

# Care Reform in Rwanda



PROCESS AND LESSONS LEARNED 2012–2018



Republic of Rwanda



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# ACRONYMS

<b>IZU</b>	Inshuti z'Umuryango (Friends of the Family)
<b>NCC</b>	National Commission for Children
<b>NGO</b>	Non governmental organization
<b>TMM</b>	Tubarerere Mu Muryango (Let's Raise Children in Families)
<b>USAID/DCOF</b>	United States Agency for International Development/ Displaced Children and Orphans Fund



# Introduction



Children at a primary school in  
Rwamagana District, Rwanda.

There is widespread global agreement that children should grow up safe and protected in families rather than in harmful institutional care.<sup>1</sup> In Rwanda, the government has developed an ambitious programme of care reform and family strengthening that has seen over 3,000 children reunited with families and communities since 2012.<sup>2</sup> This programme is rooted in Rwandan cultural values, which place a strong emphasis on family care. Interventions have included legislative reform, strengthening the professional and volunteer child protection workforce, distributing support packages to vulnerable families and

developing foster care on a significant scale. This paper documents the care reform process and presents key lessons learnt. It is based on a review of Rwandan policy and programme documents and on interviews and focus group discussions with 65 stakeholders.<sup>3</sup> A glossary of key terms is included as an annex.

Rwanda is frequently acknowledged as a global leader in alternative care reform, and it is hoped that the learning presented here will assist those engaged in children's care and protection in Rwanda and beyond.

1 United Nations General Assembly (2010). Guidelines for the Alternative Care of Children. New York: UN.

2 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango / Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

3 This involved interviews or focus groups with 5 UNICEF staff; 2 academics; 14 NGO staff members; 6 government social work/programme managers; 6 government social workers and psychologists; 14 foster carers; 15 community volunteers and 3 orphanage managers.





Foster child with parents placed through the TMM programme.

The care reform process in Rwanda must be understood within the country's social, political and economic context. Rwanda is a relatively small country with a population of 11.8 million.<sup>4</sup> In 1994, the genocide against the Tutsi led to the death of an estimated million people.<sup>5</sup> After this devastating event, there was a strong determination for the country to heal and develop. In recent years, Rwanda has made huge progress in poverty reduction and economic growth.<sup>6</sup> However, it remains one of the poorest countries in the world and is ranked 159 out of 189 countries in the Human Development Index.<sup>7</sup>

Interviews with stakeholders suggest a highly dynamic policy context in which government priorities for reform are carried out rapidly. There is also a widely held belief in the capacity and responsibility of citizens to contribute to national development. For example, Rwanda has an extensive and active network of community health volunteers, and all adults are expected to take part in the Umuganda programme of community improvement on the last Saturday of every month. There is a strong sense of national pride, and policy reform is generally rooted in Rwandan values and community structures.

4 National Institute of Statistics of Rwanda (NISR) and Ministry of Finance and Economic Planning (Rwanda), Fourth Population and Housing Census, Rwanda 2012 (2014). Thematic Report, Population Projections. Rwanda: NSIR.

5 <http://www.cnl.gov.rw/index.php?id=80>

6 Better Care Network (2015). Country Care Profile Rwanda. New York: BCN, UNICEF and USAID.

7 United Nations Development Programme (2016). Human Development Report 2016: Human development for everyone. New York: UNDP.

# The number and characteristics of children in institutional care

Before 1994, Rwanda had 37 institutions caring for 2,800 children. Following the dramatic increase in the number of orphans and separated and unaccompanied children as a result of the genocide against the Tutsi as well as AIDS-related mortality, the number of institutions rose, and by 1995 there were 77 facilities caring for some 12,700 children. Efforts to reunite children with their families reduced the number of children in institutional care to about 5,380 in 1998.<sup>8</sup>

In 2011, the government of Rwanda and the non-governmental organisation (NGO) Hope and Homes for Children carried out an extensive survey that identified 3,323 children and young adults in 33 institutions. The survey suggested a 5 per cent rise in the numbers of children in institutional care since 2007; 55 per cent were boys and 45 per cent were girls. Eleven per cent were under three years of age, and the majority were placed in care prior to age seven. More than a quarter (26 per cent) were young adults who had entered these facilities as children and had been unable to integrate into community settings. Most children were placed in facilities in or close to their communities, for reasons including

the death of a parent, poverty, and family conflict or breakdown. Survey results and interviews carried out for this report suggest that institutions act as magnets for vulnerable children and their families, and that – prior to the current reforms – limited efforts were made to support families or identify other care options for children.

“Instead of being a solution, the institution creates something negative in the mindset of the population. When you have an institution, people around think this is the solution. Instead of looking for a better solution for children’s problems they think it’s better to send the child to the institution.”

– **NGO worker interviewed for this paper.**

The survey found poor standards of care in many facilities, with one member of staff often responsible for 13 or more children. Only 28 per cent of staff had received training in childcare or child development, and there were rarely sufficient resources to care for children well. Many institutions had been established by faith-based organizations, and most were run by national rather than international organizations. Facilities ranged in size from eight to over 500 children.<sup>9</sup>

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<sup>8</sup> Better Care Network (2015). Country Care Profile Rwanda. New York: BCN, UNICEF and USAID.

<sup>9</sup> All figures in these two paragraphs from Government of Rwanda and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda. Rwanda: Hope and Homes for Children.

