

Evaluation of the Tubarerere Mu Muryango



(LET'S RAISE CHILDREN IN FAMILIES)
PROGRAMME IN RWANDA, PHASE 1: SUMMARY



Republic of Rwanda



Advancing Child Rights and Protection



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ACRONYMS

CBO	Community-based organization
M&E	Monitoring and evaluation
MIGEPROF	Ministry of Gender and Family Promotion
NCC	National Commission for Children
NGO	Non governmental organization
TMM	Tubarerere Mu Muryango (Let's Raise Children in Families)
USAID/DCOF	United States Agency for International Development/ Displaced Children and Orphans Fund
UN	United Nations

EXECUTIVE SUMMARY

Introduction

The government of Rwanda is deeply committed to ensuring that all children can grow up safe and protected in families. In collaboration with UNICEF, it has established the Tubarerere Mu Muryango (TMM - Let's Raise Children in Families) programme to ensure that all children living in institutional care in Rwanda are reunited with their families or placed in suitable forms of family-based alternative care. The TMM programme began in May 2013: Phase 1 was evaluated in 2017 using a combination of quantitative and qualitative methods to consult 289 individuals.

Rationale for the TMM programme

The programme was started in response to the large numbers of children growing up in institutional care in Rwanda, with a survey conducted by the Ministry of Gender and Family Promotion and Hope and Homes for Children in 2011-2012 showing 3,323 children and young adults in government-registered facilities alone. Global evidence suggests that institutional care can be deeply harmful to children's wellbeing and development. The use of institutional care also contradicts Rwandan cultural norms around the value of the family, and government policies. De-institutionalization was seen as catalyst for the wider strengthening of the child protection system.

Aims and activities of the TMM programme

The TMM programme Phase 1 aimed to ensure that the children and young adults living in institutional care were placed in families and communities, and that further institutionalization was prevented. Key project activities included:

- Strengthening the National Commission for Children (NCC) and developing national standards and guidance on children's care
- Recruiting and training 68 professional social workers and psychologists, and absorbing these professionals into the civil service
- Providing support packages to the families of reintegrated children, to young adults leaving care to live independently and to 1,000 foster carers
- Preventing further institutionalization, including awareness-raising and the use of short-term emergency foster care
- Enabling 29,674 community volunteers (known as Inshuti z'Umuryango (IZU) or Friends of the Family) to monitor vulnerable children and families, help prevent unnecessary separation and reintegrate children into family care
- Transforming residential care facilities into centres for community outreach that support reintegration and prevention efforts
- Developing case management and monitoring and evaluation (M&E) systems.

Outcomes of the TMM programme

- **A dramatic reduction in the number of children in institutional care:** At the end of TMM Phase 1, 70 per cent of children (2,388 of 3,323) had left institutional care and been reintegrated into families or placed in foster care. Leaving institutional care had improved children's lives in a number of respects including stronger family relationships, reduced stigmatisation, and a greater sense of belonging and identity. A number of young adults who had grown up in institutional care had also learnt to live independently.
- **Stronger government agencies responsible for care reform, and a professional child welfare workforce:** Due in part to the TMM programme, the NCC is now a fully functioning government agency with a cadre of professional social workers and psychologists. A total of 68 social workers and psychologists were recruited and trained through the TMM programme, 30 of whom have been absorbed into the civil service. Children in general feel satisfied by the support they received, though many would like to see social workers/psychologists more frequently.
- **The development of IZU community volunteers:** 29,674 community volunteers were recruited and trained. Church and community leaders were also utilised to spread awareness of the importance of family-based care.
- **The provision of range of care choices for children and support to families:** Support was provided to children's biological families, to kinship carers and to foster carers, ensuring that children leaving institutional care had a range of options. A total of 1,102 foster carers were trained through the TMM programme and 1,601 families received a social assistance package. Social assistance included educational support, medical care, counselling, clothing and livelihoods support. Many families were also supported by NGOs and through national social protection programmes, though some still felt they needed further support.
- **Cooperation and transformation of institutional care:** An approach of engagement rather than enforcing compulsory closure led to many care homes being transformed into community outreach centres, providing family support, schooling and early childhood development interventions.
- **Prevention of further institutionalization:** TMM put in place a range of mechanisms to prevent children from entering institutional care including the mass closure of institutions, a two-year mass media campaign, the development of emergency foster care, work with teenage parents, and closely monitoring remaining facilities to check that they were not allowing new children to enter.

Sustainability and efficiency of TMM

The evaluation suggests that the programme used resources efficiently and sustainably with five factors responsible for this:

1. Government commitment and ownership of the process.
2. The lower cost per child of family-based care compared to institutional care.
3. Basing programme design on research and piloting.
4. Community mobilization and the use of volunteers.
5. Effective partnership and coordination.

The evaluation also found that reintegration was more sustainable when supported by a professional social workforce to support vulnerable children and their families.

Remaining challenges and priority next steps

Despite these successes, some challenges remain:

- At the time of the evaluation (September 2017), approximately 900 children still needed to be reunited with families and supported to effectively reintegrate in communities, or to be placed in foster care.
- Further support is needed to enable children with disabilities to integrate into family care.
- There needs to be greater government ownership of care reform and of child protection structures at district level.
- Social welfare staff workloads need to be reduced, the number of professional social welfare staff increased, and the capacities of IZU further increased.
- Social assistance packages are not yet available to all families.
- Some managers of residential care facilities remain resistant to change.

The evaluation suggests that the most urgent challenge is to augment the capacity of the professional social workforce and the community volunteers. This will have a positive impact on all of the other challenges. It is therefore recommended that TMM Phase 2 focuses particularly on building cadres of professional social workers and community volunteers.



Woman of the government working in the project. Visiting a school Rwamagana District.

INTRODUCTION



Official launch of the Tubarerere mu Muryango / Let's Raise Children in Families child protection initiative.

The government of Rwanda is deeply committed to ensuring that all children can grow up safe and protected within families. This commitment has long been reflected in Rwandan laws and policies.¹ More recently, it led to the establishment of the Tubarerere Mu Muryango (TMM, Let's Raise Children in Families) programme in collaboration with UNICEF. The TMM programme aims to ensure that children living in institutional care in Rwanda are reunited with their families or placed in suitable forms of family-based alternative care. The programme uses childcare reform as a springboard for wider strengthening of the child protection system.

