Chapter 18
Enabling Full Participation: A Community-Led Approach to Child Protection

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18.1 Introduction

Humanitarian and development work are currently of high importance, as the global burden of refugees and displaced people has reached unprecedented levels and inequalities have multiplied rapidly. Although humanitarian and development work has made significant contributions to human well-being, there is considerable room from improvement (Slim, 2015).

Peace psychology offers a useful lens for identifying and guiding some much needed improvements in the way in which humanitarian and development work are done. A cornerstone of peace psychology is the importance of social justice and the ending of the structural violence that both enables much direct, episodic violence and causes extensive suffering itself (Christie, Tint, Wanger, & Winter, 2008; Christie, Wagner, & Winter, 2001; Deutch, 1985; Galtung, 1985). From this standpoint, it is useful to use a peace psychology lens to analyze ways that humanitarian and development work may unintentionally contribute to social injustice and structural violence.

As we argue below, work on humanitarian support in emergency settings and on longer-term development in more stable settings has typically used a top-down approach in which outside experts and nongovernment organizations (NGOs) analyze a problem, identify the relevant intervention, and lead the intervention and its evaluation. This approach marginalizes local people and often imposes outside approaches that marginalize local culture (Kostelny, 2006; Wessells & Monterio, 2001). In fact, local people are actors who can bring local resources, understandings,

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and creativity into play in service of solving their own problems in ways that fit the local context (Wessells, 2015).

Even when humanitarian and development agencies have deliberately enabled participation by local people, it is often neither highly inclusive nor very deep. In the field of child protection, for example, humanitarians (the authors included) work under intense pressure for urgent results, leading to a "participation light" approach. As explained below, the most vulnerable people are often left out, and local people hold little real power.

Fortunately, current global efforts in the humanitarian sector call for a transformation in the way humanitarian assistance is provided. This proposed transformation, known as the Grand Bargain, has as one of its central pillars full participation – with voice and power – by all people, including children and people who are most vulnerable (Australian Aid et al., 2016; IASC, 2016; ICVA, 2017). This revised way of working applies to many different sectors, although this chapter attempts to show its transformative power within the field of child protection.

The purpose of this chapter is to analyze how more participatory approaches to community-based child protection can help the child protection sector achieve the high levels of inclusivity, participation, and local ownership that contribute to relevant, effective, and sustainable support for vulnerable children. The chapter begins with an analysis of the limitations of the dominant, top-down approach to community-based child protection. Next, using a case study from Kenya, it examines a bottom-up, community-led approach to child protection that places the power to make the key decisions in the hands of local people and achieves high levels of inclusivity and local ownership. It concludes with a reflection on the potential value of enabling bottom-up approaches in developing wider child protection systems.

18.1.1 The Limits of Top-Down Approaches

Top-down, expert-driven approaches are needed and effective in specific contexts, but not in all contexts. For example, in emergency situations where protective processes have been damaged or do not exist, it may make sense for agencies to use a top-down approach. Nonetheless, they have limits to enabling full participation by communities.

A first limitation is that communities are viewed as beneficiaries and thus become passive recipients of an intervention. The communities are viewed as in need of education about child protection and child rights and are seen as having harmful traditional practices and norms, such as female genital mutilation, child marriage, child labor, and corporal punishment (Wessells et al., 2015).

A second limitation is the power asymmetry between the experts and local people. Organizations hold the power, and communities have little input as to the issue to be addressed or what action will be taken. Experts analyze the situation and select the intervention according to the issue to be addressed and child protection standards. They, or a local community-based organization (CBO) partner, typically

manage, guide, and train community members. They also provide most, if not all, of the resources for the intervention. The intervention often follows a manual or protocol with specific time schedules and log frames that are not part of the community's usual rhythms.

A third limitation of a top-down approach is that children's participation is often low or marginal. Though many NGOs aim to support child participation, this is seldom achieved. For example, because most children do not attend community meetings, and children are typically not given a platform to speak, they would have no input into decisions to partner with an NGO on a child protection issue. Furthermore, when children are members of an intervention such as a child welfare or child protection committee, they often are token members with little voice or influence (Wessells, 2009).