Since the start of concerted reform efforts in 2012, there has been a dramatic reduction in the number of children and young adults in institutional care. Of the 3,323 identified by the survey, 3,142 (95 per cent) have been

placed in families or are living independently in communities. At the time of writing, just 178 children remain in residential institutions.<sup>10</sup> The table below shows the types of placements for children who have left institutional care.<sup>11</sup>

Type of Placement	# of children	% of children
Extended Families	1460	46
Biological Parents	628	20
Long-term Foster Care	522	17
Supervised and Supported Independent Living (for young adults only)	440	14
Adoption	66	2

Many institutions have closed down and others have been transformed into schools or centres for family support. The survey and initial reform efforts did not cover children with disabilities, though as discussed towards the end of this paper, efforts are currently under way to reunify these children with families or place them in foster care.

<sup>10</sup> TMM programme records and monitoring reports.

<sup>11</sup> Information provided by UNICEF.

# The elements of successful childcare reform in Rwanda

The literature review and interviews with key stakeholders suggest that the dramatic reduction of the number of children in institutional care may be attributed to seven key factors:

- Government commitment
- Legislative reform
- The Tubarerere Mu Muryango (TMM) programme, and developing partnerships for reform
- Strengthening the capacity of government agencies to oversee reform
- Developing a strong workforce of volunteers and professionals
- Packages of support and case management for reintegrated children and their families
- Developing foster care.
- Each key factor is discussed below, followed by an analysis of current efforts to reintegrate children with disabilities.

## Government Commitment

All of those interviewed for this paper commented on the importance of high-level government commitment to Rwanda's care reform process. This commitment is attributed to:<sup>12</sup>

**Children's demands:** Every year in Rwanda the National Children's Summit elicits children's perspectives on priority areas for change. The summit

involves elected representatives from all villages in Rwanda and the government takes conclusions seriously.<sup>13</sup> In 2011, children called for an end to institutional care, and the government made a commitment in response.

**Strong beliefs in the value of the family:** The idea of children being cared for by strangers and outside the community is widely perceived as alien to Rwandan culture.

**Evidence on institutional care:** The 2011 survey confirmed large numbers of children in institutional care, and the harmful conditions in which they were living, prompting government concern.

**Demonstrating that residential institutions can be closed down:** Following the 2011 survey, the NGO Hope and Homes for Children successfully piloted the successful return to family care of children from one institution and its subsequent closure. They then documented the lessons learnt. Reports on this process provided both proof that a transition to family care is possible, and a model for others to follow.<sup>14</sup>

## Legislative reform

Government commitment to reform is reflected in laws and strategies focused on children's care, the most important of which are listed in the box below. These policies were locally generated rather than prompted by external actors (such as donors). They are widely known about at multiple levels from national decision-makers to community volunteers.<sup>15</sup>

<sup>12</sup> These factors were identified by stakeholders interviewed for this report and in Better Care Network (2015). Country Care Profile Rwanda. New York: BCN, UNICEF and USAID.

<sup>13</sup> For further detail of the summit see: <https://reliefweb.int/report/rwanda/voices-most-vulnerable-children-heard-rwanda%E2%80%99s-annual-national-children%E2%80%99s-summit> [https://www.unicef.org/rwanda/media\\_12195.html](https://www.unicef.org/rwanda/media_12195.html)

<sup>14</sup> For further details of the pilot see: Government of Rwanda and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda. Rwanda: Hope and Homes for Children.

<sup>15</sup> Better Care Network (2015). Country Care Profile Rwanda. New York: BCN, UNICEF and USAID. Also confirmed by interviews with stakeholders for this paper.



## *Key policies relevant to childcare reform*

### **The Constitution of Rwanda (2003)**

The Constitution is the supreme law of the country, and it enshrines the rights of children including the right to be raised and protected in a family-based environment (Article 18 on Protection of the Family and Article 19 Child's right to protection).

### **National Integrated Child Rightst Policy (ICRP) and accompanying strategic plan (2011)<sup>16</sup>**

This legislation combines all policies related to children's rights to enable better coordination between ministries. The policy has seven key themes including alternative care. The policy states that every child has the right to be cared for by a family and commits the government to providing support for families and alternative care for children who cannot be looked after by parents. It states that care by extended family members will always be explored as the first option, and that children should only be placed in institutional care as a last resort. The strategic plan for policy implementation outlines necessary actions for closing down institutions and strengthening families. It commits the government to developing a professional social workforce and cadre of community volunteers with child protection expertise. The policy led to the establishment of the National Commission for Children (NCC) in Rwanda, which sits under the Ministry of Gender

and Family Promotion and is responsible for coordinating actions to promote children's rights. The NCC has developed operational guidelines outlining obligations for implementing and monitoring the seven key themes of the ICRP.

### **Cabinet brief – strategy for child care reform (2012)<sup>17</sup>**

- The strategy for care reform provides a detailed action plan for deinstitutionalisation, including:
- Building social workers' capacity
- Raising awareness of the harm caused by institutional care
- Developing foster care
- The reintegration process, including family tracing, assessment, preparation and follow-up
- Transforming institutions from residential care homes to family support centres.

The brief states that the Ministry of Gender and Family Promotion, and specifically the NCC, are responsible for care reform in Rwanda.

### **Other policies**

- In addition to these key policies, Rwanda's commitment to family-based care is also supported by the ratification of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

<sup>16</sup> Ministry of Gender and Family Promotion (2011). National Integrated Child Rights Policy. Rwanda: Government of Rwanda.