Phase 1 of the TMM programme ran from May 2013 to October 2017 with a budget of USD 2.3 million. It was evaluated in September 2017. Phase 2 runs from October 2017 to September 2019. This report presents a summary of the Phase 1 evaluation.

The remainder of this report is divided into five sections:

- Description of the TMM programme
- Objectives and methods of the evaluation
- Outcomes of the TMM programme
- The sustainability and efficiency of the TMM programme
- Conclusion and recommendations.

Throughout the report, text boxes are used to highlight key learning from the evaluation. These are designed for those engaged in further care reform in Rwanda, and also for other policy makers and practitioners involved in care reform in other countries.

¹ Government of Rwanda (2003). The Constitution of Rwanda. Rwanda: Government of Rwanda; and Government of Rwanda (2011). Integrated child rights policy. Rwanda: Government of Rwanda.

Description of the TMM programme



Rationale for TMM

Large numbers of children vulnerable to inadequate care

Prior to the introduction of the TMM programme, there were substantial numbers of children in institutional care in Rwanda, with a survey in 2012 showing 3,323 children in government-registered facilities.² Many children in Rwanda have lost one or both parents, and around 17 per cent of households host children who are separated from their parents.³ Households caring for orphans and other vulnerable children are often food-insecure and lack external support.⁴

The harm caused by institutional care

Global evidence suggests that large-scale institutions harm children's development. Children living in such facilities do not usually receive individualized care and attention, and typically cannot form a bond or attachment with a consistent carer. This deprivation frequently leads to developmental delays, lower levels of intelligence and problems

forming relationships. Standards of care are also often poor, and abuse and neglect are common.⁵ The survey of residential care facilities in Rwanda found that on average there was only one staff member employed for every 13 children, and as most staff worked in shifts, it was likely that at any given time staff to child ratios were even lower.⁶

Building on government commitment and global guidance on children's care

The government of Rwanda has long recognised the importance of ensuring that children grow up safe and protected within well-supported families, and of replacing institutional with family-based care. This recognition is reflected in the country's constitution,⁷ and in policies such as the Integrated Child Rights Policy and Strategy⁸ and the Strategy for National Child Care Reform.⁹ Government policies on care reflect global guidance in this area, which also calls for the development of alternatives to institutional care and the prioritisation of support to families.¹⁰

2 Ministry of Gender and Family Promotion and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda. Rwanda: Government of Rwanda and Hope and Homes for Children.

3 National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH) [Rwanda] and ICF International. Rwanda Demographic and Health Survey 2010. Rwanda: NISR.

4 UNICEF and the National Commission for Children (2012). Tumbarerere Mu Muryangyo! Let's Raise Children in Families! Proposal. Rwanda: Government of Rwanda and UNICEF.

5 Williamson, J. and Greenberg, A. (2010). Families not Orphanages. New York: Better Care Network.

6 Ministry of Gender and Family Promotion and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda. Rwanda: Government of Rwanda and Hope and Homes for Children.

7 Government of Rwanda (2003). The Constitution of Rwanda.

8 Government of Rwanda (2011). Integrated Child Rights Policy; and Government of Rwanda (2011). Integrated Child Rights Strategy.

9 Government of Rwanda (2012). Strategy for National Care Reform.

10 United Nations General Assembly (2010). Guidelines for the Alternative Care of Children. GA Res 142, UNGAOR 64th Session, Supplement No.49, Vol. 1 (A/64/49 (2010)) 376. New York: UN.

Strengthening the wider child protection system

Both UNICEF and the government of Rwanda recognise the importance of developing a wider child protection system that addresses all forms of abuse, neglect, exploitation and violence in Rwanda. Such a system requires laws and policies, an effective child welfare workforce, strong community structures, and supportive attitudes and social norms. Given the momentum around de-institutionalization in Rwanda, care reform is viewed as an effective catalyst for wider improvements in child protection.

The process of developing TMM

TMM was developed through a collaborative process involving the National Commission for Children (NCC), the Ministry of Gender and Family Promotion (MIGEPROF), other relevant government agencies, UNICEF, and non-governmental organizations (NGOs) working on care reform, such as Hope and Homes for Children. TMM was funded by the United States Agency for International Development (USAID) through the Displaced Children and Orphans Fund (DCOF). It is based on a survey of residential care facilities¹¹ and the piloting of a reintegration programme in one facility. TMM also drew on global evidence related to children's care, including on disability and care.¹²

TMM guiding principles

Several guiding principles are inherent in the TMM programme design:

- Children should only be removed from their families where necessary, and

maximum efforts should be made to prevent unnecessary family separation.

- Children who cannot be cared for by their parents need a range of care options so that the most appropriate form of care can be found for them. In Rwanda, this includes:
 - Kinship care, which is care by wider extended family members or others known to the child and family.
 - Short-term emergency foster care and longer-term foster care, both of which involve children being formally placed into a family other than their own by government social workers.
 - Domestic adoption.
- When children cannot live with their parents, kinship care should be explored as the next option. Institutional care, in large-scale residential care facilities, should not be used.
- Children with disabilities need particular support to ensure that they are cared for in family care, if at all possible.
- Siblings should be kept together, unless there are circumstances indicating that this would not be in their best interests.
- While institutions are being closed down, efforts should be made to ensure that any children still being cared for in these facilities receive the best care possible in those circumstances.
- Reintegration should be viewed as a long-term process requiring extensive preparation, follow-up monitoring and relevant support.

¹¹ Ministry of Gender and Family Promotion and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda. Rwanda: Government of Rwanda and Hope and Homes for Children.

¹² Better Care Network and Every Child (2012). Enabling reform. Why supporting children with disabilities must be at the heart of child care reform. New York: The Better Care Network.

Aims and strategies of the TMM programme

The TMM programme seeks to ensure that:

“Vulnerable children who are returned from residential institutions live in loving and safe family or community-based care environments.”¹³

Table 1 below summarizes the outcomes and strategies of the original proposal.

