case is progressing appropriately toward reintegration (for temporary placements, review of permanency plans).	Every 6 months from date of reunification/placement
Visit in preparation for case closure/transfer	Final review of the case plan, goals, objectives, and actions needed for case closure.	Exact timing on a case-by-case basis, but after minimum 12 months of monitoring

***Note*:** Each time a child is transitioned to a new placement (e.g., from institution to temporary foster care, then to their caregiver—which is intended to be the permanent placement), the process starts afresh with monitoring schedule "resets" back to the First Post-Placement Visit.

During monitoring visits, the caseworker will talk to the child, caregiver/s, other members of the household, neighbors, and community members to learn how the reintegration is progressing. The primary task of the visit will be to review the child's/family's progress on the goals identified in the case plan, and to realign goals or add new goals as needed, which will then be noted in the case plan. When the placement is temporary, permanency planning should always be discussed and included in the case plan.

Pertinent areas of the child's wellbeing should also be reviewed, including child health and development, psychosocial health and wellbeing, protection and safety, attachment with caregiver, social and community belonging, and education. Community members may also be consulted to assess the community's response to the child's presence, how the child is adjusting to community norms, and if community resources are being accessed by the family. A visit to the child's school should be conducted to learn from the teachers about performance, behavior, and peer relationships.

Each visit of the family and household will assess (through observation and conversation) areas of risk, changes (both improvements and deteriorations), progress toward case plan goals, and required actions or follow-ups. Support is offered to strengthen any areas of concern identified during the visit. This may include:

[97] The standard duration for post-monitoring visits is two weeks; however, it should be determined based on the needs of each case.

- Guidance on basic parenting skills, child protection issues, health, nutrition, education, communication, and family relationships
- Guidance on disability-specific needs, including follow-up on referrals and connections with people with disabilities in the community to mentor the family, school integration, etc.
- Psychosocial support via counseling and guidance to create the opportunity to express any concerns or expectations
- On-going child or family member health needs, including follow-up on referrals
- Household economic status, including follow-up on referrals to groups, programs, and services
- Household hygiene and sanitation, family nutrition and feeding, family support system within their extended family and community, etc.

Between home visits, contact can be made by telephone if there are no pressing child safety issues or other risks. If they do not have a telephone, the child and family should be made aware of where they can access one in emergency. Family Group Conferencing can be used whenever a difficult decision needs to be made, particularly if the school plans are not working, there is a change in family situation or dynamics (such as remarriage or divorce), or there is concern over safety, mental health, physical needs, etc. If the family seems to be having difficulty coping, case conferencing should be used to brainstorm and problem solve.

People involved: Child, family, extended family, caseworker, case managers, community leaders, and service providers (CBOs, NGOs, etc.).

Documentation: Case Plan Form, Monitoring Form, Department of Children's Services Referral Form, and Case Notes Form (if extra space is needed).

Tools and resources: *Checklist for Preparing for Monitoring Visits, Engaging with Children,* and *Guidance for Knowing When a Child or Family Needs Greater Support.*

SOP 12: Case Review

Purpose: The purpose of a case review is to do a holistic evaluation of the progress made to date regarding reintegration. Progress on the case plan will be reviewed along with key reintegration benchmarks. New resources and needs that have arisen since the original child/family assessments were conducted may also be identified. Once case plan goals and benchmarks have been achieved, it is assumed that the reintegration is sustainable and the case may proceed to preparation for closure.

Guiding notes: Regular reviews are essential to ensure every child is receiving what she/he needs. Likewise, every family is unique and will need different types of support in order to be successful. Reviews and re-assessments should be *family-focused*, keeping the *child's best interests* at the forefront. The family's views, concerns, expectations, and perceptions should be given due weight. The dignity of the family is to be *respected* and information shared should be maintained in *confidence*. Key focus should be placed on the ongoing necessity, appropriateness, and permanency of the placement.

Outcomes: The outcome is a completed Case Review Form with scores across domains, including a summary of the total scores. These can be used to evaluate how the case is progressing toward sustainable reintegration, and to guide further targeted goals and actions (for the domains which are not achieving appropriate scores) that may be needed to achieve reintegration. These new goals and actions will be noted in the case plan.

Actions: A case review is done at least after every six months after placement and more regularly if needed, based on:

- Home visits to the child and family
- Review of the case plan and individualized goals together with the child and family
- Completion of the Care Review Form (Reintegration Evaluation)

- Review by case manager and SCCO

*Case reviews are required a *minimum* of twice each year during the post-placement monitoring of reintegration cases; however, they can be more frequent as required. Caseworkers should never wait if there is reason to have a case review.

To conduct the review, a caseworker first makes a home visit and uses the "case review or reintegration evaluation" tool. The caseworker also uses the case plan and Monitoring Forms to make any notes and updates.

The case review and revised case plan is then discussed with the case manager and can be provided as an update to the SCCO. As the case approaches reintegration, the case review is used to discuss supports that will be required to safely close the case.

People involved: Child, family, extended family, caseworker, case managers, community leaders and members, service providers (NGOs/CBOs), and SCCO.

Documentation: Case Review Form, Case Plan, Monitoring Form, and Case Notes Form (if extra space is needed).

Tools: Reintegration benchmarks.

SOP 13: Case Closure

Purpose: Case closure will ensure that the family is able to continue caring and providing for the reintegrated child independently, or that the young adult is able to continue caring for themselves independently, without case management support.

Guiding notes: Closure is anticipated, discussed, and planned for from the very beginning, but can only be considered once the child/family or young adult are approaching complete reintegration (meaning, it can only be considered when the child or young adult is in what is intended to be their permanent placement, and it is progressing smoothly). Closure does not mean that the child/family or young adult will never need support in the future, but that they feel equipped to seek this out for themselves. Working with families, young adults, and children to identify and access their broader community support networks is important to instill confidence that supports to them other than case management will still be available post-closure (e.g., neighborhood groups, economic strengthening groups, parenting groups, or other support groups to provide important peer-to-peer support and reduce isolation). Timing for transitioning children and young adults can vary widely—for older children and young adults it may go slower or over a longer period of time, while transitioning young children may be shorter and more intense.

Outcomes: Child, young adults, and other family members are safe and well and feel confident to continue to provide for their needs independently without the support of case management.

Actions: As the end of the reintegration period nears, the caseworker will conduct a case review, including review of the progress made against the case plan, and completion of a final Reintegration Evaluation (to confirm all benchmarks have been achieved). A recommendation should be made for the young adult or family to be phased out of case management and presented to the case manager and SCCO in a case conference. If all agree that reintegration has been achieved, the caseworker can begin planning to formally close the case. This will include discussion with the child and family about case closure and what supports, if any, they envision needing in the future. The plan will outline specific objectives and actions for the final months of case management. Discussions with the family and child will also include reflecting on the experience of working together, celebrating the child's/family's achievements, ending the caseworker relationship, and future problem-solving tools for when/if issues arise.

In the final home visit the caseworker will leave contact information for the DCS as well as public services, local authorities, and CBOs/NGOs in case of need.

People involved: Child or young adult, family, caseworker, case managers, and SCCO.

Documentation: Closure Form, Caregiver Feedback Forms, and Case Notes Form (if extra space is needed).

