REPUBULIKA Y'U RWANDA

NATIONAL CHILD DEVELOPMENT AGENCY

Tubarerere mu Muryango programme
(‘Let’s raise children in families’)

Inclusive Case Management for Children’s Reintegration

Facilitators Manual

Training module for the Social Service Professionals

January 2021

Inclusive Case Management for Children's Reintegration

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Training module for the Social Service Professionals

In partnership with

National Council of Persons with Disabilities

unicef
for every child

USAID
FROM THE AMERICAN PEOPLE

This training module has been developed through a partnership between the National Child Development Agency, Rwanda and UNICEF Rwanda.

The authors are:
Elayn M. Sammon elaynsammon@gmail.com and Joseph Munyandamutsa josephmunyandamutsa@gmail.com

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Abbreviations

CHW	Community Health Worker
DMO	District Mainstreaming Officer
ECD	Early Childhood Development
ICF	International Classification of Functioning Disability and Health
IZU	Inshuti z'Umuryango (Friends of the Family)
MIGEPROF	Ministry of Gender and Family Promotion
NCDA	National Child Development Agency
NCPD	National Council for Persons with Disabilities
NST	National Strategy for Transformation
SDG	Sustainable Development Goal
TMM	Tubarerere Mu Muryango programme ("Let's raise children in families")
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

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- The Minimum Standards for Alternative Care and Considerations for Strengthening the Tubarerere Mu Muryango (TMM) Programme for the Inclusion of Children and Adults with Disability prepared for the Government of the Republic of Rwanda Ministry of Local Government by International Centre for Disability and Rehabilitation, University of Toronto, Canada

- The Coordinating Comprehensive Care for Children Programme (4Children). Initiated in 2015, this five year United States Agency for International Development (USAID) – funded consortium of organizations led by Catholic Relief Services with other partners including IntraHealth, Maestral, Pact, Plan International and Westat, helped countries identify practical and appropriate policies, programmes and services that promote child well-being

- The Partnership for Every Child Regional Alliance incorporating Partnership for Every Child in Ukraine, Russia and Moldova along with Partnership for Children in Georgia and For Our Children Foundation in Bulgaria, who focus on preventing loss of parental care for vulnerable children and ensuring safe, secure family care for children without parental care.

- The National Society for the Prevention of Cruelty to Children in the United Kingdom (UK), and their learning hub on Safeguarding Children and Child Protection.

- Displaced Children and Orphans Fund of USAID, June 2018, Family Care for Children with Disabilities: Practical Guidance for Frontline Workers in Low- and Middle-Income Countries

- Faith to Action Initiative and their work on transitioning to family care for children

- Lumos who work to make sure children live safely in family care or family-based alternative care, who have collated useful research on the risks of harm to children growing up in residential institutions.

Glossary

Word or term	Definition as applied in this text
Alternative care	Formal or informal provision for the protection and well-being of children who are deprived of parental care or care in their immediate family of origin. This can include extended family care, adoption and foster care.
Case management	The process of helping individual children and families through direct social-work type support, and information management,[1] A process practiced by social service workers that supports or guides the delivery of social service support to vulnerable children and families and other populations in need.[2]
Case worker	A person employed by the NCDA as a Child Protection and Welfare Officer, usually a graduate social worker or psychologist.
Child	A person under 18 years of age.
Child Protection and Welfar Officer	A graduate social worker or a graduate psychologist working for the NCDA who uses his or her knowledge and skills to provide social services to ensure the healthy development, protection and well-being of children and their families.
Child protection system	Formal and informal structures, functions, capacities, and other elements organized to achieve safety for children.
Community-based Inclusive Development	Enhances and strengthens earlier work described as community-based rehabilitation.
Community-based Rehabilitation	A community development strategy that aims at enhancing the lives of persons with disabilities within their community. It is a multi-sectoral approach working to improve the equalization of opportunities and social inclusion of persons with disabilities through provision of rehabilitation services, while combating the perpetual cycle of poverty and disability. It emphasizes utilization of locally available resources including beneficiaries, the families of persons with a disability and the community.
Disability	"Persons with a disability include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (United Nations Convention on the Rights of Persons with Disabilities – UNCRPD).
Discrimination	Discrimination happens when individuals or institutions unjustly deprive others of their rights and life opportunities due to stigma.
Family	In this operational guidance, 'family' describes the immediate relatives of the child. This can include parents and siblings or another long-term caregiver who has adopted a parental role. Extended family includes grandparents, uncles and aunts, cousins among others. The definition of family acknowledges that primary caregiver/s for the child may be extended family members.
Habilitation	A process aimed at helping persons with disabilities attain, keep or improve skills and functioning for daily living; its services include physical, occupational, and speech-language therapy, various treatments related to pain management, and audiology and other services that are offered in both clinical and community settings.[3]
Inclusion	Inclusion involves a full reform which means that children with disabilities can participate fully in the life of the family and community; this means making changes to the environment, to the way we all communicate, to our attitudes and belief systems, and to the way we provide services.