<sup>17</sup> Government of Rwanda (2012). Cabinet Brief – Strategy for Child Care Reform. Rwanda: Government of Rwanda.

## The Tubarerere Mu Muryango programme and developing partnerships for reform

The TMM programme was developed by the government of Rwanda and UNICEF in consultation with the United States Agency for International Development (USAID) to implement the cabinet brief strategy on alternative care. USAID's Displaced Children and Orphans Fund (USAID/DCOF) provided most of the funding, which has been in two phases.

Phase 1 (total budget USD 2.3 million) ran from May 2013 until September 2017. It focused on developing the capacity of the NCC, building the social workforce, closing or transforming institutions, and establishing a programme of family reintegration and support.<sup>18</sup> An evaluation of this first phase highlighted numerous successes, including:<sup>19</sup>

- A dramatic reduction in the number of children in institutional care
- Stronger government agencies responsible for care reform, and a professional social workforce
- Capacity building of a cadre of 29,674 child protection community volunteers
- Support to children's biological families and foster carers to enable safer reintegration into families and communities
- Successfully preventing new entry into institutional care through improved entry requirements and case management, awareness raising, and the development of emergency foster care.

Phase 2 (USD 3.5 million) runs from October 2017 to September 2019. It continues to strengthen the social workforce, community volunteers and NCC; and works to reintegrate and support separated children not reached by Phase 1, including children with disabilities and street-connected children. Phase 2 also works to address the high levels of violence and abuse experienced by children in Rwanda, which are a major cause of family separation.<sup>20</sup>

Having a large-scale programme that allowed for systematic and comprehensive rather than piecemeal reform has been important for three reasons. First, the TMM programme has allowed the near simultaneous closure or transformation of most institutions in Rwanda, meaning that children who leave one facility cannot simply enter another. Second, the resources devoted to the TMM programme have enabled the closure of facilities and reintegration of children in a safe and supported manner, thereby reducing the risk of further harm to children. Third, the TMM programme has led to systematic improvements in government and social welfare workforce capacity. These developments will help ensure the sustainability of change, and that benefits are not just restricted to alternative care, but extend to the wider protection of all boys and girls from violence, abuse and neglect.

The success of TMM may in part be attributed to the strong partnerships within the programme. The programme is managed by government through the NCC, with technical support from UNICEF and funding from USAID/DCOF. NGOs have also played a crucial role in providing technical assistance and supporting reintegration activities. A strong coordination body has helped prevent duplication of efforts, and enabled learning to be shared between partners.<sup>21</sup>

18 UNICEF and the National Commission for Children (2012). Tubarerere Mu Muryango! Lets Raise Children in Families! Proposal. Rwanda: Republic of Rwanda and UNICEF.

19 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango / Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

20 UNICEF (2016). Let's raise children in families! Preventing family separation and violence against children in Rwanda – Project description for phase 2. Prepared by UNICEF for USAID.

21 Benefits of having a large programme and other reasons for the success of TMM are noted in UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango / Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

This is of benefit not just to the TMM programme, but also to ensuring wider collaboration in child protection in Rwanda.

## **Strengthening the capacity of government agencies to manage and coordinate reform**

The NCC has overall responsibility for childcare reform, and for the implementation of the TMM programme. TMM programme managers are paid for by the TMM grant, but are employed by the NCC and report to the NCC Executive Director. This leadership from the NCC has been crucial: it means that the process is recognised as a home-grown government initiative, rather than as something that developed elsewhere.<sup>22</sup> As the NCC is responsible for coordinating all efforts regarding child rights, it also supports linkages to other relevant initiatives, such as those relating to early childhood development and disability.<sup>23</sup> To ensure that the NCC is able to effectively manage the TMM programme, the USAID/DCOF grant included funds to build capacity in relation to areas such as budgeting, planning and coordination, and monitoring and evaluation.<sup>24</sup> In addition to its two grants to support TMM, USAID/DCOF also provided, through a separate project, over USD 634,000 to support capacity-development of the NCC. This, plus UNICEF's continuous engagement with NCC, has created a stronger organization – the benefits of this are likely to extend beyond the care reform process.<sup>25</sup>

## **Developing a strong professional and volunteer workforce**

### **Introducing and strengthening a professional social workforce**

Before the TMM programme was introduced, there were no professional government-employed frontline staff working on child protection in Rwanda. The TMM programme enabled the NCC to recruit 34 social workers and 34 psychologists to support the reintegration of children and the closure of institutions, as well as staff at the central level to manage the programme. Thirty of the professionals have been absorbed into the civil service to become a permanent part of the government child protection system.

All of the social workers and psychologists have a relevant degree, and they also received additional training in child protection, case management and family reintegration through the TMM programme. The training was developed by the University of Rwanda and Tulane University in the United States. It involved a one-week course, followed by four weeks of training, spread over a year. The curriculum was developed in Rwanda to ensure that it was locally relevant. Training methods focused largely on participatory exercises and case reviews based on real challenges faced by social workers and psychologists in the field.

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<sup>22</sup> Ibid and confirmed by stakeholder interviews.

<sup>23</sup> From stakeholder interviews.

<sup>24</sup> UNICEF and the National Commission for Children (2012). Tumbarerere Mu Muryangyo! Lets Raise Children in Families! Proposal. Rwanda: Republic of Rwanda and UNICEF.