SOP 14: Case Conferencing

Purpose: Case conferencing is used to enhance problem solving and decision-making in complex cases. It is a multidisciplinary meeting of professionals known to and/or working with the child to discuss risk factors; the care and protection needs of the child; required supervision and support interventions with the child, family, and alternative caregivers; and the roles of the professionals involved. Case conferencing can be scheduled by the caseworker at any time during the case management process when they feel the case is facing a significant challenge, risk, or bottleneck, and they require additional support. At a minimum, case conferencing should be utilized to support tentative placement decision-making after child and family assessment (to help determine which placement might be in the child's best interest) and for decision-making regarding case closure.

Guiding notes: Case conferencing should be initiated on an as-needed basis to ensure the protection and wellbeing of children. All participants should be aware of and abide by key confidentiality protocols. Participants should be selected based on their knowledge and understanding of the child/family and the challenge/risk to be discussed (e.g., teachers or health care providers may be included when they can provide useful input, or a statutory authority may be included when there are suspected protection concerns). Wherever possible and appropriate, both the child and the family should be included in case conferencing to enhance ownership. Key outcomes should be recorded in the case file and followed up by the caseworker with the child, family, and other relevant stakeholders.

Outcomes: The primary outcome of a case conference will depend on the initial objective of the conference. Proposed solutions will have been generated to address the challenges presented during the conference, or decisions will have been made regarding key questions presented during the conference (e.g., which placement option might be in the best interest of the child, or if the case is ready for closure). Overall, the caseworker will have gained clarity regarding the safest possible ways to proceed with the case.

Actions: The caseworker should schedule a time suited to all participants and mobilize them in advance, informing them of the key risk/challenge within the case to be discussed. Upon meeting, the caseworker should remind all participants of relevant confidentiality protocols. The caseworker should then present a holistic overview of the case, including key strengths and protective factors, before narrowing it down to present the key risk/challenge, and asking the key question/support they require from participants.

People involved: Participants selected to contribute will depend on the issue at hand, and may include the lead caseworker, other caseworkers within the same team, case manager(s), child, family, extended family members, service providers, and a statutory authority as needed in the most complex cases.

Documentation: Case Plan Form (to record any new agreed-upon goals/actions), Referral Form (if new goals require referral), and Case Notes Form (to record other key notes from case conference).

Tools and resources: Case File (all case management forms completed to date), steps for presenting a case, Case Conference Checklist, and *Engaging with Children.*

SECTION 4: Additional Information and Job Aids

General Principles in the Provision of Alternative Family-Based Care

The following principles, as outlined in the UN Guidelines, inform these Guidelines and the provision of alternative care services in Kenya.

1. The four main principles of the UNCRC—best interests of the child, non-discrimination, participation, and survival and development—should be key in all alternative care arrangements (refer to Section 2 for additional information).
2. Family is the fundamental group in society that provides the care and protection for children and all efforts need to be in place to support and nurture families to uphold this primary responsibility. This includes ensuring provision of family support, tracing, and reintegration services.
3. All alternative care placements should consider the importance of placing the child as close as possible to his/her usual place of residence. This will enable continued contact between the child and his/her family (as long as the contact is in the best interests of the child) and possible family reunification; it will also minimize disruption to the child's education and wellbeing.
4. The primary priority for all alternative care placements—both formal and informal—is the provision of a stable, loving, and protective home for the child, with permanency as the long-term goal.
5. Participation and the wellbeing of the child should be at the center of all decision-making and he/she should be safeguarded from abuse, violence, and exploitation.
6. Poverty should never be the driving factor or primary justification for removing a child from his/her family and placing him/her in alternative care.
7. Removal of a child from his/her family should be seen as a last resort and should be temporary and carefully monitored.
8. A child outside of parental care or in alternative care should be afforded all basic human rights, as stipulated in the Constitution of Kenya and The Children Act, 2001.
9. Siblings should be kept together during removal and placement in alternative care, except where this is deemed to be unsafe or not in the best interests of the siblings.
10. Proper gatekeeping measures should be in place to ensure that placement is appropriate to the child's individual needs.
11. Informal care arrangements should be recognized and supported in line with the best interests and cultural heritage of the child.
12. All children in alternative care should be under the protection of a legal guardian or the relevant public body or authority.
13. Provision of alternative care should never be carried out under the primary purpose of advancing the caregiver and providers' religious, political, or economic goals.
14. Use of institutional care should be limited, provided under strict standards and regulations, and children under-3 should be placed in family- and community-based care settings, not institutional care.
15. Coordination, information-sharing, and cooperation among all government and non-governmental authorities, agencies, and alternative care providers are needed to provide alternative care appropriately and safely for children.
16. All alternative care providers should be registered, licensed, authorized, and monitored by the Government of Kenya.
17. Special consideration should be placed on the quality and safety of alternative care facilities and services, ensuring that they meet international standards and enhance the best interests of the child.

18. Alternative care providers should ensure that a child receives adequate nutrition, health, hygiene, education, religious, and recreational services in order to promote his/her developmental needs.
19. All children in alternative care should be provided with consistent and stable care.
20. Government and non-governmental agency staff and alternative care providers should be trained, supervised, and resourced to effectively provide safe alternative care services.
21. The Government of Kenya shall ensure that appropriate laws, policies, and resources are in place to support a functioning alternative care system, with priority given to family- and community-based care.
22. The Government of Kenya shall ensure that a range of alternative care services is available to all children.
23. Continuous research should be conducted to address emerging issues and enhance preventive measures in alternative care arrangements.

Determination of the Most Appropriate Form of Family-Based Care

To determine which alternative care option is the most appropriate for each child, the following measures should be in place as recommended by the UN Guidelines:

1. Alternative care decision-making should be carried out via a judicial or administrative procedure, with clear legal safeguards, as stipulated in the Constitution of Kenya, 2010 and The Children Act, 2001.
2. The Government of Kenya shall ensure that a comprehensive regulatory framework is in place to guarantee authorization, registration, monitoring, and accountability of all alternative care providers. The framework will serve to monitor referral and admission of a child.
3. Alternative care providers should implement rigorous, multi-disciplinary approaches to decision-making that include the full participation of children, families, and legal guardians.
4. From the start, authorities and alternative care providers must maintain comprehensive records of the child to guide all future decision-making and case planning.
5. All decision-making should be carried out on a case-by-case basis and based on a thorough, carefully organized assessment. A qualified, multi-disciplinary team of professionals should carry out the assessment. The assessment should consider the child's general wellbeing and safety; ethnic, religious, family, and community background; medical history; education; and other personal and development characteristics. The child and the family should be fully consulted throughout the process.
6. Authorities and alternative care providers should minimize frequent changes in care placements.
7. Case planning will be initiated at the earliest possible time and within 1 month of care placement. It should be based on the child's emotional, physical, and mental development needs; the family's capacity to protect and promote his/her wellbeing; the child's relationship with his/her siblings; the child's desire to stay close to his/her family or community; and the child's cultural and religious background. The case plan objectives and timeline should be clearly stated and shared with all responsible members of the decision-making process, including the child and his/her family.
8. If the child is placed in alternative care via a court or administrative body, the child's family or legal guardian shall be informed of the decision and discuss the ruling with the respective authorities.
9. The child, depending on his/her age and evolving capacity, should be informed and prepared throughout the process.
10. Alternative care providers and authorities should conduct periodic reviews of the care placement, taking into consideration the child's wellbeing, personal development, and views. It is recommended that at minimum the reviews be conducted every 3 months.