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[1] Inter-agency Child Protection Working Group, Inter-agency Guidelines for Child Protection and Case Management, 2014. http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_ guidelines_ENG_.pdf

[2] Global Social Service Workforce Alliance, Case Management Concept and Principles, GSSWA: Washington DC, 2018. http://www.socialserviceworkforce.org/sites/default/files/uploads/Case-Management-Concepts-and-Principles.pdf

[3] Adapted from RI Global http://www.riglobal.org/projects/habilitation-rehabilitation/

Independent living	Independent living/living independently means that individuals with disabilities are provided with all necessary means enabling them to exercise choice and control over their lives and make all decisions concerning their lives. UNCRPD General comment on Article 19: Living independently and being included in the community). For children with disabilities this involves ensuring that in line with their evolving capacities they have the same freedoms as typically developing children to make choices in life, and that they receive support for the choices they make.
Inshuti z'Umuryango (Friends of the Family)	Cadre of community volunteers composed of one man and one woman with responsibility for promoting child rights and supporting reintegration.
Malayika Murinzi (Guardian Angels)	A cadre of honest parents known for their good reputation in various Rwandan communities for their goodwill effort to care, protect, and educate vulnerable children, particularly orphans.
Occupational therapy	Focuses on helping people with a physical, sensory, or cognitive disability to be as independent as possible in all areas of their lives. It can help children and adults with a disability to improve their cognitive, physical, sensory, and motor skills and enhance their self-esteem and sense of accomplishment.
Physiotherapy	A science-based profession that helps to restore movement and function when someone is affected by injury, illness or a disability. It can also prevent deterioration and further loss of function through a maintenance programme of rehabilitation based on individual treatment plans.
Placement	The physical act of placing the child in family-based alternative care; it is one step in the reintegration process.
Rehabilitation	Refers to regaining skills, abilities, or knowledge that may have been lost or compromised as a result of acquiring a disability or due to a change in one's disability or circumstances.[4]
Reintegration	Reintegration is the process of a separated child making what is anticipated to be a permanent transition back to their family of origin and community or to live in family-based alternative care, where they can have their rights fulfilled and receive the support and love needed to reach their future potential.
Reunification	Reunification is the physical act of returning the child to their family; it is one step in the reintegration process.
Residential institution	A residential institution is defined as any group living arrangement for children without parents or without surrogate parents, in which care is provided by a smaller number of paid adult carers.[5]
Speech and language therapy	Supports children and young people who have a speech disorder (a problem with the actual production of sounds) or a language disorder (a problem understanding or putting words together to communicate ideas). They work on augmentative and alternative communication which are the methods used to supplement or replace speech or writing for those with impairments in the production or comprehension of spoken or written language.
Stigma	Stigma refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different.
UNCRC	The United Nations Convention on the Rights of the Child is a legally binding international agreement and human rights instrument setting out the civil, political, economic, social and cultural rights of every child, regardless of their race, religion or abilities.
UNCRPD	The United Nations Convention on the Rights of Persons with Disabilities is a legally binding international agreement and human rights instrument which reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.

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[4] Ibid.