<sup>25</sup> UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tumbarerere Mu Muryangyo / Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

An assessment of reintegration in Rwanda in 2013 illustrated the vital role played by these professionals, and the importance of having trained and skilled staff available to support care reform. This review compared the reintegration of children whose placements were supported by professionals with those who had been returned to their families by institutions without this support. It found that the involvement of professionals was associated with children having higher levels of self-esteem and satisfaction with their placement. It also found that experience in institutional care led to some children being withdrawn, and that families receiving support from the social workforce had a better understanding of such behaviour and responded more appropriately to it.<sup>26</sup>

The 2017 evaluation of TMM Phase 1 had similar findings. It found that social workers and psychologists had helped to counsel and guide children in institutional care through the process of deciding to return to their families, and provided crucial follow-up support to children. The work of these professionals also had an impact on wider community attitudes towards children's care, and on the willingness of institutions to close or transform and provide other services. The evaluation showed that having a sufficient number of social workers and psychologists is vital, and that large caseloads can prevent children from getting the support they need.<sup>27</sup>

Interviews for this paper with social workers, psychologists, foster carers, institution managers and community volunteers confirmed the complex needs of children and their families during reintegration. Children may exhibit challenging behaviours or be anxious or depressed as a consequence of their separation. The families of separated children are often extremely poor, and have frequently experienced family breakdown, conflict, violence or abuse. Dealing with these

challenges requires both time and professional expertise, and these are not tasks that can be carried out by untrained volunteers without professional support.

The introduction of a case-management system has been vitally important to the effective work of the social workers and psychologists. This system provides guidance on each step of the reintegration process and sets out formats for making assessments and recording progress. Those interviewed for this paper reported that the use of a case-management system supported the provision of consistent, high-quality services; better record-keeping to ensure that children do not become lost in the system; and easier collaboration between professionals.

### **Establishing community child protection and care volunteers throughout Rwanda**

In addition to the professional child protection workforce, community volunteers are also playing critically important roles at village level. The Inshuti z'Umuryango (IZU – Friends of the Family) network of child protection and care community volunteers was initiated in 2015. Since then, 29,674 volunteers have been selected by their communities and received basic training, with one woman and one man active in every village in Rwanda.<sup>28</sup> The IZU identify particularly vulnerable children, including recently reintegrated children or those in foster care, and make household visits. Some IZU actually become foster carers. Depending on the needs of children and families, IZU make referrals to schools, health clinics and social workers or psychologists. IZU also raise awareness in the community, highlighting the problems associated with institutional care or promoting foster care. Some IZU run parent groups, which may include the parents or caregivers of recently reintegrated children.

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26 Lavin, B. (2013). *Assessment of Children from Orphanages in Rwanda*. USA: Tulane University.

27 UNICEF/ Primson Management Services (2018). *Summative Evaluation of the Tubarerere Mu Muryango / Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda*. Rwanda: UNICEF.

28 Ibid.



Although IZU are unpaid volunteers, interviews for this paper suggest that they need some support in order to be effective. UNICEF and Save the Children have established a programme across 11 districts in Rwanda that provides IZU with mobile phones, mentoring and refresher training. Comparing results between these districts and districts where IZU do not receive this support suggests that IZU are far more active and better able to help vulnerable children and their families when they receive this basic package.<sup>29</sup>

## Supporting reintegration and vulnerable families

The TMM programme has introduced a careful process of reintegration, including packages of support for vulnerable families. Steps in the reintegration process are set out in the box below. Effective engagement by professional social workers and psychologists in supporting children's reintegration was greatly enhanced by their placement directly into the care homes. This meant that they could have early contact with children and work closely with staff to support the reintegration process.



Foster child (first from right) with his foster family placed through the TMM programme.

<sup>29</sup> From interviews with UNICEF and Save the Children staff.

## ***Steps in the reintegration process***

1. Engage care-home managers and gain their commitment to the reintegration process.
2. Do an initial assessment of children, through interviews and care-home records.
3. Carry out a series of sessions with children – in groups and individually – to explain the reintegration process and explore the possibilities for their reintegration.
4. Develop a care plan to address any issues that may inhibit reintegration, such as challenging behaviours or health problems.
5. Carry out family tracing and identify relatives who could care for the child. These may be parents or other relatives such as grandparents or aunts and uncles.
6. Assess the family and explore their willingness and capacity to care for the child.
7. If reintegration is deemed to be in the child's best interest, begin the reintegration process.
8. If reintegration is not possible or advisable, seek a suitable foster or adoptive family for the child.
9. Prepare the child and family for reintegration. Support the family to overcome issues that may have led to the original separation (such as conflict in the family or extreme poverty). Ensure regular contact between the child and the family during this period.
10. Reunite the child with the family. At this point, the parent comes to the institution and receives a briefing to remind them of their responsibility and to prepare them for some of the initial challenges of caring for a child who has been institutionalised. For example, parents are told that the child may be withdrawn, and that they may not know how to carry out simple tasks or chores that have been done for them in the institution.
11. Have the parent to sign a contract to show that they are taking responsibility for the child.
12. Provide a reintegration package, which may include material support such as bedding or clothing, assistance to enrol in the national Ubudehe social protection programme, support to generate income, counselling and help with school fees.
13. Provide follow-up monitoring. Social workers usually visit two weeks after children return to families, then after a further month, then after a further two months, and finally after a further six months, though this timeframe may be adapted according to need. IZU are involved in monitoring children's safety and the reintegration process. Social workers and psychologists sometimes provide telephone support.