11. The paramount consideration during all decision-making is to ensure that decisions are based on the individual needs of the child and that care placement promotes stability and permanency through family reunification or provision of a stable alternative care placement.
12. Every child in care should be supported with aftercare services once he/she leaves an alternative care placement.
13. The best interest determination process (refer to Glossary of Key Terms) should be promoted for all care arrangements

Best Interest [of the Child] Determination

The best interest determination (BID) is a formal process with specific procedural safeguards and documentation requirements conducted for certain children, whereby a decision-maker is required to weigh and balance all the relevant factors of a particular case, giving appropriate weight to the rights and obligations recognized in the UNCRC and other human rights instruments, so that a comprehensive decision can be made that best protects the rights of children.[98] This is a process that is governed by the children officers.

Making a decision in the child's "best interests" involves three key considerations:

1. It is necessary to get all necessary information that will affect the decision on the child's placement, which means talking to all relevant people, especially the child. This is important where different people have conflicting opinions.
2. Any decision must also consider the rights and legitimate interests of any other party, such as parents, siblings, other family members, or the State (represented by social workers).
3. When a best interest decision must be made between a number of possible care options, the preferred solution should be the one considered to be the most positive for the child, both immediately and in the longer term. At the same time, any final decision should respect all the child's other rights.

Key considerations:

- Child's opinions and wishes are encouraged and valued, taking into account the child's maturity and ability to evaluate the possible consequences of each option presented
- Situation, attitudes, capacities, opinions, and wishes of the child's family members (parents, siblings, adult relatives, and close "others") and the nature of their emotional relationship with the child
- Level of stability and security provided by the living environment being considered
- Child's special developmental needs related to physical or mental challenges, or other particular characteristics or circumstances
- Child's ethnic, religious, cultural, and/or linguistic background, so that all possible efforts can be made to ensure continuity in upbringing and maintenance of links with the child's community
- Any need to prepare the child for transition to independent living

Using all these guidelines, a review of the suitability of each possible care option is undertaken for meeting the child's needs. This assessment should form the basis of a decision. The same questions about best interests should be repeated whenever a placement comes up for review. Ideally, this assessment should be done before a child is moved or placed. When a child is in danger and immediate protective action is needed, the full BID process should be completed as soon as possible, and the emergency placement should be only short-term.[99]

[98] Government of Kenya (2014). *Guidelines for the Alternative Family Care of Children in Kenya*.

[99] Adapted from: Government of Liberia, Ministry of Health and Social Welfare. (2014). Guidelines for Kinship Care, Foster Care and Supported Independent Living

Tips on Engaging Children, including those with disabilities, in Case Management[100]

An integral part of the case management process is intentionally engaging both caregivers and children in the different steps of the case management process. This helps foster a sense of ownership and builds the capacity of both caregiver and child. Engaging children takes special skills and the social service workforce[101] should utilize the following suggestions when engaging children.

- Always **introduce yourself** and explain your role. For example, "I am Samuel and I work with XXX. I am here to work with you to ensure that you are happy and healthy. I really want to hear from you and see how we can work together. Is that OK?"
- When speaking or listening to a child, **pay attention** with your ears and use your body language to express interest.
- **Pay attention to the child's non-verbal communication**, including verbal inconsistencies and what the child might not be saying.
- **Sit at the same level** as children. Lean in or get down on the floor so you can meet the child's eye and be an "equal" with them.
- **Use simple language**. Think about the words you use. Long sentences will confuse children.
- **Use a child's experience to explain things**. Use examples from other children without using "real" names. For example, "I have a friend, *Elizabeth,* and she is also XX years old. She loves to play outside with her friends. What do you like to do?
- Be **friendly and approachable**. Do not look bored, angry, or worried while a child is talking because this will stop him/her from talking. Maintain eye contact and have a warm and welcoming look on your face. Even if the child tells you something concerning make sure your face stays neutral. You want to exude comfort, trust, and compassion.
- **Actively listen and respond** to the child. Try to answer his/her questions as honestly as possible.
- Provide **adequate time and space** and talk to the child in an appropriate and conducive environment. **Do not rush things** or be in a hurry.
- Make sure that the child knows you will **observe confidentiality**. Reassure them that you will not share with anyone unless it is an emergency or they need help. If it is an issue that needs to be shared (like suspected abuse), depending on the child's age, explain that you will need to tell someone whose job it is to keep them safe.
- **Be empathetic.** Show that you understand what the child has been feeling (without saying that you are feeling it yourself).
- Do **not be afraid of silence** when the child needs time and space to gather thoughts. Children sometimes need quiet time to get comfortable or will talk a lot before getting to the point.
- **Encourage the child** by nodding or smiling, but not so often as to distract.
- **Ask open-ended questions**. For example, instead of saying, "do you like to play outside?" you can say, "tell me what you like to do when you are not at school."
- **Summarize and clarify regularly** what the child has said, making sure that you have understood what the child is trying to say and clarifying what the child knows about the situation.
- Use **other means of getting children to express things**. Young children may find it easier to talk by playing games (such as making sad or happy faces) or by pointing at happy or sad pictures. This may also help when communicating with a child who has a learning or speech impairment. Be sure to carry paper and a pencil or crayons so they can draw.
- Be **aware of age specific behavior and dynamics**. For example, older children may not always want to share thoughts, feelings, or say what happened for fear of negative consequences for themselves or

[100] Keeping Children in Healthy and Protective Families, MWENDO project case. Management standard operating procedures and guidelines for promoting child participation, FHI, by Lucy Y Steinitz.

[101] May include social workers, children officers, and volunteers working with and for children.

others. A child may believe they were responsible for an incidence in the past (such as abuse). In these cases, it is important they know you are not being judgmental and that you are there to support them.

Additional Issues and Approaches to Know When Engaging Children with Disabilities

It is a right of children with special needs (i.e., physical, emotional, or intellectual disabilities) to include them in programs and activities—regardless of their abilities—to participate actively in daily activities within their home, school, neighborhood, places of worship, and community. The child's active participation should be guided by **developmentally and individually appropriate** strategies that **promote meaningful involvement aimed at the best interests of the child**.

When working with children and youth with disabilities, remember to:

Introduce yourself. Persons with disabilities mention the "golden rule"—treat others as you would like to be treated. Refer to them by their names.

When talking to a child with a disability remember that you are **interacting with a child and keep the same tone and language as you would with any child of a similar age.** Speak directly to the person and not through a third party.

Do not **assume that the child who cannot speak or see,** also cannot think or understand. Speak from a position that is comfortable for everyone; for example, sit or squat when speaking to someone in a wheelchair.

Do not speak about the child as if they are not in the room. Many people make the mistake of talking in front of a child with a disability about them, as if they cannot understand or do not have the same feelings as any other child.

Be **empathetic, warm, genuine, and appreciate** that they have a valuable perspective, too. This is important when speaking to any child but is especially important for speaking to a child who has difficulties with their sight. This lets him/her know you are there and helps them to locate your position in the room. If appropriate, you can touch their hand or shoulder to give them a sense of your presence.

