ASSESSMENT OF ALTERNATIVE CARE FOR CHILDREN WITHOUT PARENTAL CARE

Swaziland
BACKGROUND

Swaziland has little history with residential care homes for children. When a child lost one, or both parents, the larger family unit, be it aunts and uncles, grandparents or even community members, took that child in as one of their own to be raised in a family setting that provided care, support and love. Indeed, even as late as the 1990s, there were few institutional options for children without parental care.

That situation changed however, as HIV and AIDS began its hold on Swaziland. As the HIV prevalence rate continues to climb, from 3.9% in 1992 to 39.2% in 2006¹, few family members are left to take in orphaned or vulnerable children, and many of those that remain are too old, too sick or have resources that are simply stretched to thin to take in another needy child. Today the country is home to 60,000 orphans. That number is expected to double by 2010. That means that more than 10% of the country's population will be orphaned in only three years time. No country has ever experienced this trauma. Not through war, not through drought, not through poverty.

The Swazi Government and its many partners have implemented a number of interventions to protect and care for the needs of children. Among these are Neighbourhood Care Points (NCPs) which offer a hot meal and informal education to children at the community level; the establishment of Child Protection Committees and the training of Lihlombe Lekuhalela (meaning “shoulders to cry on”) volunteers to protect children from abuse and exploitation; the development of the National Plan for Universal Primary Education to extend free primary education to all children no matter their family situation; and the creation of a National Children's Coordinating Unit in the Ministry of Health and Social Welfare to ensure that children are receiving the care and support they need.

In addition, orphanages and other residential care facilities for children were established, some by and with Government support, and others by private individuals or organizations.

Despite these commendable efforts, more remains to be done. Most of the residential children's care facilities were established without any legal framework, policy guidelines, registration requirements or national standards. There are also currently no monitoring mechanisms for the protection of children in these institutions. The absence of these necessities could result in more abuse than protection of these children.

In response, the Ministry of Health and Social Welfare (MOHSW), responsible for the care and protection of children, launched this needs assessment of all residential care facilities for children. The results will serve as a guide to establish standards of care and practices for these institutions, helping to ensure that the children under their care are protected and grow up with their hopes and dreams intact.

¹According to bi-annual sentinel surveillance of pregnant women visiting antenatal clinics in the country.
PURPOSE

Cognizant of the gaps that exist in the establishment of many of the residential care facilities for children in the country, the Ministry of Health and Social Welfare embarked on an assessment of these alternative care facilities. This assessment will form the basis from which to establish national standards and guidelines to ensure that quality care is provided to all children in these facilities. The national standards must also ensure that the care provided to the children is closely aligned with the provisions articulated in the Convention on the Rights of the Child (CRC), which was ratified and adopted by Swaziland in 1995. The care must also be congruent with the call of Swaziland’s Child Care Services Order of 1977 and international summits such as the World Summit for Children (September 1990); United Nations Millennium Declaration (September 2000); and the Vienna Declaration and Programme of Action adopted in June 1993 by the World Conference on Human Rights.

Objectives
The objectives of the assessment were to measure the status of residential care facilities and long-term institutions providing care and protection to children, as well as to compile a database of all facilities providing care and protection to children in Swaziland.

Methodology
The assessment aimed to provide a better understanding of the status of residential homes regarding:

- Aims and objectives
- Legal status
- Governance and management
- Admission criteria
- Funding
- Accountability
- Child protection practices
- Environment for the child’s growth
- Treatment of child (privacy, respect, dignity and discipline)
- Recruitment and training of caregivers
- Exit strategy
- Monitoring and evaluation

The assessment focused on children in residential care facilities and excluded other types of care at community level. It involved a census of each facility that included a prepared questionnaire capturing both quantitative and qualitative information from managers, caregivers and children at the facility. Observations were also made during visits by the assessment investigators.

Limitations
Many of the respondents were put off by the time needed to complete the questionnaire as it was lengthy and no appointments were made prior to the investigator’s visit. Some facilities therefore had to be visited several times. In addition, many respondents were reluctant to cooperate with a MOHSW questionnaire as they do not receive any financial support from Government.
KEY FINDINGS
Alternative Care for Children without Parental Care

Establishment of Facilities
The first residential care facilities in Swaziland were established in the 1940s and '50s by missionaries. While a few of these are still in operation today, less than 10 residential care facilities for children were operational as of 1970. However, in recent years, the desperation created by poverty, the HIV/AIDS epidemic and ever-escalating cases of abuse, neglect and exploitation of children have lead to the doubling of residential care facilities for children.

The assessment reached 20 residential care facilities (listed in Table 1) caring for a total number of 659 children (see Table 2 for a breakdown of boys and girls). Several of the facilities are registered as not-for-profit companies under the Companies Act No. 7 of 1912, Section 21. Others are registered with the MOHSW because the facilities are responsible for the care, protection and welfare of children. While there are most likely more residential care facilities operating in the country, these facilities were not registered either as not-for-profits or with the MOHSW and as such were unknown to the assessment investigators.

Accommodation for Children
Five of the facilities are village-type homes built in a Swazi family style. They have adequate-sized rooms to allow for two or three bunk beds, comfortable space in between beds and private lockers in each bedroom. These facilities have at least two toilets as well a large common area, a dining room and kitchen. Children living in these facilities seem to have a sense of ownership of the environment and treat one another as brothers and sisters. Meals are typically taken together with children and staff.