TABLE 1: THE PLANNED OUTCOMES AND KEY STRATEGIES OF THE TMM PROGRAMME

PLANNED OUTCOMES	KEY STRATEGIES
The NCC leads national childcare reform and coordinates a functioning child protection system.	<ul style="list-style-type: none"> Assessing the capacity building needs of the NCC and developing a strategy for capacity building. Technical support to the NCC in areas such as M&E, strategic planning and communications. Recruiting and building capacity of senior management staff. Developing national guidance and standards on various aspects of children’s care, including residential care, foster care and adoption.
Childcare services are delivered in a coordinated manner at district level.	<ul style="list-style-type: none"> Recruiting 34 social workers and 34 psychologists to be deployed across Rwanda. Training social workers and psychologists in family assessment, care planning and reintegration support etc. Providing support and services to gradually reintegrate all children in institutional care into their families or place them in other forms of alternative care. This includes the recruitment of around 1,000 foster carers for long-term care. Supporting young adults currently living in institutional care to live independently.
PLANNED OUTCOMES	KEY STRATEGIES

¹³ From: UNICEF and the National Commission for Children (2012). Tumbarerere Mu Muryangyo! Let’s Raise Children in Families! Proposal. Rwanda: Government of Rwanda and UNICEF.

TABLE 1: CONTINUED

Families are united for integration, resilience and prevention of unnecessary separation through the social protection system.	<ul style="list-style-type: none"> • Making plans and contracts with the families of reintegrating children to improve their economic and social situation and help ensure that they can care for children well. This process includes linkages to national social protection systems. • Supporting parents and wider families to prevent further placements into institutional care, including preventing child abandonment through early intervention in maternity care. • Establishing emergency foster care by recruiting 150 foster carers who can care for children at short notice to prevent their placement into institutional care. • Developing a cadre of community volunteers known as Inshuti z'Umuryango (Friends of the Family) to monitor child wellbeing and support prevention and reintegration efforts. • Transforming residential care facilities into community outreach centres that support reintegrating (and other vulnerable) children in the community.
National care and protection system is maintained in a sustainable manner.	<ul style="list-style-type: none"> • Securing increased and sustainable government funding for care reform. • Integrating the 68 social workers and psychologists into the civil service so that by the end of the project they are paid for by government. • Working with the University of Rwanda and Tulane University to develop a training curriculum for the social workforce. • Ensuring that the roles and responsibilities of social workers and their managers (at both district and local levels) are clarified and understood.
M&E knowledge management systems inform policy formulation and decision-making.	<ul style="list-style-type: none"> • Developing a case-management system for identifying and planning support for families and children, and keeping records related to individual cases. • Developing wider M&E systems for assessing progress and impacts.
Parents, caregivers and community members offer family environment and protection for vulnerable children.	<ul style="list-style-type: none"> • Changing norms and attitudes in communities to reduce reliance on institutional care and increase willingness to foster or adopt vulnerable children. • Advocating that church and community leaders support the TMM programme. • Encouraging young adults to become agents of change in their communities and supporting them to become responsible parents.

TMM Programme partners

TMM Phase 1 was led by the NCC, with UNICEF providing technical and financial management support, and USAID/DCOF funding the programme. MIGEPROF was responsible for government oversight. The NGOs Hope and Homes for Children and Global Communities, and Tulane

University (USA) provided further technical assistance. Other NGOs and community-based organizations (CBOs) also contributed to programme activities and provided technical support.

Objectives and methods

The evaluation aimed to examine the level of implementation of TMM Phase 1 in relation to the work plan, and to consider the outcomes of the first phase on child and family wellbeing. The evaluation took place as Phase 2 of the TMM was being implemented and was designed to inform the development of Phase 2 strategies.

The evaluation took place in five districts, one from each of the five provinces of Rwanda. It used a mixed-methods approach using both

quantitative and qualitative data. Quantitative methods involved three separate surveys administered to family-based caregivers, children, and young adults who had left institutional care to live independently. These surveys focused on exploring the extent to which planned programme activities had been carried out effectively. Qualitative methods involved in-depth interviews and focus groups, and explored programme performance in greater detail.

TABLE 2: PARTICIPANTS IN THE EVALUATION BY METHOD

Method	Stakeholder group	Males	Females	Total
In-depth interviews (Qualitative)	Policymakers and practitioners working at national level	7	7	14
	Inshuti z'Umuryango ¹⁴	2	5	7
	District officials and local leaders	5	8	13
	Social workers and psychologists	3	3	6
	Childcare institution managers	1	1	2
Focus groups (Qualitative)	Caregivers ¹⁵	5	24	29
	Children	6	7	13
Survey (Quantitative)	Caregivers	21	63	84
	Children	24	18	42
	Young adults	44	35	79
Totals		118	171	289

¹⁴ The Inshuti z'Umuryango ('Friends of the Family') are a cadre of community volunteers who provide support to vulnerable children and families. Inshuti z'Umuryango identify vulnerable households, conduct regular household visits, and report concerns to social service professionals. They also carry out awareness raising activities on child protection issues at the community level.

¹⁵ Caregivers included foster carers, kinship carers, adoptive parents, and parents caring for their biological children.

In total, 289 individuals were consulted during the evaluation (see Table 2 below). The child and caregiver participants represent approximately 10 per cent of the total households supported through the TMM programme. Caregivers included foster carers, kinship carers, adoptive parents, and parents caring for their biological children. The caregivers cared for a total of 233 children of whom 52 per cent were the caregivers' biological children, 32 per cent were children in formal foster care, 14 per cent were children in kinship care, and 2 per cent were adopted. The evaluation team gained ethical clearance for the evaluation from National Institute of

Statistics of Rwanda (NISR), and UNICEF's child safeguarding guidelines were adhered to. Informed consent was sought and obtained from all participants.

The evaluation had some limitations. It was only possible to speak with two managers of residential care facilities, as other managers were not available at the time of data collection. The number of child participants, particularly in the focus groups, was also lower than had been anticipated, and so it may not be possible to make generalizations from the focus group findings.



A foster parent who has fostered a child through the TMM programme.

Outcomes of the TMM programme

A reduction in the number of children in harmful institutional care

Since the adoption of the Strategy for National Childcare Reform (March 2012), 2,338 out of 3,323 children left institutional care and were supported to reintegrate into families and communities or placed in foster care.¹⁶ Many of the 935 children who remained in institutional care had been unable to leave, as care home managers were resistant to change, and would not provide the information needed to trace the children's families.