[5] See 'United Nations Disability and Child Rights Groups On Behalf of Children without Parental Care Key Recommendations' 20 June 2019, Core Principles: Right to Family Recognized Under International Law. https://validity.ngo/wp-content/uploads/2019/07/UNGA-Right-to-Family-2019_06_20.pdf

A note on terminology

'Persons with disabilities' or 'children with disabilities' are the terms most often used in global development reporting and are preferred by the Rwandan National Council for Persons with a Disability (NCPD). This is because they use 'people-first' language. That is, they put the person's humanity first, so that they are not defined by their impairment. The term 'persons with disabilities' is used in UNCRPD. However, many disability rights campaigners believe that this connects disability solely to the medical model. The use of the word 'persons' is also considered by some to be legalistic and formal, while 'people' is considered more acceptable for general usage. Under the social model of disability many disabled people see themselves as those who experience barriers within society. Thus, many prefer the term 'disabled people' or 'children with disabilites'. [6] In general, it is important to listen to how people talk about their disability themselves and take your cue from them. Therefore, the terms persons with disabilities and children with disabilities are used in this document to take account of the position taken by the National Policy on Persons with Disabilities 2019.

NCPD has developed recommended terminology to replace culturally-based usage that is considered a contributing factor to negative attitudes towards persons with disabilities in Rwanda. The table indicates discriminative terminologies (left column) and appropriate terminologies (right column)

Terminology associated with disability in Rwanda

N°	Ntibavuga (inyito zipfobya)	Bavuga (inyito iboneye)
1.	Ikimuga, uwamugaye, ubana n'ubumuga, ugendana n'ubumuga	Umuntu ufite ubumuga
2.	Ikirema, Ikimuga, Karema, Kajorite, Igicumba, Gicumba, Utera isekuru, Kaguru, Jekaguru, Ikirema, Karema, Muguruwakenya, Terigeri, Kagurumoya, Kaboko, Mukonomoya, Rukuruzi	Umuntu ufite ubumuga bw'ingingo
3.	Impumyi, Ruhuma, Maso, Gashaza, Miryezi, ...	Umuntu ufite ubumuga bwo kutabona
4.	Igipfamatwi, Ikiragi, Nyamuragi, Ibubu, Ikiduma, Igihuri, Bihurihuri	Umuntu ufite ubumuga bwo kutumva no kutavuga cyangwa bumwe muri bwo.
5.	Igicucu, igihoni, ikijibwe, ikirimarima, ikiburaburyo, ikiburabwenge, indindagire, ikigoryi, igihwene, ikimara, zezenge, icyontazi, inka, inkaputu.	Umuntu ufite ubumuga bwo mu mutwe
6.	Kanyonjo, gatosho, gatuza	Umuntu ufite ubumuga bw'Inyonjo
7.	Nyamweru, umwera, ibishwamweru, nyamwema, umuzungu wapfubye	Umuntu ufite ubumuga bw'uruhu rwera
8.	igikuri, gikuri, gasongo, nzovu, zakayo, gasyukuri, kilograma	Umuntu ufite ubugufi budasanzwe

Source: NCPD

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[6] For example, see Damon Rose, 4 October 2004, 'Don't Call Me Handicapped! 'http://news.bbc.co.uk/2/hi/uk_news/magazine/3708576.stm; The Conversation, 11 April 2019, 'Should I say disabled person or person with a disability?' https://theconversation.com/should-i-say-disabled-person-or-person-with-a-disability-113618; Disabled World, 1 September 2011, 'Disability or Disabled? Which Term is Right?'
https://www.disabled-world.com/definitions/disability-disabled.php; Penny Pepper, 22 November 2016, 'We've had all the insults. Now we're reclaiming the language of disability'. https://www.theguardian.com/commentisfree/2016/nov/22/language-of-disability-stereotypes-disabled-people

Introduction

This training package is primarily for Government of Rwanda's Child Protection and Welfare Officers[7] who work directly with children and families on reintegration of children (including children with disabilities) from residential institutions. It can also provide useful information to people working in other local government roles, for example, District Disability Mainstreaming Officers and Gender and Family Promotion Officers, as well as people working in non-governmental organizations (NGOs) or community-based systems (for example, *Inshuti z'Umuryango* – Friends of the Family) who support children and families, and particularly those who have contact with children during the reintegration process. It can be helpful for all workers who have limited or no training specifically on inclusive practices.

