

Central Ethiopia Regional state
Women and Children Affairs Bureau
Directive on Alternative Childcare and
Support

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Preamble

RECOGNIZING the increasing number of children in Ethiopia and in our region facing natural and man-made disasters and the need for alternative childcare and support, it is necessary to provide standardized and comprehensive childcare and support for these children;

IDENTIFYING current alternative support and care mechanisms are found scattered in different documents and legally not binding making implementation difficult. It is necessary to develop a comprehensive directive that encompasses all alternative childcare services.

NOW THEREFORE, The Central Ethiopia Bureau of Women and Children Affairs issued this directive in accordance powers and functions of the regional Executive stated on **Proclamation No. 199/2015 Article 19 (3)(4) and Article 36 (P)(R) and (U)** of to ensure the provision of standardized service delivery in alternative care and support.

PART ONE

GENERAL

1. Short title

This Directive may be cited as “Directive on Alternative Childcare and Support.

2. Definition of terms

In this Directive, unless the context otherwise requires:

1. **“Bureau”** means the Central Ethiopia Regional State of Women and Children Affairs Bureau.
2. **“Abuse”** means any act that causes physical, sexual, psychological, or mental injury to a person, including a child, and includes physical abuse, neglect, sexual abuse, and emotional maltreatment including other similar acts causing harm.
3. **“Adoption”** means a childcare service which is established by a contract between a vulnerable child and an adoptive family under the revised family code that enables an accompanied child to benefit from permanent family care.
4. **“Temporary Alternative care”** means an arrangement as set out in this Directive whereby a child is looked after at least overnight outside the parental home, either by a decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents and does not include where a child stays overnight with friends or family as part of a visit or holiday.
5. **Care** –means the process of promoting a child's well-being that contributes to their physical, mental, spiritual, moral, and social development by ensuring they have access to adequate nutrition, safety, healthcare, appropriate guidance, and direction while also ensuring their best interests are met.
6. **“Assessment”** means the process of building an understanding of the problems, needs and rights of a child and his family in the wider context of the community.

7. **“Attachment and Bonding”** means the formation of a secure, reciprocal, and long-lasting emotional and psychological closeness between children and their parents or primary caregivers.
8. **“Best interests of the child”** means taking into account the most beneficial advantages of the child in every action or decision concerning him. The child’s best interests should be determined by consulting the child, care givers, laws and appropriate governmental bodies.
9. **“Best Interest Assessment (BIA)”** means an assessment that must be undertaken before taking any action affecting a child of concern. This process is referred to differently by various agencies and is sometimes called a ‘child protection assessment’. BIA is an essential element of case management that ensures appropriate participation of the child throughout the process and is intended to support child protection actors in any decision or action taken on behalf of a child in line with Article 3 of the Convention on the Rights of the Child.
10. **“Best Interest Determination (BID)”** means an assessment that involves evaluating and balancing all the elements in a case in order to make a decision in a specific situation for a specific child or group of children. It is carried out by the decision-maker and his staff – if possible as part of a multidisciplinary team – and requires the participation of the child.
11. **“Caregiver”** means a person who is charged with the responsibility for a child’s welfare.
12. **“Care Plan”** means a written document which outlines how, when, and who will meet the child’s developmental needs, including support, activities, and resources required for the individual to achieve personal goals. The Care Plan is developed to articulate decisions and agreements made using a participatory and child-centered and family-focused process of information gathering, identification of needs, goal setting, and planning.
13. **“Case closure”** means a process involving a series of meetings and discussions with a child and his caregiver/family and a final review of the case plan and documents in the case file to determine if the child and caregiver/family have achieved the case management goals and objectives which might include case closure if the goals of the case plan have been achieved and the reintegration is deemed to be safe and stable, or transfer of the case for continued monitoring by statutory authorities or another service provider.
14. **“Case manager”** means the person responsible for ensuring that decisions are taken in the best interests of the child, that the case is managed in accordance with established procedures, who provides oversight of caseworkers, and who is responsible for coordinating the interventions of all actors involved and managing data flow.

15. **“Case management”** means a collaborative process of ensuring that an identified child has his needs for care, protection, and support met.
16. **“Case Worker”** means a social worker or para social worker who is employed by a government agency, nonprofit organization, or another body approved to provide alternative care services in accordance with this Directive and who is the key worker in a case who maintains responsibility for the child’s care from identification to case closure.
17. **“Child”** means a young person under the age of 18.
18. **“Child protection”** means the process of ensuring children are protected from all forms of harm through structures, measures, and services to prevent and respond to abuse, neglect, exploitation, and violence, including putting into place the procedures necessary for addressing situations or issues as they arise.
19. **“Child Protection Expert (CPE)”** means a well-trained professional who works to protect children from all forms of abuse, exploitation and harm.
20. **“Community Care Coalition (CCC)”** means a multi-sectoral, volunteer community structure that plays a vital role in child protection activities, including the identification of vulnerable children, social protection, and the coordination of services at the kebele level. CCCs report to and are supported by the kebele administration.
21. **“Family”** means relatives of a child, including biological or adoptive mother, father, step father, step mother, siblings, grandparent or extended family, relatives, or ‘kin’ including aunt, uncle and, cousin.
22. **“Guardian”** means a person who provides a caring, safe home for a child or young person until they turn 18. A guardian is required to cater for the child or young person’s emotional, social, intellectual, cultural, legal and spiritual needs.
23. **“Informed Assent”** means the expressed willingness to participate in services. For younger children who are too young to give informed consent, but who are old enough to understand and agree to participate in services, the child’s “informed assent” is sought.
24. **“Mentors”** means a professional identified to support a child emotionally and socially to achieve holistic reintegration and independence.
25. **“Persons with disabilities”** means those who are prevented from participating fully in the society due to one or a combination of physical, sensory, mental, or other impairment, including any visual, hearing, learning or physical incapability, which impacts their social, economic, or environmental participation.

26. **“Psychosocial Support”** means care and support which influences both the individual and the social environment in which people live and ranges from care and support offered by caregivers, family members, friends, neighbors, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialized service providers.
27. **“Reasonable Accommodation”** means is necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.
28. **“Referral”** means the process of formally requesting services for a child or their family from another agency (e.g., cash assistance, health care, etc.) through an established procedure and/or form; caseworkers maintain overall responsibility for the case regardless of referrals made.
29. **“Relevant Institutions”** means , Zonal departments and Special weredas offices including Woredas offices level structures legally mandated to work on women and children and affairs in Central Ethiopia Region.
30. **“Risk”** means poverty, disability or isolation related to individual vulnerability, and it includes the occurrence of threats, magnitude and the resulting damages, caused by external and internal problems, violence with weapons, natural disasters, and gender-based violence.
31. **“Risk assessment”** means taking into account the community’s capacity to resist or recover from the hazard’s impact specially the methodology to determine the nature and extent of risk by taking into account potential hazards and existing conditions of vulnerability that together could harm children and their families.
32. **“Risk factors”** means attributes, characteristics, or exposures of an individual, including a child, that increase the likelihood of developing a disease, injury, or other form of harm to wellbeing.
33. **“Tracing”** means activities by authorities, community members, relatives, or other agencies for the purpose of gathering information and locating a separated child’s parents or extended family.

34. **“Vulnerable child”** means a child whose safety, wellbeing, survival and development is, for various reasons, at risk. This includes children who are emotionally deprived or traumatized and those who experience negative outcomes, such as the loss of their education, morbidity, and malnutrition, at higher rates than do their peers.
35. **“Vulnerability”** means physical, social, economic, and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering and death.
36. **“Young persons”** mean persons between the age of 15 and 18.
37. Provisions in this directive set out in the masculine gender shall also apply to the feminine gender.

3. Scope of the Directive

1. This Directive shall apply to all appropriate bureau , Government institutions, charitable organizations, relevant stakeholders, and alternative childcare service providers authorized to provide childcare services as per the requirements of Central Ethiopia region.
2. This Directive shall not apply to institutions for children in conflict with the law

4. Guiding Principles in the provision of alternative care services

1. All interactions, plans, decisions, and actions taken under this Directive shall be guided by the four general principles as set out in the UN CRC:
 - a. **Non-discrimination:** All decisions taken on alternative care shall respect the right of the child not to be discriminated against, including on the basis of gender, ethnic origin, religious belief, birth, status of parents, disability, language and political or other opinion. Services are to be provided without discrimination and with attention to the specific needs of the child. All children, regardless of their nationality, ethnicity, gender, age, ability or status, must be protected and provided with the basic services required for their survival and development.
 - b. **Best interests of the child:** The best interests of the child shall be the paramount determining factor in all decisions made and actions taken under this Directive.

- c. **Survival and development:** All decisions made and actions taken under this Directive shall be aimed at ensuring to the maximum extent the survival and development of the child.
 - d. **Participation:** The right of the child to express views and have those views taken into account and given due weight shall be fully respected during all decisions and actions taken under this Directive. This includes the right of children to receive information to enable them to participate meaningfully.
2. Subject to the general principles of the United Nations Convention on the Rights of the Child set forth in sub article (1) of this article all interactions, plans, decisions, and actions taken under this Directive shall also be guided by the following:
- a. **Preventing separation:** All reasonable measures should be taken to understand the causes of separation, to help families stay together and to reunite families who become separated, where this is in the best interests of the child.
 - b. **Do No Harm:** All actions and decisions in relation to children should aim to benefit and avoid or prevent harm, giving consideration to preventing abuse and all forms of violence, addressing stigma, ensuring informed assent, and respecting confidentiality.
 - c. **Consent:** In all circumstances, consent should be sought from children and their families or caregivers prior to providing services.
 - d. **Proximity to habitual place of residence:** All decisions on alternative care shall be made taking into account the desirability of maintaining the child as close as possible to his habitual place of residence, in order to facilitate contact and potential reintegration with his family and to minimize disruption of his educational, cultural and social life.
 - e. **Permanency:** Decisions regarding children in alternative care, including those in informal care, should have due regard for the importance of ensuring children enjoy a stable home and of meeting their basic need for safe and continuous attachment to their caregivers, with permanency generally being a key goal.

PART TWO

RESPONDING TO CHILD ABUSE AND NEGLECT

5. Responding

1. Children must be protected from abuse, neglect and all forms of exploitation in all care settings.
2. If there is a serious, current threat to the child's physical, sexual, emotional, or psychological safety, the child should be directed to the police or to the relevant bureau or One-Stop Center.
3. In cases of suspected or actual sexual abuse or other forms of physical harm, the child shall be provided with appropriate medical care.

6. Procedures Applicable for the Implementation of this Part

1. The prevention of child abuse and neglect and family preservation should be the overriding objective of responses to reports received.
2. State intervention to remove children from the family setting should only be undertaken where necessary for the safety and welfare of the child.
3. Removal should be seen as a last resort and should be temporary and carefully monitored and regularly reviewed.
4. Placement of a child who has been removed into residential care shall be a last resort and recourse shall first be had to kinship care and foster care.
5. The child's best interest and safety shall be the determining principle in any decision taken under this part.
6. Siblings should not be separated unless its in their best interests.

7. Reporting of Child Abuse and Neglect

1. Any person who has concerns about a child's welfare, safety or wellbeing should make a report to the relevant bureau or One Stop Centre, police, or a child protection expert at the woreda level. Children may also report abuse themselves.
2. An unfounded report that was made in good faith in accordance with this article sub article (1) will not be liable.

3. The official to whom the report is made should note the details of the time, place, and address at which the alleged abuse or neglect occurred, and details such as name of the child or children and estimated age or ages of the children concerned.
4. The report should include as many details as are known or suspected about the nature of the abuse, exploitation, or neglect and any physical, psychological, or sexual injuries to the child, as well as any identificatory details relating to the alleged perpetrator, the date and time of incident(s), and any other relevant information, such as immediate treatment, provided.
5. The official to whom the report is made should record this information in the prescribed format.

8. Child Assessment

1. The caseworker in the Community Care Coalition or the Child Protection Expert carries out an assessment which includes a risk assessment.
2. If the assessment reveals that the child is in imminent danger or the victim of an alleged crime, the case worker or Community Care Coalition shall immediately inform the Child Protection Expert or the relevant bureau and take immediate steps to secure the safety of the child, including by protecting the child from further contact with the perpetrator in cases of abuse, exploitation, or sexual abuse.
3. If the results of the assessment indicate that the child cannot remain in the care of the person in whose care he is, an application for removal of the child to alternative care may be made to a court. The relevant bureau or Child Protection Expert shall place the necessary documentation to support the application for removal before the court.
4. The assessment should be conducted in accordance with the case management procedures set out in the National Case Management Guidelines. When conducting the assessment, case workers shall also consider the following questions:
 - a) What is happening to the child that is harmful to him, including physical, psychological, and/or emotional harm?
 - b) What are the reasons to be concerned that something harmful might happen to the child, even if the risk situation is not currently happening?
 - c) What has happened in the past that has inflicted harm on the child?

- d) Provide preventive services to the family or family preservation services, or referral to another suitable organization including counselling, mediation, early intervention services, family reconstruction, or problem solving mitigate the risk of harm to the child whilst keeping the child within the family.
 - e) Provide preventive services or family preservation services to the family whilst the child is placed in temporary safe care or foster care for defined period likely to have the effect of mitigating the risk of harm to the child.
 - f) If the child is to be placed in alternative care, all efforts shall be made to place a child in a form of alternative family-based care for a defined period of time as contemplated above, the relevant bureau or Child Protection Expert shall arrange for the placement of such child for a period of no more than 6 months for the purposes of the provision of such services.
 - g) The findings of the assessment and the motivation for the decisions taken must be recorded in the prescribed manner.
5. Depending on who the first contact is, the initial pathway by presenting him to police, health care, the relevant office should be based on the case management framework.
 6. Any child who becomes the victim of abuse shall be accorded appropriate treatment, including medical treatment, as soon as possible, and within 24 hours in the cases of sexual abuse.

9. Removal of a Child from Care

1. An emergency removal of a child without a court order can be effected by the relevant bureau together with the police if there is reason to believe that the child is in need of protection services, that this is an emergency need, removal is necessary and, in a child's, best interest, and that any delay in getting a court order to remove the child and place the child in temporary safe alternative care would jeopardize the child's safety and wellbeing.
2. The relevant bureau together with a police officer effecting such an emergency removal may without a warrant enter into any premises for the purposes of removing a child in respect of whom a report of abuse and neglect has been received.

3. As soon as possible after receipt of a report of potential abuse or neglect, the intake screening must be conducted by the relevant bureau in accordance with the procedures established in Part Eleven on case management to establish whether the child is safe or not, and if there is an immediate threat to the child, take steps taken to secure the safety of the child and to place the child in alternative care, with preference being given to family-based alternative care. Placement of a child in a form of alternative shall be for a maximum duration as established in Part 7 of this Directive for the particular form of alternative care.
4. If the initial assessment reveals that it is not a statutory case and that there is no immediate threat to the child but that he is vulnerable and in need of services, the case is referred to the Community Care Coalition and managed at the community level with oversight by the relevant bureau.

10. Application for Removal

1. In case of any emergency removal of a child due to the imminent risk of harm, notice must be given to the parent or caregiver within 24 hours by the person who effected the emergency removal.
2. As stated in this article sub article (1) the location of the child shall not be disclosed where it is not in his best interests.
3. The relevant bureau shall confirm the emergency removal within 48 hours and placement of the child in alternative care with detailed documentation before the court.
4. Where removal has been ordered by the Court, caseworkers assigned to the case shall undertake case management procedures in accordance with this Directive with the ultimate goal of reunification of a child with his family or placement in another form of alternative family or community-based care.
5. Any person or responsible body stated under Article 7(1) of this directive to receive a report for abuse and exploitation may be held liable under the relevant criminal or administrative law for negligence where he fails to take all reasonable measures to prevent and respond to reports of abuse and exploitation.