Several of the village-style facilities feature additional innovations. One facility has a poultry house and a back yard garden; another has vegetable plots for each child.

Five other facilities provide family type arrangements with rooms large enough to accommodate a maximum of four bunk beds and allow for easy movement between the beds. Relationships among children and staff seemed positive and comfortable. Only one of these facilities suffers from poor ventilation and lacks a fire place, despite its location in a colder area.

The remaining facilities provide hostel-type accommodation. In the majority of these facilities, overcrowding, a lack of privacy and poor diet are common features. In one facility the floor had holes and was uneven. Movement is restricted between the beds yet the children use the bedside as a place to study. In another facility 15 bunk beds were in the garage and some children slept on the floor. This facility had mattresses that were old and dirty and there were no linens or blankets. The children in this facility seemed apprehensive and fearful. Similar conditions existed in a sister house. Despite its size, one of the largest hostel-type facilities, housing more than 120 boys and girls, provides a good example for other facilities to follow. It has well-thought out, formal policies and processes in place, and provides ample room for the children. It has good ventilation and sufficient sanitation facilities which are regularly cleaned and disinfected. The physical environment is clean and tidy and the children seemed happy and relaxed.
### Table 1: Residential Care Facilities

<table>
<thead>
<tr>
<th>Name</th>
<th>Legal Status</th>
<th>Date of Reg.</th>
<th>Type of Establishment</th>
<th>Sources of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned Babies for Christ (ABC), Bulembu</td>
<td>Not for profit company</td>
<td>1996</td>
<td>Foster home for abandoned babies</td>
<td>Donations</td>
</tr>
<tr>
<td>Cabrini Ministries, Mhlatuze</td>
<td>Not for profit company</td>
<td>2002</td>
<td>Residential co-parenting home</td>
<td>Local and International donations</td>
</tr>
<tr>
<td>Crisis Centre, Mbabane Government Hospital</td>
<td>Not registered</td>
<td></td>
<td>Crisis centre</td>
<td></td>
</tr>
<tr>
<td>Elshaddai Ministries, Ekufiken</td>
<td>Not for profit company</td>
<td>2003</td>
<td>Residential home</td>
<td>International Assemblies of God and local donations, farm produce</td>
</tr>
<tr>
<td>Emmanuel Khayalethu Eveni, Mbabane</td>
<td>Not for profit company</td>
<td>2003</td>
<td>Residential home</td>
<td>Church, local and international donations</td>
</tr>
<tr>
<td>Half-Way House, Motshane</td>
<td>Government Establishment</td>
<td>1993</td>
<td>Government half-way house serves as temporary residence until children are placed back at home, in foster care, adopted or other more permanent care</td>
<td>Government</td>
</tr>
<tr>
<td>Hawane Light House</td>
<td>Not for profit company</td>
<td></td>
<td></td>
<td>Church, local and international donors</td>
</tr>
<tr>
<td>Hope House, Motshane</td>
<td>Not for profit company</td>
<td>2004</td>
<td>Government half-way house serves as temporary residence until children are placed back at home, in foster care, adopted or other more permanent care</td>
<td></td>
</tr>
<tr>
<td>Jacaranda Home, Bulembu</td>
<td>Not for profit company</td>
<td></td>
<td></td>
<td>International Church</td>
</tr>
<tr>
<td>Jesus Care, Mpolonjeni</td>
<td>Not for profit company</td>
<td>2004</td>
<td>Home</td>
<td>Church and individual donors</td>
</tr>
<tr>
<td>Manzini Youth Care, Manzini</td>
<td>Ministry of Home Affairs</td>
<td>1978</td>
<td>Institution for rehabilitation of street children</td>
<td>Local and international donors and Church</td>
</tr>
<tr>
<td>New Hope Centre Bethany, Manzini</td>
<td>Not for profit company</td>
<td>2002</td>
<td>Home</td>
<td>Local and international donors and Church</td>
</tr>
<tr>
<td>New Life Home, Kamfishane</td>
<td>Not for profit company Leadership</td>
<td>2003</td>
<td>Village homes</td>
<td>Mother Body Africa Leadership, Church, income generation, egg production</td>
</tr>
<tr>
<td>Pasture Valley Home</td>
<td>Not for profit company</td>
<td>2003</td>
<td>Home</td>
<td>Church, friends, income from farm</td>
</tr>
<tr>
<td>Remar</td>
<td>Not for profit company</td>
<td>2000</td>
<td>Institution</td>
<td>Church backed</td>
</tr>
</tbody>
</table>
Table 1: Residential Care Facilities cont.