In March 2012, the Government of Rwanda endorsed the Strategy for National Child Care Reform[8]. The implementation mechanism for this strategy is the Tubarerere Mu Muryango (TMM) Programme ('Let's raise children in families') led by the National Child Development Agency (NCDA). 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 and that children in families are prevented from separating. The programme uses the childcare reform as a springboard for wider strengthening of the child protection system. The first phase of TMM did not have a specific focus on residential institutions for children with disabilities but included reintegration of a small number of children with disabilities who were residing in the target institutions. [9]The 2018 evaluation of the first phase of TMM reported that placement of children with disabilities into families utilizing the existing model was challenging. [10]The second phase of TMM has been initiated by NCDA in partnership with the National Council for Persons with Disabilities (NCPD).

This training package is embedded in the TMM programme which has been adjusted in 2019 to make it more inclusive through the addition of a third module on inclusive case management for reintegration. Inclusive design is considered more appropriate than development of a stand-alone and parallel system which can contribute to further stigmatization and discrimination. The Operational Guidance on Inclusive Children's Reintegration constitutes the guiding framework for the development of Module 3 of the training package. Given that all children, including children with disabilities may require different services across multiple sectors at different times in their lives, the operational guidance is underpinned by the functioning case management system and existing mechanisms for coordination and collaboration. Module 3 will help the social service workforce to better understand the reintegration process for all children, including children with disabilities who may require more support than children without disabilities.

This Training Package is organised in three parts:

- **Module 1:** Pre-service Training Module for Social Service Professionals, 2017
- **Module 2:** In-service Training Module for Social Service Professionals, 2017
- **Module 3**: Inclusive Case Management Reintegration, Training Module for Social Service Professionals, 2019

Using this facilitator's Manual

Two facilitators, at least one of whom should be female, are required for each group. The number of participants should not exceed 30. The facilitators should have experience both in delivering training and in practice-based child protection, including reintegration of children from residential institutions.

Although this training programme focuses on case management for reintegration, issues of child protection will arise and therefore it is possible that some of the training participants may find the content challenging. It is also possible that some of the training participants may have first-hand experience of violence and abuse and the subject matter may prompt unpleasant memories and emotions.

In order to create an environment conducive to learning within this context, the facilitators must take careful steps to:

- Create a calm and safe atmosphere;
- Allow the group to take breaks when the need arises;
- Allow individual members to leave the room should they wish to; and
- Make contact details of relevant counselling services available to the participants.

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[7] Previously referred to as a social worker or psychologist depending on their graduate level qualification and now called Child Protection Welfare Officers, these are also referred to hereinafter as 'case workers'.

[8] Cabinet Brief: Strategy for National Child Care Reform (n.d.).

[9] Through the implementation of the Tubarerere Mu Muryango Programme, 3,216 children and young adults have been placed in family-based environments or supported in independent living by December 2018.

[10] Primson Management Services, Summative Evaluation of the Tubarerere Mu Muryango/Let's Raise Children in Families (TMM) Phase I Programme in Rwanda, NCDA and UNICEF: Kigali, 15 January 2018.

Facilitator's note - sensitivity to discussions on child abuse

Due to the sensitive issues being discussed, firm ground rules should be established at the start of the sessions and distancing techniques used. Participants should not be encouraged to make personal disclosures and should instead be given information on where they can talk about personal matters in a safe, one-to-one setting. However, we know that in spite of these rules being set, participants may share information during the session which raises safeguarding or disclosure issues. If a disclosure is made you should follow the policies of the Social Service Centre on safeguarding, child protection and information sharing.