A fourth limitation is lack of inclusiveness – typically, the views of the entire community are not brought forth. At the beginning of an intervention, community meetings organized by NGOs often consist of several meetings where some subgroups of the community are not represented. These are often the most vulnerable groups, including the poorest of the poor, the disabled, and the children. The discussion usually is focused on specific categories of child protection or child rights that fit the programming approach of NGOs – such as violence against children, child marriage, and child trafficking. Typically, the discussion is not geared to deep and extensive listening about the community's main concerns about children.

The limits of a top-down approach are strikingly apparent in one of the most widely implemented child protection interventions – community child welfare committees or child protection committees (Wessells, 2009). In a comprehensive, global review of this extensively used child protection intervention, it was found that child protection and welfare committees were overwhelmingly based on NGOs' agendas. Community members played secondary roles to the roles of experts who organized, trained, and "mobilized" the communities. For the most part, the outside experts did not learn about or take into consideration the communities' traditional beliefs and practices regarding children. Not surprisingly, the community viewed these child protection committees as NGO projects, and local people felt low ownership of the projects. The child welfare committees were thus not sustainable when the NGOs finished their projects at the end of funding cycles – a finding of great concern as this review also found that community ownership was the most important factor for effectiveness and sustainability (Wessells, 2009).

Moreover, there is increasing evidence that top-down, impositional approaches, such as teaching child rights, can lead local people to view child rights as a harm to children and to even go to great lengths to continue traditional practices that clash with human rights standards under the radar to NGOs (Wessells & Kostelny, 2017; Wessells, Kostelny, & Ondoro, 2014).

18.1.2 Community-Led Approaches

Previous research has documented the effectiveness of community-driven approaches in other sectors, yet in the field of child protection, it has not been widely used. Such community-led approaches are part of a wider family of participatory action research (PAR) grounded in the work of Paulo Freire (1990). Primary tenets of community-led approaches include high levels of participation and stress equality where researchers and community members contribute equally while paying attention to issues of power, gender, and class (Minkler & Wallerstein, 2008).

Importantly, in advancing community-led approaches to child protection, communities are recognized as having social and cultural strengths, experience caring for children, concern for children's well-being, and agency. Their strengths are at the forefront, with community structures and processes built on whenever feasible. A primary tenet is that communities hold the main power. They decide the issues to be addressed on behalf of vulnerable children, plan the action, and guide and implement the work at their own pace (Wessells, 2018). The community also decides whether and how to work with NGOs, community-based organization, or government actors. For example, NGOs may have roles as facilitators who help communities engage in inclusive discussions and problem-solving, but who do not lead communities to a predetermined conclusion such as needing to engage in "child rights" or "violence against children." Also, if invited by communities, NGOs may help to build the capacities for designing and implementing the intervention.

Community-led approaches are highly inclusive as communities themselves decide how to include people who do not usually participate in full community decision-making, such as the disabled, the poorest of the poor, the marginalized ethnic groups, and the children. The entire community undertakes this work, with many community members engaging in the process. Importantly, children achieve high levels of participation as adults become more aware of the value of children's views and recognize the importance of children's leadership in addressing harms to children.

In a community-led approach, NGOs play a nondirective role. As co-learners, they listen extensively to communities and learn about children's issues and existing community mechanisms to support children's well-being. In assessments, the focus is on open-ended learning rather than on predefined questions or surveys, and local people may help to collect the data. International child rights and child protection language that are alien to the community should be avoided. Following the assessment, the findings are shared with the community in a respectful, appropriate manner.

Throughout the community action, the community monitors its work through agreed-upon processes, with room for making adjustments. Communities also evaluate their action using locally derived outcomes for children's well-being. External evaluations may also be conducted, using locally derived outcome indicators, with the findings shared in a culturally appropriate manner with community people, who discuss the implications of the findings.

Although community-led approaches have not been widely used in child protection work, they have shown promising results. In Sierra Leone, rural communities chose to address teenage pregnancy using a combination of their own locally grown approach to family planning, sexual and reproductive health, and life skills. This work was notably holistic and entailed making connections between health and child protection sectors. Before the community-led action was scuttled by the Ebola crisis, it had achieved significant reduction in the levels of teenage pregnancy. Also, it achieved high levels of community ownership, with significant leadership by children and participation by people who had been marginalized previously (Wessells, 2015). In this respect, it contributed to social justice within the community. This constellation of benefits resonates with those visible in a case study from Kenya, which is described below.