<table>
<thead>
<tr>
<th>Name</th>
<th>Legal Status</th>
<th>Date of Reg.</th>
<th>Type of Establishment</th>
<th>Sources of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra Lee</td>
<td>Not for profit company</td>
<td>2003</td>
<td>Home</td>
<td>Mother Body Leadership for Africa, church, income from farm</td>
</tr>
<tr>
<td>Selula Sandla</td>
<td>Not for profit company</td>
<td>2002</td>
<td>Village homes</td>
<td>AME International Church, donations</td>
</tr>
<tr>
<td>S.O.S Children's Villages</td>
<td>Not for profit company</td>
<td>1987</td>
<td>Village homes</td>
<td>Kinder noting, local and international donors and government</td>
</tr>
<tr>
<td>McCorkindale</td>
<td>Ministry of Home Affairs</td>
<td>1999</td>
<td>Orphanage</td>
<td>Donations and government</td>
</tr>
<tr>
<td>Zondle Women's Organization</td>
<td>Ministry of Home Affairs</td>
<td>1999</td>
<td>Home</td>
<td>Donations, income generation and government</td>
</tr>
</tbody>
</table>

Table 2: Number of children living in residential care institutions

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>M</th>
<th>F</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>15</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Cabrini</td>
<td>67</td>
<td>60</td>
<td>127</td>
</tr>
<tr>
<td>Crisis Centre</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Elshaddai</td>
<td>16</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Emmanuel Khayalethu</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Half-way House</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hawane Light House</td>
<td>17</td>
<td>18</td>
<td>35</td>
</tr>
<tr>
<td>Hope House Motshane</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Jacaranda</td>
<td>0</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Jesus Cares</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Manzini Youth Care</td>
<td>64</td>
<td>0</td>
<td>64</td>
</tr>
<tr>
<td>New Hope Centre</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>New Life Home</td>
<td>14</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Pasture Valley</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Remar</td>
<td>62</td>
<td>54</td>
<td>116</td>
</tr>
<tr>
<td>Sandra Lee</td>
<td>7</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Selula Sandla</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>S.O.S</td>
<td>117</td>
<td>102</td>
<td>219</td>
</tr>
<tr>
<td>McCorkindale</td>
<td>23</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>Zondle Women Hlatikhulu &amp; Manzini</td>
<td>27</td>
<td>30</td>
<td>57</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>382</td>
<td>287</td>
<td>679</td>
</tr>
</tbody>
</table>

Of the total number of children in residential care facilities, 155 are double orphans, 112 are single orphans and 463 are vulnerable.
The age range of the children is broken down in Figure 1.

**Figure 1: Age Groups of Children in Residential Care Facilities in Swaziland**

- 34% 0-5 years
- 17% 6-10 years
- 18% 11-15 years
- 31% 16+ years

*Image of children in a classroom*
Alternatively Care for Children without Parental Care

QUALITY STANDARDS AND PROFESSIONAL PRACTICE

Defined Aims and Objectives
Clearly defined goals, aims and objectives are considered a necessary requirement for a well-run residential care facility. Sixty percent of all children's care facilities surveyed have written statements of the aims and objectives of the facility that are in line with the best interests of the children at the facility. Examples of some of these statements are:

- Provide a home for orphaned and vulnerable children.
- Offer rehabilitation for abandoned and abused children.
- Care for orphans and vulnerable children by giving them hope for the future and providing a happy family environment.
- Provide the child with love, care and security.
- Take care of and help orphaned and abused children to give them a happy family environment, education, and love, and provide them with food.
- Protect the interest and education of children in the programme so that they become self-sufficient.

These statements of purpose are within the framework of the Child Care Services Order of 1977, as well as the CRC and other international documents. Most of the statements were developed by the founders of the facilities with support from executive boards or committees. Typically, neither the children, nor the caregivers participated in the crafting of the statements, and in many cases neither was aware of the existence of the statements. Two facilities do review their objective statement on an annual basis and include management, staff and caregivers in this review. The children are not, however, included.

Twenty percent of the programmes do not have statements of aims and objectives written down.

Child Protection Policy
Residential care facilities are expected to have a written policy regarding the protection of the children under their care. This policy should align to national laws protecting children from abuse, neglect or exploitation, as well as to the minimum standards set by the CRC, which provides guidance and procedures for staff who discover or suspect that a child has been abused or neglected.

Despite the existence of individual laws governing children in Swaziland, there is no comprehensive framework for the protection of children from which child protection policies can be adapted. As a result, only 25% of the
residential care facilities for children have a child protection policy in place.

One facility follows a policy that was developed by its global office and is shared by its sister programmes throughout the world. This policy recognizes emotional, physical or sexual abuse that can be perpetrated by carers, children or other adults. The policy states that once a case of abuse, neglect or exploitation has been established, it will immediately be reported to the police. Measures to rehabilitate the abused will then be undertaken. Under this policy, caregivers are trained with knowledge and skills to recognise signs and symptoms of abuse. Children are also taught about abuse and the forms it can take.

The other care facilities have similar child protection policies defining abuse, neglect and exploitation. Most follow reporting guidelines that first establish the abuse, then report it to the police, the Swaziland Action Group Against Abuse (SWAGAA), or both.

The remaining 75% of residential care facilities for children do not have child protection policies in place. Some managers and owners of these facilities even pointed out that the CRC is not ratified in Swaziland and they are therefore not compelled to use it as a guideline. This shows the need for continued advocacy and education on child protection, as the CRC was ratified in Swaziland in 1995. Despite this, these facilities do have practices which they apply in cases of suspected abuse, neglect and exploitation. These practices are similar to the formal policies of other care facilities. Caregivers report any suspected cases to the director or manager, who tries to establish the suspicion. It is then immediately reported to either SWAGAA or the police. The Police Child Protection Unit is also helpful, particularly in the rural areas. The Unit has worked closely with carers by training them on child protection and responding promptly to reports of abuse.