If a person starts to tell you about something that might indicate potential abuse, listen but do not ask for detail. You need to let them know as soon as possible that if they tell you something that might cause concern, you will have to tell someone else, and you will need to follow the policies of the Social Service Centre on safeguarding, child protection and information sharing. Under no circumstances agree to keep it a secret. Remember abuse thrives on secrecy. Do not ask probing questions. It may undermine any subsequent investigation.

Each session should begin with introductions, followed by any housekeeping issues including the duration of the session and the timing of breaks and issues of confidentiality so that participants feel they can speak up and express ideas and opinions freely.

For an online interactive session this can include instructions on how and when to ask a question, using the appropriate functions of the conferencing application, to mute microphones when not speaking so as to eliminate background noise, and to switch off notifications to reduce distractions during the learning workshop.

For a face-to-face session this can include instructions on how and when to ask a question, by raising a hand at any time, or if the facilitator prefers, asking participants to write down questions to be answered at the end of each session; to respect individuals' ideas and not talk over or through them; to switch off mobile phones, to close laptops and only take handwritten notes with provided pen and paper; access to break rooms and toilet facilities and so on.

You can use icebreakers, games and energizers during the introductions and at any appropriate time during the training sessions. More examples can be found at the library of facilitation techniques.

In preparation, facilitators should read through and familiarize themselves with the materials for each session. **Facilitators can then deliver the content at their own pace and in their own words, using the manual as a prompt.** If this entails adjusting the timing to suit their pace, style, expertise and knowledge we encourage this adjustment and personalization.

Facilitators should also think about the logistics for the training and can develop a preparation checklist for materials (Table 2).

Table 2. Sample checklist – preparation of materials for the training

The **facilitators** require:		The **participants** should be provided with:	
Flip chart papers	☐	Note pads	☐
Flip chart board if possible or a blackboard	☐	Folders Pens	☐
10-12 marker pens	☐	A copy of the programme	☐
Sellotape		A list of participants	☐
Scissors	☐	A copy of the participants handbook (including the simplified version of the Convention on the Rights of the Child)	☐
Large clips to hold the flip chart papers on the board	☐		
PowerPoint (otherwise provide materials as handouts)	☐		

Similarly, to create an appropriate training environment consider wherever possible:

- Seating participants in a semi-circle;
- Seating the facilitators at the head of the semi-circle;
- The room should have enough light and air, and space for participants to move around as well as to work in groups;
- Keep minimum furniture in the room. One table is required at the head of the room to keep materials;
- There should be wall space to stick flip charts;
- Drinking water should be made available in the training room; and
- Food and tea/coffee should be served in another room.

The symbols used in the facilitators text include:

Discussion
PowerPowent Slide
Written Exercise
Facilitators Say
Group Activity
Any question
Refer to Participants Manual
Timing

Proposed schedule for the Module 3 three-day training programme

Time	Day One	Day Two	Day Three
09.00-10.00	Welcome, introductions and ground rules	Children with disabilities	Inclusive Case Management for Reintegration - step by step use of the Guidance using real-life case studies
10.00-10.30	**Coffee break**	**Coffee break**	**Coffee break**
10.30-11.30	Refresher - child rights and child protection	Children with disabilities	Inclusive Case Management for Reintegration - step by step use of the Guidance using real-life case studies
11.30-12.30	The importance of family-based care for children		
12.30-13.30	**Lunch**	**Lunch**	**Lunch**
13.30-15.00	The importance of permanency planning	Support for reintegration of children with disabilities to family-based care	Inclusive Case Management for Reintegration - step by step use of the Guidance using real-life case studies
15.00-15.30	**Coffee break**	**Coffee break**	**Coffee break**
15.30-17.00	Defining reintegration	Support for reintegration of children with disabilities to family-based care	Clarifications and discussions; planning for implementation; and closure

Module One.

National Child Development Agency and UNICEF Rwanda, 2017, Facilitator's Guide: Pre-Service Training Module for the Social Service Professionals

1.1. Session 1: Child Protection

- Child protection in Rwanda
- Rwandan laws and policies governing child protection
- Key structures in child protection

1.2. Session 2: Community Practice

- What is community practice
- Key areas of community practice
- Community practice models in child protection

1.3. Session 3: Self-care and burnout

- Good and bad stress
- Stress and performance
- Self-awareness
- Self-care

1.4. Session 4: Case Management for Professional Social Workforce Guidelines

Module Two.