This reintegration process can vary greatly in length, from a few months to several years, depending on the challenges faced by children and families and on how easy it is to find families. The evaluation of the TMM programme found that in most cases reintegration was successful. Children usually remained within families and were able to identify many benefits to living in a family, including stronger family relationships and greater guidance from carers, reduced stigma, and a sense of belonging and identity.<sup>30</sup>

30 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango/ Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF. Forty-two out of the 2,388 children who were placed back in families were interviewed as part of this evaluation. Of these, only four had relocated to another family, and this was usually due to family conflict and divorce as opposed to the failure of support through the TMM programme.



“I feel less embarrassed when living in my family than when I was in an institution....Children in institutions are stigmatised, especially through name-calling.”

– **13-year-old girl interviewed for the TMM evaluation.**

As noted at the start of this paper, there were many young adults in institutional care who had been separated from their families as children. These young adults were reintegrated into communities at the same time as the children using a similar process, though they usually left institutions to live independently rather than in families. Young adults were

encouraged to support one another, and were helped to find housing and employment. For example, in Rubavu District, UNICEF and the NGO Hope and Homes for Children organized a meeting of 50 young adults who had left institutional care and were living in the community. Local entrepreneurs were also invited, to encourage them to employ de-institutionalized young adults, and care-leavers who are doing well in the community spoke to inspire others. It is hoped that meetings such as these will create local mutual support networks of care-leavers.



The TMM social workforce in post placement visit with a foster family.

Social workers reported that young adults often struggled to reintegrate.<sup>31</sup> Many were reluctant to leave facilities and were nervous about living outside. They were unable to care for themselves and did not know how to do basic tasks such as cooking or washing clothes. Young adults also needed help finding work and housing.

“The institution teaches dependence and the family, independence. In the institution, most things are done for the children and they missed opportunities to learn how to work for themselves. You can find a 30-year-old formally employed young man standing in the queue with a plate to receive his share of porridge with five-year-olds, yet he can rent a home of his own and live an independent life.”

– **Social worker interviewed for the TMM evaluation.**<sup>32</sup>

Social workers and psychologists were also able to cite many success stories of young people marrying and leading happy lives in the community. Interviews with young adults carried out during the evaluation of the TMM programme confirmed that of them are happier in the community.<sup>33</sup>

“In the family we learn about our culture and have role models to guide us on these things, but in the institutions they concentrate on keeping us well fed and going to school.”

– **Young adult who had grown up in institutional care interviewed for the TMM evaluation.**<sup>34</sup>

“I am now part of society and belong to a community.”

“I enjoy more options in life.”

“I have neighbours to talk to.”

“My family values me.”

“I feel more motivated to be a good person.”

– **Young adults who had grown up in institutional care interviewed for the TMM evaluation.**<sup>35</sup>

Interviews conducted for this paper and the TMM Phase 1 evaluation show that successful reintegration hinges on the role played by professional social workers and psychologists.<sup>36</sup> This suggests that care reform efforts must be carefully phased so that the workforce is in place before facilities are closed. Efforts to rush reintegration or carry it out without proper professional assessment and follow-up support can place children at serious risk of harm.<sup>37</sup>

## Preventing Further Separation

Reintegration efforts will not reduce the number of children in institutional care unless they are also accompanied by efforts to prevent the flow of children entering those facilities. Prevention efforts are therefore vital to care reform. In Rwanda, these efforts have included:<sup>38</sup>

- **A two-year mass media campaign** focused on the harm caused by institutional care and the benefits of children growing up in families. The TMM phase one evaluation suggested that those reached by this campaign developed a negative attitude towards institutional care. The campaign was strengthened by building on Rwandan cultural values around the importance of the family and through the use of church and local leaders.

31 Ibid. and confirmed in interviews carried out for this paper with social workers.

32 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango/ Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

33 Ibid.

34 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango/ Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

35 Ibid.

36 Ibid.

37 Inter-agency Group on Children's Reintegration (2016). Global Guidelines on Children's Reintegration. London: Inter-agency Group on Children's Reintegration.

38 UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango/ Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.



- **Closely monitoring remaining institutional care facilities** by social workers to ensure that they did not take in new children.
- **Development of emergency foster care** as an alternative to placing a child in institutional care. Carers could take children at short notice and look after them while assessments were made about whether they could return to families or be placed for adoption or longer-term foster care. In total, 150 emergency foster carers were trained during TMM Phase 1.
- **Working with teenage parents:** social workers and psychologists offered counselling to young parents and their families to try to avoid child abandonment, and the government is also supporting a wider public awareness campaign to prevent teen pregnancy.

“We noticed through our rapid assessment that a sizeable number of children in childcare centres had been dumped at the doorsteps of orphanages by teen mothers fearing rejection by their parents ... We therefore decided to provide advance counselling to pregnant teenagers to enlighten that an unplanned pregnancy is not the end of their life, while also sensitising parents to accept their children who make such mistakes.”