Use **active listening skills. This will help deal with the child's emotions and build trust.**

Consider the following when communicating/discussing the assessment and case planning process with children:

- Ensure that the child **understands what the project and/or the process** is about, what it is for, who is involved, and their role within it.
- Involve the child from the **earliest possible stage**. Considering use of age appropriate approaches (e.g., using play materials, role plays, or dance; telling the child's narrative in a simple but clear story; drawing with the child; and using toys and other figures) to gauge the child's understanding and explain the situation may be helpful with some children.
- Treat the child with **respect regardless** of their age, situation, ethnicity, abilities, or other factors.
- Establish **ground rules with the child at the beginning**.
- Provide the **child enough time and space to ask questions** in their own words so that they are the ones forming the framework for understanding what is happening in their lives.
- Assist the child in **expressing their thoughts and feelings without fear** or worry.
- Let the child know that his/her **participation is voluntary, and they can withdraw at any time**. The child should give informed consent before being involved.
- Try to **manage the child's expectations carefully** so that the child can avoid making assumptions based on their limited understanding of the entire situation.

Very young children may not be able to express themselves in words, but if you put out a series of games and toys for them to play with, they will be able to show you which ones they prefer. Junior-primary school children may be able to express themselves more easily about what they like/do not like rather than answer questions directly. They may find it easier to draw a picture or take some photographs and then describe what their picture is about. With older children, generally above 10, a variety of techniques may be applied, including role-plays/drama, drawing, and small group discussions.

General Methods/Approaches for Use During the Assessment and Case Planning Process

- Engage in a conversation from which you can provide information. Keep the conversation friendly and relaxed.
- Start with a story about yourself as a child about at the same age as they are. Make the story something to which the child can relate. When possible, show photos of your children or family. It is also good to share a small treat together and engage in small talk while drawing or playing hand games. Laughter expedites trust.
- When the child is feeling safe and engaged (5–10 minutes from beginning), start with open-ended questions. Open-ended questions facilitate the child's offering information rather than choosing a yes/no answer that interrupts the flow of conversation.
  - "Tell me how you participate in the daily activities in….?" Instead of "Do you participate in activities in….?"
  - "What do you think assessment and planning is?" instead of "Do you know what assessment or planning is?"
  - "Why do you think it is important for you to participate in this assessment or case planning?" Instead of "Do you want to participate in this assessment?"
  - "Tell me about yourself" and ask to follow-up questions (e.g., "Do you like….?").
- Briefly summarize your discussion and explain what will happen next. Thank the child for participating in the sessions and sharing their story with you. Let them know you have enjoyed your time with them and leave them happy and feeling appreciated.

Table 7: Child Participation

Why child participation?	Questions to ask children after their participation
▪ Hearing what children/youth have to say gives adults new understanding about their wishes and needs. ▪ Involving children/youth builds their self-esteem and helps them find ways to support themselves and others. ▪ Giving children opportunity to share their thoughts and feelings can result in a better and more sustainable support-plan. ▪ When children/youth feel they are taken seriously and respected by others, they gain more control over their lives and develop hope for the future. ▪ Children/youth can influence the behavior of their peers and others in the community. Respecting children by including them in decision-making can help ensure that this influence is positive, rather than negative.	▪ Do you feel that you were listened to? ▪ Are there some processes or activities you would have liked to participate in but were not given the chance? ▪ Are you in agreement with the outcomes of actions and decisions made on your behalf? Why or why not? ▪ Have your suggestions or requests been followed, did the adults explain the reasons to you, and do you understand those reasons? ▪ Was the process respectful and supportive? ▪ Did you always feel safe and protected during your participation? ▪ How has your life changed since the participation: Are you participating more in making decisions about your life? Do you feel more self-confident as a result of your participation? ▪ What recommendations do you have for future child-participation programs/activities? How can the process be improved?

Depending upon the child's age, development, and evolving capacity, they can play a very important role in their own care decisions and in the development of services to address their needs and those of their family. Meaningful participation goes beyond simply letting children give their opinions; children can participating as full partners in the process. Children must be a part of building their profile, the assessment, family tracking and can be part of case planning, family group decision-making and case review boards. Principles of child participation include:

- Children (and their families) must understand what the project or the process is about, what it is for, who is involved and their role within it.
- Children should be involved from the earliest possible stage of any initiative or process.

- All children should be treated with equal respect regardless of their age, situation, ethnicity, abilities, or other factors.
- Ground rules should be established at the beginning with all the children.
- Children's "evolving capacities" to participate in decision-making typically refers to their ability to understand multi-dimensional and abstract concepts. Therefore, taking into account the child's information processing ability and using appropriate methods are essential. Using simple language and basic stories about the child, drawing with the child, and using toys and other figures to gauge the child's understanding and explain the situation may be helpful with some children.
- Further, children should have the opportunity to ask questions in their own words so that they are the ones forming the conceptual framework for understanding what is happening in their lives.
- Children should be assisted in expressing their thoughts and feelings without fear or worry, and they should also understand that a group of caring adults will listen carefully and make a decision that will take into account their feelings and serve their best interests—even though some of those decisions may be difficult.
- Participation should be voluntary and children should be allowed to withdraw at any time. They should give informed consent before being involved.
- Children's expectations must be managed carefully, as they may make assumptions based on their limited understanding of the entire situation.

Determining Child's Wishes on Reintegration

It is best to commence child assessment after all possible information has already been gathered and entered onto the appropriate forms (e.g., a Child's Bio Data Form is completed for the child and they have been identified as a child for whom reintegration may be possible, pending family assessment validation). You want to be careful in talking in detail with the children during this process, to prevent false hope that they will be going home, pending tracing, family assessment, and approval. At the same time, you want to know the child's thoughts and feelings about going home.

When you are ready to commence child assessment, the information on the child's history of past placements, education, health, and some psycho-emotional items (if appropriate) should be already filled out. The caseworker's role is to verify these in a friendly, conversational way, and to address the question of reintegration.

General principles and methods (see also page 55)

1. Engage in a conversation from which you can extract information, rather than simply filling out the form. Keep the conversation friendly and relaxed.
2. It is always good to start with a story about yourself as a child about at the same age as they are. Make the story something to which the child can relate. Show photos of your children, or family. It is also good to share a small treat together and engage in small talk, while drawing, or playing hand games. Laughter expedites trust.
3. When the child is feeling safe and engaged (observed by their more open communication, excitement to engage, body language, etc.), start with open-ended questions. Open-ended questions facilitate the child's offering information rather than choosing a Yes/No answer that interrupts the flow of conversation.
    a. "Tell me about your family" and ask follow-up questions, instead of "Are your parents alive?"
    b. "What do you think about…" instead of "Do you like…?"
4. When you need to go to the important question of reintegration, use a narrative approach with the child as the center of the story. Here again it is good to tell your story, and then transition the story to focus on

the child. “I grew up in the country and then I left home when I was 13 to go to secondary. At first, I missed my family so much, but I made new friends and enjoyed learning, and now I get to see my family regularly. Maybe you can share with me your own story about growing up in different places.” Keep the story going with warm responses.