National Child Development Agency and UNICEF Rwanda, 2017, Facilitator's Guide: In-Service Training Module for the Social Service Professionals

2.1. Session 1: Professionalism

- Social service professional workforce code of conduct
- Professional communication
- Accountability

2.2. Session 2: Childhood Trauma

- Understanding child trauma and grief
- Risk and protective factors
- Reactions and response to child trauma

2.3. Session 3: Positive Parenting

- Principles of positive parenting
- Parenting styles and approaches
- Positive parenting and child development

2.4. Session 4: Case Management

- What is case management?
- The guiding principles of case management
- Case management process and skills

Module Three.

National Child Development Agency, National Commission for Persons with a Disability and UNICEF Rwanda, 2019, Facilitator's Guide:
Inclusive Case Management for Reintegration, Training Module for the Social Service Professionals

3.1. Session 1: Welcome, introductions and ground rules

Timing 30-45 minutes

PowerPoint slide 2. **Introduction and objective**

Objective: *The participants feel welcomed, comfortable and interested in the training, and are able to observe certain parameters so that the training is successful.*

TO PREPARE: Select an icebreaker exercise[11] to suit the group you will be working with. This will depend on whether or not participants already know each other. Prepare the necessary materials.

Let's discuss…

The facilitators introduce themselves; your names, the organization(s) you represent and the experience you bring to the training. You should welcome all the participants. Ask each participant to introduce herself or himself including name, role, how long they have worked at NCDA, what they did before and when they completed Modules 1 and 2 of the TMM case management training. Write down the first name of each participant on a flip chart paper and the number of years of experience they have. At the end of the introductions, add up the number of years mentioned and add the number of years' experience of the trainers. Tell them that in the group there is X number of years of experience working with children and this is important because it means there is a lot that we can learn from each other.

Group activity

Icebreaker exercise as selected – 'getting to know you' or 'creating interaction in the group'.

Written exercise

The facilitator moves onto setting ground rules. These rules are important if the training is to be successful. It sets the boundaries for everyone – trainers and participants. Participants take two minutes to write their preferred ground rules on sticky notes. The facilitators ask the participants to read out and group their sticky notes on a flip chart paper. These can then be listed into a 'charter' for the duration of the training. They should be written down and posted somewhere in the room where they are clearly visible and can be referred to if necessary. Each participant and the facilitators should sign the charter to show that they agree to be accountable for keeping the rules. The ground rules/charter can include the following:

Being on time	Respecting each other	One person to speak at a time, no simultaneous conversations
Joining in	Keeping the conversation confidentiality	Switching phones and laptops off during the Sessions

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

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[11] ihttp://www.cjcp.org.za/uploads/2/7/8/4/27845461/technical_manual_-__games_icebreakers_and_energizers.pdf and https://www.sessionlab.com/library/energiser

3.2. Session 2: Refresher - children's rights and child protection

Timing 60 minutes

PowerPoint slide 3. Introduction and objectives

Objective: *Participants will reiterate their commitment to children's rights and child protection and refresh their knowledge of the Social Work Code of Ethics.*

TO PREPARE: Be familiar with the materials; have copies of the relevant human rights treaties and legislation under discussion; make sure each participant has a copy of the participants manual.

Discussion

In the plenary, one facilitator asks participants to shout out the names of the key human rights instruments which are important for children, and the key legislation in Rwanda which supports child rights and child protection. The co-facilitator should make a list on a flip chart of all responses.

Facilitators say…

The 1989 **Convention on the Rights of the Child (CRC)** sets out the human rights which apply to all children, from birth to the age of 18. CRC guarantees the rights of all children, without discrimination in any form. It obliges State parties to ensure that each child, girl or boy, within their jurisdiction has all the rights recognized by the Convention.