While most caregivers and staff, and even some children, are aware of and can take action in a case of abuse, the majority are unaware of the laws governing abuse, exploitation and neglect. More training in this area would be beneficial to both caregivers and children.

Child Referral
A great majority of the residential care facilities for children (80%) have clear referral processes based on the Child Care Service Order of 1977. Children are referred to all residential care facilities by welfare agencies, both government and non-government, including Rural HealthMotivators (RHMs), hospitals, the Crime Prevention Unit, Save the Children, the police, and family and friends of the child.

Because of the great number of referral agencies, there is often unnecessary congestion in many residential care facilities for children, indicating a possible need to streamline the referral process. The flow chart in Figure 2 demonstrates the current referral processes.

Referrals made by social workers provide the most comprehensive information on children. Social workers’ reports typically detail the circumstances of the child and justify the need for admission to a facility. However, the majority of referral agencies seem unaware of their rights and responsibilities once a child has been placed into care. Many carers stated that social workers and other agencies only appear at the time of referral and are not seen again until another referral is given.
Figure 2: Referral Flow Chart

1. Vulnerable:
   - abandoned
   - abuse, neglect
   - disabled
   - alcoholic parents
   - no school fees
2. Death of Parents:
   - Both
   - Single

SOCIAL WELFARE

- Save the Children
- Social welfare
- Police Child Protection Unit
- Rural Health Motivators
- Umphakatsi
- Neighbours
- Friends
- Family
- Self

Children’s Court

Adoption

. Halfway house
. Foster Homes
. Children’s Home
. Village Homes
. Institution

Independent Living
(Integration)

Street Children

Family Re-Union

Child Admission Process

Similar to the referral processes of care facilities, the child admissions process is clearly mapped out in most (80%) residential care facilities for children. However, one noted gap is the need for a standard evaluation instrument to determine the exact needs of the child. Facilities as well as referral agencies should use a consistent assessment of the child's situation before removal from the child's home. Children have many needs, some of which do not warrant removing them from the care of parents.

There are several types of admission processes used by the residential care facilities. In one facility an admissions committee reviews the child's case and enters the information into special tracking software. A second assessment is conducted once the child is placed in the facility. This second assessment uses a Child Development Tool (CDT) to evaluate the physical, emotional, spiritual, psycho-social and educational needs of the child.

Another large facility, which receives children mainly through referral by RHMs, carries out an assessment using UNICEF standards to establish if the child is in need of admission to the facility. Each of the child's needs is addressed by a relevant staff member, including a social worker, psychosocial counsellor, teacher or nurse. Each child is given the necessary attention before he/she is admitted to join the regular school system.

Of the facilities without clear referral and admissions processes, two offer much to improve children's circumstances. These facilities take in older children (ages 16-19) and enrol them in skills and character building schools. The facilities also spend much time and money on tracing families in order to reunite children with their families when appropriate.

However, programmes without structured referral and admissions processes often suffer from overcrowding and a lack of resources. One
such programme makes no attempt to establish vulnerability as most of the children admitted are not in any “crisis” that warrants separation from their parents - reasons such as lack of school fees or children's own decision were cited.

**Child Care Plans**

A child care plan is a written document which outlines how, when and who will meet the child's development needs. The child should be involved in the development of this plan.

All but three of the care facilities surveyed have no written care plans. In the facilities that have care plans in place, there are professional staff who are able to prepare these technical documents. Nurses, psychosocial counsellors, social workers, educationists and youth leaders are on staff or are consulted regarding the plans. The care plans manage the case of each child to help prepare him or her for the future. Staff members are held accountable for each identified need within a specific time frame.

Child care plans are typically reviewed in quarterly meetings at these facilities. Caregivers also submit quarterly reports on the progress of each child. Caregivers also meet more regularly, usually on a monthly basis, to share experiences they have had with the children. Only in one facility do caregivers meet every Monday morning for case conferences.

In the facilities without child care plans, individual needs are addressed as they arise. For example, some children are HIV positive and take Anti Retroviral (ARVs) medication. Thus a plan will be developed on how they are to take their medication and who is responsible at what specific times. Despite the lack of care plans in some facilities, the caregivers and directors meet on a monthly basis to share experiences on their work. In this process, issues are brought up and addressed.

**Review of Child Placement**

All residential care facilities meet to discuss issues, problems and progress with each child. The six smaller facilities meet on a daily basis. Two village facilities meet every two weeks and three facilities meet on a monthly basis. The larger facilities with more than 10 staffers meet on a monthly, quarterly and annual basis. No matter the frequency or formality of the review meetings, no facility allows the voice of the child to be heard in these meetings.

The majority of the facilities also hold board meetings on a monthly to quarterly basis. While the board meetings focus mainly on concerns regarding the children's care, such as financial costs, board members do not seem to be closely involved. They do not monitor and evaluate the performance of the facility on an on-going basis, but rather rubber stamp the decisions of the director.