a. “So, you were very little when you came here. You have been growing up here for the last 3 years. Tell me what you like about being here (discuss). And are there things you do not like about being here(discuss)?
b. Get the child’s reaction to growing up in the institution versus growing up at home. “Let’s think about some different places you could finish growing up until you become fully grown. What are those places?”
    i. You may need to prompt the child that the institution is one place. “One place where you could finish growing up is here. Can you imagine yourself growing up to be an adult here? What will you look like by then? What kind of work do you want to do when you are older? Tell me who you will be close to when you leave this place? How will you relate to your family then?”
    ii. “What might be another place where you could finish growing up (child may need to be prompted that his/her family *might* be another place, and say that we are just imagining different places)? Can you imagine yourself growing up back in your family? What would that be like (read the child’s emotions as he/she answers)? How will it work out with your brothers and sisters? How do you feel when your mother and siblings visit you? How do you feel when you are around your stepfather?”
c. Help the child explore the pros and possible concerns of either option.
    i. “It seems like you could finish growing up here, or maybe it would be possible for you to grow up at home. What do you like about each option? What do you think might be a problem in each place?” DO NOT SUGGEST answers but instead ask “what do you think…” questions (have the child or you draw each item the child brings up—one side for institution and other side for home).
    ii. Pros at the institution may include food, education, and friends. Concerns may include not having enough adults to talk to, feeling lonely for family, possible peer or staff abuse, etc. Pros at home might include being with family members, living in the community, and feeling a sense of belonging. Concerns may include not enough food, school too far away, possible abuse, or rejection at home or in the community.

5. Briefly summarize your discussion and let the child know you understand. “It seems like you really miss your family. I can remember doing that, too.” But DO NOT say that you will make sure they go home. Or, “It seems like there are things you like both here and at home,” or another accurate and empathic response. Thank the child for telling you their story. Reassure them that regardless of where they finish growing up, they are special and should always remember they should be treated with respect and care, and that they should treat others that way, too. Let them know you have enjoyed your time with them, and leave them in an upbeat, happy mood.

   For young adults, a more direct approach can be taken depending on their evolving capacity. Similar consideration should be given to avoiding setting expectations, and to helping the young adult think through the pros and cons of different possible living arrangements in which they express interest.

Essential Preparation for Children with Limited Participation Capacity

It is important that caseworkers ensure children are well prepared for their new placement, to ensure that reintegration will progress well. Having children participate to the full extent of their evolving capacity during the preparation phase can make certain it is done well. However, participation can be more complicated for some children than others, and caseworkers will be required to think creatively during the preparation stage. Caseworkers should remember that there are many ways to help prepare children who cannot participate verbally (for example, babies or children with severe intellectual disabilities); in particular, ensuring that the new home is as similar as possible to their current setting in terms of their tactile, auditory, visual, and sensory experiences. Some examples include:

- Daily routines (feeding, bathing, bedtime, etc.) should be kept as similar as possible to what was occurring in the institution, to keep the child in a familiar routine and help them be able to know what to expect.
- The new caregivers should be informed of which soap, powder, and lotion was used with the child in the institution and endeavor to use the same. Similarly, the new caregiver should attempt to use the same washing powder for clothing and bedding. This will give children a sense of familiarity and safety.
- Transitional objects will be very important and can include a blanket the child has been using, toys, books, etc.—whichever objects are most favored by the child. Additionally, if floor mats were used for children with disabilities, these should also move with the child to the new placement.
- In the lead up to placement, the institution could play music during the day around the child that he/she becomes familiar with that music. The same music can then be played for the child during bonding visits to the new home, during the journey to the new home on the day of placement, and after placement in the new home while the child is getting settled.

Steps for Presenting a Case

The presenter of the case will give an overview of the case being presented, highlighting the following details:

- Introduction of self and project site supported
- Date when case was opened as in the case plan
- Brief description of the case, including
  - the core problem or primary vulnerability (e.g., child is HIV positive)
  - magnitude of problem and contributing factors (e.g., consistently misses medical appointments due to lack of transportation and caregiver availability to accompany him/her)
  - anticipated consequences if not addressed (e.g., lack of adherence to anti-retrovirals (ARVs), unsuppressed viral load, sick and missing school)
  - actions that have been tried to date (including current efforts being undertaken by caregivers and other service providers)
  - summary of strengths and protective factors within and surrounding the child/family
- Gaps/challenges identified
- Recommended actions and resources needed

Life Story

The National Standards for Best Practices in CCIs recommends that each child living in an institution should have a "Life Story Book" which contains words, pictures, photos, a "family tree," and documents relevant to the child. A Life Story Book is designed to enable the child to understand significant events in their past, confront the feelings that are secondary to these events, become more fully involved in the future planning of their lives, help the child maintain a sense of unique identity, help the child share their story with others (e.g., new caregivers), assist the child to resolve separation issues, and etc. The book will ultimately be important to the child in their future as a record of their childhood. Life Story Books should be created by the child (according to their evolving capacities)

and updated through regular family contact (including family photos where possible). They can also be updated with information of the child's life at the institution. If a Life Story Book has not already been created by the child, it is vital that it is created during the preparation stage of the case management for reintegration process and should be continued after the placement.

Essential Support for Young Adults Moving to Supported Independent Living

When conducting case management for reintegration, it is critical to recognize the unique needs of older children/adolescents as they transition into community settings, particularly when the child will be placed in a supported independent living setting rather than directly with a family. When young adults have spent a significant portion of their childhood growing up in an institution, they may have limited understanding of life outside of the institution and lack some of the necessary skills or information to fully reintegrate back into the community—and transition into independent life. If young adults are not prepared appropriately for independence, they can become vulnerable to abusive relationships, substance abuse, or exploitive work environments. It is critical that young adults who are leaving care are empowered with the basic information and skills to protect themselves from these risks and transition into self-reliance in a healthy way.

The National Standards for Best Practices in CCIs requires that CCIs strengthen their programs to support these children as they prepare to exit the CCI. Similarly, the Kenyan Society of Care Leavers (KESCA) notes supportive services are essential for care leavers to become self-reliant and succeed in transitioning to independent life.

Below is a suggested minimum "check list" of supportive factors that caseworkers should explore with older children to empower them to feel more self-reliant and confident and facilitate a smooth transition from institution into independent living. These supporting factors are collated from the National Standards of Best Practices in CCIs, the Kenyan Society of Care Leavers,[102] and a 2019 case study from Uganda.[103]

- Facilitate the acquisition of National Identification Card and Huduma number.
- Assess possible new independent living arrangements together with the child/young adult and identify protective factors and risks of proposed arrangements. Have ongoing discussions about the new arrangement and plan the transition together (i.e., case planning). For young adults who are looking to develop a small group home together, the assessments can occur with all involved to start building a positive group spirit and sense of joint ownership.
- Explore referrals to educational and vocational training.
- Provide financial and material support and training for self-employment (i.e., advice on starting a business and financial management).
- Support the improvement of employment skills (i.e., resume development, interview skills, formal employment behavioral norms, and expectations).
- Support the improvement of life skills (i.e., personal hygiene, home hygiene, cooking, budgeting/saving, interacting with community members, cultural topics and community expectations, coping with peer influence, intimate relationships, adolescent health, gender issues, the importance of relationships. and a support network for mental health). (Note: refer also to the KESCA Life Skills Manual, forthcoming in 2020.
- Initiate the opening of a bank account to encourage a culture or normalization of savings.
- Create opportunities to build a support network around the child/adolescent before the transition (e.g., identify and facilitate their joining of a new mosque/church/savings group/sports team/other recreational group in their new proposed community), so they feel they have a positive social circle and to ensure stigma or discrimination are not present.