18.2 An Exemplar from Kenya: Starting with the Community

In Kenya, action research on community-based child protection mechanisms (CBCPMs) stressed the importance of learning from communities by listening to children and other community members about children's lived experiences. It then supported the communities' efforts to address their most serious child protection issue.[1] Throughout Kenya, many of the child protection risks identified by international NGOs were female genital mutilation (FGM), early marriage, and violence against children, and many organizations had specific, agency-developed interventions for these issues. This research, on the other hand, sought to learn what communities found to be the most serious harms to children and what protective factors were already there within the community. It then gave the reins to the community to plan and implement its own intervention.

The action research featured two phases: The first phase featured ethnographic processes to learn about children, child protection harms, and community responses to those harms.[2] In the second phase of the research, which took place in two rural communities in Kilifi county in Kenya, communities identified the child protection issue to address and then planned and carried out the intervention activities themselves. The planning phase took 1 year, followed by the intervention, which will be for 2 years (the intervention has been in progress 1 year at the time of writing).[3]

[1] The research was initiated by the Interagency Learning Initiative.

[2] The first research phase took place in three locations: Kilifi, Mombasa, and Kisii/Nyamira.

[3] Prior to the intervention activities, a baseline was conducted with an endline evaluation planned after 2 years.

18.2.1 Phase 1: Deep Listening Through Rapid Ethnographic Research

The research began with deep listening to children and communities through a rapid ethnographic process (Charmaz, 2004; Kostelny, Ondoro, & Wessells, 2017). It sought to learn about local conceptualizations of harms to children, protective factors, and community mechanisms for supporting vulnerable children.

The research used a mixture of narrative and participant observation methods, including in-depth interviews, group discussions, and timelines with adolescents and adults that enabled learning about children's development, and body mapping that enabled learning with young children. Recognizing that people in communities are positioned in very different ways, deliberate effort was made to learn from subgroups of young girls, older girls, young women, elder women, young boys, older boys, young men, and elder men (Kostelny, Wessells, & Ondoro, 2014).

Kenyan researchers carried out the research after extensive training in ethnographic methods by international and Kenyan researchers and after gaining permission to talk with the community from the village chiefs and elders. The national researchers lived in the communities for several weeks and were overseen by experienced Kenyan mentors. In the communities, the researchers emphasized that they were not experts, but learners, and asked communities to teach them about the situation of children in their communities as they knew best about the situation of their children.

This ethnographic process aimed to provide a rich, grounded picture of local beliefs, values, and practices regarding children, their developing activities and social relations, and the community mechanisms for their protection and well-being (Mignone, Hiremath, Sabnis, et al., 2009). It sought to identify how local people understand children and childhood, what they saw as the main harms or risks to children, what CBCPMs existed and how they were used, what protective factors enabled children's positive coping and resilience, and whether and how the CBCPMs linked with elements of the formal, government-led aspects of the national child protection system (Kostelny et al., 2014).

The researchers/learners asked simple questions to explore the actual functioning of CBCPMs, including:

- Whom do children go to when they need help?
- Who makes decisions?
- Which actions are taken?
- Which outcomes are achieved?
- How do stakeholders who occupy different social positions (such as parents, children, and community members) view the outcomes?

18.2.2 Harms to Children

Two of the main harms to children consistently raised by all subgroups in the community were early pregnancy and early sex. Early pregnancy was viewed as a harm primarily when the girl was not married, as a married girl was viewed culturally as "ready" for pregnancy. Early sex was also viewed as a major harm as girls and boys engaged in consensual sex at as early as 10 years of age, and girls became pregnant after reaching puberty, at around 14 years of age. Consensual sex frequently took place at or around video halls, dances, or *disco matangas* (funeral celebrations that raised funds for the grieved family). Also widespread was nonconsensual sex between young girls and older boys and men that was rooted in male power, economic hardship, and inability to meet basic needs. The other harms that were frequently identified – children being out of school, alcohol and drug abuse, poor parenting (e.g., parents neglecting children, not providing for children's basic needs, not sending their children to school, and not being good role models), negative influences (e.g., video halls, mobile phones, pornography), heavy labor, and child beating – overlapped and were frequently associated with causes or consequences of early pregnancy and early sex.