PART THREE

COORDINATION STRUCTURES

11. Regional Task Force

1. Regarding children's matter a Regional Task Force is established by this directive the task force is consisting of institutions working in coordination stated under article (3) of this directive.
2. This Task Force has the responsibility to exercise general supervision over the planning, financing, and coordination of child right activities and to advise the Bureau on all aspects related to children.
3. The Regional Task Force is a group led by the Bureau. Other members, including but not limited to government agencies, Regional Child Parliament, CSOs and technical training and education institutions may be included in the Regional Task Force as necessary in accordance with the Regional Task Force's Terms of Reference.
4. The Regional Task Force can establish technical working groups that oversee the implementation of alternative care as per the different area of expertise.

12. Technical Working Group on Alternative Care

1. Establish a Technical Working Group on Alternative Care (TWG) which shall be a body that oversees the development and oversight of the multisector coordination of the alternative childcare chaired by the Bureau.
2. The TWG comprises of government bodies at the regional bureaus and Civil Society partners as established in the Terms of Reference of the TWG.
3. Roles and responsibilities of the TWG are to be established in a Terms of Reference and Standard Operating Procedure.

PART FOUR

ALTERNATIVE CARE DUTY BEARERS

13. Responsibilities of Government Institutions

1. The Bureau is responsible for:
 - a) Overseeing the development and implementation of this Directive.

- b) Leading and coordinating the Regional Task Force and technical working group.
 - c) Coordinating with other line ministries with mandates related to child protection to ensure integrated service delivery.
 - d) Creating clear guidelines/Standard Operating Procedures on the involvement of, and collaboration, reporting and complaint handling mechanisms and monitoring and oversight of service providers on child protection, case management and this Alternative Childcare Directive.
 - e) Communicating policy decisions to the relevant bureau and its different level offices
 - f) Overseeing the resources and budgeting process for this Alternative Childcare Directive.
 - g) Advocating for alternative childcare and case management resources.
 - h) Advocating for and supporting the workforce development for the Alternative Childcare Directive.
 - i) Identifying and addressing gaps in both the coordination and implementation of the Alternative Childcare Directive.
 - j) Establishing an information management system on child protection, alternative childcare, and working with other sectors to monitor and analyze data related to child protection, alternative care, and case management.
 - k) Planning the ongoing development of services to support a well-functioning and coordinated child protection and alternative care system.
 - l) The relevant bureau is responsible to facilitate a court order concerning a child whose parents have been convicted of a crime or who has been remanded in custody to access one of the alternative childcare services set forth in this directive.
2. A number of other governmental bodies provide complementary services to child protection and children in alternative care police, health, education, transportation and their roles shall

be defined in Standard Operating Procedures or memoranda of agreements and should include the following conditions:

- a. Identification and reporting of vulnerable children or those in need of care and protection.
- b. Awareness raising and advocacy around child protection issues, including sensitization on family-based care at community level.
- c. Mobilization of community resources to support vulnerable children and families.
- d. Communicating closely with the relevant bureau or Child Protection Expert regarding child protection issues and the needs of specific children.
- e. Advocacy and awareness on prevention of specific issues and determining community solutions for general issues.
- f. Promoting community based alternative care arrangements.
- g. Engaging children and family in community events.
- h. Supporting the reintegration of children into families and communities.

14. Service providers

1. Service providers are:
 - a. are organisations which are duly licensed in Ethiopia as well as in our region and accredited in accordance with Alternative Care Service Delivery Guidelines to be developed to provide one or more of the services described in this Directive; or
 - b. social and cultural institutions; or
 - c. government agencies or other statutory service providers of one or more parts of this Directive will be applicable.
2. Service providers which shall be legally registered and licensed entities in accordance with this Directive and other relevant Regional and Ethiopian laws.
3. Service providers may also be government agencies or departments authorized to provide services to children and families.

4. Service providers shall have the capacity and resources to meet the children's needs effectively, including by ensuring that all staff receive training and meet qualifications requirements.
5. Service providers must demonstrate that they have systems, procedures, and the capacity to provide care and protection or services to children. Including a sufficient ratio of staff to children where alternative care is directly provided. Service providers shall ensure that staff are deployed effectively to ensure safety, welfare, and development of children.
6. Service providers must ensure a sufficient level of independence, structurally and beyond. This includes by demonstrating that they have an operational plan which describes the deployment of staff, how and what activities shall be provided, and how the continuing training needs of staff will be met.
7. Service providers shall adhere to the following ethical principles:
 - a. **Informed Consent:** Consent should be obtained from children and young people who are eligible by law about their participation in any support programs or interventions with full knowledge of what will happen and the probable effects on that child or young person.
 - b. For children, who are not legally able to provide consent, assent should be given by their family or caregivers and reflect the opinion and wishes of the child.
 - c. **Confidentiality:** Service providers should respect confidentiality in all aspects of service provision. Service providers should protect this confidentiality and ensure that efforts to ensure that information shared by children and their families are not disclosed unnecessarily without the child's and/or family's consent.
 - d. **Accountability:** All service providers must follow case management procedures and be responsible for closely monitoring implementation and evaluation of an intervention.
 - e. **Strengths-based:** Services and interventions should build upon a child's natural resilience and family and community support mechanisms, examine possible risk and protective factors, decrease the impact of vulnerabilities and attempt to provide additional experiences that will promote coping and positive development, despite the

adversities experienced. Social services, including psychosocial interventions, should empower children and young people to grow and develop to their fullest potential.

- f. **Holistic needs:** Service providers should ensure that interventions are child-focused and age appropriate, with services tailored to the holistic needs of children.
 - g. **Evidence based:** Service providers should ensure that their interventions aimed to address the needs of children in need of care and protection should be evidence-based. Programs should apply available evidence to tailor activities and services accordingly and place a particular focus on monitoring and data collection to generate the evidence for improving service delivery mechanisms.
8. To this end, service providers undertake the following:
- a. Coordinate the provision of care with government and community partners.
 - b. Identify children with protection needs and facilitate referrals to appropriate stakeholders.
 - c. Provide a wide range of specialized services, e.g., counselling and psychosocial support, reunification of children on the move, best interest determinations, health services, reducing harmful traditional practices, support services to children living outside a family environment, etc.
 - d. Provide temporary shelter for children in need of safe accommodation.
 - e. Expand the workforce adequately through the provision of staff engaged in issues related to children.
 - f. Provide capacity building of local child protection structures.
 - g. Advocacy and awareness raising on child protection issues.
 - h. Resource mobilization to support alternative care services.
 - i. Support services to children in emergencies.

9. Service providers shall ensure that all caseworkers and case managers in their employ:
- a. Hold a university degree, preferably in social science Social Work, Sociology, Psychology or Law with a combination of relevant work experience on child protection or have a training from recognized institution
 - b. Have at least 2-5 years of experience working with an NGO environment or government department in a child protection program, have ability to train others, be able to effect data management as well as monitoring and evaluation.
 - c. Have received formal training in the area of child protection and alternative care.
 - d. Have good communication skills.
 - e. Have the ability to respect the inherent dignity and worth of the children and their families and be mindful of individual differences and cultural diversity.

15. Non-service providers

Non-service providers are those who do not directly provide alternative care services for children. Non-service providers may perform the following activities:

1. Contribute to policy formulation in specific areas.
2. Contribute to advocacy.
3. resource mobilization and provide funding to service providers.
4. Provide technical support in conceptualizing and implementing.
5. Refer cases of unaccompanied or separated migrant children due to different reasons to the National Referral Mechanism.

PART FIVE VOLUNTEERS AND VISTORS

16. Services provided by volunteers and visitors

1. A volunteer means someone who offers his time, skills, and resources under the guidance of a service provider defined in this Directive or in a residential care facility without remuneration.
2. Any service providing institutions, including residential care facilities, must record the names and contact details of volunteers in the visitors' book and purpose of visit.
3. Volunteers may only offer services to service providers or residential care facilities with the written permission of the relevant bureau or government department. Such permission shall only be granted upon submission of:
 - a. A curriculum vitae or resume, and application.
 - b. The names and contact details of two references of good character who are unrelated to the applicant;
 - c. Proof of a professional qualification relevant to the care, support, and skills development, including education, of children;
 - d. A criminal background check in Ethiopia for Ethiopian nationals and residents.
4. In addition to the items referred to above, foreign volunteers, shall provide:
 - a. A criminal background check in the country of the applicant's nationality and residence as well as any other country where the applicant has previously lived and/or provided volunteer services in the last ten (10) years;

- b. Proof of appropriate authorization to be in Ethiopia legally for the purposes of providing voluntary services.
 - c. Proof of medical insurance cover.
5. A volunteer should never act as a primary caregiver to any child in the residential care facility or be attached to any individual child.
6. A volunteer shall not be directly in charge of children but should assist staff who are employed by the residential care facility.
7. The residential care facility shall communicate to a volunteer his role and responsibilities and duties which shall be restricted to non-caregiving activities.
8. Volunteers shall apply for the opportunity to be a volunteer and sign a volunteer contract which clearly outlines the tasks to be undertaken by the volunteer.
9. Volunteers shall sign a code of conduct and be made aware of and sign the residential care facility's child protection policy.

PART SIX

THE CONTINUUM OF CARE

17. Continuum of Care

This Directive sets out and recognizes the following continuum of family, community, and residential care:

1. Family Based Care
 - a. Family preservation and strengthening
 - b. Reintegration and reunification

- c. Kinship care
 - d. Foster care
 - e. Adoption
2. Community-based care.

Supported independent living is a type of support that can be integrated into community-based care.

3. Residential care
- a. Community Integrated Child-Care
 - b. Residential care service for Children with special needs
 - c. Residential Homes for Children:

PART SEVEN

FAMILY-BASED CARE

Sub section One

18. Family Preservation and Strengthening

Family-based care is short-term 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. This includes family preservation and strengthening services, reunification and reintegration, kinship care, foster care and adoption.

19. Family Preservation and Strengthening Objective and Purpose

1. Family preservation and strengthening services aims to support families, including parent(s), legal guardians, or members of the extended family who act as primary caregivers, to enable them to care for their children effectively and avoid risk of separation and placement into alternative care.
2. Family preservation and strengthening service includes a range of support services and strategies meant to prevent the family from breaking down, and to protect children from abandonment, neglect, or separation from the family.
3. The service involves a variety of approaches including the provision of support, referral to services, and inclusion in social protection programmers that support family life and help to diminish the need for a child to be separated and be placed in alternative care, except in situations where children are determined to be at significant risk and other forms of alternative care are necessary, suitable, and in the child's best interest.
4. The provision of family strengthening and preservation services shall follow a holistic approach to respond to the unique needs of families to promote independence and resilience.
5. The Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs shall apply to the provision of family preservation and strengthening.
6. Family strengthening and preservation recognizes that the best place for children is to stay safe in their families which is realized through holistic support to the entire family, including support provided by communities, and support derived from volunteers.
7. The family's as well as the child's views, concerns, expectations, and perceptions should be given due weight in the provision of family preservation and strengthening services.

20. Family Preservation and Strengthening Service Recipients

1. Family strengthening and preservation services identify the following criterion for target beneficiaries:
 - a. Ethiopian nationality.

- b. Vulnerable families caring for children are kinship carers, other members of extended family serving as primary caregivers, and guardians.
2. Vulnerable families are those who have:
 - a. limited or no means of subsistence
 - b. are unable to provide for the basic needs in the household.
 - c. Families with a primary caregiver who is living with a disability or chronic illness.
 - d. Families with a child or children in the household who have a disability or chronic illness.
 - e. Family with a child exposed to different forms of abuse, violence and/or exploitation.
3. Family preservation and strengthening service providers should work collaboratively to ensure services provided include, but are not limited to, the following standard service components as set forth in the Standard Service Delivery for Orphans and Vulnerable Children's Care and Support Programs:
 - a. Food and nutrition
 - b. Shelter
 - c. Legal protection
 - d. Health care
 - e. Psychosocial support
 - f. Education
 - g. Economic strengthening
4. Family perseverance and strengthening service include but are not limited to:
 - a. Specialized support for children with disabilities and/or a chronic illness
 - b. Positive parenting/caregiving support services
 - c. Day care services
 - d. Linking families with community structures for support and assistance.

21. Minimum Standard Requirements of Family Strengthening/Preservation Services

1. Family Preservation and Strengthening shall apply in reference with the Standard Service Delivery for Orphans and Vulnerable Children's Care and Support Programs.
2. Vulnerable families in need of services can refer to the local authority or be identified by case worker or Child Protection Expert and be referred to the service provider.
3. Families as well as the children within a particular household shall be assessed to understand their specific needs and determine their eligibility for the services. Assessments shall include all members of the household and children, using the relevant case management forms for child assessment and family assessment.
4. Where service recipients are receiving services from a number of service providers, the provision of those services shall be coordinated by the lead case manager appointed by the relevant bureau or the Child Protection Expert to avoid duplication.
5. Services provided to families with children should be holistic social, psychological, counselling, parenting skills, abuse, addiction, nutrition, medical, housing, economic, business, and vocational skill trainings and be both preventative and responsive.
6. Based on the initial assessment case workers should create a service plan in collaboration with the client/service recipient to address the identified needs of families with children.
7. Case workers, through periodic home visits, should follow up on children's overall wellbeing and development, document progress made as a result of the intervention and amend service provision as needed.
8. Caseworkers should update the care plan following monitoring to reflect changes and circumstances within the household.
9. Case workers shall use the appropriate monitoring form provided by the Ministry.
10. Case workers should establish and maintain a supportive and empowering relationship with service recipients.
11. The bureau and its different level offices , Child Protection Experts, and delegated service providers should organize and facilitate the support provided for families with children.

12. The values, opinions and beliefs of children and families must be respected while delivering services.
13. Caseworkers shall adopt a strengths and resilience-based approach to case management which seeks to identify the strengths of the families with children to ensure development of their strengths to ultimately empower them to become self-reliant and resilient.
14. Families with children should receive appropriate training on parenting and other life skills that will build and enhance their resilience and capacity to provide care.
15. Service recipients have the right to fully participate to the best of their ability in all decision making, including safety and well-being in service planning to meet their needs. In all actions concerning the children, the primary consideration shall be the best interests of the child or children.
16. Service providers have the responsibility to enable participation of service recipients through translation to their preferred language, access to specialist services and to offer culturally appropriate and respectful interventions.
17. Biological parents or extended families should be encouraged to play an active role in monitoring and responding to care and protection issues facing children in their care.
18. Service providers are responsible for making the necessary arrangements to ensure children in families have access to basic services such as food, shelter, clothing, education, health care, social assistance, legal assistance and economic empowerment opportunities, as required.
19. The Ministry, in collaboration with relevant stakeholders, should develop standardized national tools and guidelines for the provision of family preservation and strengthening.
20. Service providers should make their services measurable and time bound and strive to ensure families with children are empowered to attain self-sufficiency within the duration of the intervention to prevent dependency on services.
21. Communities should be actively involved in supporting vulnerable children and families in their midst.

Sub Section Two

Reunification and Reintegration

22. Reunification and Reintegration

1. Reunification is the physical reuniting of a child and his family or previous caregiver with the objective of this placement becoming permanent.
2. Reintegration is the process of a separated child making what is anticipated to be a permanent transition back to his 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.
3. The objective of reintegration is to ensure the successful transition of the child or young adult from his current form of care to family care.
4. Case workers shall undertake a careful process, with clear objectives and activities, and should be guided by assessments and by the child's individual care plan. It is supplemented by monitoring and support mechanisms that take into account the child's age, needs, evolving capacities, causes of separation and current alternative care placement.