[102] Kenyan Society of Care Leavers (2018). How to Engage Care Leavers in Care Reform.
[103] Ibid.

- Facilitate supported learning/exposure visits to the new living arrangement (e.g., begin by staying for one or two nights at a time) and new education/training/workplace.
- Identify (together with the adolescent) and connect the adolescent with at least one "mentor" in their proposed community. Care leavers stated that "*every child and young person needs to know that they matter to someone."*[104] Given that many care leavers already struggle with abandonment and broken relationships, it is important they feel at least one person cares and is looking out for them during the transition (which is stressful in itself). A potential mentor could be a family member, teacher, coach, employer, church member, or another care leaver who understand the transition—*anyone who the child/adolescent perceives as trustworthy and who can commit to providing emotional support.* Ideally, the mentor should be coached by the caseworker and receive support from the caseworker.
- Emphasize the importance of healthy relationships and encourage—where possible and appropriate—a relationship between the young adult and their family, emphasizing the young adult's autonomy in setting norms and boundaries in these relationships.
- Ensure care leavers are provided with personal belongings and mementos prior to exiting the institution. These may include photographs, copies of relevant documentation (including case file), clothing, or any other items deemed important by the child.
- Arrange for ongoing contact between care leavers and children still living in the institution. Often the bonds developed with other children in the institution are the closest thing to family that the child has experienced and will continue to be important to them going forward. When children have a history of abandonment and disruptions in close relationships, any strong and healthy attachments that exist should be protected and attempts made to maintain them (noting that some relationships will transition and exist in a new form).
- Be proactive in creating links to other care leavers who also live in the community. The care leaver experience is unique and only shared by other youth who have lived in similar circumstances. Care leavers who have successfully made the transition can be a huge support and important source of information for others going through the same transition.
- The caseworker should ensure periodic monitoring based on the needs of the child/young adult. Contact information should be provided for services/supports they can access between monitoring visits.

Note. All the above support is also essential for young adults with disabilities moving into supported independent living. Additional considerations for young adults with disabilities moving into supported independent living arrangements may include the need to facilitate registration with the National Council for Persons with Disability (NCPWD) at the county level. The registration is done by the CGSDO. This is a continuous process. Below are the requirements for the registration process:[105]

- Arrange to support the child and family via an assessment by the Education Assessment and Resource Center (EARC) and at government hospitals
- Ensure that the child and family have a copy of the assessment report
- Support the family to help the child acquire a colored passport-size photo
- Make sure the individual registration form is complete

Submit the above to the county office for registration and acquisition of an identification card for the person with disabilities in no more than 1 month. With this card the individual child/young adult with disability will benefit from the following (in addition to others not on this list):

- Cash transfer for Persons with Disability (PWD)

[104] Ibid.

[105] https://ncpwd.wordpress.com/services/registration-2/. Accessed August 29, 2019.

- Free medical insurance through the National Hospital Insurance Fund
- Sunscreen lotions and lip balms for persons with albinism
- Financial support to expand their businesses upon availability of funds or equipment
- Various assisting devices from the government
- Education support scholarships from all departments
- Tax exemption at the workplace and in businesses (in some counties a parent with a child with disabilities will also benefit from these fees as long as they have proof)
- Purchase duty-free vehicle importation upon review by the national council

Checklist: Preparing for a Monitoring Visit

The preparation to make a monitoring visit will depend somewhat on the case. However, the following steps are basic to every case:

- Review the case notes from the last visit.
- Review any work you have done on the case since last visit.
- Review the Case plan. For each, review
  - the goal
  - responsible party
  - actions to be taken
  - timeline
  - determination of how you will engage with the child and family to review each goal
- Make some inquiries in advance of the visit to verify progress on the Case plan.
  - for example, if a caregiver committed to enroll a child in school, you can call the school to find out if the child has been enrolled and is attending
  - if a caregiver committed to take a child to get an immunization, you can check with the health clinic
- Check on any referrals made previously in the case.
  - follow up with the service providers to check progress and any difficulties
- Prepare to bring copies of
  - Case Plan (on-going)
  - Child Wellbeing Assessment (blank)
  - Family Protective Capacity Assessment (blank)
  - Referral Form (blank)
  - Case Note Form (on-going)
  - SOPs and Case Management Guidelines
- Contact information for important stakeholders in the case, including
  - teachers
  - local council
  - probation officer
  - para social worker
  - health clinic
- If available, bring a directory of service providers in the client family's area.

High-Risk and Emergency Situations in the Reintegrated Setting

Child safeguarding

The safety of a child within the reintegrated setting is of primary importance. Comprehensive family assessments will help identify and address risks to minimize the likelihood of harm so that the child can be safely

reunified/placed with the proposed primary caregiver and that there is no serious cause for concern regarding the child's wellbeing if she/he were to be reunified/placed with the family under caseworker supervision. When a child has revealed previous experiences of abuse or neglect at the home, every caution must be taken to minimize the risks to the child, should reunification to the same family go forward. Past issues related to abuse, neglect, violence, and exploitation should be dealt with prior to reunification, including giving the child a safe space to talk about previous violence so that risks can be understood and addressed with the whole family. The family assessment must include assessment and clear understanding of any criminal background or violent propensities of parents, siblings, other household members, and any frequent visitors to the home.

During pre-placement visits, caseworkers should seek out extended family, community, and local institutions that can offer additional support and monitoring. This must be done sensitively and with appropriate awareness-raising rather than "watch dogging," so that the child is not stigmatized. These institutions should agree to provide regular follow-up to the child and family and report back any issues immediately. Caseworkers should be well versed in recognizing when children are in imminent danger. They should be able to carry out their organization's procedures for reporting suspected neglect, abuse, and exploitation of children, and report to the relevant statutory authority holding the mandate to remove the child and transfer to an emergency (preferably family-based) placement if needed. Alternatives/additional support may come from extended family, community members, teachers, health professionals, NGOs, etc.

It is vital that caseworkers and case managers report **any and all** suspected cases of neglect, abuse, and exploitation of children that meet the national threshold within their case load to the SCCO and all cases to (whoever internal reporting goes to) as soon as possible (within 48 hours]. The caseworker's safeguarding responsibilities will be outlined in their respective organization's Child Safeguarding and Protection Policy. Everyone is responsible for keeping children safe and reporting concerns and disclosures. **Every caseworker and case manager are responsible for reporting and following up on safeguarding (child protection) concerns.**

Children's Officers may assess reported child protection concerns and find that it is in the child's best interest to be removed from their family-based care placement and placed in an alternative temporary placement (preferably an alternative family-based care arrangement). In this situation, **case management should continue** with the same caseworker and case manager, updating child assessment, family assessment, and case plan.

Children should be empowered (at an age appropriate level) with information on who and how to make contact if they are not safe. They need child-friendly, safe, easily accessible ways to report any concerns they have without fear of repercussions (e.g., giving children a cheap mobile phone or phone card). Take into consideration accessibility concerns specific to children with disabilities so that they can also effectively use the feedback mechanism. Families will also have information on how to contact caseworkers if an emergency arises.

The organization's safeguarding policy, including a child-friendly version of the policy and Code of Conduct should be read and upheld by everyone, with information regarding how to report concerns and disclosures clearly displayed on the documents. There should be a named person responsible for safeguarding whose contact details are clearly displayed and advice on who to contact if a child is at risk of immediate harm.