**Rehabilitation and Exit After-Care**

Less than half of the residential care facilities (43.7%) have a clearly written exit policy. An exit policy governs the process by which the facility ends its work with a child. The policies range in detail, but most acknowledge that exiting the facility is the start of integration of the child into the community. Other issues covered in some of the policies are a supervised move to the community, necessary material needs, including financial allowance if the child is not employed, the period of monitoring after exit, as well as follow up by social workers to provide a safety net. Some of the facilities provide children with life skills such as agriculture and computer skills to assist them with life after the care facility. Some of these facilities also encourage exiting children to attain tertiary education, teacher training, apprenticeship and other professional skills. Exit policies also cover family visitation and integration. Under some policies, family members are allowed to visit the children while in care so that re-unification with family upon exit will go smoothly.

While other facilities do not have explicit exit policies, some put much emphasis on tracing and reuniting the children with their families. Two programmes encourage children to visit their families on school vacations or encourage family members to visit the children while in care. Other facilities encourage adoption and foster care.

Despite the best efforts of some facilities, the need for a clear exit policy is evident. In one facility that admits children on a temporary basis, decisions to discharge a child are made by referral agents without much information on the children. No follow up is made after the
discharge from care. In one instance a child was discharged to a grandmother who could not care for the child properly. As a result, the formerly healthy child was weak and “unrecognizable” after only two weeks at home. In another instance, a child was returned to his mother who had been discharged from a mental hospital. The child suffered public humiliation as the mother carried the overgrown child on her back wherever she went. These incidences point to the need for a well-thought-out exit strategy that takes into account the future environment and care the child will receive.
Children’s Nutrition

Children’s nutrition in residential care facilities is extremely varied. Some facilities have sufficient amounts of food, while others struggle to feed children once a day. Some facilities have balanced nutritious meals, while others simply ensure children do not go hungry. Few facilities (two) follow a written menu. All other facilities prepare meals from whatever foods are available on that day. Some of the facilities in rural areas grow their own food to supplement food donated by World Food Programme (WFP), churches, and other donors. Some programmes serve three meals a day plus two snacks while others serve only two meals, i.e. breakfast and an evening meal. A few of the facilities have experts on staff to advise on nutritious, balanced food, while others do not. Despite this inconsistency, children are healthy and physically nourished in nearly all facilities. Three facilities even supplement the children's diet with daily vitamin tablets. Only one residential care facility had unsatisfactory conditions for the children's nutrition.

Meals in all the facilities are taken at regular intervals, especially breakfast and evening meals. Lunch is more difficult as many children attend schools that are quite far from the facility and some facilities do not provide the children with lunch boxes.

All of the facilities are endowed with safe drinking water and proper hygiene is emphasised in all facilities. Food is kept in clean storage and covered to protect it from pollution or insects. There is currently no regular monitoring of the residential care facilities by health inspectors.

Many children did complain of a monotonous diet, dominated by beans and pap, or pap alone when beans run out. Children also complained that they were not involved in preparing the menu for their own meals. Children are however, involved in preparing and serving food. According to children interviewed, it is a joy for them to relax together and join in the meals. Special dietary requirements due to ill-health are provided for at all facilities.

Children’s Sense of Identity

With increasing numbers of Swazi children losing their families to AIDS, it has become vital to give these children the opportunity to preserve their identity and sense of culture and heritage. Sharing the same home with siblings and continuing an education and experience...
with Swazi culture, food and language helps ensure that these children continue to feel part of a family and the larger Swazi community.

Of the residential care facilities assessed, 90% ensure that siblings are not separated and are cared for in one facility.

The majority of facilities try to keep the children's lives as close as possible to their original family environments. One example is by serving traditional foods such as *tindlubu*, *emaselwa*, sour porridge, pap and *emasi*. The facilities also place emphasis on siSwati, ensuring that children can speak both English and siSwati in order to communicate with all the players in their lives. The facilities also do everything in their power to obtain birth certificates for the children that do not have them.

Facilities make varying attempts to keep the children in contact with their families and communities. Several homes allow children to visit their families during school breaks or allow family members to visit children at the facility. A few facilities that have children with special needs, such as those on ARVs, allow these children to visit their families under the supervision of a staff member. Still other facilities allow children to visit their families despite a dependence on medication. Some caregivers expressed serious concern that all children, regardless of their family environment, should be allowed to visit their families. In many cases, this was risky and unsafe, as some children needed to be treated for sexually transmitted infections upon their return.

A few facilities did not allow children to visit their families under any circumstance. Home visits were not seen as an important element of development and maintenance of the child's self-esteem and emotional well-being. Some caregivers said that forbidding home visits protects the children from abuse. On interviewing children in one such home, the children were in tears or said they contemplated escape because they have not been allowed to see their families. Children in another care facility said they were allowed to visit their homes only shortly before they were to exit the facility. This was like “being released to complete strangers” because the children had not been allowed to continue an emotional bond with their families.

One extreme violation of children's identity is the practice of one facility of changing all the children's individual surnames to one surname. These children are allowed to experience only one culture, the culture of the care facility.

**Access to Preventative and Remedial Health Care**

Forty percent of the children's facilities have their own fully fledged clinics, equipped with necessary facilities and medications for children. Despite this, 60% of the children's residential care facilities do not conduct medical assessments prior to or after the child's placement to establish the health status of the children. However, all the facilities have good working relationships with the local health clinics or hospitals where they bring children for medical attention, and medical care is available to all the children if they fall sick.

Several facilities have at least one child with a terminal illness such as HIV/AIDS. Sick children in the facilities, including those with HIV/AIDS, receive suitable treatment. In one of the facilities, children that were on long term treatment of ARVs had a personal drawer where their medication was kept. While children were responsible for taking their own medications, a nurse monitored this and recorded the details. Medical expenses in all the facilities are paid for from facility budgets.