23. Prerequisites for Reunification and Reintegration

In order to make a child recipient of reunification and reintegration services, the following prerequisites should be fulfilled:

1. The child and family should be appropriately supported and prepared for transitioning. And preparation shall be based on the plan outlined in the case plan.
2. To help the child prepare for reunification or placement and set expectations and adequate time should be allocated to such activities.
3. Preparation should include home/bonding visits between the child and his family. These visits shall be planned by the case worker and will be used to identify the support needed before a child can safely return home. The frequency and duration of visits shall be determined on a case-by-case basis.

4. Caseworkers shall assist in the preparation of the family as well as other household members to receive the child.
5. Due weight shall be given to the views, expectations, concerns, and perceptions of the family when undertaking preparation for reunification.
6. Children and families shall be supported by a wide range of services that meet their needs and strengthen their resilience.
7. Prior to reunification, the immediate needs in a household should be addressed, including by referral to services and counselling, and training on topics including positive parenting, trauma-related or institutional behaviors, and home hygiene/health.

24. Reunification and Reintegration Process

1. The process of reunification and reintegration shall be carried out in accordance with standard procedures outlined in the National Child and Standard Operating Procedures that will be established following this Directive.
2. If the child is unwilling to return to the family, his reasons should be objectively evaluated, and the decision made in the best interests of the child.

25. Preconditions before a child is reunified and reintegrated

No child shall be reunified and reintegrated unless the following condition are verified.

1. The child's family has been traced and verified.
2. The reasons for separation have been established and addressed and, where possible, follow-up mechanisms to address these reasons put in place
3. The child's family are willing to take him back and are mentally and physically capable of taking care of the child.
4. The child has agreed to be reunified with his parents or extended family members
5. Where the is not willing, his reasons have been objectively evaluated, and a decision made in his best interests.
6. Case workers shall use the relevant reunification forms as provided in the National Case Management Guidelines.

7. The family, relevant bureau, Child Protection Experts or service providers and alternative caregiver's primary responsibilities should be set out in writing and agreed on by all concerned. A post-placement visit shall be conducted no later than two (2) weeks after the reunification/placement.

26. Monitoring and Support

1. Regular post-reunification monitoring visits shall be conducted within two weeks for post reunification or post placement.
2. Unless there is a need requiring further frequency, the regular post placement should be conducted for the first two months.
3. Caseworkers should conduct quarterly follow-up visits of the reunified child or family during the first year following reunification and once per year thereafter until the child and family are well adjusted.
4. Based on the follow-up visit findings, the caseworker should provide additional support services to enable the child to be properly reintegrated with his family in accordance with this sub section.
5. Progress against the case plan will be reviewed, as well as against reintegration benchmarks that have been developed.
6. Case closure should only occur when case plan goals and benchmarks and permanency or sustainable reintegration has been achieved,
7. Notwithstanding the provision of sub article (6) of this article, case closure does not occur within foster care, only case transfer.
8. Where a child who has been reunified is unable to successfully reintegrate into his family, a revised case plan should be put in place based on the child's specific needs and situation in accordance with the National Case Management Guidelines.
9. Any decision to remove a child shall be conducted in accordance with the removal section in Part Two of this Directive.

Sub Section Three

Kinship Care

27. Provision of Kinship Care Service

1. Kinship care is defined as a private arrangement within an extended family whereby a child is looked after on a temporary or long-term basis by his maternal or paternal extended family, without it being ordered by an administrative or judicial authority.
2. Where a child is transitioning from any other form of alternative care into kinship care the need for the transition must be examined and approved by the relevant bureau, Community Care Coalition Or Child Protection Expert.
3. For the purpose of kinship care service provision family members include grandparents, aunts, uncles, cousins and older siblings.

28. Standards for Kinship Care Service Provision

In order for any child provide Kinship care service for a child,

1. Where a child is unable to live with their biological parent/s for any reason, and where it has been determined that it is not in a child's best interest to remain with his biological parent(s) or where they are untraceable or deceased.
2. Any information or documentation of his education, immunizations, birth, and other documents must be registered by a local government authority that has the mandate to register.
3. The provisions stated on sub-article (2) of this Article also applies for children who are already in informal or traditional kinship care arrangement.
4. In order to ensure that the requirements set forth from sub-article (1) to (3) of this article are met, the ministry and the relevant stakeholders must follow the following process.
 - a. Recognize the role played by this type of care and take adequate measures to support its optimal provision on the basis of an assessment where appraised of it.

- b. Where children or families need support for informal kinship care, registration with relevant bureau or local authority (kebele) could be made to help link the family with support services.
5. The relevant bureau or relevant authority should encourage and enable informal caregivers, with the consent of the child and parents to formalize the care arrangement after a suitable lapse of time, and promote the child's welfare and protection including financial and other support.
6. Services outlined in the section of this Directive on family strengthening and preservation and in line with the Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs will be applicable for this article.
7. Where a kinship family is registered and provided with support, monitoring is to be conducted in accordance with case management procedures as described in this Directive to offer ongoing support and assessment to ensure that the placement remains in the child's best interest and their needs are being met.
8. Kinship care can be an appropriate form of short or long-term care for a children in other forms of alternative care, including residential care, while efforts to reunify and reintegrate a children with biological parent(s) are being undertaken.
9. Where children are in other forms of alternative care, child identification, child assessment and family tracing and assessment should take place in accordance with the National Case Management Guidelines to identify possible carers within the extended family and assess their suitability, taking also into consideration the views of the child and the family's ability and desire to care for and protect the child. Where parent(s) are alive but their whereabouts are unknown, caseworkers shall continue to undertake a thorough and documented tracing exercise.
10. Where biological parent(s) are known, the Child Protection Expert or caseworker should ensure a full assessment of the parent/s to explore options for eventual reunification and reintegration.

11. Based on the results of the assessment will determine the most suitable kinship household, and who will be matched with the family who can be best able to meet the unique needs of the child. The child should involve in the matching process and the children in the host family must also participate in the decision. Steps should be taken to ensure the protection of children in informal care from abuse, neglect, child labour and all other forms of exploitation.

Sub section Four Foster Care

29.Provision of Foster Care Services

1. Foster care is a temporary form of alternative family-based care where a child is placed by a foster care service provider with a pre-selected, trained, and approved carer who is not the child's parent(s), relative, or guardian and who is willing to undertake the care and maintenance of a child.
2. Prior to placement of children to stay in an institutional care, it must be confirmed that there is no option for foster care family.
3. Foster care service providing organizations or groups that are certified by the Region are responsible to provide individual foster care placements for children, to take active steps to recruit prospective foster parents, and to provide with case management support and training.
4. The Region has the responsibility of monitoring and supporting foster care services.
5. The Child Protection Expert has the responsibility over the provision of foster care and oversight.
6. The Child Protection Expert may, as appropriate, delegate case management and other activities as indicated in this part to case workers in the Community Care Coalition or case workers employed by foster care service providers.

7. A contract should be entered prior to the placement of the child with the foster family specifying the rights and responsibilities of the child, foster family, of the biological parent/s (if alive) and of the foster family care service provider organization.

30. Guiding Principles

1. Due regard to the principle of placement of the children in their own social-cultural environment.
2. Refugee children shall be integrated in host communities and accorded services.
3. Children shall participate in decision-making on all issues relating to their living circumstances and be encouraged in an age-appropriate way to share information that will assist adults in the provision of their care.
4. Guiding principles set out in this Directive shall apply to the provision of foster care, including the best interests of the child.

31. Types of Foster Care

1. This Directive established three forms of foster care:
 - A. Emergency foster care
 - B. Short-term foster care
 - C. Long-term foster care
2. This Directive also establishes respite care as a form of family support service for long-and short-term foster care placements.

32. Emergency Foster Care

1. Emergency foster care is a temporary form of placement of a child with a pre-selected, vetted, and qualified emergency foster carer.
2. Emergency foster carers are willing to provide care and protection for the child with short advance notice or on the same day or less than 24 hours.

3. An initial emergency placement is established for up to ten (10) to fifteen (15) days prior to review by Child Protection Expert, after which the placement may be converted into short-term foster care as suitable and necessary.
4. In case of an emergency foster placement, the Child Protection Expert or case worker shall receive the foster parent(s)' written consent to accepting the child under emergency circumstances.
5. Where it is determined that a child cannot be reunified with previous caregiver(s) or placed with extended family member(s) in his best interests and in accordance with the National Case Management Guidelines, after fifteen (15) days, the emergency foster care placement may be converted into short-term foster care by decision of the relevant bureau or Child Protection Expert or Community Care Coalition on application of the foster care and/or caseworker.

33. Short-term Foster Care

1. Short term foster care is the planned temporary safe placement of a child in family-based care which is established while permanency is sought.
2. A child may be placed in foster care for up to twelve months, upon which the placement can be renewed on an annual basis by relevant bureau or Child Protection Expert for up to three (3) years.

34. Long-term Foster Care

1. Long-term foster care is the placement of a child in foster care, potentially until he reaches the age of 18 years.
2. Long-term foster care may be suitable where family reunification is not possible or in the child's best interest and other suitable permanent alternatives have not been identified.
3. Where long-term foster care is considered to be a suitable and necessary form of care for a child already in foster care, and the foster carers have already provided care for a child for three years, the Child Protection Expert shall make an application to the relevant bureau or for an order for long-term foster care.

4. Long-term foster care may be suitable where all efforts have been made for a child's permanency without success, including when:
 - a. Efforts to reunify a child with his biological parent(s) or place him with extended family remains in process.
 - b. A child cannot be reunified with his or her biological parent(s) in his or her best interests.
 - c. Placement of the child in another form of family-based care, including kinship care and adoption has not been possible or is not in the child's best interests.
 - d. If the child has developed a significant attachment and relationship with their short-term foster carer(s).
 - e. The child gives written consent to remain in the foster placement at ten years of age or older.
 - f. The child does not wish to be adopted and is of an age ten and over and of such understanding as to be able to offer an informed view in this regard.
 - g. If the child has waited at least one year to be matched with an adoptive family and failed to obtain adoptive family.

35. Respite Care

1. Respite care is short-term care that provides temporary break for foster families and reduces the risk of harm or neglect to children.
2. Respite care is short-term relief foster carers by providing breaks from daily caregiving responsibilities for up to one week, as appropriate.
3. Respite care is not a form of alternative family-based care but is provided as a family-support service where children and young people are temporarily looked after by other pre-selected, vetted, and qualified foster carers, as necessary and suitable.

4. No child shall be placed in respite care without informing the Child Protection Expert or Community Care C.
5. Where foster carers require respite, respite care may be provided according to sub-article 4 of this article as an intermittent and temporary form of care provided for children placed with existing short- or long-term foster parents.
6. Relevant bureau will maintain a register of pre-selected, trained, and approved carers within the foster care registry who may be able to provide respite care.
7. Respite care matching or arrangements are made by the foster parents in consultation with the Child Protection Expert or case manager/case worker and the views of the child should be taken into account in making decisions in relation to respite care.

36. Legal Implications of Foster Care

1. Foster care grants the foster parent the parental responsibilities of maintaining and caring for the child.
2. A foster parent shall not remove a child from the jurisdiction of Ethiopia without the leave of the Court and such leave shall only be granted upon exceptional circumstances being shown.
3. Parental responsibilities of maintaining and caring for a child shall not cease where a respite care is provided to a child.

37. Eligibility Standards

Eligibility standards for foster care services ensure that foster care service providers know when to consider foster care and that the service is suitable to meet a child's needs and that foster carers fulfill criteria that make them suitable to provide care and protection.

38. Eligibility criteria for a child to be placed in foster care

1. Foster care may be an appropriate form of placement for a child when:
 - a. A child is a double orphan, abandoned, or living and/or working on the streets, and whose parent(s) or extended family are untraceable.

- b. It is not in the child's best interests to live with his biological parent(s) or with extended family or in kinship care.
 - c. The child is not provided with adequate care and protection in his present care environment.
 - d. Parents are certified to be terminally ill or mentally incapacitated as certified by a relevant authority and have been assessed unable to provide care.
 - e. The child is separated from his biological parents due to detention or another emergency and placement in an extended family setting or kinship care is not in the child's best interests.
 - f. The child is a victim of neglect, exploitation or physical, sexual, or other form of abuse within the family and/or considered to be at significant risk if left in the care of the biological or extended family or in kinship care.
 - g. The child is considered to be affected by a physical or mental disability and is at risk of being placed in institutional care due to the family's inability to provide safe and effective care.
 - h. The child is displaced due to disaster or armed conflict and is unaccompanied.
2. Foster care is not appropriate where:
- a. A child is removed from his home due to financial or material poverty.
 - b. There is a danger of separating siblings, unless it is in a child's best interests.

39. Eligibility of prospective foster carers

1. The following criteria must be met in order to foster a child:
 - a. Ethiopian by nationality and solely resident in Ethiopia permanently.
 - b. Notwithstanding sub article 1 of this article foreign nationals who can demonstrate Ethiopian origin and have lived in Ethiopia for a total of at least two years preceding the foster care placement.

- c. The foster care family Be at least 25 years of age.
- d. In the case of a married person, the consent of the applicant's spouse. The consent of any other member of the household may also be necessary, including that of the prospective foster parent's children.
- e. Be able to demonstrate that they have the knowledge and skills to protect and nurture children in a safe, healthy environment and meet the developmental needs of the child.
- f. Be able to provide proof of their physical and mental health status.
- g. Be able to demonstrate that they are able to provide for a foster child's needs independently, financially.
- h. Be a person who has not been convicted by a court of competent jurisdiction of any offence related to the abuse of children.
- i. Be able to demonstrate that they are of good character by providing two letters of recommendation testifying to their good character.
- j. HIV positive applicants ready and willing to foster HIV positive children are eligible.

40. Application to Register Foster Carers

1. No person shall, for the purposes of fostering a child in his care, take possession of the child or children without notifying and receiving approval from the relevant bureau, Child Protection Expert, or Community Care Coalition.
2. **Application to foster** Any individual who meets the eligibility requirements above can make an application to be registered as a foster carer by submitting an application in the relevant Form to the relevant bureau foster care service care provider which includes the following documents:
 - a. Identification Card or Passport
 - b. Marriage Certificate

- c. Proof of income
 - d. Police clearance certificate
 - e. Medical certificate
 - f. Two references of good character
 - g. Criminal background check
 - h. Photograph
 - i. Proof of Ethiopian origin for foreign nationals and proof of having lived in Ethiopia for a total of at least two years preceding the foster care placement.
3. Where the application is complete and eligibility requirements have been met, the Child Protection Expert shall undertake an assessment of the family or delegate the undertaking of an assessment to a foster care service provider or the Community Care Coalition, as deemed appropriate.
 4. The foster care application shall only be approved after receipt of a favorable home study visit to be conducted by the Child Protection Expert or delegated case worker, as the case may be.

41. Training of Foster Carers

1. Special preparation, support and counselling services for foster carers should be developed and made available to carers at regular intervals, before, during and after the placement.
2. All prospective foster carer(s) trained in accordance to sub article 1 of this article by the relevant bureau prior to certification as foster carer.
3. The Child Protection Expert or delegated case worker shall arrange training sessions either on an individual basis or in group setting from time to time for prospective and existing foster carer(s), including on topics such as positive parenting, positive behavior management, child rights and development, health and wellbeing, trauma counselling, and such other topics as may be deemed necessary.