Family violence in the home

Children may not directly experience abuse, violence, neglect, or exploitation in the reintegrated setting, but they may be exposed to domestic violence between adults or youth within the home. This may include physical, sexual, emotional, or psychological exposure—all considered forms of child maltreatment with a variety of potential harmful short- and long-term effects. Furthermore, the caseworker should be aware that domestic violence and child abuse often co-exist, and the child's physical safety may be at risk. In extreme cases, the child's primary caregiver may be injured or incapacitated from being victimized by domestic violence. The caseworker will need to make referrals for services for adults engaging in or being victimized by domestic violence, monitor the case

very carefully (even if the domestic violence services provider may be more directly involved), and mobilize community members to lend support with additional monitoring. Referrals will help to ensure continuity in fragile family situations after the reintegration case is closed. It may become necessary to request assistance from the community leadership or statutory bodies to ensure that the family is receiving the necessary services and that they are learning healthier ways of solving problems and communicating. The caseworker should use case conferences regularly for the possibility of re-placing the child with another family.

Mental health risk situations

Even well-meaning and kind caregivers can suffer from mental health issues that compromise their ability to provide care and safety for their children. The stress of extreme poverty, lack of support systems, loss of a loved one, or unexpected hardships can negatively impact the mental health of caregivers. In some cases, they may have more chronic and possibly cyclic mental health issues that may not have been detected in the tracing and assessment process. It will be important to assess the mental wellness of caregivers as part of the regular visits and possibly gather information from community members who have frequent contact with them. Wherever possible, referrals to mental health service providers should be made, including counseling and possible medical treatment. If mental health issues pose a safety threat for the child, emergency temporary re-placement (following appropriate protocol in collaboration with the SCCO) may become necessary until the caregiver can be stabilized.

Medical, natural, or other emergencies

As always, the child's safety and wellbeing are of paramount concern, and the family's preparation for these needs will be critical in protecting their best interests. To prevent medical emergencies as much as possible, children who are sick should be given adequate treatment within the transitional center until they are fully recovered.

Part of preparing the families will entail identifying where they can get assistance in the event of medical, natural, or other emergencies. These resources may include hospitals, disaster assistance programs, and community-level response mechanisms. Ensuring that the child has an official birth certificate (and national ID where age appropriate), information related to the family in case of a sudden separation, and emergency food and water storage are all part of emergency preparedness for which the family should be aware and given assistance.

Barriers to engaging families

Families and children may be considered hard to connect with or engage for many reasons. These may include barriers to engagement such as their own resistance to change, reluctance to openly discuss their problems, unwillingness to follow through with necessary services, lack of motivation to improve their situation, becoming uncooperative, moving without notifying their caseworker, or other reasons. Sometimes the barrier can be differences in culture, language, values, or perspectives between the caseworker and the clients. Whatever their reason, reintegration case management is about the wellbeing and best interests of the child and must be pursued.

Under these challenging circumstances the caseworker will practice their "people skills" more than ever, and reflective supervision and learning motivational interviewing skills will be critical in order to engage the caregivers and/or older youth who are avoidant or with whom it is difficult to connect. Before determining to close the case, it is important to determine how much choice the person has and where they have choice. For example, can they refuse services or only accept some interventions? In some cases it may become necessary to insist that the case go forward, assess the entire situation, and ensure that the child is safe. Requesting a respected member of the extended family or community leader to intervene (when appropriate) can rebuild trust and re-engage the client. In other cases, navigating these situations requires specialized skills and it may become necessary to transfer them to senior-level practitioners who have greater experience.

Children impacted by trauma

It should be noted that children who are being reintegrated have already experienced significant trauma in their young lives. First, they were separated from family, friends, community, and familiar environment. Next, they lived in institutions, where their need for attachment and closeness were likely not consistently met by available adults, although they may have developed friendships with peers. When they are reunified with their families, they experience the loss once again of their familiar surroundings and the relationships they had at their former care. Some children end up in alternative care after running away or living on the streets, where they likely experienced abuse, neglect, violence, or exploitation. Furthermore, they may have experienced similar forms of maltreatment in the alternative care, as well as social stigma and cultural isolation. For these reasons, it is almost universally true that reunified children have already experienced personal trauma.

It is not uncommon for reunified children to exhibit symptoms of trauma such as bad or sad dreams, bed-wetting, lack of appetite, complaints of headaches, or stomach problems. Others may have flat affect, appear stoic, show no interest in making new friends or participating in normal group/play activities, or become disruptive or disobedient. Caregivers should be prepared for these possible symptoms and coping mechanisms so that they do not take them personally and begin to blame the child or themselves. Instead, caregivers should be provided with education, support, and resources to use—and be encouraged to seek the help the child may need. In general, children are resilient and can often heal from trauma if they experience love in a safe, stable, responsive family where they have the time and support to re-attach to their caregivers; however, some children may need professional counseling. Caseworkers should keep in mind that it is often only when a child is in a secure and stable place that some of the past traumas and resulting behaviors can be effectively addressed.

Children and caregivers with disabilities

When caseworkers maintain a respectful, positive, and strengths-based approach to family reintegration, disability should never pose an unnecessary barrier to reunification—if appropriate support that enables adequate caregiving can be provided. Caseworkers will recognize and endeavor to seek access to the unique services, assistance, and interventions required to successfully support the reintegration of children with disabilities into family- and community-based care, as well as the support needed by caregivers with disabilities. It is important for caseworkers to consider what skills are needed to assess support requirements of children with disabilities—what services exist, how society views children with disabilities, and whether there are collaborative approaches to service provision in their community.[106] Community-based rehabilitation (CBR) can be a helpful multisectoral approach for meeting basic (health, education, and social) needs and enhances quality of life of people with disabilities while empowering and promoting their participation in the community.

It should be recognized that a family member who desires to care for the child is a great resource for the child; however, their capacity to care for the child must be realistically assessed prior to reunification. During the assessment and initial visit, the caregiver's desire and capacity to care for the child needs to be thoroughly assessed. This could be done by reviewing any medical history of the caregiver, as well as any available prognosis on the disability. Further, the assessment should consider information that can be gathered from extended family, community members, or neighbors in a manner that is not stigmatizing or disrespectful of the caregiver. Talking very openly with the proposed caregiver about the physical, emotional, mental, and financial demands of caring for a child; the specific care needs of the child; and learning about the caregiver's support system are all important parts of the assessment. Available services and the caregiver's ability to access those services should also be thoroughly researched. This includes identifying other caregivers with children with disabilities in the community, adults with disabilities who can serve as mentors, disabled people's organizations, and disability-specialized service providers.

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[106] Sammon, E. and G. Burchell (2018). *Family Care for Children with Disabilities: Practical Guidance for Frontline Workers in Low- and Middle-Income Countries*. Retrieved from: https://bettercarenetwork.org/sites/default/files/FamilyCareGuidance_508.pdf.

Where a child has a long-term illness (such as HIV/AIDS, epilepsy, or sickle cell) or a disability (such as blindness or a missing/weak limb), which require on-going treatment or adaptive equipment (crutches, splint, or prosthetic), extra steps should be taken to ensure the family can provide the necessary care with locally available support. As part of the assessment, the caseworker should assess the family's capability and willingness to address and work with the child's situation and any special needs. At placement, a referral letter to a health service provider should be provided and access to disability-specific services and support groups confirmed. During the initial visit, staff should investigate the local health services to see if medicine, regular check-ups, and maintenance/repair for assistive devices would be easily accessible (including cost, time, and transport). Local support groups should also be contacted to ensure that the child and family can access specific support locally.