– **Social worker interviewed for the TMM evaluation.**<sup>39</sup>

## Transforming institutions

Since the start of the care reform process in 2012, a dozen institutions have closed and 14 transformed to provide other services to children and the community. These services include schooling, early childhood development, counselling and income-generating activities. Interviews with social workers, care-home managers and TMM programme managers suggest that although some managers and staff are resistant

to change, many are willing to transform facilities once they learn of the harm caused by institutional care, and receive the support needed to change. The evaluation of TMM Phase 1 found that reformed care homes were able to make a valuable contribution to supporting reunited children and their families.<sup>40</sup>

Transforming a residential care facility is not easy, and social workers described repeated meetings with care-home managers to promote reform. Staff and managers were concerned about their own jobs, but were also often worried about what would happen to the children in their care. As one of the managers of a former orphanage which has transformed to a centre of community outreach explained:

“Those children had become my children, I loved them as my own, to let them go was really tough, my passion was orphans. I felt like my heart was being taken away.”

– **Manager of Nibakure Community Village interviewed for this paper.**

Social workers reported that media campaigns on deinstitutionalization and government commitment to reform helped them in their work with care home managers. Once facilities had started to transform, managers also became powerful advocates for others involved in childcare reform.

“I advise [other care home managers] to let children go back to their families. If you take a child in a family and another one in an orphanage and if you put them together, you realize the one who is in the family is more equipped to deal with life. For the one in the family, you have time to care for them individually, but when they are in a group this is very hard.”

– **Manager of Ibambe Abajambo Orphanage interviewed for this paper.**

The box on the next page provides an example of the transformation of an institution.

<sup>39</sup> UNICEF/ Primson Management Services (2018). Summative Evaluation of the Tubarerere Mu Muryango/ Lets Raise Children in Families (TMM) Phase 1 Programme in Rwanda. Rwanda: UNICEF.

<sup>40</sup> Ibid.

## *An example of the transformation of institutional care<sup>41</sup>*

The Gisimba Memorial Centre was opened as an orphanage in 1980 by the parents of the current manager. The founders of the orphanage began by taking vulnerable boys and girls into their own home, gradually expanding until they were caring for 75 children at the time of the genocide against the Tutsi in 1994. During the genocide, the orphanage became a refuge for children and families in the neighbourhood, and many children who had been orphaned continued to live in the facility afterwards, leading to the orphanage growing to over 300 children. By 2012, there were 126 children being cared for in a large site on the outskirts of Kigali.

Despite having dedicated his life to the orphanage, the orphanage manager was enthusiastic about the changes proposed under the TMM programme. As he explained, he strongly believed in the value of family care, and saw orphanages as something alien to Rwandan culture:

“The family is part of traditional Rwandan culture, there never used to be any orphanages. Because of the advancement of technology and globalisation, people have become selfish and lost their sense of humanity and this is when orphanages come in.”

The manager had experienced the challenges and risks of poorly supported reintegration in the aftermath of the genocide against the Tutsi, and knew that children who were returned to families without proper assessment or follow-up could face discrimination and abuse. The TMM programme enabled him to fulfil his dream of safely returning all of the children in the facility back to their families or into foster care.

Now the Gisimba Memorial Centre supports extremely poor families from the surrounding neighbourhood, teaching them about basic nutrition. The centre runs after-school clubs, helping

children with their homework and instilling beliefs in the value of education. It also provides a holiday play scheme and feeding programme.

## **Introducing foster care in Rwanda**

Foster care involves the placement of children with unrelated carers who have been assessed by social workers. Since the start of concerted care reform efforts in 2012, 522 children have been placed in foster care. This has involved government-employed social workers recruiting, vetting and training foster carers; matching separated children with suitable placements, and providing follow-up monitoring and support. Foster carers usually come from modest, though not the poorest, backgrounds and are assessed to ensure that they can care for children without additional pay (foster carers in Rwanda are not paid). IZU are used to provide extra support and monitoring.

Foster care in Rwanda has been established in a number of different forms:

- Emergency foster care for children who need sudden and immediate short-term care. This may be appropriate for children living on the streets, or for children suddenly separated from parents due to death or accident and who need foster care to avoid being institutionalized.
- Short-term placements for children leaving institutions or following emergency foster care while efforts are made to initiate a reintegration process for children with their families or prepare for another long-term placement.
- Long-term foster care for children who cannot be reunited with families.
- Specialised foster care for children with disabilities.

<sup>41</sup> Taken from an interview with the manager of the Gisimba Memorial Centre for this paper.

Foster carers often provide more than one of these forms of care; and children placed in emergency foster care may remain in the family for short or long-term placements as necessary.

Foster care in Rwanda was initiated prior to the 2012 reform efforts, including through an initiative run by the Imbuto Foundation, a charity set up by Rwanda's First Lady, Janette Kagame. She had previously established a system of Malaika Mulinzi (Guardian Angels), who were community volunteers with a remit to identify and support vulnerable children. Some Malaika Mulinzi were encouraged to start taking children into their homes. They were initially supported by the Imbuto Foundation, and then through the TMM programme, which expanded and formalised the use of foster care.

Many in Rwanda continue to refer to foster carers as Malaika Mulinzi. This form of care is not perceived as externally imposed or 'Western', and is supported by the strong sense of citizen responsibility and the value placed on the family in Rwanda. However, there has been some cultural resistance to foster care, and foster carers interviewed for this paper reported that their families, friends and neighbours questioned their decision to bring an unrelated child into the household. Raising awareness through the church and at community forums has been important in overcoming these barriers, and IZU and social workers have played key roles in this process.

The foster carers interviewed for this paper were highly motivated by a desire to help the most vulnerable and to contribute to the growth and development of Rwanda.