42. Registration of Foster Carers

The relevant bureau must keep a register of all children for whom placement in foster care has been approved, together with a list of the approved foster carers and the address at which the foster carers and the children reside.

43. Standards/Minimum Requirements for Foster Care Services

Standard 1: Qualification of case workers and of a case manager

The requirements for hiring a case worker or case manager must be met in accordance with Article 14.9 of this directive.

Standard 2: Awareness Creation and Advocacy to develop foster care services

1. The bureau and its different level offices, foster care service providers, Community Care Coalition's, other government departments and other stakeholders working on alternative care should contribute to public awareness raising and educational programs.
2. Foster care service providers in partnership with the government should employ a variety of different communication approaches and techniques to ensure that the central message is received and understood by a diverse audience with the aim of recruiting potential foster carers.
3. There should be no promise of gifts or financial support to prospective foster carers for participating in any advocacy program.

Standard 3: Child Intake and Preparation Process

1. Referral for placement shall be made to the Child Protection Expert, Community Care Coalition, foster care service provider, or case worker from the one following sources:
 - a. Relevant bureaus
 - b. Community Care Coalition
 - c. Residential care facilities

- d. Police
 - e. Hospital
 - f. Community-based organizations
 - g. Faith-based organizations
2. An intake screening assessment must be made to determine that foster care, and which form of foster care, is the most suitable placement for the child. This must be done within 48 hours. The intake screening establishes basic demographics of the child, background information, immediate concerns for/of the child, and assessment of the extent of the risk to which the child is exposed.
 3. In emergency situations, initial intake information may determine suitability of placement of the child into foster care and also allows the Child Protection Expert, Community Care Coalition or case worker to identify a suitable home to meet the child's emergency needs.
 4. A medical check-up or health screening must be done for the child within 24 hours of the actual placement into the foster home.
 5. A detailed initial child assessment should be completed by a foster care service provider, Child Protection Expert or case worker while the child resides in the foster home and submitted to the relevant bureau within one week of placement, unless there are extenuating circumstances discussed and accommodated by the department.
 6. A detailed service plan outlining the child's short- and long-term needs should be developed and communicated to the relevant bureau within one month of placement.

Standard 4: Matching, attachment & bonding and placement that meets children's assessed needs

1. The prospective foster parents must be provided with all available information at the time of placement that would assist them to understand the child's background, health, emotional and developmental needs, and the practical implications for fostering that child before they agree

for the match to be effected. This must be communicated to the foster care service provider, Child Protection Expert, case manager or relevant bureau.

2. Foster parents in emergency placements must acknowledge they understand that little information may be available in these circumstances and be prepared to manage the care with appropriate support. During their care they must inform the Child Protection Expert or case manager/case worker about the child's developmental needs.
3. The child should be matched with foster carers who have the capacity to safely meet the child's holistic needs.
4. Placements should aim, to reflect a child's culture, language, and religion in order to support their sense of identity. However, children must not be left waiting for a specific match for a prolonged period and may be placed in emergency foster care to prioritize their basic needs for protection and security.
5. The Child Protection Expert or case worker/case manager must have in place care plans which include clear actions and activities for preparing children for the foster care placement. Based on the evolving capacity of a child, information about the prospective foster parents should be provided in an age-appropriate manner before placement. Emergency situations will be managed within the best possible practice parameters at that time.
6. Foster carers shall provide a welcoming, inclusive, and safe environment for children, biological or prospective adoptive parents of the foster child, social workers, and volunteers.
7. Foster families are expected to respect the opinions of others and encourage open collaborative communication between children, their biological or prospective adoptive parents, staff and volunteers and they must support children to participate in the decisions that affect them.
8. Foster families must report any incident of concern about the child to the relevant bureau, relevant foster care service provider, Child Protection Expert or Community Care Coalition within 24 hours. Where the matter is statutory or criminal, the matter shall also be referred to the police.

Standard 5: Placement, Post Placement Services and Transitional Plan

1. The Child Protection Expert or case worker, shall accompany the child to his new placement.
2. The Child Protection Expert or case worker, is responsible for completing monitoring visits.
3. Monitoring visits conducted in accordance to sub article 2 of this article, first monitoring visit shall occur within two weeks of placement, and once within the next the next two months, three months, six months, one year, and one year and six months, and annually for long term foster care, and write required reports, and attend to any identified clinical issues.
4. Children should be supported prior to placement, while in foster care, and during any transition to a new placement, to independent living or to reunification and reintegration or to kinship care in accordance with the care plan.
5. The Child Protection Expert or case manager/caseworker should clarify the importance of all contact arrangements, relevant background information on the children and detail their role and responsibilities in the arrangements. They also shall explain and manage the roles and responsibilities of the various professionals involved with the child or children concerned and with the foster carers.

Standard 6: Cross Regional Placement

To the extent possible, efforts should be made to place children with a foster carer in the same region of origin. Only where cross-regional placement is the best solution to meet the needs of a specific child, the host region shall prepare a report and immediately communicate with the receiving/region of destination within one month. A memorandum of understanding should be signed between the relevant bureau in the region of origin and the relevant authority in the destination region.

1. Two months after transition of the foster placement, the receiving/region of origin has the power to decide about the permanency of the child, in agreement with the region of destination.

Standard 7: Permanency planning for children in foster care

1. Permanency shall be sought for all children through reunification with birth parent(s) or placement in extended family, adoption, or long-term foster care. Community based care or residential care should be a last resort.
2. Child Protection Expert or case managers/case workers are required, after comprehensive assessment, to create service plan goals to support the child into permanency.
3. Children should be regularly supervised in accordance with this Directive in their foster placement until such time as permanency is achieved.

Standard 8: Responsibilities of Foster Care Service Providers

1. Foster care service providers must be registered with the appropriate authority and must comply with the government laws, rules, and regulations.
2. Foster care service providers must ensure sufficient numbers of trained personnel in their employ.
3. The foster care service provider must implement policies, procedures and have agency ethics in place and make these accessible to all staff.
4. The foster care service provider must provide job-appropriate training for the staff in its employ and maintain documentation standards.
5. There must be a clear description of the foster care service provider structure, including clear explanations of the authority, accountability, roles and responsibilities of the managers, staff, volunteers, and foster carers.
6. A complaint handling procedure must be established by the Ministry for receiving and resolving complaints in order to promote the wellbeing and safety of the children.
7. Foster care service providers shall have emergency contact information that should be available for foster families to utilize if necessary.
8. Foster care service providers shall have standards, indicators and tools and systems of monitoring and evaluation in place.

9. Data management systems should be effectively regulated and independently monitored to ensure confidentiality, accessibility of data and ensure oversight of quality-of-service provision standards.
10. Policy and guidance should be in place that outlines the statutory requirements for minimum service provision by foster care service providers.

Standard 9: Contact with birth family, friends, and other significant persons

1. Child Protection Experts and case workers shall ensure the right of children to have constructive contact with their birth and extended family to help establish and maintain bonding, with the goal of reunification, and keeping contact with friends and other significant persons in their lives, where in their best interests.
2. Foster families should be supported by the Child Protection Expert, case workers, and other relevant government departments to facilitate communication with birth parents and/or relatives. If this is determined to be in the children's best interest of the child, contact will be supervised with his foster carers, as well as the Child Protection Expert or case manager/case worker.
3. The foster care service provider, Child Protection Expert, case manager or the relevant government department will arrange visits and will always try to be considerate of the child, the birth family, and the foster family.
4. The relevant office, Child Protection Expert, foster care service provider, and/or case worker must give practical assistance to support appropriate contact, including by preparing children and families for contact and providing psychosocial support following contact.
5. A risk assessment of the venue/environment where contact outside the foster home must be conducted by the Child Protection Expert, foster care service provider, or case worker prior to the visitation being made.
6. Feedback from each contact and the perceived impact on the child must be recorded in the child's case file.

Standard 10: Dealing with Allegations and Suspicions of Harm

1. All foster care service providers and the relevant government departments should have a policy and written guidance on dealing with allegations and suspicions of harm to children in foster care.
2. Foster carers, Community Care Coalitions and volunteers must be aware of and understand what they must do if they receive an allegation or have suspicions that a person may have:
 - a. Behaved in a way that has harmed or could prove harmful to a child; or
 - b. Possibly committed a criminal offence against or related to a child or behaved towards a child in a way that indicates he is unsuitable to work with children.
3. The Child Protection Expert, foster care service provider, case manager/case worker or other relevant bureau of a government department must ensure that the action that is taken in any relevant situation of which it is aware is in line with established procedures.
4. The relevant bureau, Community Care Coalition, and foster service care providers should establish independent mechanisms for children to report any concerns they may have in relation to their placement.
5. Any complaint made by or in relation to a child within the foster home must be investigated in a manner which is fair and transparent, and which provides effective protection for the child. Any death of a foster child must be reported to the foster care service provider, case manager and the relevant government department as soon as possible, but not later than 24 hours after it occurs.

Sub section Five

Adoption

44.Provision of Adoption Service

Principles and Objectives Applicable to Adoption

1. Domestic Adoption is an agreement, made under Ethiopian law, between adoptive child and adoptive family with Ethiopian nationality and must be approved by a court.
2. Adoption is a childcare measure which seeks to provide a child with a permanent legally binding family environment. It creates a legal tie for all purposes between the adopter and the adopted child, although the child must be allowed to retain his bonds with the family of origin.
3. As a result of its permanent nature, adoption is not considered a form of alternative care but a permanent solution for a child who cannot be with his biological parents. Alternative care-related principles apply only from the moment the child concerned is separated from biological parents and placed in alternative care, and where the child is effectively placed in the custody of prospective adoptive parents whilst waiting for a final adoption order until that order is granted by a court, or as otherwise expressly provided for in this Directive.
4. Material poverty is not a reason of the separation of a child from his biological or extended family and making the child available for adoption. All efforts must be made to support families so that they can take care of their children by, for example, linking them to existing social protection programs, sponsorship, and other support services.
5. Before any steps are taken to initiate adoption, the biological parents or custodian shall be provided with an advice and training service issued from the relevant bureau that will enable them to give consent, to understand the permanent nature of an adoption order, and to recognize the impact of the adoption on the child, the parents or the custodian or guardian.
6. Adoption should only be considered after all reasonable efforts have been made to determine that a child cannot remain within his family of origin or cannot be cared for by members of the extended family.

7. Where adoption is suitable and necessary, all processes and procedures shall be concluded without delay. Priority shall be given to the adoption of young children aged below three (3) years and to children with special needs, where suitable prospective adoptive parents have been found.
8. The overriding principle in placement of a child in an adoptive relationship is the best interests of the child.
9. Siblings should be kept together except where it is not in their best interests.
10. When deciding on an adoption placement, due consideration must be given to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural, and linguistic origins.
11. When deemed in the child's best interest cross regional adoption placement can be arranged.
12. Preference must be given to adoption by members of the child or children's extended family where they are found eligible to adopt.
13. No consideration may be paid to an adoption service provider, adoption social worker, biological parent(s), extended family, or a responsible government official in respect of the adoption of a child.

45. Eligibility Criteria for a Child

1. Be below eighteen years of age;
2. Give consent to his adoption by the identified protective adoptive parents if the child is aged ten years or older;
3. Be the biological son/daughter of one spouse may be adopted by the other spouse;
4. An abandoned child in respect of whom it has been established that his parents or extended family cannot be traced and that all efforts to trace his parents and family have failed after at least six months of comprehensive family tracing efforts and must ensure it was unsuccessful.
5. Single orphan in respect of whom no other parent, guardian or member of the extended family has been identified or a double orphan with no guardian or no member of the

extended family willing to care for the child has been identified, and only after a thorough and documented tracing process has been unsuccessful. Where family members of single or double orphans are identified but are ineligible for adoption, adoption may be considered.

6. A child whose parent or parents are unable to support the child due to medical conditions or by reason of a disability approved by a medical board or based on a statement issued from the relevant government body that confirms the parent or parents are economically unable to properly care for the child and that they cannot be supported to acquire such economic assistance
7. Be without parental care and after a period of no less than six months no parent, guardian or adult caregiver can be traced after comprehensive tracing efforts which are thoroughly documented in accordance with case management procedures provided in this Directive.
8. Living in a residential care institution and is in need of a permanent placement after all efforts to identify and trace parents(s) and/or family members have been made, and other forms of alternative care such as foster care or kinship care are not in the best interests of the child.
9. Where parent(s) and/or extended family are identified but it has been determined that reunification or placement with them is not in the child's best interests and that reasonable efforts to support reunification cannot be made.
10. Have been displaced or separated and the child's parents or extended family cannot be traced and that all efforts to trace the child's parents and family have failed after at least six months of comprehensive family tracing efforts.
11. The child's parent or guardian has abused or neglected the child or has allowed the child to be abused or deliberately neglected as found by a court or a competent government authority, and other forms of alternative care including foster care and kinship care are not in the best interests of the child.

46. Eligibility to Adopt

An applicant is eligible for domestic adoption if he is:

1. Found to be eligible, and the placement is suitable and, in the child's, best interests. Priority should be given to adoption by a member of the child's extended family.
2. Ethiopian by nationality and has lived in Ethiopia for at least two years prior to the application being submitted to adopt.
3. At least twenty-five years of age. When adoption is made by two spouses, it is sufficient for one of them to be of twenty-five and above years of age, and an age difference of a maximum of 50-year difference and a minimum 18-year age difference between the adoptive child and the prospective adoptive parent is present.
4. Able to produce a document from a relevant authority certifying that he has an income that is sufficient to raise the child who has been assessed and approved by the adoption social worker or adoption service provider.
5. Able to produce a document from a relevant health authority certifying that he is free from any health problem that can impede his qualification to provide care and custody for the child.
6. Able to produce a document from a relevant authority certifying that he is free from any criminal activities related to human rights violation.
7. Able to produce a marriage certificate or prove otherwise if the potential adoptive parent is married.
8. Able to produce the written consent of the applicant's spouse to adopt the child, in cases when the applicant is married.
9. Is able to provide a character reference from a religious entity, the applicant's employer and a member of the immediate community who have known the applicant(s) for at least two years.

10. Unless the child is adopted by extended family members preference shall be given to married couples in selecting prospective adoptive parents.

11. Subjected to sub article 10 of this article a child may be given to a widow/widower, unmarried person or divorced person.

47. Standards/Minimum Requirements of Adoption Service Providers and Adoption Social Workers

Standard 1: Qualification and competencies of adoption social workers/ adoption service providers

1. Governmental authorities working at different levels with adoption, adoption service providers and adoption social workers should have relevant professional qualifications and experience.
2. For each post there should be an up-to-date job description, in which the required educational level or qualification and/or experience is clearly described and is verified.
3. Employees working on adoption should develop and maintain their knowledge and experience. The employer should give access and opportunities to staff to get regular development and training.
4. Every person working on adoption should adhere to a confidentiality agreement, which prohibits disclosure of information about the children who may be or are being considered for adoption and their background.
5. Adoption social workers must have a license from the licensing authority. The Bureau shall determine standards the requirements to hire case workers.
6. Adoption social workers must be able to provide a police clearance certificate and two references attesting to their good character.