Guidance for knowing when a child or family needs greater support

The following signs may signal the presence of child abuse or neglect.[107]

The child:

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the caregivers' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision
- Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home

The primary caregiver:

- Shows little concern for the child
- Denies the existence of—or blames the child for—the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of emotional needs

The primary caregiver and child:

- Rarely touch or look at each other
- Consider their relationship to be entirely negative
- State that they do not like each other

The child, young adult, and wider community:

- Feel unaccepted by the community members
- Consider their relationship with the community to be negative
- Have trouble using the available resources with the community (i.e. feel stigmatized)

Developmental Milestones

The early years of a child's life are very important for his/her health and development. Healthy development means that children of all abilities, including those with special health care needs, are able to grow up where their social, emotional, and educational needs are met, within a safe and loving family home.[108] A child's growth is more than just physical. Children grow, develop, and learn throughout their lives. A child's development can be

[107] Child Welfare Information Gateway (2007). Recognizing abuse and neglect: Signs and symptoms. Retrieved from: https://www.childwelfare.gov/pubPDFs/signs.pdf.

[108] Centre for Disease Control and Prevention (2019). *Child Development Basics* (webpage). Retrieved from: https://www.cdc.gov/ncbddd/childdevelopment/facts.html.

observed in how she/he plays, learns, speaks, and behaves. Proper nutrition, exercise, sleep, and positive parenting can make a big difference in child's development.

Positive Parenting

Parenting is critical in supporting and shaping children's developmental outcomes as well as helping to support parents' own growth and wellbeing. The importance of parenting is documented in a large body of research detailing how parenting of children is related to children's subsequent cognitive, behavioral, and socio-emotional development[109, 110] as well as how parents interact with other major socializing forces to promote children's optimal development.[111] Parenting that is supportive, proactive, responsive, and involved promotes children's positive adjustment, whereas parenting that is neglectful, abusive, rejecting, and controlling predicts poor outcomes in children's development.[112] Parenting that is warm and supportive facilitates the development of strong and secure relationships between parent and child and can also act as a buffer, improving associations between adverse influences and poor child outcomes.[113] Guidance or training on basic positive parenting skills should be made available for caregivers assessed to be in need of parenting knowledge and skills, prior to reunification of a child.

Reflective Supervision

Supervision provides the opportunity for checking on how caseworkers are doing, reflecting on practice, dealing with time management, identifying where support is needed, checking on personal responses and coping mechanisms, and providing technical support on complex cases. Supervision also plays a role in ensuring that caseworkers have the skills to deliver quality, competent services in accordance with the guidelines and SOPs. Supervision—both individual and group—can be a way of providing skills training and mentoring related to real case situations. There is a wide range of guidance and different models available to support Reflective Supervision. Within Kenya, Catholic Relief Services' Making Well-Informed Efforts to Nurture Disadvantaged Orphans and Vulnerable Children (MWENDO) project has excellent materials and tools available for use.[114]

[109] Collins, W. A., E. E. Maccoby, L. Steinberg, E. M. Hetherington, and M. H. Bornstein (2000). Contemporary research on parenting: The case for nature and nurture. American Psychologist, 55(2), 218-232. http://dx.doi.org/10.1037/0003-066X.55.2.218.

[110] This brief introduction to the 4Children Evaluation Framework was adapted from a comprehensive review of parenting programs supported by ChildFund in 2014. The complete review, *Parenting Education and Support for Families with Young Children: A review of evidence and recommendations for action,* was prepared by Cassie Landers and is available through Maestral International. http://maestral.org/contact/.

[111] Better Parenting Facilitator's Manual, 4Children Nigeria. Retrieved from: https://bettercarenetwork.org/sites/default/files/Better-Parenting-Facilitator-Manual_FINAL_high-res-for-printing_23-5-2018.pdf.

[112] Ibid.

[113] Ibid.

[114] Supportive Supervision guide and tools for case management MWENDO project (2017).

SECTION 5: Annex

Annex A: List of Participants for the Development of the Case Management for Reintegration of Children into Families or Community-Based Care

No.	Name	Organization
1	Noah Sanganyi	DCS HQ-Director
2	Marygorret Mogaka	DCS HQ-Deputy Director
3	Carren Ogoti	DCS HQ
4	Justus Muthoka	DCS HQ
5	Caroline Towett	DCS HQ
6	Janet Mwema	DCS HQ
7	Alfred Murigi	DCS HQ
8	Elizabeth Mbuka	DCS HQ
9	Hudson K. Imbayi	DCS HQ
10	Jane Munuhe	DCS HQ
11	Ruth Areri	DCS HQ
12	Lilian Osero	DCS HQ
13	Harrison Ng'ang'a	DCS HQ
14	Ruth Njuguna	DCS HQ
15	Beatrice Maina	DCS HQ
16	Peter Kabuagi	DCS HQ
17	Jennifer Wangui	DCS HQ
18	Eunice Moraa	DCS HQ
19	Orina Amima	DCS HQ
20	Elizabeth Mbuka	DCS HQ
21	Humphrey Wandeo	DCS
22	Aggrey Ambwaya	DCS
23	Alice Wanyonyi	DCS
24	Bilha Amino	DCS
25	Esther Wasige	DCS

26	George Migosi	DCS
27	Gilbert Simba Nyaribo	DCS
28	Harriet Ichenihi	DCS
29	Jemin Onyango	DCS
30	John Odinya	DCS
31	Joseph Otieno	DCS
32	David Magogo	DCS
33	Beatrice M. Obutu	DCS
34	Joyce Nyandika	DCS
35	Julian Enoi	DCS
36	Lawrence Ogutu	DCS
37	Mark O. Keya	DCS
38	Masika R. Wasike	DCS
39	Nelly P. Asunah	DCS
40	Patrick A. Awino	DCS
41	Peter Kutere	DCS
42	Rose Barine	DCS
43	Sammy Korir	DCS
44	Wainana Jonh Gitau	DCS
45	Amos Makori	DCS
46	Allan V. Onguka	DCS
47	Lavenda Busungu	DCS
48	Everlyne Annam	DCS
49	Stephen Ucembe	Hope & Homes for Children
50	Grace Njeri	Human
51	Miriam Musyoka	SOS Village (K)
52	Ruth Wacuka	KESCA
53	Kelley Bunkers	Maestral International
54	Anna Jolly	Maestral International

55	Michelle Oliel	Stahili Foundation
56	Benson Kiragu	Stahili Foundation
57	Joseph Kimani	Stahili Foundation
58	Yoko Kobayashi	UNICEF
59	Jack Onyando	UNICEF
60	Catherine Kimotho	UNICEF
61	Fredrick Mutinda	CRS-CTWWC
62	Cornel Ogutu	CRS-CTWWC
63	Crispus Natala	CRS-CTWWC
64	Fidelis Muthoni	CRS-CTWWC
65	Kaiser Bernard	CRS-CTWWC
66	Khadija Karama	CRS-CTWWC
67	Maureen Obuya	CRS-CTWWC
68	Mercy Ndirangu	CRS-CTWWC

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