The evaluation suggests that the de-institutionalization of children and young adults has improved their lives in a number of respects:

- **Family relationships:** The survey showed that many children were able to maintain bonds with their family whilst in institutions: approximately 80 per cent of boys and girls reported having a strong relationship with their family both while in residential care and once they got home. In the focus groups, children and young adults spoke of the importance of strong family relationships for their happiness, and said that being back with families was a key advantage of de-institutionalization.

"As much as the staff of the institution did their best to show us love, we knew that they were not our family because they did everything for us as part of their jobs. They were paid for it. But in the family we are truly loved because our parents do not require a payment for supporting us."

– **Young adult who had grown up in institutional care.**

- **Learning to live independently:** Children, young adults and social workers spoke of children having everything done for them in the institution and of enjoying learning to live independently once they left and lived in a community.

"I could never have learned to be responsible with my money until I started living outside the children's home, by myself. I have learned to manage my money well and even pay for my young brothers' education, which makes me feel proud."

– **Young adult who had grown up in institutional care.**

"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.**

¹⁶ Most of this support for reintegration took place during the TMM programme period. A few institutions started to spontaneously reintegrate children before the TMM began in response to the new government childcare reform strategy.

- **Reduced stigmatization:** Focus group participants and key informants reported that children in institutional care are often stigmatized, and that this discrimination reduced when children or young adults returned to their families.

"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.**

- **Guidance and role models:** Young adults spoke of learning about their roots and enjoying having family to guide them through life once they returned to live in communities.

"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.**

- **A sense of belonging and identity:** Whilst in the institution, young adults reported feeling separated from mainstream society:

"I did not have people to talk to," "I had nowhere to go during school holidays," "I was unhappy, not knowing my parents," "I had no motivation to be a good person," "I had no neighbours to talk to," "I lived apart from my siblings," "I thought I was not important."

– **Young adults who had grown up in institutional care.**

After they left, children felt connected with their community and more valued:

"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.**

The evaluation found that many children and young adults returned to communities to live in households that were poor and food-insecure: 82 per cent of caregivers included in the survey reported worrying about food availability, and 45 per cent were unable to afford food of their preference. Female-headed households suffered greater food insecurity than male-headed households. Despite this poverty, those that took part in the focus groups reported preferring to live in families:

"I am happy to be living in a family because, although I do not get everything that I need, at least I live with people who love and respect me."

– **Young adult who had grown up in institutional care.**

"In the institutions we enjoyed luxuries and accessed most basic needs that we wanted, but here, living in my own place, experience of lacking some of the things that I need teaches me how to be strong and how to work harder."

– **Young adult who had grown up in institutional care.**

The evaluation showed that most reintegrated children were able to continue with their schooling upon returning to their communities. Of the 42 children surveyed, only one was unable to go to school.¹⁷ High levels of schooling were attributed to the financial support for schooling provided to many households included in the TMM (see below for further details).

¹⁷ This child was denied access to schooling because of a disability, and social workers subsequently worked to resolve this issue.

Lessons learnt

- Large-scale de-institutionalization and family reintegration programmes are possible in low-income contexts, especially where there is strong political buy-in from government and a strong and well-qualified professional child welfare workforce.
- De-institutionalization benefits children and young adults who have grown up in institutional care.

Stronger government agencies responsible for care reform

The evaluation found that, due in part to the TMM programme, the NCC is now a fully functioning government body with a team of well-trained social workers, psychologists and community volunteers. The NCC is able to coordinate activities through the development of a Programme Coordinating Team which meets regularly. The NCC has developed effective systems for case management that allow the needs of each child and family to be assessed and recorded, for plans to be developed to meet these needs, and for the effectiveness of such efforts to be monitored. The success of the NCC capacity building at national level is attributed to strong government commitment and oversight from MIGEPROF, and to technical support from UNICEF and Hope and Homes for Children.

Despite these successes at national level, work remains to be done with district authorities, which have not yet assumed ownership of the reform process. Although performance contracts have been signed with these authorities, the in-depth interviews revealed that many local authorities perceive the TMM to be an NCC project. As a result, these authorities have not taken their own initiative in improving children's care. Local authority ownership has been hindered by changes in personnel due to local elections. Furthermore, only seven out of a proposed 30 district child and social service units were established during the evaluation period, and even these seven are not yet fully functioning. The small number of units established is a reflection of the fact that forming these structures is a time-consuming process, involving engagement and negotiations with Gender and Family Promotion Officers and other stakeholders, and a series of case management meetings.

Lessons learnt

- Government commitment to de-institutionalization is key to success of care reform. The strong mandate and increased capacity of the NCC has greatly helped to push the reform efforts forward.
- Partnership is vital in care reform, and NGOs, donors, and UN agencies can provide crucial technical and financial support.
- Ownership of care reform must exist at all levels of government, and particular efforts may be required at the local level.

A stronger professional child welfare workforce

The TMM programme has led to the recruitment of 68 social workers and psychologists to support children's care. These professionals have been trained in a range of areas including counselling, family tracing, referral system management, child development and community mobilization. Training has been carried out using lectures, and practice and reflection. It was designed with the support of Tulane University (USA), which made particular efforts to engage stakeholders and ensure that the content and style of training reflected the Rwandan context. This training has also been used in the curriculum for the wider training of professional social workers through the University of Rwanda, which is likely to lead to lasting benefits for the child protection system in Rwanda.

When asked about levels of satisfaction with the services and support provided by trained social workers and psychologists, two thirds of children felt satisfied or very satisfied. Boys and girls reported appreciating the advice given to them about whether or not to return home, and felt listened to and understood.

"[Social workers/ psychologists] do not tell us whether to join a specific family or not, but they educate us on the factors that we need to consider in making our choices and they leave us to make our own independent decisions."

– **Child who has left institutional care.**

Once children returned to their communities, social workers and psychologists helped to ensure that they and their caregivers received support packages (see below for details under 'Stronger families better able to care for children'). The professionals also supported young adults leaving institutions to live in the community for the first time, and worked to prevent children entering institutional care. Their work was found to have had an impact on wider community attitudes and behaviours

related to children's care. The caregiver survey results suggest that, following training by the social workforce, 76 per cent of caregivers preferred sitting down and talking to the child rather than punishing them by denying the child food or beating them. Social workers also inspected and monitored institutions, helping to ensure that new children were not admitted.