Standard 2: Awareness Creation and Advocacy on Adoption Service Providers and Adoption

1. Adoption service provider implementing agencies along with the government and other stakeholders working on the service should design and conduct a public awareness and training program with a view to raising public awareness about adoption.
2. The adoption service providers and those within the government should employ a variety of different communication approaches and techniques to ensure that the central message is received and understood by a diverse audience with the hope of recruiting potential adoptive parents.
3. There should be no disclosure of personal information, stories, photos, videos, or other images, including digital images, of children except to a competent authority.
4. There should be no promise of gifts, financial or other benefits or financial support to prospective adoptive parents for participating in advocacy programs.
5. Adoption service provider implementing agencies along with government and other stakeholders must strive to create awareness campaigns which can dispel myths around adoption.
6. Relevant bureau or delegated adoption service provider agencies shall provide the appropriate sensitization that enables a prospective adoptive parent(s) to understand the legal implications of adoption, roles and responsibilities, as well as the process of adoption in Ethiopia.

Standard 3: Recruit, assess, train and certify prospective adoptive families

1. The adoption service provider should recruit, assess, train, and approve, a range of adoptive families to meet the needs of children they can potentially provide care for, and be proactive in assessing current and future needs of children who might be eligible for adoption.

2. The adoption service providers together with the government stakeholders should implement an effective strategy to encourage suitable persons to apply to be considered as adoptive families.
3. People who are interested in becoming adoptive families should be treated fairly, without prejudice, openly and with respect, and their details kept confidential.
4. Prospective adoptive families should be provided with timely and relevant information following their initial enquiry and be kept informed about the progress of any subsequent application for approval as prospective adoptive parents.
5. All persons being considered as prospective adoptive families must undergo a comprehensive assessment and home study visit or visits to determine their suitability to undertake the child caring task, and the details of these assessments and home study visits must be recorded on the applicable assessment forms.
6. Assessments and home study visits reports should include details as to the age and gender of other children in the prospective adoptive parent's family, the adoptive parent's geographical proximity to the child's biological parent or parents, and detail any special issues pertaining to the prospective adoptive parent's health, economic stability, and cultural, religious, and ethnic background.
7. Prospective adoptive family should be prepared through counselling and other forms of learning to become adoptive families in a way which addresses, and gives practical techniques to manage, the issues they are likely to encounter, and which identifies the competencies and strengths they have or need to develop.
8. Prospective adoptive families must be considered in terms of their capacity to look after children in a safe and responsible way that meets children's developmental needs, including any special needs that a child may have.
9. Qualified adoptive families should treat all children with respect and equity irrespective of cultural differences and they should participate the child in the decisions that affect them.

10. Before the placement of the adoptive child, the relevant government body or adoption service provider or adoption social worker shall provide the appropriate training that can enable adoptive parents to make the necessary psychological preparation that includes systems of child custody, strategies of building good conduct of children, family strengthening and capacity development. Training should also include topics such as positive parenting, positive discipline and where needed, specialized treatment and care for children with special needs.
11. When an employee is adopting a child through the agency he works for or provides services to, the employee shall obtain a home study visit and assessment report from another independent adoption service provider and social worker who can provide an independent assessment of the suitability of the applicant.

Standard 4: Matching, attachment & bonding and placement that meets children's assessed needs

1. Placing the identified child with prospective adoptive parents(s) should only be done after a mandatory three-month bonding period.
2. The prospective potential adoptive parents must be helped to fully understand the child's background, health, emotional and developmental needs, and the practical implications for caring for that child before they agree for the match to be approved by the adoption service provider or adoption social worker.
3. Adoption service providers should be focused on finding the most suitable family to meet the individual needs of a particular a child, not finding a child for a family.
4. Prior to attachment and bonding sessions with each child, the adoptive parents must be provided with all the information held by the adoption service provider or social worker that enables them to understand more about the child and able to make their decision about the matching, including having access to a photograph and assessment report relating to the child.

5. The adoption service provider or social worker shall gain an understanding of the adoptive parents' strengths, experiences, and skills to manage the challenges ahead in case of matching a child with special needs.
6. Based on the matching activities performed, the adoption service provider or social worker must introduce the prospective adoptive parents to the child in the living place of the child.
7. The introduction process shall be conducted at the presence of adoptive parents social worker and the child; where appropriate, other children in the household of the prospective adoptive parents could be included.
8. All pre-placement attachment and bonding sessions should be supervised by social workers, and progress reports should be documented.
9. An agreement of adoption shall be signed between the potential adoptive parent(s), and the parent/guardian of the child, if available, which shall contain the following information:
 - a. Name, address and photographs of the child and the prospective adoptive parent(s)
 - b. Date of placement of the child
 - c. Obligations of the contractual parties, namely: fulfilling the basic needs of the child, such as medical care, education, clothing, sheltering, food, legal protection, and other supports required to be provided by the family and ensuring the child's wellbeing and optimal growth and development.
 - d. Agreement follow up mechanisms of the concerned governmental institution or adoption service provider, for a two-year period following the granting of the adoption order, subject to the standards below.
10. The application submitted to the court should be prepared in three copies by the social worker or the institution providing adoption services and signed by the institutions heads and the agreement must be duly approved by two witnesses.

11. Copy of the agreement shall be attached to the court where proceedings are lodged for confirmation of the adoption.
12. After receiving the court's approval, relevant authority or adoption service provider shall write a letter of support to facilitate issuing the birth certificate to the adopted child.
13. After receiving the court's approval, the employing agency must provide the adoptive parents adoption leave post-partum maternal and paternal leave.

Standard 5: Post adoption Services

1. Children should feel safe, cared for, and valued as the result of post adoption service given to them.
2. The adoption service provider or social worker shall ensure post placement follow-ups and reports are performed.
3. At a minimum, post placement visits shall occur at the following intervals: on arrival, at 6 months, at 1 year, at 1 year and six months and at two years, unless there are reasons to continue providing post adoption services after the two-year period.
4. An adoption service provider or adoption social worker shall provide continuing support to the child and the adoptive family after placement to monitor the child's adjustment and development, to provide and make referral services for counselling and for crisis intervention, if needed.
5. The adoption service provider or adoption social worker shall apply in accordance with Part Two of this Directive and Article 195 of the Revised Family Code to facilitate the removal of the child from the adoptive placement due to circumstances that may impair the child's wellbeing, safety and security which may include but not is limited to abuse, neglect, or rejection of the child, but revocation of adoption.

Standard 6: Adoption Service Provider Organizations duty and responsibility

1. The adoption service provider agency should be registered by the relevant bureau and must comply with the government laws..
2. Adoption service providers must ensure sufficient numbers of trained personnel.
3. A Child Protection Policy and Code of Conduct must be in place, and this has to be communicated to the staff, parents/relatives of the placed children, the prospective adoptive parents and social workers.
4. Social workers and other relevant staff of adoption service providers must sign and adhere to the Child Protection Policy, Code of Conduct and Confidentiality agreement.
5. An appeal mechanism for a complaints procedure by the Bureau must be established to inquire into any complaint received in relation to adoption services with a view to resolving these and to promoting the wellbeing and safety of the children.
6. An adoption service provider should have a budget and financial plan, including an actual or projected statement of revenues and expenses.

Standard 7: Dealing with Allegations and Suspicions of Harm

Adoption service providers that received allegation or suspicion of harm should investigate the matter following the procedures below;

1. Allegations or suspicions of harm should be handled in a way that provides effective protection and support for children and the person making the allegation, and at the same time supports the person who is the subject of the allegation.
2. There must be a Child Protection internal directive and written guidance on handling allegations and suspicions of harm to children in adoption.
3. If the harm to the child is serious and is subject to criminal and other laws, the party that received the complaint shall immediately report it to the relevant authority.

Standard 8: Preservation of Records

1. Adoption service providers must keep records of all adoptions concluded, and the identifying details related to the child's genetic origins, their biological parent or parents, and their adoptive parent or parents. These must be submitted quarterly to the relevant government authority, who must maintain a Regional adoption register.
2. No persons other than the child, who reaches the age of 16, or the adoptive parent(s) of the child, may have access to the child's file.

Standard 9: Documents and requirements for court application for confirmation of an adoption

1. Where a child has biological parents, both parents shall appear before the court to express their consent at the approval of the adoption.
2. Where a child has only one biological parent, that parent shall appear before the court to express their consent at the approval of the adoption.
3. Documents to be submitted to a court which will consider the adoption application include:
 - a. An adoption agreement, containing the signature of the parent, or guardian and prospective adoptive family, one passport size photograph of the adoptee child and the date of execution of the contract.
 - b. The affinity, relatives or parent or guardians/custodians' details shall be attached with the biography of the child.
 - c. Birth certificate of the child, short profile, health certificate and other necessary documents shall be submitted.
 - d. A copy of the assessment and home study visits reports.

- e. In relation to the prospective adoptive parent(s), the documents confirming their identity, proof of income, good conduct, police clearance, proof of marital status, and a full health examination certificate issued from a recognized health institution.

PART EIGHT

COMMUNITY BASED CARE

48. Community Based Care

Community-based care is range of care options that locate the child within the community and ensure that the child maintains links with the community.

49. Supported Independent Living

1. A supported independent living arrangement means that children and young persons are living independently under a supervised arrangement approved by the service provider.
2. Supported independent living services are services and supports that are designed with and provided to the children and young persons.
3. The service builds upon the strengths and meet the unique needs of children and young persons in preparing for adulthood.
4. Supported independent living services offers services to all children and young person's as of the age of 14 and who are in the process of transitioning from differing alternative childcare services to adulthood or have been out of parental care due to various reasons.
5. Supported independent living services may also be provided to a child of 14 years or older or a group of children who assume the primary responsibility for the day-to-day running of the household, providing and caring for those within the household.
6. Access to these services should be based on an assessment made to initiate supported independent living and include a broad range of services including education, housing, health and medical services, access to employment/job opportunities, vocational training, money

management, skills development, counseling, rehabilitation, access to vital registration documents and other appropriate services to help children and young person's prepare for self-sufficiency.

50. Eligibility Criteria

1. To determine that supported independent living is an option for a child/young person, subjected to the eligibility criteria stated above must first be considered, and the following circumstances should be followed and family-based care options should have first been explored and exhausted.
 - a. A child is to be no younger than 15 years of age and above
 - b. A household in which a 15 -year-old child or group of children or young person assumes the primary responsibility for the day-to-day running of the household, providing and caring for those within the household;
 - c. Young people who are at the age of 18 to 24 in an alternative form of care who are unable or unwilling to live with, or reintegrate with, their biological family or an alternative family, or who have aged out of alternative care, and who express desire and ability to start living independently;
 - d. Children and young persons who are mature, mentally, and emotionally stable, and have the psychological readiness to live independently as determined through assessment;
 - e. Children and young persons who are in an out-of-home placement and are a current recipient of other alternative childcare services;
 - f. Children and young persons who are in need of support to become self-sufficient and independent;
 - g. Willingness to participate in and comply with service expectations by signing assent or consent forms.

51. Provision of Services

1. Supported independent living service providers should ensure services provided include the following service components but not limited to:
 - a. Basic needs (food, shelter, and clothing);
 - b. Formal and informal educational support;
 - c. Post-secondary/higher education support;
 - d. Career preparation;
 - e. Vocational training;
 - f. Budget and financial management training and practice;
 - g. Home management training;
 - h. Health education and risk prevention;
 - i. Mentoring;
 - j. Community integration and social skills training;
 - k. Youth-driven permanency and transition planning that addresses education and employment goals;
 - l. Medical and health services;
 - m. Providing reasonable accommodation for children with special need
 - n. Legal support services

2. Supported independent living service providers should ensure that there is development and maintenance of the transition plan for those who are mature.

52. Identification

1. Community members or Community Care Coalitions may identify vulnerable children or young people who live alone, unsupported within their community who may benefit from supported independent living support and services.
2. Children or young people who are aging out of alternative care, who are unable or unwilling to reintegrate to a family setting, and who could benefit from support to live independently may also be identified by the Child Protection Expert, case managers and foster care service providers.
3. Identification and assessment shall be completed, ensuring eligibility criteria are met, and all options for family-based care alternatives have been exhausted.
4. All options must have been deemed unsuitable or not in the child/young person's best interests including their unwillingness to enter any of the explored forms of care, before supported independent living can be considered.
5. An assessment must be conducted to determine eligibility of children and young persons to receive assistance and support services within the supported independent living arrangement.
6. The information about the child or young person obtained during assessment will also be used throughout the case management process to support the child/young person to identify a mentor, to support their transition into the supported independent living arrangement, and to monitor their progress toward reintegration into the community.

53. Mentors

1. A mentor is identified to support the child/young person emotionally, socially, and practically during their transition period into the community, until they have achieved holistic reintegration, or until each child or young person member of the household is able to live independently, or when a permanent solution that is in the best interest of the children or young person is viable.

2. Mentors should be made aware of the need to ensure that the supported independent living arrangement and mentorship does not create long term or permanent dependency.
3. Where a young person is transitioning from another form of alternative care, the case worker will work with the child/young person to identify a mentor during the preparation phase, prior to placement into supported independent living to ensure they know at least one adult in the community where they will live with whom they feel comfortable and can seek advice and help from, as needed.
4. Community members may identify vulnerable children/young people who live alone, unsupported within their community who may benefit from supported independent living services. In such cases, a mentor should be immediately identified by the Community Care Coalition or the Child Protection Expert.
5. Mentors shall be formally registered by the Community Care Coalition or Child Protection Expert to ensure there is a record that the mentor has been assessed.
6. Eligibility criteria for mentors:
 - a. 25 years and above, and older than the child or young person;
 - b. Willing and able to support the child/young person emotionally, socially, and practically;
 - c. Is perceived as trustworthy and supportive by the child/young person;
 - d. Lives independently and has acquired practical life skills that they can coach the child/young person to learn;
 - e. Is known in the community to be of good character and lives an overall healthy and positive life (i.e., would be a positive role model for the child/young person);
7. Roles and responsibilities of the mentor include:

- a. Regularly monitor the child or children or young person, confirming all children in the household have their basic needs met and provide feedback to the case worker who shall report to the Child Protection Expert or relevant bureau.
 - b. Support may include links to education and health or medical services, psychosocial support, material support, social protection or sponsorship, and life skills necessary for day-to-day life including basic housework skills. They should prepare children and young people to lead healthy lifestyles through training in children's rights, peace building, healthy living, nutrition, family relations, hygiene, reproductive health, and HIV prevention, among others.
 - c. Shall support and/or ensure that children and young persons, including the child head of the household, are attending school by supporting school attendance costs and fees.
 - d. Shall work with schoolteachers to raise awareness around the educational needs of children and their need for psychological support while in school.
 - e. The capacity of older children and young people through training in literacy, household management, agriculture, and small business development, as relevant, should be facilitated by the mentor.
 - f. Shall support and/or provide or refer to other community-based childcare such as daycare for younger children so older children can attend school.
8. Where the child/young person is unable to identify a person to act as mentor within the targeted community, the Community Care Coalition or Child Protection Expert may engage individuals around the child/young person to help identify a mentor.
 9. Gender of the assigned mentor can be determined based on the preference of the child.
 10. The Community Care Coalition or Child Protection Expert should discuss with the child / young person their expectations of a mentor, and the different options they have identified as mentors.

11. Caseloads assigned by service providers should not create a burden on mentors to provide efficient services.
12. Mentors may at the discretion of the Bureau or relevant institutions be paid a stipend or be reimbursed for expenses in accordance with any policy on remuneration adopted by the Ministry.
13. Service providers who are not government agencies may provide mentors that they recruit with remuneration or reimbursement for expenses at their discretion.
14. Relevant bureau shall provide overall monitoring and coordination of mentors, in conjunction with service providers.
15. A mentor may indicate his unwillingness to continue with the mentoring service, in which case another mentor should be identified and appointed by the service provider, the Community Care Coalition or the Child Protection Expert.