18.2.3 Preventive Factors

Preventive factors were identified at diverse socio-ecological levels (Bronfenbrenner, 1979) such as family, peer group, school, and community levels, and families and communities made efforts to keep their children safe and out of harm's way. For example, at the family level, in the past, parents played a key role in protecting girls from early pregnancy by teaching and advising on good behavior, though many parents were not doing this anymore. At the peer level, youth groups provided peer education about family planning. In schools, the provision of food reportedly helped to prevent children from dropping out of school and thus being more susceptible to becoming pregnant. The preventive factors, as well as the limits of preventive factors, are presented in Table 18.1. With such an approach, it should be noted that preventive factors identified by the community may clash with international child protection standards. For example, beating children who went to places where alcohol was available to children and where girls were sexually exploited was considered a preventative measure, though beating children would not be endorsed by the child protection sector.

A key finding of this research was that local people relied overwhelmingly on family and traditional community mechanisms and seldom, if ever, used the formal system (e.g., child protection officers, police, courts), even when criminal offences are involved. In this regard, there is a near total disconnect between communities and the formal child protection system. This disconnect, also reported in other studies (Bai, 2009; Thompstone, 2010; Wessells et al., 2014), owes not only to limited

Table 18.1 Protective factors, limits, and intervention activities at different social-ecological levels

	Risks and limits to preventive factors	Existing protective/ preventive factors	Intervention activities developed by community
Individual		Good behavior such as dressing modestly by girls	Life skills of "saying no" to boys and men
Family	Poor parenting (lack of knowledge and skills about talking with children about puberty and sex) Strong peer norms of consensual sex outweighed guidance and threats of punishment for engaging in early sex Girls were often coerced into sex and became pregnant as a result of sexual exploitation and abuse Poor families were unable to meet girls' basic needs, leading many girls to engage in transactional sex	Paying school fees, taking on additional work *Education:* Parents and extended family advised children and taught them good values and behavior *Discipline:* Parents did not allow children to go to night events at which drinking and sex were likely and beat children if they went *Economic support:* Parents with sufficient income met girls' basic needs for food and items such as sanitary pads	Parent training and support groups Parent-child dialogues Advising and counseling daughters
Peer	Norms of early sexual debut and consensual sex with peers, peer pressure from boys to have sex in exchange for goods, norms of having boyfriends/girlfriends and engaging in sex	Youth clubs; village soccer team for girls	Soccer teams for all girls and boys; child and adolescent messaging; peer mentoring
School	Significant numbers of children were out of school; teachers sexually abused girls	Teachers provided guidance and education about appropriate behavior, and they monitored children's behavior Provision of food at school to encourage children to attend; pregnancy tests	Life skills training

(continued)

Table 18.1 (continued)

	Risks and limits to preventive factors	Existing protective/ preventive factors	Intervention activities developed by community
Community	Older men sexually abused girls Boda boda (motorcycle taxi) drivers enticed girls with money and transportation Norms of boys and men giving girls material items in exchange for sex	*Religion:* Religious leaders counseled abstinence and taught good values and behavior. Religious groups helped to raise money to help children stay in school *Contraception:* Birth control methods such as "injections," pills, and implants were available *Discipline:* Village elders disciplined girls for inappropriate behavior *Economic support:* Community groups helped to raise or loan money that enabled children to stay in school	Sports; mentors; parenting classes and support groups; children out of school committee; theater group

access but also to cultural norms that favored traditional family and community mechanisms and mitigated against taking problems outside one's family or community.

18.2.4 Phase 2: Community Action – Selecting the Issue to Address and Developing the Intervention

At the end of the ethnographic research, a community-wide meeting in each of the two communities, with nearly the whole community in attendance – including children and the disabled – was held. This was important as the community reported that while NGOs had previously come to do surveys and research, none had ever come back to discuss the findings. After presenting the priority issues that they had learned about, the researchers invited discussion, and the communities validated the harms identified, including that early pregnancy, early sex, and children out of school were priority issues. Importantly, this meeting served as a catalyst for community members to begin their own planning of how to address these issues. In one community, an immediate action was that a "children out of school" committee was formed on the spot to address the issue of children not in school by encouraging parents to take children to school early (i.e., at age 6) and to monitor children and parents to ensure that their children are going to school regularly. In the other community, a youth group took on the issue of early pregnancy, initiating outreach to

vulnerable youth and providing peer mentoring and information about contraceptives.