Although social welfare workforce capacity grew significantly during TMM Phase 1, around a third of children said that they were unsatisfied or very unsatisfied with the support they received from social workers and psychologists after they returned to family care. This dissatisfaction was attributed to infrequent visits. Reintegrated children, children in alternative care and their caregivers reported varying numbers of visits from social workers, though the majority were visited several times each year. Social workers and psychologists work as a pair, and had average caseloads of 69 families. As noted above, child welfare staff had many responsibilities on top of their casework with families. The evaluation found that high workloads prevented the social workers and psychologists from visiting children and families as frequently as they would have liked, though efforts were made to compensate for this lack of face-to-face contact by keeping in touch through phone calls. Some key informants also expressed concern that social workers may burn out as a result of their high workloads, though the NCC has tried to counteract this problem by using external consultants to provide clinical supervision and build the resilience of the workforce. Social workers and psychologists have also found their own ways to support one another and have set up social media

platforms to share challenges and ideas.

The Inshuti z'Umuryango network of community volunteers was not fully established at the time of the evaluation, and it is hoped that these volunteers will be able to support professional teams by carrying out home visits to monitor children's wellbeing.

Building this network is deemed critical for Phase 2 of the TMM. However, as this workforce will have neither the skills nor the time to duplicate the role of social workers and psychologists, building the professional workforce is also essential

for Phase 2. Staff from NGOs and from institutions that have transformed into centres of community outreach are already providing services that help reduce the burden on social workers and psychologists.

Lessons learnt

- Social workers and psychologists need to have the capacity to work on a case-by-case basis when reintegrating children and their families. Doing so enables them to tailor support specific to each child's needs and circumstances.
- Reform processes need to be managed so that the workforce capacity is built in time to deal with the large number of children being placed in family care. At the start of the TMM, there were too few social workers and psychologists to support the large numbers of children leaving institutional care at once.
- It is valuable to have social workers and psychologists working together as a team. The two disciplines complement each other, and having two perspectives on each case enables a more holistic understanding of the situation and the development of more effective remedies to the problems faced by children and their families.
- Government-funded social workers can be supported through the use of church and community volunteers and the interventions of NGO staff.

Stronger community support and structures

TMM aimed to recruit 2,000 community volunteers through the Inshuti z'Umuryango programme. This programme began in 2015, just over a year before the evaluation took place. At the time of the evaluation, programme targets had been massively surpassed – 29,764 community volunteers, one man and one woman for each village in the country, had been recruited. This success is attributed to awareness-raising campaigns, which created strong community commitment to de-institutionalization. Although these volunteers had been recruited and all had received basic training, at the time of the evaluation they were not yet fully trained and active. Once the Inshuti z'Umuryango are fully operational, it is hoped that volunteers will carry out household visits

to check on child wellbeing and to link families with services and support. The Inshuti z'Umuryango are already acting as an early warning system in the community, highlighting problems to professionals, including young mothers abandoning their babies.

In addition to the Inshuti z'Umuryango, the evaluation found that the TMM has also engaged other actors in the community. Church and community leaders have promoted the importance of the family and raised awareness of the harm caused by institutional care. In the survey with 42 children, approximately two thirds of those placed in families felt supported by their community, stating that neighbours would help them if they needed it. And 88 per cent of the children felt that they had access to a dependable adult who could offer them support and guidance.

The TMM programme proposal included plans for young adults who had left institutional care to become ambassadors for care reform in their communities. The evaluation did not find evidence of these young people directly working to influence

public opinion. However, the presence of former residents of institutions working, marrying and living happily in communities was felt to demonstrate to others that reintegration is possible.

Lessons learnt

- Communities are vital to care reform. Community leaders, churches and networks of volunteers can help to change attitudes towards care, and monitor and support vulnerable children and their families.

The provision of foster care

The TMM programme established a range of care options for children who could not be cared for by their biological parents. The TMM provided support to kinship carers through its programme of family support (see below). The programme trained 1,102 foster carers (the target was 1,000) who were generally recruited by social workers as part of their community outreach work. Training was provided through group sessions facilitated by social workers. The TMM overcame the significant resistance to foster care through a sensitization programme, and it proved possible to identify and recruit a large number of highly motivated foster carers despite this resistance. The survey of caregivers covered 112 children in foster care, kinship care or adoption. In most cases, these children remained in their placements, and only four were moved during the evaluation period, suggesting that most placements were successful.

The survey suggests that there are a number of ongoing barriers to foster care which may hinder the expansion of the foster care programme. Economic challenges were the most frequently mentioned barrier, with many caregivers stating that they did not have the

resources to care for their own children, and would therefore struggle with an extra child in the household. Additional barriers included:

- **Cultural barriers:** It is considered problematic to live with a child who is not related to caregivers. Some participants reported that in some communities it is feared that if a child dies and is buried without the involvement of the child's blood relatives then misfortune will befall those that buried the child. Such cultural barriers lead neighbours and relatives to discourage foster care and adoption.
- **Resistance from biological children:** Children reportedly fear they will get less food to eat or receive less love and care if a new child comes into the family.
- **Stigma and discrimination:** Although the TMM has led to improvements in attitudes towards institutional care, children from institutional facilities, particularly those with disabilities, still suffer discrimination.
- **A lack of knowledge:** Caregivers worried that they lacked the skills to care for children who were not their own, or to deal with children with problem behaviours. Some also did not know the procedures for adoption or foster care.

Lessons learnt

- It is possible to establish foster care on a large scale in a low-income context.
- Caregivers need a range of support in order to become foster carers. Economic assistance is most important, but changes in knowledge and attitudes may also be necessary.

Cooperation and transformation of institutional care

The TMM programme adopted an approach of engagement with childcare institutions rather than enforcing compulsory closure. Awareness-raising campaigns were used to explain the importance of family care, and efforts were made to persuade care-home managers to transform rather than close down facilities. Some care homes became schools, skills training facilities, or early childhood development centres. Others focused on providing help to former child residents and their families through, for example, livelihoods support. This approach had two advantages.

First, it helped to secure the cooperation of care-home staff in family tracing and reintegration efforts. Second, it enabled the resources formerly spent on children's institutional care to be redirected to children's development in family and community care.