54. Support and Referral to Services

1. Service providers should proactively provide services to children or young persons of the children and young persons having to search for services.
2. Service mapping conducted by relevant bureau, service providers or Child Protection Experts to identify the variety of service providers relevant to the needs of the children and young persons.
3. Service providers should aim to equip children and young persons with coping skills to successfully live independently.
4. Skill trainings provided under sub article 3 of this article should at least cover personal self-development and well-being, safety, financial awareness, health awareness, social awareness, community service and participation.
5. Children and young persons should also be supported in career development through their choice of profession or vocation and through skills development.

6. Following training, service providers should ensure children and young persons have attained the capability to behave within the boundaries of social acceptability and to express needs to the appropriate persons, as a self-advocate.
7. Where applicable and is determined to be in the best interests of the children and young persons, service providers should encourage and facilitate on-going contact with children and young person's family of origin.
8. Service providers should help the children and young persons to familiarize him with his life story and encourage him to maintain contact with social, religious, and cultural background.
9. It is important to promote and preserve kinship, sibling, and community connections for each child and young person.
10. Through the provision of supported independent living services, children and young persons are eligible to receive an independent living stipend to help support the cost of living.
11. The stipend may be used to pay for the costs of rent, utilities, household equipment, food, clothing, personal care items, insurance, recreation, education materials and transportation.
12. Every year, each regular student at a university, a college or a training institution should receive support for clothing and a monthly allowance.
13. Once education/training and possible future career has been agreed upon, children and young persons should be given the opportunity to pursue the selected career.
14. When children and young persons are on training, he will receive living and housing allowances and pocket money based on the educational setting where he is placed.
15. Service providers should assist children and young person's efforts to live independently through creating referral linkages, facilitating internships and employment opportunities.
16. Children and young persons at the age of 15 and above shall be supported to ensure that economic empowerment and linkages with opportunities do not interfere with a child's education and are not exploitive or hazardous to the child or young person.

17. Supported independent living services for children and young persons should focus on providing individualized solutions that build on their strengths to meet their needs. Engagement is the primary channel through which children and young persons make positive changes.
18. Service providers should provide ongoing training on reproductive health and link children and young persons with age-appropriate reproductive health care services.
19. Service providers should further assist children and young persons with specific needs to help them identify and utilize their strengths, overcome challenges, access, and make use of resources, and integrate well into their community to lead a successful and fulfilling life.

55. Service Planning and Agreement

1. Service planning should ensure the participation of the children and young persons themselves in the design and delivery of services as well as in decision making process regarding their own care.
2. The service provider should draft a service agreement consisting of the requirements and expectations to participate in the program and have the child or young person read, understand, and sign the agreement in the form of an assent or consent. This should be documented in the case record.
3. In instances where children and young persons fail to comply with the requirements and expectations stated in the service agreement, all efforts should be made by the service providers to assess the situation, identify the problem, and take appropriate measures to ultimately support the children and young persons to comply with the recommendations as outlined in the agreement.
4. Service providers should help program participants to recognize and accept their personal responsibility to prepare and make the transition from adolescence to adulthood.
5. The service agreement should include the name and personal details, including address and contact details, of the identified mentor.

6. Upon receipt or any complaint from a child or young person about an appointed mentor, the service provider should undertake investigation to determine whether the grounds for complaint are justified. In situations where the complaint is of such a nature as to threaten the mentoring relationship with the child or young person, the mentor should be replaced with another suitable mentor.

56. Case Closure

1. The Community Care Coalition, Child Protection Expert or service provider shall close the case after the young persons are able to meet their basic needs independently across all domains of well-being.
2. Supportive mentor-mentee relationships that are aimed at positive behavioral and ethical transformations are encouraged.

PART NINE RESIDENTIAL CARE

57. Residential Care

1. Residential care is an establishment founded by a governmental, a non-governmental organization or individuals according to appropriate procedures that provides care in any non-family-based group setting but does not include boarding schools.
2. Residential care is as an out-of-home care placement option providing temporary, short-term, and last resort option for children who have lost parental care.
3. Where due to the special needs of the child, and unless it is believed that, a longer-term placement is in the best interests of the child residential care is a short-term placement.
4. Standards of care and support services in residential care are designed to fulfill the physiological and psychosocial needs of children in the residential childcare institutions which are offered by professionally qualified workers or experienced and trained personnel.

5. In accordance to this article sub article 4 the service will be provided until the children are reunified with family or placed in another form of alternative family-based care.
6. A child should not stay in a residential care more than two months unless circumstances force the child to stay longer.

58. Types of Residential Care

1. Community Integrated Child-Care:

- a. Community Integrated Child-Care is a temporary form of care for children, numbering not more than eight, under the care of a trained and paid adult care giver.
- b. The hired caregiver must be a person who is not responsible to care for the child by reason of biological or kinship ties nor a foster career, in the community.
- c. Community Integrated Child-Care of care relies on placement of the child there by a service care organization, who is also responsible for the recruitment and training of caregivers, and for creating, supporting and monitoring the community integrated childcare facilities.
- d. Children who benefit from community integrated childcare are admitted on a temporary basis for protection while other options are identified.

2. Residential care service for Children with special needs

- a. This is a form of residential care for children with specific needs resulting from natural or accidental disability, identified behavioral problems, or diagnosed medical needs.
- b. Such care is intend to provide intensive and professional care on a temporary and short-term basis to help children rehabilitate and prepare them for reintegration back to their original family, transition to alternative family or independent living, in line with the national child policy.

- c. Service providers and staff attached to these specialized homes should ensure that also provide outreach services to children with such identified needs who are living in the community.

3. Residential Homes for Children:

- a. These are temporary and transitional care centers where children receive care until authorized stakeholders facilitate a permanent care option.
- b. Children are admitted on a temporary and short-term basis for protection while other family and community-based care options are identified.
- c. The number of children accommodated in such residential homes should be limited and the Bureau will issue guidelines on the maximum number of children that residential homes may admit.

59. Specific objectives of residential care

Residential care shall have the following specific objectives:

1. To provide short-term alternative care;
2. To cater for the basic and psychosocial needs (food, shelter clothing, education, sanitation, and health, play and recreation, counseling, emotional needs as well as social interaction) of children in the residential care institutions for their holistic growth and development;
3. To contribute actively to a child's reintegration within their family or, where this is not possible or in the best interests of the child, to secure their safe, stable, and nurturing care in an alternative, family-based care arrangement.
4. Residential care shall in no way, irrespective of size, shall in no way be viewed as a way to fulfill a child's right to live in a family environment.

60.Registration of residential care facilities and reporting

1. All residential care facilities including community integrated childcare facilities must be registered in accordance with government directives contained in the Organizations of Civil Societies Proclamation 1113/2019.
2. No organization shall operate as a residential care facility unless it has received prior approval from the Bureau or the relevant licensing authority to operate a residential care facility.
3. Upon receipt of an application, the relevant licensing authority shall either:
 - a. Reject the application in whole or in part where it does not meet the requirements; or
 - b. approve the whole or part of the program if it complies with the requirements; and
 - c. Issue the institution with a Certificate of Approval.
4. The relevant licensing authority may apply to withdraw the Certificate of Approval on good cause shown, in which case the residential care facility must make arrangements for the transfer of children in its care to another form of care and close on the date indicated on the notice of withdrawal.

61. Application to establish a residential care or community-integrated care or special needs care institution

1. An organization that proposes to establish a residential care facility shall produce a document affirming that it has the required financial, material, human capital, and technical capacity to provide this service. A residential care facility can be established by the governmental, nongovernmental organizations or the community groups. Residential care facilities should specify both local and foreign sources of annual income upon registration and subsequently in bi- annual and annual reports to the registering authority.
2. The residential care facility should keep proof of all administrative costs it has incurred and have these available for inspection should the relevant authority or the Bureau require evidence to be produced.
3. Management and staff of residential care facilities shall prioritize the best interest of the child and no institution shall be established or used for any personal benefit.

4. Financial and material poverty, or conditions directly and uniquely attributed to such poverty, such as access to education and health services, should never be the only justification for placement of a child in residential care, but such conditions should be seen as a signal for the need to provide appropriate support to the family in accordance with the part of this Directive concerning family preservation and strengthening.
5. Education shall not be a reason to separate a child from his family and place him in a residential care facility.
6. Residential care facilities, in addition to the services referred to below, shall facilitate the family reunification and reintegration or the provision of alternative care services for children in its care, including tracing and reintegrating children with their own parent(s) or placement in a kinship care arrangement.
7. Where the reunification of a child with his parent(s) or placement in kinship care is not possible or suitable and in the best interests of the child, another form of alternative family-based care shall be sought. Such alternatives include foster care, facilitating local adoption services for children who cannot be raised by their own families, where appropriate and desirable. Children aged below three (3) years should not be admitted to residential care facilities in line with international best practice, unless this is strictly temporary with the view to foster care placement or another community-based placement as soon as possible.
8. Where any child in residential care does not have a birth certificate, the manager of the residential care institution or his deputy shall take immediate steps to apply for such a birth certificate.

62. Eligibility Assessment and Admission Process

1. Admission to any form of residential facility should occur only after a case management process as outlined in Part Eleven, Case Management Guidelines of as set forth this Directive.
2. The Residential care facility should:
 - a. Prior to placement, facilitate a general medical checkup of the child at a recognized health center or facility.

- b. Arrange an isolated separate place if a child is suffering from a communicable disease and provide proper medical treatment and care before letting the child join the children in the facility.
3. All volunteers and visitors to the residential care facility must comply with the provisions in the part of this Directive concerning roles and responsibilities of visitors and volunteers

63. Admission Form

1. An admissions form for each child admitted to a residential institution should include:
 - a. Name;
 - b. Age and sex;
 - c. Family name;
 - d. Place and date of birth;
 - e. Previous and current address;
 - f. Religion;
 - g. Educational status;
 - h. Health status; nutritional status;
 - i. Disability (if any); psychological profile;
 - j. History of abuse (if any);
 - k. Status of a child at admission (orphan/abandoned/parents terminally ill or mentally incapacitated);
 - l. Information on the child's personal history;
 - m. Information about the child's parents and relatives, if available;
 - n. If available, the consent of the children's parent or guardian;
 - o. The child's birth certificate, if available;
 - p. Death Certificate/Burial notification of parents (where applicable);
 - q. Copy of parents/guardian's national identification card, where applicable;
 - r. Police letter for abandoned children, including case number (where applicable);
 - s. A photograph of the child;
 - t. A support letter from the concerned government body that states the grounds why other options could not be of use for the child concerned.

2. The residential care facility must provide for every child a case file in which all information that is related to his history form, education, health status, nutritional status; physical development; and social development and emotional wellbeing is included.
3. All services the residential care facility has provided should be made part of the child's case file.
4. Every child should have an individual file opened upon admission and the file should be updated regularly. Each file should contain at minimum:
 - a. A copy of any court committal order (where applicable);
 - b. The child assessment and family assessment;
 - c. Map of the child's home location or place where the child was abandoned;
 - d. The individual child's care plan;
 - e. All review assessment reports.

64. Gate keeping

1. The following clear criterion should be considered for children prior to admission any residential care facility:
 - a. A child who is a double orphan, abandoned, or living and/or working on the streets, and whose parent(s) or extended family is untraceable.
 - b. It is not in the child's best interests to live with his biological parent(s) or extended family.
 - c. The child might have a parent(s), but such parents are not fit enough to raise the child and cannot be supported to do so.
 - d. The child has special needs and cannot be cared for in a home or community environment nor can the child's family be assisted to provide care and support to the child.
 - e. Placement in foster care or kinship care is either temporarily or on a longer-term basis not possible.

- f. Children who are subject to domestic violence and other difficult situations in the home
2. A residential care facility shall participate in the preadmission assessment of the child to learn about the background of the child, together with the experts from relevant bureau or the Child Protection Expert.
3. Community integrated child-care and government authorities should be very thorough in their assessment and placement procedures.
4. The assessment and placement procedure must ensure that only eligible children are admitted and, upon admission, that simultaneous efforts are being made for reunification and reintegration and family-based care or other forms of permanent care.
5. All available background information on children and their parents, or if the child is not living with parents, the child's current living circumstances, should be gathered by the service provider performing the screening so that proper gate keeping is done. This should include all documents pertaining to legal and non-legal affairs in accordance with the case management procedures outlined in this Directive.
6. Only after thorough gate keeping procedures are taken, a child should be placed according to his needs in his best interests, and placement in a residential care facility should occur only when strictly where suitable and necessary.
7. The child's opinion and participation should be considered whenever possible and appropriate and the views of the child included in any pre- assessment and case management report.

65. Standards/ Minimum Requirements of Community Integrated Child-Care facilities

Standard 1: The home structures

1. The accommodation, which is generally provided, houses must not be more than 8 children.
2. Boys and girls may live together in one community-integrated child-care setting

3. The facility should be secure from entry by unauthorized persons.
4. The structure shall be well constructed and kept in good structural repair.
5. The structure should be useable and accessible to children with disabilities and other special needs.
6. There must be suitable gender separation in sleeping arrangements and these should be supervised.
7. Children who are living in one room should be children with similar age group, where possible.
8. Each child should be allocated with one individual bed and where possible there should be a one-meter distance between each bed.
9. Sleeping arrangements should take into account the safety of the child and should be well ventilated.
10. Sanitation, washing and food preparation arrangements must be conducive to the wellbeing of the child.
11. There should be safe play spaces and sitting, dining and general recreational space.
12. Each child of age 6 years and above must have their own place for safe keeping and privacy. This may be a lockable and secure box or drawer or similar private space. The child's box should be accessible to the head caregiver for supervision.

Standard 2: Care-givers

1. A Community Integrated Child-Care residential facility has one or two consistent care-giver(s) who manage/head the care setting.
2. Care-givers should be professionally trained to provide quality care, accompany and support the children in their development, their relationship with the family of origin and leaving care trajectory, as well as to recognize, understand and handle certain behaviors and psycho-social needs of children.

3. There should be an age difference between the child and the caregiver that creates a child caregiver relationship.
4. Caregivers should be at least literate and have adequate care giving training
5. Service providers should provide timely training to caregivers on child handling and care during the recruitment of caregivers as well as while on the job.

Standard 3: Support system

1. Community Integrated Child-Care facilities shall be part of a comprehensive local support system.
2. This local support system comprises a multidisciplinary team or network that can be composed of professional staff including social workers, counselor/psychologist, and health care workers or other specialized service providers.
3. Peer-to-peer networks between caregivers, and between children in alternative care, can be a part of mutual support.

Standard 4: Links to the community

1. Community Integrated Child-Care residential facilities should take appropriate measures for facilitating the interaction of children with the surrounding communities, so that children could feel part of their community.
2. The child and the household live in an integrated manner within the wider community, making use of locally available services.
3. Depending on the context, different Community Integrated Child-Care facilities can be located in close proximity to each other, which provides for a close mutual support network and a sense of security. At other times, Community Integrated Child-Care facilities can be located in a dispersed manner throughout the community.

Standard 5: A professional or paraprofessional approach and specific focus on care

1. Through its professional or para-professional caregivers, the Community Integrated Child-Care institution is able to provide a more professional approach towards supporting specific care needs of children.