The next phase of the action research included identification of the issue to address, planning the intervention, and implementation of the activities. Critical to the intervention was the community-led action. To support the communities, a community facilitator was hired by the Interagency Learning Initiative. Qualities of the facilitator included being humble, patient, tolerant, and understanding. The facilitator was of the same ethnic group, spoke the same language, and was knowledgeable about local customs. Their role was to support the communities – facilitating meetings, posing reflective questions to encourage participation, and observing and documenting the process. Throughout the process, the facilitator worked to build the communities' trust. It was important that the facilitator did not identify as being affiliated with any particular NGO so as not to risk being viewed by the communities as having an NGO-driven agenda. The aim was to put the communities in the driver's seat: They would identify the child protection harm to address, develop and plan the intervention, and carry out the activities.

For example, at the first community meeting of this phase, though the meeting was well attended by adults, youth, teenagers, and children, the facilitator posed a series of reflective questions that enabled the community to start thinking about the importance of involving everyone in the process.

Facilitator: Are all the community members here?
Chorus: Yes!
Facilitator: Do all the members of the community attend meetings?
Chorus: Yes!
Facilitator: I would like us to reflect back home. Think about your house, your homestead, about your neighbors, and about the people you interact with everyday. Is there anyone that is not here?
Man: I have a neighbour who swore not to attend any meeting because he did not get the benefits that other people got who attended the meeting, like relief food.
Facilitator: Thank you. Do you have people with disabilities in this community?
Chorus: Yes.
Facilitator: Are they here?
Chorus: (Murmuring and people begin talking amongst themselves).
Woman: We have realized that there are people who are members of this community not here. People like those with disabilities, some of those who have completely shunned community meetings, some of the youth, especially the boda boda (motorcycle taxi drivers).

The dialogue continued to discuss how, in addition to the above mentioned, youth who worked as day laborers and people who lived at the far end of the village were not there. As a result of this discussion, the community made a plan for various outreach activities, including home visits by a task force committee that was formed, to invite and encourage those who do not usually come to community meetings. Many of these people attended subsequent meetings, and for those who could not attend because of disability, work, or other reasons, home visits were made to update these community members and seek their input to the planning process.

The facilitator then asked how the community would like to identify which harm to children to address. There were varied responses from different people. The adult

men suggested that there should be a larger community meeting where all the community members meet for a discussion. However, women differed with men saying that they would like to have a group of their own because they would not be able to talk freely in front of their husbands. The youth, on the other hand, also felt that they needed to discuss issues in their own group because they have their own unique issues. Children also said that they would like to discuss their own issues, because when they are in a group with the adults, they cannot always talk freely, especially the girls. Thus girls wanted their own group apart from the boys. The community continued to talk among themselves and ultimately decided that they would organize subgroup meetings to make sure that everyone is free to say whatever they feel like without fear. The following subgroups were formed, and each subgroup elected their own leaders:

- Girls (aged 9–12)
- Boys (aged 9–12)
- Teenage girls
- Teenage boys
- Female youth
- Male youth
- Women
- Men

With the aid of the community facilitator, the communities organized a series of meetings of the various subgroups and larger community meetings where all community members took part. Through continuous, intensive dialogue that occurred at all levels of the community during a several-month-long process, communities ultimately chose the issue of "early sex" to address, after coming at it via discussion of the causes of early pregnancy.

After deciding on the issue to address, the community decided *how* to address the issue, taking charge of the planning process. As before, the community members created an inclusive process with all the subgroups continuing to meet to dialogue about activities for the intervention. Because communities made their own decision about which issue to address and how to address it, they saw the intervention process as their own and were highly motivated to achieving success.

In each of the two communities, each subgroup elected a representative to an Implementation Planning Task Force that coordinated all the recommendations from the various subgroups. To include marginalized people such as children with disabilities, the Task Force members made home visits on a regular basis. The recommendations from all the subgroups were fed back to the Task Force and discussed in depth at community-wide meetings, which were attended by nearly the entire community. To enable people who lived far from the meeting place to attend, the community organized transportation via the *boda boda* drivers.