"I lost my father in senior secondary and I remained with my mother. It was very hard to get school fees. God helped me, and one family who were friends decided to pay for school fees. My mother told me always to care for needy people. I decided to do what my mother told me."

– **Male foster carer interviewed for this paper on why he became a foster carer.**

"When the child gets someone who gives them love, their sorrow and anxiety is reduced and goes away."

– **Female foster carer interviewed for this paper on why she became a foster carer.**

Foster carers spoke of great satisfaction at being able to support children in need, but also of the challenges they faced in addressing the problems faced by the children in their care, who are often sad and anxious, and can exhibit difficult behaviours. Despite being selected as supposedly having enough income to care for children without extra support, some foster carers had struggled financially. This was especially the case if they had to stop work to care for a baby or child with disabilities, or if the child had complex health needs that required frequent visits to specialist health care. Foster carers said that although most of the other foster carers they knew were motivated by a desire to help children, they had heard of cases of fostered children being exploited and subject to discrimination. Social workers and IZU currently provide some monitoring and support to foster carers, and this observation suggests that this is vital.

"They [the social worker and psychologist] never put off their phones, night or day, and when there is a problem I can always call them and get support from them."

– **Female foster carer interviewed for this paper.**

Social workers reported that some groups of children were especially hard to place into foster care. Such children included those older than five years, abandoned children who needed emergency care, and children with disabilities. Social workers have tried to overcome this problem through discussions with foster carers to ensure that their reluctance was not based on misconceptions.

## Focusing on children with disabilities

The use of institutions is a deeply entrenched response to disability in Rwanda. Discrimination against those with disabilities is high. Charities (particularly faith-based agencies) rather than families, communities and government are widely perceived as being primarily responsible for the care of boys and girls with physical and intellectual disabilities. Services and support for children with disabilities are also extremely limited, and assistance devices (such as wheelchairs), physiotherapy and other services are scarce, especially in rural areas. Public buildings are not designed to give accessibility to those with physical disabilities. Only 57 per cent of children with disabilities in Rwanda attend primary school, compared with 87 per cent of children without disabilities.<sup>42</sup>

Interviews with disability experts carried out for this paper suggest that the reintegration of children with disabilities in Rwanda may be especially challenging, requiring extensive additional service provision, and changes to community and parental attitudes.

In Rwanda children with disabilities who do not live with their families are usually cared for in specialized facilities, and these institutions were not included in TMM Phase 1. Phase 2 is making a concerted effort to return children with disabilities to their families. This process began with a survey of institutions in 2016, which covered 49 of the 59 facilities run by the National Council for Persons with

Disabilities. These institutions care for a total of 4,349 children, with 71 per cent

of these centres offering overnight care, and 29 per cent day care. Evidence from the survey suggests the quality of care is poor. There are very high child to staff ratios, with an average of 31 children per caregiver. While staff from 27 facilities had been trained for their role, staff in the remaining 22 institutions had not received training. The survey found that many facilities lacked sufficient assessment, care planning, and exit strategies, and that children with disabilities commonly remained in institutions for long periods, often into adulthood.<sup>43</sup>

Following the survey, efforts have been made to lay the foundations for care reform focused on children with disabilities. UNICEF has supported the capacity of the National Council for Persons with Disabilities through strategic planning guidance and assistance in the development of partnerships. Guidelines have been developed on community-based rehabilitation, and institutions are being encouraged to do more outreach work in the community. Plans are also underway to pilot the closure of a residential facility for children with disabilities, drawing on learning from TMM Phase 1, and adapting processes to meet the specific needs of these children. The case-management guidelines used for children's reintegration have been reviewed and proposals made to develop these guidelines to inform work with children with disabilities.<sup>44</sup> For example, social workers will need to consider communication challenges that some children face and ensure that initial assessment for reintegration includes an

42 UNICEF Rwanda/ International Centre for Disability and Rehabilitation (2017). Rwanda Disability Situation Analysis Report. Rwanda: UNICEF. These issues were also confirmed by interviews with disability experts carried out for this paper.

43 National Council for Persons with Disabilities and National Commission for Children (2016). Report on the national assessment of centres caring for children with disabilities in Rwanda. Rwanda: Government of Rwanda.

44 International Centre for Disability and Rehabilitation (2018). Alternative care report and considerations for strengthening the TMM programme for the inclusive of children and adults with disabilities. (Unpublished).





Children's paintings from the TMM campaign.

appraisal of the child's functioning by a qualified professional. Efforts have also been made to develop standards for the institutions that care for children with disabilities, ensuring that the care of the children living in them is improved while reintegration procedures are being developed.

Those interviewed for this paper argued that it would be important to consider the use of small group homes for the care of children with disabilities. Some believe that family-like, community-based homes catering for fewer than 10 children or young adults can offer a viable alternative to institutional care for children with disabilities, and indeed such an approach was already successfully piloted for 47 young adults

during TMM Phase 1. Others, including the UN Committee on the Rights of Persons with Disabilities, take the view that the use of small group homes for those with disabilities is inherently inappropriate.<sup>45</sup> In addition to potential shortcoming as a type of care, small group homes might also act as magnets for the families of children with disabilities, leading to further family separation.

Care reform for children with disabilities in Rwanda is still in its infancy, and efforts are ongoing to place these children in family care and enable them to grow up safe and protected, and fully supported in families. This process will be documented and shared.

45 Committee on the Rights of Persons with Disabilities, General comment No. 5 (2017) on living independently and being included in the community.