2. As care-givers are employed professionals or para- professionals, their main focus is on the care needs of the child.

Standard 6: Creating safe environment for children in Community Integrated Child-Care:

1. Organizations and individuals that are involved in the provision of Community Integrated Child-Care services shall commit to create a safe environment for children in their custody at all times by implementing child safeguarding measures and procedures in line with national child protection policies, conventions ratified by the country and best practices.
2. Any residential care homes should provide legal protection to all children under their care.
3. Child safeguarding measures include, but are not limited to:
 - a) Ensuring that particular care is taken to ensure preventive measures are put in place to safeguard children if activities or events are to take place in unfamiliar places and outside the community integrated care setting.
 - b) Minimizing the risk of inappropriate use of information, stories and visual images, photographs or videos of children.
 - c) Any person should report on suspected or actual child abuse taking place, also outside the community integrated care setting.
 - d) Positive discipline methods should be used by the caregivers.
 - e) Ensuring that care-givers have access to advice and support where concerns or incidents arise
 - f) Ensuring that there is a sound assessment of any partner organization or identified service provider that will have contact with, and impact on, children.
 - g) Knowing who has responsibility for the care of a child at any given time.
 - h) Discussing with children what makes them feel safe and unsafe and priory agree on ways for children to complain if they have a concern about themselves or their friends
 - i) Ensuring that anti-bullying principles are applied.

- j) Ensuring that the different needs of girls and boys are considered, and that the different needs of younger children and of adolescents are taken into account.
4. Community-integrated child-care service providers shall put in place tailored measures to access, analyze, and reduce child safeguarding risks associated with each care-giver, partner, and community, as well as with any functional areas of the organization such as human resources, communications, or fundraising.

Standard 7: Supported caregivers

1. Organizations running Community Integrated Child-Care facilities must provide training for care-givers before appointing them to serve as care-givers. This takes place through a thorough selection process, training, and by first taking on a supporting role in the setting before becoming a primary care-giver.
2. Where individuals wish to operate Community Integrated Child-Care facilities, they must be vetted by the relevant government department, and trained for this role.

Standard 8: Promote reintegration, placement on other forms of alternative care, education, participation, and steps to independent life

1. Where reunification and reintegration or placement in another form of alternative care is not possible, organizations and partners that operate Community Integrated Child-care facilities should support every child and young person in taking steps towards an independent life at the earliest opportunity.
2. According to their age and stage of development, organizations should support them to acquire a wide variety of skills to prepare them for responsible independent life in society and strengthen their employability, including facilitating the acquisition of vocational skills.

66. Standards for Specialized residential facilities for Children with Special Needs

1. Specialized residential care service providers should follow and comply to the national child policy weighted towards inclusion of children with a disability.

2. The eligible children are those who have long-term severe physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others, and who cannot be supported to remain in their home environment.
3. No person shall treat a disabled child in an undignified manner. A disabled child has a right to special care, education, and training to develop their maximum potential and become self-reliant.
4. Children with special needs shall not be denied the right to participate in creative or recreational activities.
5. Care-givers shall provide a caring and healthy environment in accordance with the special needs of the child, giving children love, acceptance, guidance, protection and a sense of security, healthy living, and well-being.
6. Care-givers shall be selected for their ability to offer services to children with special needs and for their expertise to offer such services to these children. Specialized homes for children with severe disabilities shall create a child-friendly space for play and recreation.
7. Specialized homes for children with severe disabilities shall ensure a well-maintained environment for children with special needs which include opportunities for active play - especially outdoors, opportunities for quiet play and rest, opportunities for developing motor, social, language and cognitive skills through play.
8. As most children that experience a disability may require additional assistance, specialized homes shall ensure assistive devices such as wheelchairs, helmets, floor mats, braces, hospital beds, adaptive rails, prosthetic devices and shower chairs, and special services such as Braille training and sign language to the extent that these are needed to fulfill the special needs of the child.
9. The care-giver shall consult with the child's physician if there are any concerns regarding the safety of specialized home care for the child e.g., in the case of epileptic children or the quality of care necessary for the child. The nutritionist/dietician or physiotherapist shall also have an advisory role to play.

10. When the specialized home is offering services to children with disabilities, the facility must be fully accessible and adapted to the needs and safety for these children.
11. The shelter of the specialized home should have enough space for children to sleep, achieve education and for their recreational needs.
12. Placement of children with special needs should take into account their wellbeing and specific needs so that appropriate and quality care is provided for them and should take into account the national child policy.
13. The focus and service should go beyond catering for children's immediate needs, and be aimed at their holistic development, including skills development.
14. Children with special needs should participate in decision making processes, on matters concerning their treatment and choices, whenever possible
15. Children with special needs have a right to an education which is appropriate to their needs.
16. Specialized homes shall ensure the full inclusion and involvement of children with disabilities in the social life of their families and communities and must support and assist them to enable them access to social opportunities. Communities should be sensitized to the need for children with special needs to be integrated into community settings.
17. Specialized homes should provide legal protection to all children under their care.
18. The specialized home should recognize the move away from a purely medical conception of disability, which focuses on impairments, towards a recognition of the importance of social context and inclusion.
19. Care-givers and institutions providing specialized needs services shall recognize the need to end the use of specialized homes for children with disabilities, and instead support care in families and communities.
20. Each residential home providing specialized needs services for children shall adopt a child safeguarding policy.

21. Every organization shall delegate a child safeguarding officer and an alternate.
22. Child safeguarding measures include, but are not limited to:
 - a. Building the capacity of staff and children to recognize signs of abuse of children with disabilities.
 - b. Incorporate elements of disability-inclusive child safeguarding.
 - c. Ensuring that particular care is taken to ensure preventative measures are put in place to safeguard children if activities or events are to take place in unfamiliar places and outside the community integrated care setting.
 - d. Minimizing the risk of inappropriate use of information, stories and visual images (photographs, video or social media) of children.
 - e. Reports on suspected or actual child abuse taking place inside and outside the residential care setting.
 - f. Ensuring that care-givers and staff have access to advice and support where concerns or incidents of abuse or exploitation arise
 - g. Ensuring that there is a sound and holistic assessment of any partner organization or identified service provider that will have contact with, and impact on, children.
 - h. Knowing who has responsibility for the care of a child at any given time.
 - i. Discussing with children what makes them feel safe and unsafe and agree on ways for children to complain if they have a concern about themselves or their friends, including through alternative communication methods.
 - j. Any reported child safeguarding incident or concern is carefully assessed and based on the results of the assessment; concrete actions are decided and put in place.
 - k. Ensuring an independent reporting mechanism for staff and children is in place.
 - l. Ensuring that anti-bullying principles are applied.
 - m. Ensuring that the different needs of girls and boys are considered, and that the different needs of younger children and of adolescents are taken into account.
23. Specialized residential facilities for children with special needs service providers shall put in place tailored measures to assess, analyze, and reduce child safeguarding risks associated with each care-giver, partner, and community, as well as with any functional areas of the organization such as human resources, communications, or fundraising.

67. Residential Homes for Children

Identification and admission criteria of an eligible child:

1. The identification and admission of children into any residential home should follow standard procedures outlined in the National Child Protection Case Management Framework and other relevant Standard Operating Procedures established by Bureau of Women and Children Affairs and Zonal and Special wereda actors overseeing services to children and families as well as the case management rules provided for in this Directive.
2. During the screening of children, each organization needs to consider each child's degree of vulnerability i.e., whether he is:
 - a. Single and double orphans out of parental care;
 - b. Children who are homeless and unaccompanied;
 - c. Abandoned children whose parents /families are untraceable;
 - d. Children with disability;
 - e. Children exposed to the worst forms of child labour;
 - f. Child victims of sexual abuse and exploitation;
 - g. Trafficked children;
 - h. Children infected or affected by HIV/AIDS;
 - i. Displaced children;
 - j. Non-orphan children whose parents are not able to support the child due to illness, injury, or detention;
 - k. Child headed households;
 - l. Children with major behavioral problems;
 - m. Separated children;

- n. Refugee children;
 - o. Other target children, depending on the local definition of risk or vulnerability.
3. The location of the residential home shall take into account the availability and accessibility of the following infrastructure:
- a. Potable water supply;
 - b. Roads (either a dry or all-weather road);
 - c. Electric power or generator;
 - d. Telephone communication;
 - e. Education facilities;
 - f. The location should be free from dangerous environments or settings with potential hazards or areas susceptible for recurrent dangers such as military camps, war-prone areas, places with dangerous wild animals, flood prone areas, polluted areas, and high traffic areas;
 - g. The admissions sheet within the childcare institution should include such information as referred to above;
 - h. Unless there are reasons agreed with the relevant government office, groups of children living in the residential home for children should include mixed genders and ages

68. Standards/Minimum Requirements

Standard 1: Location and Premises and staff of the residential home

1. The residential home should be located in places where major social, economic, emotional, educational and health needs can be addressed whenever needs arise.
2. Lodgings in a residential home shall be well ventilated and well lighted, and toilets, shower rooms and washing basins should be easily accessible. These facilities shall be kept clean at all times.
3. The service giving building of a residential home shall, at least have:
 - a. Lodging (dormitory or self-contained homes);

- b. A counseling office (therapy room);
 - c. At least one meeting or /dining room;
 - d. One first aid room;
 - e. Recreational facilities (in-door and out-door facilities);
 - f. One administrator's office, One record office, Finance office;
 - g. A storeroom;
4. The number of service giving and support staff within the residential home should be proportional to the number of children in care and no less than the ratio of one (1) care-giver to six (6) children.
 5. Staff should be provided with periodic on the job training in order to enhance and update their capacity to effective and efficient service.
 6. Residential homes should have the following staff:
 - a. Manager or Administrator;
 - b. Finance Officer;
 - c. Security personnel;
 - d. Health Officer
 - e. Counselor;
 - f. Care-givers;
 - g. Janitor.
 7. When employees are recruited by the residential home there should be a proof of whether the employees are mentally healthy and proof that they have no criminal record. They should also be checked for any prior record of child abuse.

8. All residential homes must have a staff Code of Conduct which sets out the expected behavior of staff.
9. All staff must read, understand, and then sign at least two copies of the Code of Conduct upon employment. One copy should be kept in the employee's personal file while the staff member keeps the second copy.
10. The residential home should have a Drugs and Alcohol Policy within the workplace.
11. The residential home must set an acceptable dress code, prohibit intimate relationships between children and/or staff and intimate relationships between members of staff within the workplace, unless two staff members are legally married to each other.
12. All children are entitled to privacy and no written material or files containing a child's information should be left exposed for all to view. Each home must have a space where children's individual case files and care plan can be confidentially stored. Access to the files of children should be limited, and information accessed on a need-to-know basis.
13. Residential homes shall define staff shift and working hours as per Ethiopia's Labour Laws and allow for clear rest days and time off for all staff. The employer shall ensure that all statutory requirements are met which includes remittance of contributions and any other government requirements that have been made.
14. Care-givers should be trained on confidentiality and sensitivity of information. There should never be any public discussion about a child's sensitive issues, either in the presence of the child or other persons.
15. Residential homes shall avail a child's information to any person if it is in the best interest of the child, e.g., child welfare, for exit purposes and other relevant positive intentions.
16. Children have the right to access their files depending on their age and mental capacity and also have the right to access and have copy of their file(s) even after they have exited the residential home.
17. Children's files must be stored at the residential home for at least 7 years, where after they must be sent to the relevant bureau or the Ministry for archiving. Where a residential facility

closes before the expiry of the seven year period, files must be sent to the relevant bureau for safekeeping.

18. Each residential home must have a confidential complaints mechanism, including a process for complaints to be lodged with an authority outside the residential home.
19. Copies of this complaints mechanism must be made publicly available within the residential home, as well as explained to each child upon admission to the residential home, where the child is of such an age and level of understanding as to benefit from the explanation.

Standard 2: Shelter and Clothing

1. Shelter

- a. The residential home should have sufficient space for children and the setting should consider any special needs children may have.
- b. The residential home should have separate offices for administration and the following well furnished rooms: dining/television or recreation rooms, stores, kitchen, toilets, laundry, well-ventilated bedrooms with enough space, play areas for the children outside and a room for indoor games.
- c. There should be gender separation in sleeping arrangements and children who are living in a single room should be with children of a similar age group, where practicable.
- d. Each child should be provided with one bed, where practicable, and there should be a one-meter distance between each bed.
- e. One bedroom should not hold more than six children.
- f. Each bedroom should have a cabinet or a secure box or drawer or similar private space for the children to store their belongings.
- g. For children who are below the age of seven (7) beds with stairs that tie with an upper bed are not allowed.

- h. The bedrooms should be well ventilated and also should have bathrooms and a separate section for washing clothes. The room should guarantee the privacy of each child in the home and provide for sufficient supervision at night.
- i. A residential home shall, at least, make the following sanitary materials (including tampons and sanitary towels for girls) available to beneficiary children: personal sanitary materials; laundry materials; sanitary materials for keeping the sanitation of the site and the building and; waste disposal facilities.

2. Clothing

Clothing should be provided based on the Ministry Service Delivery Standard for Institutional Care.

Standard 3: Meal Provision

1. Meal should be provided with a nutritious and varied diet, which meets child's individual and recorded dietary needs and preferences.
2. Meal should be served based on the guidance provided by dietitians and other professionals and disciplines.
3. Staffs should be aware of any matters concerning children's eating and there should be adequate numbers of staff to provide necessary support.
4. Meal provision should be according to the Bureau Service Delivery Standard for Institutional Care.

Standard 4: Education

1. The focus of education interventions in residential homes should be to ensure access to education and retention in education of all children under care.
2. Children should have access to early childhood education, primary, secondary, senior secondary, vocational, and special education. Preferably all forms of education should be delivered outside the residential home in community facilities.

3. To ensure quality education for children with special needs the residential home should collaborate with potential partners including relevant government departments to address accessible and inclusive learning and recreational spaces for children with special needs.
4. Staff at the residential facility should undergo such training as is appropriate to equip them to cater to the special needs of children as may be admitted to the residential home.

Standard 5: Health and first aid

1. The health and social care needs of each child under care must fully be understood and addressed.
2. There should be a professional health care assistant nurse on the staff or available, a first aid room, access to a clinic, whether in-house or in the community.
3. All staff must be fully trained in basic First Aid skills, and this should be part of the induction /orientation process upon employment. Staff should be given periodic refresher courses on First Aid.
4. Training should take into consideration children with special needs and include (but not be limited to) training on choking and choking hazards (toys, food size, texture, and consistency), seizures and Cardio-pulmonary resuscitation (CPR). They must also need to have knowledge of basic health practices and interventions that promote the health and welfare of each child.
5. All residential homes must have several accessible and fully equipped First Aid Kits and devices for the extinguishing of fires. First Aid Kits should be placed in conspicuous points and checked regularly to ensure that medicine and other items in the kit do not run out or expire and are adequate to address any kind of emergency.

Standard 6: Psychosocial Support

1. Psychosocial support should be an ongoing process of meeting the physical, social, emotional, mental, and spiritual, psychosocial needs of children.

2. It should involve all forms of support that enable children to live a meaningful and positive life.,
3. the organization should ensure psychosocial support to maintain and enhance the children's existing links with their family of origin, friends, and the local community whenever it is in their best interest.
4. Family reunification as provided for in this Directive shall be applicable wherever this is possible and not contrary to the child best interests.

Standard 7: Behavior management

1. Care-givers should avoid any physical punishment and instead use positive discipline techniques.
2. Children should be protected from emotional abuse such as insulting, warning, belittling, humiliation, bullying, teasing and any form of isolation. Group punishment for individual behavior is prohibited.
3. Isolation except where necessary for medical or public health reasons is prohibited except where necessary for the immediate safety of other children and then only after all other possibilities have been exhausted and in accordance with policy.
4. Each residential facility should develop a behavior management policy which must be communicated to staff and children.

Standard 8: Inspection and monitoring

1. Inspection and monitoring of residential homes for children should take place annually.
2. A team of management and monitoring professionals should be established by the Bureau through representatives of government agencies, civil society organizations, community members, comprising not less than 5 people to conduct inspection and monitoring visits.