Efforts to engage care-home managers were not always successful, and some refused to provide information needed for family tracing. This, as noted above, slowed the pace of family placements. Social workers spent considerable time talking to and explaining the value of reintegration – high levels of government commitment, public awareness-raising campaigns and success stories from already transformed institutions greatly helped this process.

Lessons learnt

- Working to ensure the cooperation of care home managers and staff in the de-institutionalization process helps to redirect resources from institutional care to care in the community.
- There may be a limit to the extent to which cooperation can be relied on, and government enforcement may be necessary for care-home managers who refuse to support de-institutionalization.

Stronger families better able to care for children

The programme targeted 3,000 families providing foster care or caring for children reintegrated into their own families. At the time of the evaluation, the programme had reached all the target families through facilitated group-work designed to exchange

knowledge and experience around child protection and care. A total of 1,601 families received a social assistance package. Packages varied according to need, but could include educational support, support for physical or mental health, clothing and/or social protection. Figure 1 below shows the percentage of caregivers included in the survey who had received these different forms of support.

FIGURE 1: PERCENTAGE OF CAREGIVERS INCLUDED IN THE SURVEY RECEIVING DIFFERENT FORMS OF SOCIAL ASSISTANCE

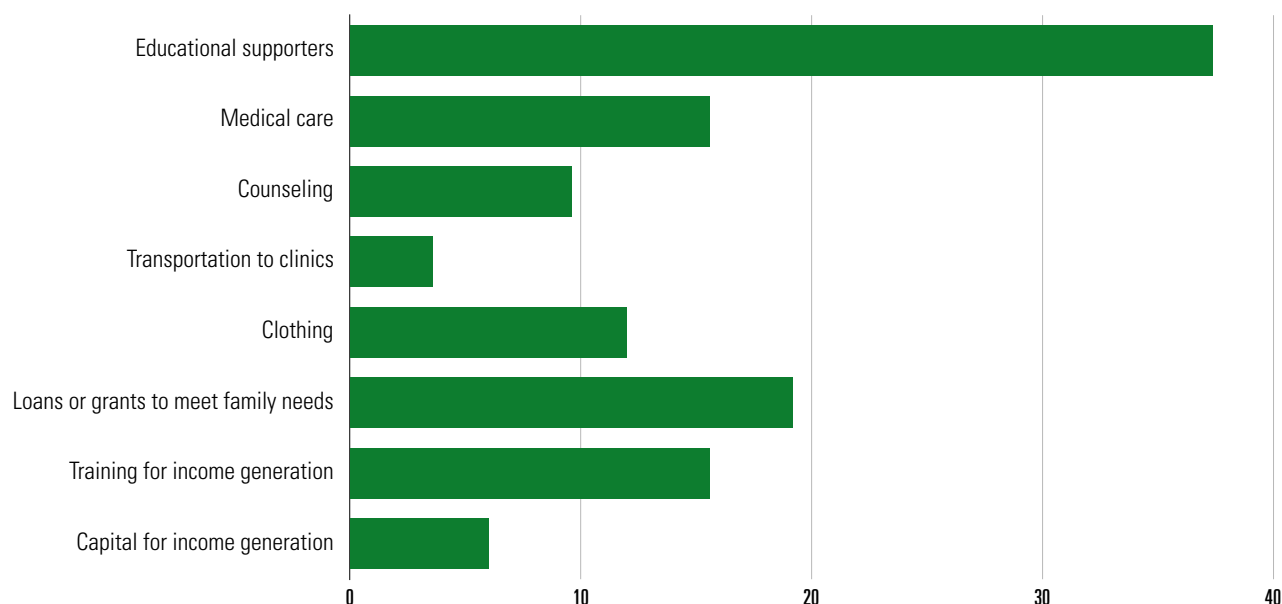
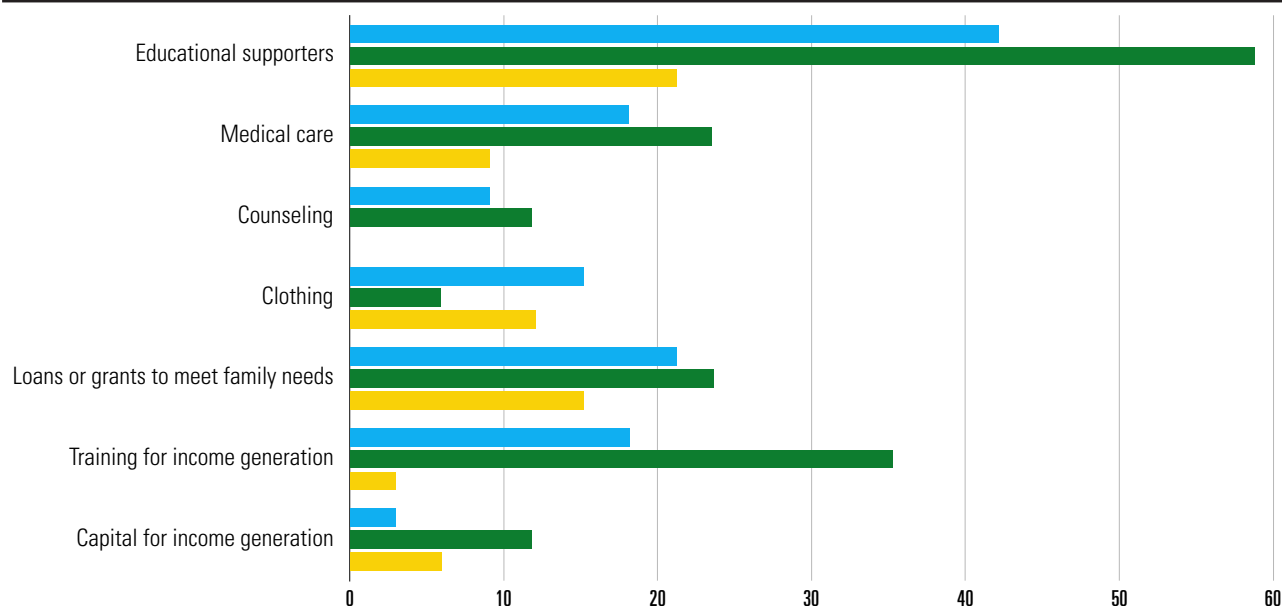


Figure 2 shows how the social assistance packages varied according to the type of caregiver. In all areas except clothing, kinship carers were the group most likely to receive assistance. Children's biological parents were generally the group least likely to receive assistance. This variance may be explained by needs and expectations. For example, foster carers' financial capacities were assessed

before recruitment, and extremely poor households were not allowed to become foster carers, meaning that this group needed less financial assistance than kinships carers. One key informant said that parents were generally expected to meet children's needs without external support and did not seek out this assistance as often as foster or kinship carers.