An Inter-Village Implementation Task Force was also formed, with elected representatives from both communities. The Inter-Village Task Force integrated diverse inputs and helped to define viable options, which were then fed back for wider community discussion. Over several months, the Task Force developed implementation

plans that outlined *what* the intervention activities would include, *who* would carry them out, and *when* and *where* they would take place. A coordinator was also elected by each community to be the focal point and oversee the intervention process.

The communities decided on multiple activities, tailored to their specific needs, avoiding the common error of taking a one-size-fits-all approach to intervention (Wessells, 2018). The activities were also constructed to reach different groups in the community. In addition to young girls, activities included parents, young boys, teenage girls and boys, and *boda boda* drivers as well as community-wide activities. The activities initiated by the community at various levels of family, peers, school, and community are aligned with the existing risks and preventive factors already identified by the community and can be viewed at various levels of the social-ecological framework (Table 18.1).

Importantly, child participation and leadership were at the forefront of the intervention as children and teenagers advocated for peer mentoring, sports activities, drama groups, and life skills training, and planned how the activities would be carried out. To help implement the intervention, the communities identified three key individuals from within their communities – a male teacher who had parenting education skills and was passionate about supporting good parenting practices; a female teacher who was a positive role model and had experience in life skills training; and a male youth activist who had experience working with a theater group – to help build capacities to address early sexual debut. The children out of school committee had already been formed with concerned community members at the community feedback session and was deemed to be an important part of the intervention.

Key elements of the intervention included:

Peer Mentoring: Older girls who were positive role models mentored younger girls about making good decisions, staying in school, and avoiding getting involved in early sex.

Life Skills: The girls' life skills facilitator is one of the few young women from the community who has gone to college and become a successful primary school teacher. A positive role model, she facilitates life skills sessions with girls that focus on critical thinking, decision-making, and problem-solving. She provides mentoring on weekends and especially during school holidays when children are idle and tend to get involved in early sex activities. Informal peer education occurred also through everyday discussions in the community.

Sports Activities: Children and teenagers identified sports activities as a channel through which they could develop leadership and life skills relating to abstaining from early sex. Girls have formed soccer teams for all girls. Recognizing that children talk in distinctive ways, children created their own messages to spread to their peers during matches and tournaments, as well as an on ongoing basis in the community. One message was *huriza ngoma, mashomo ni madzo* (avoid early sex; education is important). Older girls provide peer mentoring for younger girls on the team, and the life skills educator facilitates discussions on decision-making and critical thinking after practices and tournaments. In addition, a boy's football team was formed, and the boys are also trained on life skills including treating girls respectfully, not pressuring girls for sex, and abstinence

Theater Group: Children and teenagers reactivated a theater group as a venue for transmitting messages about early sexual debut. The theater activities include groups of 9–12-year-old and 13–15-year-old boys and girls, who also develop their own messages to pass along to their peers. They perform for adults, teens, and younger boys and girls, with discussions afterward about how to prevent early sexual debut through making good decisions.

Positive Parenting: Parents participate in workshops that cover topics such as early child development, communicating with and advising older children on puberty, sexual and reproductive health, and pregnancy prevention. Parents also formed support groups as well as shared information they learned with other parents. A well-respected local teacher, identified by the community, conducts these workshops.

Children Out of School Committee: The community identified children out of school as a critical child protection issue related to early sex. Having received feedback from the ethnographic research, the community mobilized itself and elected a "children out of school committee" that has included parents, boys, girls, village elders, pastors, and imams. Through a combination of home visits, referrals to the chief, and work with faith leaders to emphasize the importance of education, this work has reduced absenteeism and dropouts.

18.3 Conclusion

Together, these examples illustrate how work on child protection in difficult settings may be strengthened through the use of a social justice lens. By using a social justice lens, practitioners can interrogate how their engagement with communities contributes to social equity or, alternately, causes unintended harm by marginalizing particular people or subgroups. Because it promotes full participation and local ownership, the resulting community actions are more likely to be contextually appropriate, sustainable, and effective in benefitting the most vulnerable children, who too often have been marginalized in child protection work. The community-led work described in this chapter illustrates the potential value of using a social justice lens in a systematic manner to strengthen practice. The challenge for the future is to expand the use of a social justice lens throughout humanitarian and development work, enabling peace psychology to benefit highly marginalized people.

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