3. The team conducting the inspection and monitoring must interview children who reside in the residential home and may interview any member of staff employed there. Children shall not be interviewed in the presence of care-givers and shall also be interviewed separately.
4. A report outlining any concerns detected, and any improvements to be effected must be compiled within 2 weeks of the visit, and a copy made available to the manager of the residential home.

Standard 9: Safeguarding

1. Each residential home for children shall adopt a child safeguarding policy.
2. Child safeguarding measures include, but are not limited to:
 - a. Building the capacity of staff and children to recognize signs of abuse and how to prevent it.
 - b. Ensuring that particular care is taken to ensure preventative measures are put in place to safeguard children if activities or events are to take place in unfamiliar places and outside the community integrated care setting.
 - c. Minimizing the risk of inappropriate use of information, stories and visual images (photographs, video or social media) of children.
 - d. Reports on suspected or actual child abuse taking place, also outside the residential care setting.
 - e. Ensuring that care-givers and staff have access to advice and support where concerns or incidents of abuse or exploitation arise.
 - f. Ensuring that there is a sound and holistic assessment of any partner organization or identified service provider that will have contact with, and impact on, children.
 - g. Knowing who has responsibility for the care of a child at any given time.
 - h. Discussing with children what makes them feel safe and unsafe and agree on ways for children to complain if they have a concern about themselves or their friends.

- i. Any reported child safeguarding incident or concern is carefully assessed and, based on the results of the assessment; concrete actions are decided and put in place.
- j. Ensuring an independent reporting mechanism for staff and children is in place.
- k. Ensuring that anti-bullying principles are applied.
- l. Ensuring that the different needs of girls and boys are considered, and that the different needs of younger children and of adolescents are taken into account.

Standard 10: After Care Support

1. Children and young people who have left the residential home should have the opportunity to receive assistance and support after they left care for up to three years should needs be identified.
2. The residential home must designate a staff member to contact the care leaver at least quarterly to establish whether advice or support is required. The frequency however will be determined by the case worker based on the individual needs of a child.
3. The residential home should have an open-door policy. Children and young people who have lived there can always return to the residential home for advice and support, provided it remains operative.

PART TEN

CARE IN EMERGENCIES

69. General

During natural disasters, armed conflict, political violence, or any other cause which leads to mass population displacements or where migrants are returning, children are at risk of being separated from their families or caregivers and communities, extra precautions need to be in place in order to minimize this separation, which can be voluntary, involuntary, or secondary separation.

70. Principles for care during an emergency

During an emergency situation, government and service providers shall ensure that the principles set forth in this Directive are upheld, with particular attention to:

1. The primary responsibility of the care and protection of children lies with their families and communities
2. All efforts should promote and preserve family unity and ensure that families are kept together during an emergency
3. Communities should be supported to play a key role in monitoring and responding to the care and protection of separated and vulnerable children during an emergency.

71. Roles and responsibilities during an emergency

1. The Bureau shall work in close collaboration with the institutions in charge of emergency affairs and the relevant government line bureaus, agencies and bodies to ensure the care and protection of children during an emergency.
2. The Bureau shall ensure that all programmed , policies, and efforts of international and national organizations concerning the care and protection of children affected by the emergency, especially those who are separated from and unaccompanied by their families, are coordinated and that there are appropriate dialogue and coordination mechanisms in place.
3. The Bureau will work in should work together to protect refugees and coordinate refugee assistance interventions.
4. Child and Youth Protection Refugee Outreach Volunteers shall support monitoring and home visits for refugee children and their families placed in alternative care.

72. Minimizing risk of separation

1. During mass evacuation and population displacement, efforts should be in place to minimize separation by ensuring that families travel together and that children are accompanied by an adult at all times.

2. Management of internally displaced person (IDP) and refugee services shall ensure that evacuation and reception procedures do not lead to unintentional separation and include efforts.
3. Provide information by displaying prevention of separation messages at the point of arrival, identifying visible locations for parents and children to report separation cases, and deploying child protection officers throughout the camp.
4. Where children become separated, case management steps outlined in this Directive apply in an emergency context. Tracing efforts should commence as immediately as a child is identified as being separated.

73. Alternative Care in Emergencies

1. In emergencies, children should be placed in an interim care arrangement, preferably a family-type setting within his community, until he is reunified with the family and, if that is not possible, until a more permanent alternative care solution is found.
2. In case of emergencies, preparedness plans shall be put in place by identifying potential emergency foster families to minimize the use of residential care and facilitate family reintegration.
3. The following interim care arrangements should be provided during an emergency while tracing is being carried out to find the child's immediate family:
 - a. Kinship care;
 - b. Foster care;
 - c. Supported Independent Living for groups of older children.
4. Adoption should not be considered during an emergency. Adoption can only be explored after tracing and reunification efforts have been exhausted, and at least a two-year period must have lapsed before any adoption is considered must be enforced.
5. Residential care during the early stages of an emergency is not recommended and should only be used as a measure of last resort.

6. Establishment of new residential care facilities which provide care for large groups of children on a long-term and permanent basis should be prohibited during an emergency.
7. During emergencies, the opening of new residential care facilities shall be curtailed. If need be, placement in existing residential care facilities shall be as a last resort and for the shortest time possible.
8. Where the situation has ceased to be an emergency, placement in a residential care facility will not be for more than six months.
9. All efforts should be made to ensure that each child's care placement is registered, monitored, and reviewed by the respective authorities even in times of emergency.
10. All refugee children shall be included in the national civil registration and vital statistics (CRVS) database.

PART ELEVEN CASE MANAGEMENT

74. Case Management

1. Any formal alternative care for a child should follow case management processes as per the National Child Protection Case Management Framework.
2. The case manager and case worker and any other persons involved in the process of providing alternative care to a child under this Directive should follow the steps and processes described in the National Child Protection Case Management Framework (NCMF).
3. Where a child has been identified as separated from parental care, immediate efforts must be made to locate the child's parents and extended family. The process of tracing should be thorough and well-documented.
4. Where a child has been identified as separated and family cannot be traced, the case worker shall conduct verification and an initial screening using the form prescribed by the National Case Management Framework.

5. The case workers shall also perform the intake, register the child and conduct a vulnerability determination following the process and formats prescribed by the National Case Management Framework.
6. If the screening indicates that there is a serious, current threat of a criminal nature to the child, the child shall be directed to the police or to the health center if there has been physical harm.
7. The Child Protection Expert or relevant body is to be notified immediately of the report and immediate action taken.
8. State intervention to remove a child from the family setting should only be undertaken where necessary for the safety and welfare of the child as a last resort and should be temporary and carefully monitored and will be done with in accordance with the processes outlined in Part Two of this Directive.
9. Where a child is separated from family, the assessment should also seek to understand the causes of child separation and the family's views on reunification, as well as the child's views on reunification.
10. Case management must follow the steps set out in the Case Management Framework sequentially, namely identification of a child with potential protection needs, intake screening, assessment, care planning, implementation of the care plan, case review and case closure. Each of the steps must be undertaken and must be underpinned by the application of the best interests of the child.
11. No decision or action shall be taken without undertaking a Best Interests Assessment, which is carried out, if possible, by a multidisciplinary team requires the participation of the child.
12. Following an assessment, actors involved in case management shall evaluate and balance all the relevant factors in a particular case by, giving appropriate weight to the rights and obligations in the UNCRC, ACRWC, and CRPD, among other international legal instruments to which Ethiopia is party, so that a comprehensive decision for a specific child can be made that best protects the rights of children.

13. Actors shall undertake assessments and determinations of the best interests of a child in accordance with guidelines set forth by the Bureau of Women and children Affairs..
14. The Best Interest Determination (BID):should follow the formal process
15. Where it has been determined that a child is in need of protection, the caseworker is to register the child into the National Case Management System or CPIMSas per the criterion set out in these documents.
16. Procedures and responsibilities provided for in the National Case Management Framework are to be applied.

PART TWELVE

DATA MANAGEMENT AND MONITORING AND EVALUATION

75.Data Management

1. For the purpose of this Directive, data management is a process of collecting, storing, protecting, validating, analyzing, synthesizing, and disseminating data on alternative childcare services.
2. The Bureau of Women and children Affairs and service providers should dedicate adequate time and resources to data collection, recording and analysis as part of their working methods.
3. The Bureau of Women and children Affairs shall ensure that a regional database for alternative childcare services is in place and shall accord it adequate human and financial resources to support this system.
4. Data initially collected by service providers could be collected and recorded by using a paper- based data management system but should later be entered in the National Case Management System.

5. Service providers should detect and remove errors and inconsistencies from data to improve its quality. It is important to confirm that data are correct, complete and of the highest quality.
6. Where data is entered into the National Case Management System the individual entering the data shall ensure that any entry is immediately reviewed and confirmed for accuracy. Any errors shall be corrected.
7. The Bureau of Women and children Affairs and service providers should analyze data periodically to better inform decisions and budgeting.
8. The Bureau and service providers shall endeavor to produce high-quality, transparent reports to capture the achievements, challenges, and lessons learned which can offer evidence of robust evaluative processes to enhance services to children.
9. Service providers should facilitate training for their staff with the view to enhancing methods of reliable data collection.

76. Opening of a child file

1. A separate file should be opened for a child. The file of the child should accompany the child when the child is referred to another alternative childcare service.
2. Initial biographical data should be collected by the first point of contact with a child:
 - a. Date of identification;
 - b. Name (including nickname);
 - c. Sex;
 - d. Status of the child (abandoned, lost, unaccompanied);
 - e. Place and date of birth of the child/estimated age;
 - f. Whether the child has any disabilities;
 - g. Place and date of birth of family members;

- h. Previous and current caregiver;
- i. History of placement in alternative care;
- j. Name and contact details of parent(s)/extended family;
- k. Name of previous caregiver and contact (where available);
- l. Religion;
- m. Languages spoken;
- n. Current education status and name of school (where applicable).

77.Data storage, transfer, and security

1. Paper-based and electronic information should be kept in an individual file and each case should be recorded and clearly labeled with a case number.
2. Service providers and the Bureau shall ensure that data collected is secured and protected against unauthorized changes, copying, tampering, unlawful destruction, accidental loss, improper disclosure, or unauthorized transfer.
3. All electronic information on children should be password-protected, and the password changed on a regular basis. Passwords should not be shared between individuals.
4. For paper files, the Regional **Bureau** and service providers shall ensure that no identifying information is provided on the cover of each case file and that each file is clearly labeled with the individual case file number.
5. Paper files should be kept in a secure place, with access restricted on a need-to-know basis.
6. The sharing of information among key actors is limited on a need-to-know basis and only where it is in the best interests of the child.
7. Service providers should develop information sharing protocols or agreements to ensure that case-related information flows regularly, safely, and ethically.

8. Where paper files are to be transferred, files should be stored in a sealed box or sealed envelope.
9. Paper data should be discarded per data discarding procedures set by the authorized government body.
10. Where information is shared electronically, information should be transferred by encrypted or password protected files whether this is by internet or otherwise.
11. The Bureau and service providers should make backup copies of any electronic files on a regular basis. A safe and secure secondary electronic storage method shall be identified in a central location.
12. Computers should be tailored with latest anti-virus software to avoid corruption and loss of information.
13. Service providers should share files with relevant institution, and where services or projects phase out, and remaining files must be transferred to BoWCA .

78. Reporting

1. Service providers are also expected to have their own monitoring, evaluation, and reporting mechanisms. These mechanisms shall help service provider's track, understand, and ultimately improve the quality and reach of services that are being provided.
2. For the purpose of reporting, service providers shall submit disaggregated data which includes, at a minimum:
 - a. Number of children and family served through the case management system.
 - b. Demographic status of the children (age, sex, health, education, economic status of the family and other related information).
 - c. Case category of primary concern.
 - d. Number of referrals made per child and for what services.
 - e. Number of children requiring case conferences.

- f. Lengths of time children are receiving case management services.
 - g. The number of cases closed and reasons for closure.
3. The data could be collected and compiled by a monitoring and evaluation officer, project team or case workers working directly with children or families.
 4. Service providers shall submit reports to the Bureau , relevant institution , on a quarterly and annual basis utilizing the prescribed form to be developed by the Bureau. Additional data reporting requirements can be found in the forms of care set out in this Directive and SOPs to be developed.

79. Monitoring and Evaluation

1. Roles and responsibilities

Regular monitoring and evaluation of service providers shall be done by the relevant institutions or the Bureau with the intention of supporting and supervising the quality of services.

2. relevant institution is responsible for:

- a. Reviewing quarterly and annual reports submitted by service providers;
- b. Conducting the periodical review of project implementation;
- c. Organizing review meetings with alternative care service providers;
- d. Providing feedback to the service providers after the review meetings.

3. Service providers should consider conducting process and impact evaluations to evaluate their programs.

4. Evaluation

5. The Bureau and relevant institution shall monitor and evaluate the implementation of alternative child care services and service providers in accordance with the standards to be set out in a future guideline, SOP or directive on this issue. The evaluation team shall:

- a. Review of information from monitoring checklists;
 - b. Keep minutes of review meetings;
 - c. Collect feedback from beneficiaries;
 - d. Review of quarterly and annual reports from service providers;
 - e. Conduct site visits and compile field reports.
6. Evaluations conducted shall be conducted twice a year (mid-term and year end). In so doing, they will take into account:
- a. The policies and practices of the service provider;
 - b. Social service workforce and capacity;
 - c. Whether the service providers provision of services is in children's best interests and in line with the rights of the child, including by reviewing whether the service provider is effectively undertaking appropriate case management procedures;
 - d. Whether service providers is achieving or has achieved their general/specific objectives;
 - e. Whether the service provider takes into account community participation and the participation of children;
 - f. Whether the service provider mainstreams gender and disability into its services;
 - g. Well-being, protection, and safety for children in a provider's care as well as in other forms of alternative care;
 - h. Whether case transfers and closures are administered properly;
 - i. Whether post-placement services are properly implemented.
7. The evaluation team will have its own checklist by which the performance of the project is measured against the project plan in compliance with the standard.

8. Service providers should consider the feedback given by pertinent government bodies as an input to improve programming.
9. In all monitoring and evaluation activities undertaken in this Part, the National Child Protection Standard Operating Procedures are to be adhered to.
10. Lesson Learned
 - a. The Bureau should endeavor to document lessons learned at regional level based on the experience of each service and this should be disseminated to the TWG and the regional Task Force which will be established at the national level in accordance with this Directive.
 - b. Service providers should consider conducting trend analysis internally to show the lessons learned and share it to alternative and residential care. The lessons including key achievements, challenges, and lessons learned and these should be documented and shared with the Bureau.

PART THIRTEEN

MISCELLANEOUS PROVISIONS

80. Accountability

Any person, government employee or service provider responsible for taking care of children who causes harm to children in violation of the provisions of this directive shall be liable under administrative or criminal or civil law, as appropriate.

81. Transitory provisions

1. As the children's rights and operational systems stipulated in this directive are under gradual development, their applicability will have a transition period of one year. Any service provider inconsistent in undertaking its responsibilities under this directive after one year from the date of issuance of the directive is subjected to liability.

82. Mandate to Establish Standards and Procedures

1. The Bureau may issue standards and forms necessary to implement this directive.

83. Inapplicable Guidelines and Procedures

1. Any guidelines or procedures inconsistent with the provisions of this directive will not be applicable.
2. If previously issued guidelines and procedures provide better rights or care than the rights given to children in this directive, they will continue to be applicable only in that case.

84. Effective Date of the Directive

This directive will be effective as of _____ 2024.

Beyida Mundino

Head of Central Ethiopia Region Women and Children Affairs Bureau