FIGURE 2: PERCENTAGE OF CAREGIVERS INCLUDED IN THE SURVEY RECEIVING DIFFERENT FORMS OF SOCIAL ASSISTANCE BY CAREGIVER TYPE



Despite the large number of families receiving some form of social assistance, the evaluation suggests that further work is needed to ensure that the needs of children and caregivers are fully met. A total of 1,399 (47 per cent) of the 3,000 households targeted for social assistance had not received support at the time of the evaluation. This may in part be attributed to the lower than anticipated rate of placement back into families, with 935 children still in institutional care at the time of the evaluation. In other instances, families not receiving the social assistance package are getting support elsewhere, either through the national social protection scheme, or from NGOs or former residential care facilities. However, the survey carried out for the evaluation suggests that there remains a shortfall in support for families. Out of the 53 surveyed caregivers who said that they needed financial support, only 17 had received this support, with female caregivers less likely to receive financial support than male caregivers. This discrepancy may be attributed to the large caseloads of social workers, which can prevent prompt assessments of families' needs, and the development of cooperation agreements with local partners, both of which entail a lengthy process. High levels of poverty in Rwanda also mean that demand for support is high. Although not confirmed by the evaluation, females may be receiving less support than males because some are enrolled in women's savings groups outside the TMM programme.

The evaluation identifies three areas of support that may warrant particular attention in TMM Phase 2. The first is discrimination within households: approximately 13 per cent of children entering households from institutional care stated that they were treated worse than other children in the family. Focus groups also revealed that discrimination does not just come from adult caregivers – the biological children of caregivers often resented the new children coming into the household too.

Second, many caregivers felt that they lacked the skills to care for children with disabilities. Key informant interviews revealed that communities continue to discriminate against those with disabilities and that these attitudes might contribute to the low rate of reintegration among this group of boys and girls.

Third, of the 42 children surveyed, just over half did not have a birth certificate, preventing them from achieving rights to identity and nationality, hindering family tracing, and making it hard for children to prove their age. This is a common problem in Rwanda, and not unique to the children covered by the TMM.¹⁸ However, this issue is more significant for the target group as many have lost both parents, or are not in contact with parents, and lack key documents as a result.



¹⁸ Though in recent years the birth registration process has improved across the country. It is now easier for parents to register children born in health facilities free of charge, and the system has been decentralized and digitized.

Lessons learnt

- Foster carers, kinship carers and biological parents caring for reintegrated children all need support, though needs are likely to vary due to the uniqueness of each case.
- It is important that social workers have enough capacity to support all families and children in need.
- For kinship carers and foster carers, it is important that social workers and psychologists also work with caregivers' own children to avoid resentment.
- Efforts are needed to change social norms around disability and ensure that caregivers have the capacity to care for children with disabilities.
- Children who have lost parents need particular help in birth registration.

Prevention of family separation and placement into institutional care

A range of different mechanisms were put in place to help prevent children from entering institutional care:

- **Mass closure of institutions:** Stakeholders who took part in key informant interviews reported that institutions acted as a magnet, attracting children who would otherwise be cared for by their families. Working across Rwanda to close a large number of facilities simultaneously reduced the risk of children being placed into institutional care and meant that those running institutions could not close in one district and set up in another.
- **A two-year mass media campaign:** This campaign focused on the harm caused by institutional care and the benefits of children growing up in families. The findings of the focus groups and surveys suggest that those reached by this campaign developed a negative attitude towards institutional care.
- **Closely monitoring the remaining institutional care facilities:** Institutions that continued to care for children were closely monitored by social workers to ensure that they did not take in any new children.
- **Development of emergency foster care:** When attempts were made to place a child in institutional care, emergency foster care was offered as an alternative. Carers could take children at short notice and look after them whilst 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 the evaluation period.
- **Work with teenage parents:** Social workers and psychologists offered counselling to young parents to try to avoid child abandonment, and the government of Rwanda is also supporting a campaign to prevent teen pregnancy.

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.

"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.**

Social workers and psychologists played an important role in prevention, identifying and addressing specific risks in the communities in which they work, and working to change social norms.

Lessons learnt

- Effective prevention involves dealing with both supply of institutional care and demand for this care. It is vital to understand local contexts and to respond to factors, such as attitudes towards teenage pregnancy, which may push children into institutional care.
- As well as developing longer-term foster care, it is possible to develop emergency foster care as an effective strategy for making family care available.
- Remaining facilities should be carefully monitored to check that they are not admitting new children.



Foster child (second from right) placed through the TMM programme.