All facilities keep health records for the children and update them as new information is received. None of the facilities would reveal health information about children, ensuring that health records were private and confidential.

Nearly all the facilities provide health education, whether formally or informally. Forty percent of facilities have a structured health education programme. In other residential facilities, caregivers give advice on issues such as sexuality, HIV/AIDS, personal hygiene, a healthy diet and getting a good night's rest.

**Play and Recreation**

Eighty percent of the facilities provide the children with ample time for leisure activities.
Recreational resources vary, but most facilities have at least some games or sporting activities according to the children's ages. Younger children have the most options to choose from. Caregivers also often play with the younger children as part of physical, social, and educational development.

There are some facilities that provide no recreational resources. Children hang around doing nothing while the younger ones play with whatever they can find. One of these facilities is over-crowded with a small yard around the house. Another facility does not provide or encourage leisure activities. Children entertain themselves by finding things to do, e.g. making balls out of old rags to kick or play as net ball.

Children's Right to Privacy
Nearly 100% of facilities separate boys and girls rooms except where children are still infants. Privacy for children, even within same-sex rooms is often minimal. Because 70% of facilities surveyed face overcrowding issues, children typically share lockers and shower facilities. The only private things they may have is a bed and any personal belongings brought from home.

In all the facilities, carers have a private room within the house to ensure that unsupervised contact between boys and girls is minimised and also for security reasons.

Most facilities keep children's issues private and do not discuss them openly in front of others, nor do they use children's experiences or backgrounds to fund raise.

Respect for Children
In 90% of facilities children are involved in decisions that affect their lives. Their views are listened to and respected. Each child is recognized as an individual with their own needs.

Unfortunately, caregivers in some homes have difficulty treating children with dignity and respect, particularly the children that exhibit difficult behaviour traits. Children stated that some carers humiliate them, embarrass them and sometimes single them out in front of many children.

Disciplinary Action
Policies on methods of care, control and discipline exist and are clearly recorded in 40% of the residential facilities. The policies set out acceptable and unacceptable methods of discipline. Methods of acceptable discipline include reprimands, domestic work, and withdrawing privileges. Some of the unacceptable methods include food deprivation and suspension from school.

While these policies are known by caregivers, many children in the facilities (60%) are unaware of them.

More than half (60%) of the facilities keep records of all sanctions, including the punishment, the time, the date and who was involved.

Access to Education
Children in each of the residential care facilities have equal access to education. Seventy percent of facilities integrate the children into the regular school system. In addition to traditional schooling, some facilities offer additional education opportunities that cater to some children's special needs. Examples of these opportunities include: pre-school, vocational training, study sessions, personal tutoring, afternoon classes, and life skills programs. Figure 3 shows the percentage of children in various education levels.

Home schooling is a newer method of education being used by 30% of the facilities. Typically, this method is working well. However, one home school has overcrowded classrooms, limited teaching materials, no teaching aids to facilitate learning and teachers with questionable qualifications.

In nearly all the educational settings, caregivers support the children in their education by encouraging them to complete homework and lending assistance where needed.

Using the facility budget, most caregivers pay school fees for the children living in the facility. However the children in one facility have individual sponsors who pay for school fees.
Figure 3. Educational background

- Pre school: 10%
- Grade 1-7: 75%
- Form 1-5: 15%
- Tertiary: 0%
Recruitment and Selection Procedures
Of the residential care facilities assessed, 11 had formal employee recruitment and selection procedures. These procedures include advertising a position both through the print media and through word of mouth in churches and through current employees; an interview process; appointment and contract signing; and induction to the facility. Character checks are made on previous employment and references before appointments are offered. Most policies provide for a probationary period of three to six months in which the caregiver is observed interacting with children.

Nine facilities do not have formal recruitment or hiring policies but typically follow a pattern similar to facilities with a formal, recorded policy. Interviewing may be a less formal process and induction may be "on the job."

Caregivers' wages range from E300 to E800 per month, although some of the larger facilities pay higher wages of more than E1,000 per month. Annual leave varies among facilities. Leave is typically provided for in a caregiver's contract. Some contracts offer a few days off after two to three weeks of work, while other contracts offer days off that are counted toward annual leave. Still others offer no leave and few breaks.

Caregiver Supervision and Support
Supervision of staff and caregivers is taken seriously by the majority of the children's residential facilities. Informal supervision and feedback is given on a frequent basis, evaluating performance of workers and assessing if caregivers are able to effectively manage each case. Most of these informal sessions are not recorded unless major issues are raised. But such contact encourages caregivers and boosts confidence about their skills.

Formal performance reviews may be held less frequently, but these sessions allow supervisors to encourage, correct or teach the caregivers on ways of improving. These discussions typically generate agreements that are recorded and signed.
In two facilities there is no supervision of any kind. Work is routine and caregivers are not evaluated or encouraged. No instruction, correction or education is given.

Caregivers and Staff Deployment
Half of the residential care facilities for children have a sufficient complement of caregivers to meet the aims and objectives of the facility. The facilities have a ratio of caregiver to child of no more than 1:10. This low ratio allows caregivers to have relationships with the children and provide individual attention where needed.