# Conclusion and lessons learnt

There has been huge progress in care reform in Rwanda over the past decade. A family- and community-centred care system has been established that seeks to ensure that children are only separated from families when essential, and can be placed within communities rather than isolated in institutional care. The vast majority of children in non-specialized institutions have been reintegrated with their families and communities, and efforts are underway to reunite the remaining children. The process has not been easy, and numerous challenges have been overcome. Key lessons learnt include:

1. **Locally grown and owned solutions are vital.** Care reform has not been imposed externally. It has grown from Rwandan cultural values on the importance of the family, and has been driven by serious government commitment. Important components of the system, such as the introduction of foster care and the use of community volunteers, have emerged as home-grown solutions, building on existing community structures and practices. While it may not be possible, or even advisable, to precisely replicate Rwanda's reform elsewhere, the principle of identifying and building on existing strengths should be applied in other contexts.
2. **Successful care reform depends on and helps to build a strong, locally owned child protection system.** Care reform in Rwanda has solid foundations because change has been countrywide and guided by a systematically applied clear national policy. There are appropriate laws and policies, services have been established for vulnerable families, and there is a professional and volunteer workforce able to

implement change. Efforts have also been made to ensure that wider community attitudes support children leaving institutional care. The changes made through the care reform process have wider benefits, helping to ensure that there are government social workers and managers and systems in place to address other child protection concerns, such as violence against children. It is important to emphasize that TMM has not been just a deinstitutionalization programme, but a national care reform process with a clear long-term vision of all children living in safe, nurturing family care. Moving ahead, it is crucial that Rwanda maintains this momentum and continues to enhance the child protection system.

3. **Care reform requires sufficient numbers of well-trained professionals.** Social workers and psychologists have been centrally important to all aspects of care reform. They are vital for persuading institutions to support family reintegration, finding ways to meet the complex needs of vulnerable children and their families, and establishing safe and effective foster care. Community volunteers contribute to the work of these professionals but have neither the skills nor the time to replace them. The size and skillset of the workforce must be retained, and preferably increased to avoid placing children at risk, and threatening the considerable progress already made. The professional workforce is also vital to respond to other child protection concerns and to enable children with disabilities to live in family care.



4. **Community volunteers and foster carers make valuable contributions, and must be well supported.**

Traditions of volunteering have been integral to Rwanda's care reform, and have supported the establishment of a nationwide cadre of community volunteers and foster carers. The effectiveness of these volunteers rests on the support that they receive. Having systems in place to carefully recruit and monitor these volunteers is essential for the safety and wellbeing of children.

5. **Institutions can be transformed from a problem to an opportunity.** Through the careful work of social workers and psychologists, many of those running institutions in Rwanda have become key

supporters of children's reintegration. Numerous facilities are now bolstering the efforts of the government by providing services to children and families in the community. The decision to encourage buy-in rather than imposing reform on these stakeholders has paid off.

6. **Specific efforts must be made to reach all children who are outside family care.** The care reform process in Rwanda cannot be considered complete until all children are reunited with their families or provided with family-based alternatives to institutional care. Specific efforts to work with children with disabilities are essential and must be continued.



One of Rwanda's "Friends of the Family" child protection volunteers visits a family in Rwamagana District and reads some educational materials with a mother.

# Annex:

## Definitions of key terms<sup>46</sup>

**Alternative care:** Care for orphans and other vulnerable children (OVC) who are not under the custody or care of their biological parents for a variety of reasons (including abandonment, imprisonment of parents, detention/imprisonment of children, neglect of children and children who have run away from their homes or have lost contact with their parents due to conflicts/wars, and children separated from parents by natural disasters or in refugee camps). Alternative care includes foster families, guardianship, kinship care, residential care and other community-based arrangements to care for children in need of special protection, particularly children without primary care givers.

**Child adoption:** Permanent placement of a child in a family, whereby the rights and responsibilities of biological parents are legally transferred to the adoptive parent(s). An adopted child acquires the same status, rights and privileges accorded to any child of their adoptive parent(s).

**Child protection:** The process of preventing and responding to neglect, abandonment, violence and exploitation of children in any setting. It is often manifested as a specialist policy and service sector but of necessity works very closely and is sometimes integrated with other sectors.

**Child protection system:** A set of laws, policies, regulations and services needed across all social sectors, especially social welfare, education, health, security and justice

as well as community- and faith-based groups and other private service-providers. In Rwanda, child and family welfare and justice for children can be considered as the core sectors of a child protection system, while allied sectors include education and health.

**Deinstitutionalization:** Removal of children aged 18 years or younger from childcare institutions to place them in families under the care of biological, foster or adoptive parents, or extended family relatives. It also involves the removal of young adults older than 18 years from childcare institutions into communities where they live by themselves in an arrangement termed independent living.

**Foster care:** Placement of children through a competent authority into families other than the children's own home to receive care and support. Families that provide foster care first undergo thorough assessment and receive training before decisions to place a child can be made.

**Kinship care:** Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature.

**Young adults:** persons aged above 18 years who were moved through the TMM programme out of institutions to live in communities by themselves to expose them to a life of not being dependent on institutions for their upkeep.

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<sup>46</sup> Definitions are taken from: UNICEF and the National Commission for Children (2012). Tubarerere Mu Muryango! Lets Raise Children in Families! Proposal. Rwanda: Republic of Rwanda and UNICEF.