The sustainability and efficiency of the TMM programme

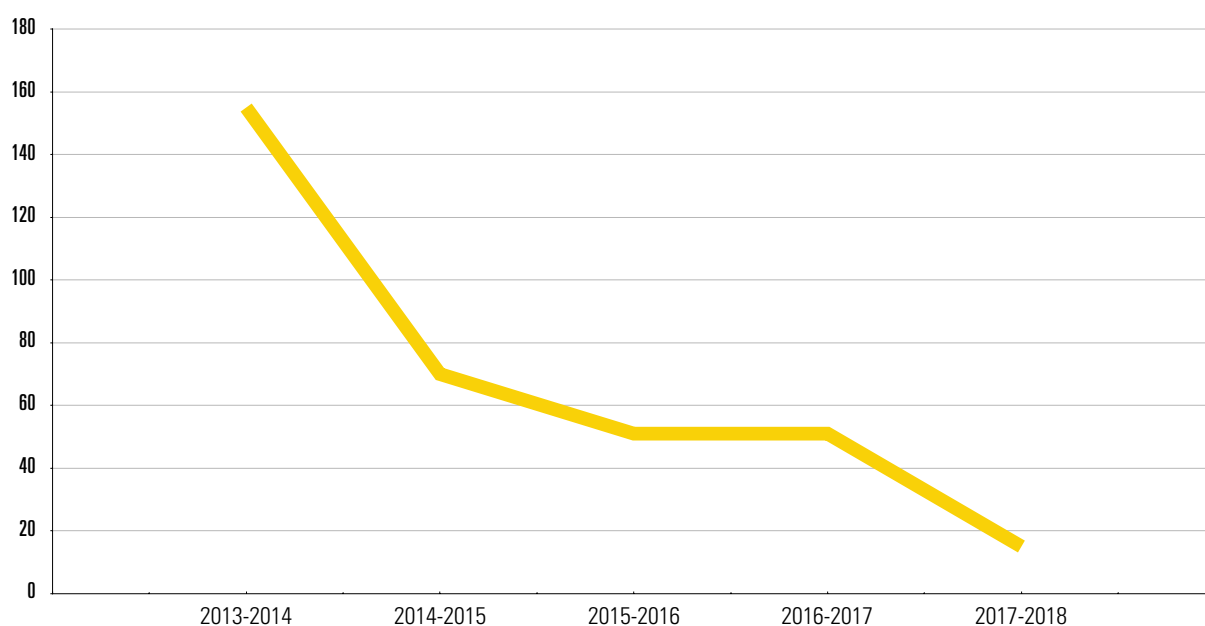
The evaluation suggests that TMM uses resources efficiently and is sustainable. Five factors are responsible for this sustainability and efficiency.

First, the programme was designed using information from a survey on institutional care in Rwanda and the piloting of de-institutionalization in one facility. The programme was thus based on evidence of what works in Rwanda, increasing its effectiveness and efficiency.

Second, by reducing its inputs to institutional care, the NCC has been able to make annual

savings of RWF 138,551,579 (USD 160,000), representing a 90 per cent reduction in expenditure on institutional care over five years (see Figure 3). Some of this money has been invested in establishing foster care and supporting children's families; no calculations have been made of this expenditure. However, many of those included in the focus groups and interviews reported that family-based care is cheaper than institutional care because, unlike staff in centres, foster carers and family members are not salaried. Overheads, such as salaries, food, clothing, fuel or property maintenance, also no longer have to be covered.

FIGURE 3: ANNUAL EXPENDITURE ON INSTITUTIONAL CARE (IN MILLIONS OF RWF)



Third, government commitment and ownership of the process is likely to ensure that care reform efforts are sustainable. Most recently, this commitment was demonstrated by the absorption of 30 of the 68 social workers and psychologists recruited through

the TMM into the civil service.¹⁹ This initiative, and the incorporation of child protection training into wider social work education, is likely to ensure that enhanced child welfare workforce capacity is long lasting.

¹⁹ Initially the government had committed to absorb all 68 of these professional into the workforce, though this changed in April 2018.

Fourth, both sustainability and efficiency were enhanced by community mobilization and the use of volunteers. Changing community attitudes and gaining the buy-in of churches and community leaders will help to ensure that reductions in the use of institutional care are sustained over the long term. Using community volunteers has the potential to provide much-needed support to professional social welfare staff and to keep costs down.

Fifth, effective partnership and coordination have also enhanced both sustainability and efficiency. Stakeholders involved in TMM have each been able to contribute their areas of

expertise, helping to ensure that resources are used effectively, and that reform is embedded across the work of government, UN agencies and NGOs. The establishment of a committee to coordinate the programme has helped greatly to ensure the useful contributions of a range of partners.

As demonstrated above, the evaluation also found that the sustainability of efforts to reintegrate children was enhanced by the use of professional social workers and psychologists to support vulnerable children and their families.

Lessons learnt

- The sustainability and efficiency of care reform processes can be enhanced by basing programme design on a pilot scheme and research, and by having government commitment and ownership, community mobilisation and the use of volunteers, and effective partnership and coordination.



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

Conclusion and recommendations

Over the period of the evaluation, TMM has had many successes:

- The number of children and young adults in institutional care has been reduced dramatically while improving some aspects of child and young adult wellbeing.
- Foster care has been established and supported on a large scale, including short-term emergency foster care.
- Systems of family support have been developed.
- Support for de-institutionalization amongst church and community leaders has grown.
- The capacity of the NCC and the professional social welfare workforce has been enhanced.
- A cadre of community volunteers has been established.

Many of these successes have impact not only on children's care, but also on the wider child protection system. Successes may be linked to a programme based on evidence and piloting, strong government commitment and ownership, and effective partnership and coordination.

Despite these successes, some challenges remain:

- Approximately 900 children still need to be reintegrated into families or placed into foster care.
- Further support is needed for children with disabilities and their caregivers.
- There needs to be greater government ownership, and child protection structures at district level.

- Social welfare staff workloads need to be reduced: to this end, increasing the number of professional social welfare staff and enhancing the capacity of community volunteers is vital.
- Social assistance packages are not yet available to all families that need them.
- Some care-home managers remain resistant to change.

The evaluation suggests that moving ahead it is important to:

- Ensure that the government fully takes over programme management and the childcare reform process, through further strengthening the NCC and increasing government social work capacity.
- Work to build the child welfare workforce, including enhancing the capacity of community volunteers and strengthening and expanding the professional child welfare workforce.
- Complete the de-institutionalization process by ensuring that all children with disabilities are reunited with families or found other forms of family care.
- Document good practice from the TMM programme and share with others in the region that are not as advanced in their care reform efforts as Rwanda.

The evaluation suggests that most urgent recommendation is the augmentation of the capacity of the child welfare workforce. Resolving this problem will have a positive impact on all of the other challenges. It is therefore recommended that TMM Phase 2 focuses particularly on building cadres of professional social workers and community volunteers.

Annex:

Definition of key terms²⁰

Alternative care: Care for 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.

Social service professionals: The team of 68 social science professional staff of NCC: 34 social workers and 34 psychologists who received specialised training to spearhead the implementation of the TMM programme. The term 'social service professionals' is used interchangeably with 'professional social workforce' or simply 'social workforce'.

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.

²⁰ The definitions are taken from: UNICEF and the National Commission for Children (2012). Tumbarerere Mu Muryangyo! Lets Raise Children in Families! Proposal. Rwanda: Republic of Rwanda and UNICEF.