The other half of facilities, however, suffer from a lack of human resources. These facilities are able to provide for the basic needs of the children but are often unable to fulfill the goals and objectives of the facility. Caregivers are poorly remunerated and are not allowed days off to relieve stress. The ratio of caregivers to children can be as high as 1:15 or 1:25. These facilities give little individual attention to children.

In speaking with these caregivers, the investigators found a lack of enthusiasm and lack of interest in the work. These caregivers remain solely for the pay and would leave immediately if a better job was secured. As a result, the quality of care for the children is compromised.

Professional Development and Training
A majority of facilities assessed (80%) recruit caregivers who already possess skills to care for children. These facilities then further train caregivers through on the job training and informal feedback on an ongoing basis. Other facilities provide formal training through partners or sister programmes.
Half of the children's residential care facilities are situated within the urban areas of Mbabane, Nhlangano, Bulembu or Manzini. These facilities are open to children from around the country and are easily accessible by public transport. Children are referred to these facilities from child welfare agencies, government, and NGOs as well as RHMs, friends, grandparents, AIDS counseling centres and churches throughout Swaziland.

Each of these facilities indicated that they maintain a good relationship with the communities in which they are located.

The other half of the residential care facilities for children are located in more rural areas. Thirty percent of these are located in chiefs' areas, while 20% are situated on title deed land. The programmes are accessible to the communities in which they are located, although their services are open to the whole country. Chiefs of the areas are given all information regarding the services offered in the facilities, including the aims and objectives. Community chiefs support these facilities fully. In one facility, the chief and libandla (chief's council) gave the facility land to build, fields to plough, and space to keep dairy cows used to feed the children. In another facility, regular meetings are held with community representatives to discuss issues relating to children, including family reunification.

These rural facilities do encounter challenges due to their distance from other resources. One facility is quite far from clinics and food stores. As a result it is challenged with food security issues and storage of medicines. Another facility is far from schools. Children leave early in the morning for school and come back at dusk. In addition, these rural-based facilities face communication challenges as many lack phone lines or access to network cell service.

To ensure widespread knowledge about their services, some facilities were officially opened and maintain coverage in print and electronic media. Information on the services provided by less-publicized facilities is disseminated through word of mouth, churches, meetings and the police.
Maintenance of Records
Three-quarters of the residential care facilities for children keep detailed case records for each child. These case records describe areas of concern and decisions made on each child, and feature admission forms, medical records, school performance, etc. Files are updated as new information is available.

The other quarter of the facilities do maintain some records, however, the information kept is not clear or complete, it lacks details or the information was simply never recorded.

A similar pattern exists on staff personnel records. The 75% of facilities that keep good personnel records have information such as; application letter, appointment letter, signed contract, provident fund, copy of travel document, job description, health and leave record, training record, and birth certificate. The other 25% of facilities keep records with information that is incomplete or out of date.

Confidentiality of Records
While only 20% of facilities have a formal confidentiality policy, the staff and caregivers at all facilities understand that information on children and staff must be kept private and confidential. Records at all facilities are secured with access given only to authorized staff. Information about a child or staff member cannot be given out without consent by the person involved. Personal histories or background on any of the children cannot be used for fundraising, promotion or any other purpose without the consent of the child.

Monitoring and Evaluation
The owners, directors and managers of most facilities meet with the caregivers on a frequent basis to discuss developments and challenges affecting children. The meetings do not, however, follow systematic procedures or methods to monitor the facility. Facilities that have boards of directors in place have more structured monitoring meetings. These are typically held at regularly scheduled intervals and discuss inputs like finance, donations, feeding, new children admitted, and care and protection of children.

A small percentage of facilities perform an annual evaluation reviewing the year’s achievements in children’s quality care, systems and procedures. Some facilities also carry out external evaluations with the support of parent organisations.
RECOMMENDATIONS

Providing a safe, loving and protective residential facility for children without parental care can be extremely complex. The reasons for out-of-home care, the forms it takes, the issues it raises, and the responsibilities it implies are all challenges faced by alternative care facilities. These challenges are compounded in the absence of a comprehensive, coherent, and detailed standard to serve as a guide and measuring rod for residential care facilities for children.

Despite these challenges, the option of residential care for children can no longer be ignored. These facilities exist and are playing a role in caring for some of the nation's children. The potential harm of turning a blind eye to these facilities is that:

Too many children may
- Be needlessly removed from their homes
- Be placed in inappropriate care situations
- Not cared for at all

Too many problems will arise
- Abuse and exploitation
- Isolation from family and community
- Deprivation of liberty
- Lack of regular review of placement
- Poor conditions of care

Too few safeguards will be in place
- Wide gaps in coverage of care situations
- Unequal detail in principles and guidelines from one care situation to another

The recommendations listed here are made based on the key findings in this assessment.

Policy Recommendations

- A comprehensive national legislative framework to guide and govern the decision making, care provision and oversight of alternative care for children without parental care must be formulated. Swaziland currently has a National Child Care Policy in draft form. If this policy is to serve as the national framework, it must be finalised as a matter of urgency, taking on board and addressing all issues related to residential care facilities and alternative care.

- While the Convention on the Rights of the Child was ratified in Swaziland in 1995, many residential care facilities and their staffs were unaware of this guideline. A workshop should be organised to educate the directors and staff members of residential care facilities on this important international instrument, as well as the national policies that exist such as the Child Care Order of 1977, the Adoption Act of 1952 and if applicable, the draft National Child Care Policy.

- The Adoption Act of 1952 is outdated and is not aligned to the CRC. The Adoption Act must be reviewed and updated with immediate effect.

- The Social Welfare Department should give written approval for the establishment of a residential care facility for children before the facility's application for registration can be considered. This recommendation is in line with Child Care Order of 1977 which places the care and protection of children under the Social Welfare Department.
All board members, directors and managers of residential care facilities should be brought together to share and develop aims and objectives of the facilities and ensure they are in line with the CRC and the national legislative framework. This will enable the facilities to work within the context of the aims and objectives and encourage the participation of stakeholders, including children, to contribute to reviewing the objectives.

Facilities that do not have child protection policies should be assisted to develop them as a matter of urgency. The policies must be understood and used fully by all people in the facilities, including children. Experienced stakeholders and facilities can be engaged to carry out this exercise.

All residential care facilities for children should have a clear policy and documented procedures relating to planned and unplanned exit of children. The policy should describe the process by which the programme ends its work with the children and what after-care is expected. This policy should apply nationally and must be in line with the national framework.

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Care and Management Recommendations

- The Child Care Service Order of 1977 establishes that the MOHSW should develop and implement adequate standards to ensure quality of care and protection of children. The Order also establishes that social workers in the MOHSW should play a co-ordinating role in all child care protection services. The recommendation is to strengthen and reinforce this order so the MOHSW develops a standard referral system to be used by all approved referral agencies. This will encourage proper coordination and cooperation among referral agencies and the care facilities. Strong collaboration with children's programmes in Swaziland, such as Lihlombe Lekukhalela, will also assist in the referral process.

- A standard assessment tool to evaluate vulnerability of children must be developed and adopted. Various methods, including the UNICEF instrument, can be assessed. Implementation of a standard assessment tool will help to minimise overcrowding.

- The minimum ratio of caregivers to children should be developed and adopted.

- Residential care facilities for children should be accountable to regional social workers. The facilities should submit scheduled progress reports and social workers should be actively involved in the supervision and monitoring of the facilities.

- All residential care facilities should have care plans for children in place. A training workshop should be organised for all facilities so they can learn how to assess children's individual needs, how to prepare a care plan, and how to review the achievements of staff members involved in implementing the care plan.

- All facilities should develop formal processes to review children's placements at regular intervals. These processes should be in line with the national framework.

- The MOHSW should consider free treatment for OVCs in clinics and hospitals, as many of the children are not able to access medical care if funds are not available from the facility.

- The MOHSW should implement a policy of regular visits by outreach nurses to the residential facilities to provide check ups on the children.

- The MOHSW should implement a policy of regular visits by the health inspectorate to evaluate the accommodation and food storage.
Alternative Care for Children without Parental Care

Facilities with both boys and girls should have both male and female caregivers. This will enable boys to have a father figure and girls to have a mother figure.

A network of exchange and experience sharing is recommended among facilities. This will allow staff and caregivers to learn all aspects of child care, including the right to privacy, supporting children to make informed decisions, listening to the voice of children, and treating children with dignity and respect.

Using agreed upon indicators, regular evaluation of all facilities should be conducted by external and internal evaluators. This requirement should also be part of the quality standards of care that will be established by the Social Welfare Department.

• A minimum standard of leave and days off work for caregivers should be established. This will allow for adequate stress release.

• A specific referral process for abandoned children should be developed. Currently, the government Halfway House is underutilized and the Crisis Centre is overflowing but understaffed. Crisis Mothers, a cadre of trained individuals interested in fostering abandoned children, the Crisis Centre and the Halfway House should each be assessed and adequately staffed to ensure abandoned children’s needs are met by the best facility.

• Facilities with both boys and girls should have both male and female caregivers. This will enable boys to have a father figure and girls to have a mother figure.

Training Recommendations

• All caregivers should be trained in the various aspects of Child Care and Protection, so that they do not see themselves just as child minders only responsible for feeding children and cleaning the facilities but to provide and promote quality care to the children.

• Crisis Mothers along with foster parents should be trained in parenting skills, psycho-social counselling and other related skills before they undertake care of children.

• A network of exchange and experience sharing is recommended among facilities. This will allow staff and caregivers to learn all aspects of child care, including the right to privacy, supporting children to make informed decisions, listening to the voice of children, and treating children with dignity and respect.

Monitoring and Evaluation Recommendations

• Regular monitoring and evaluation of all residential care facilities for children should be implemented. Monitoring will help the facilities align themselves with the provisions of the CRC and any other national framework that is developed.

• The Social Welfare Department must work with the residential care facility that has changed the children's names. The facility should be made aware of the provisions of the Constitution of Swaziland and CRC Article A30, which states that the “State has an obligation to protect and if necessary, re-establish the basic aspects of a child’s identity (Name, Nationality, and Family ties)”. The Social Welfare Department has an obligation to oversee that this anomaly is corrected.

• Using agreed upon indicators, regular evaluation of all facilities should be conducted by external and internal evaluators. This requirement should also be part of the quality standards of care that will be established by the Social Welfare Department.
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<td>ARV</td>
<td>Anti Retroviral</td>
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