The **Convention is special** because it is the most widely supported and comprehensive international human rights treaty. Every country in the world but one has ratified it, and it contains the full range of civil, cultural, economic, political and social rights. It's a fantastic tool, not only for advocacy and programming, but also for guiding our everyday behaviour with children.

All human rights, including **child rights, are indivisible and interdependent:** you cannot consider them in isolation. Fulfilling one right helps to fulfil others. **Rights are also inalienable:** you can't take them away. Having rights does not depend on fulfilling responsibilities. Rights cannot **be used as a reward or a punishment.**

Those with an obligation to respect, promote and realize children's rights are called **duty bearers.** The State is the main duty bearer, including everyone who works for the State, like police officers, lawyers, teachers and social workers. The State maintains ultimate responsibility, but it may delegate some responsibilities to others (such as private companies or civil society groups). The international community also has obligations to support the State in fulfilling its child rights responsibilities. Parents and other caregivers may be described as secondary duty bearers.

Individuals and groups who benefit from human rights treaties are called **rights holders.** For child rights, the main rights holders are children (under the age of 18). However, parents are also rights holders under the Convention. They are entitled to assistance from the State in raising their children, and they are entitled to provide their children with advice and guidance. All rights holders, including children, are strongly encouraged to respect the rights of others, but rights are not contingent on rights holders fulfilling duties or responsibilities towards others.

The **Committee on the Rights of the Child monitors** the Convention and its three Optional Protocols (on armed conflict, the sale of children, and individual complaints by children to the Committee): These are additional legal mechanisms that complement the Convention and need to be ratified separately. States must report to the Committee every five years. The United Nations Children's Fund (UNICEF), civil society organizations, and children themselves can provide extra information to help the committee assess how well States are implementing the Convention.

Child rights have grown out of the need for special care and protection and fulfilling children's rights leads to their improved well-being.

Well-being is another way to frame the fulfilment of children's material and psychosocial needs. However, **rights are stronger than needs or well-being.** A charity approach responding to children's needs reinforces power imbalances, relies on sympathy, and is not sustainable. In contrast, an approach based on child rights is grounded in obligations and accountability; working with children, not just for them, but respecting their human dignity and agency. It is more universal, holistic, respectful and sustainable.

Other human rights treaties can provide more detailed guidance on specific issues, such as the **Convention on the Rights of Persons with Disabilities (CRPD),** which is especially relevant to child protection work.

Article 7 of UNCRPD relates specifically to children with disabilities, including that "States Parties shall take all necessary measures to ensure the **full enjoyment by children with disabilities of all human rights** and fundamental freedoms on an equal basis with other children".

The **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)** calls for positive change in the lives of all girls and women. According to CEDAW, governments should take all necessary or special actions that may be required to make sure girls and women actually experience equality in their lives.

Remember – child rights are indivisible and interdependent: you cannot consider them in isolation. Fulfilling one right helps to fulfil others. **Rights are also inalienable:** you cannot take them away. CRC, CRPD and CEDAW are connected. Women who have had a good education are much better at supporting the education of their children, especially their daughters. When women's rights are protected, fathers are more likely to be involved in parenting and in protecting the rights of girls. This also helps make sure their rights will be protected when they grow up and become women. Making sure that all rights are applied equally to all children everywhere means that they also apply to girls and boys no matter their socio-economic status, ethnicity, country or origin or disability. Using CRC, CRPD and CEDAW together works better for the rights of girls, boys and women at all stages of their lives.

PowerPoint slide 4. The UNCRC Articles 19, 32, 34, 35 and 36

PowerPoint slide 5. The UNCRC Articles 37, 39 and 40

The facilitators highlight all the articles in UNCRC related to child protection and detailed in PowerPoint slides 4 and 5. The facilitator should read these out and explain the essence to the participants.

PowerPoint slide 6. The Government of Rwanda's national commitments to children

The facilitators highlight Rwandan policy and legislation related to the care and protection of children, including children with disabilities. These emanate from international treaties and conventions to which Rwanda is signatory.

The facilitators compare the responses given by participants during the discussion and noted on the flip chart, with PowerPoint slides 4, 5 and 6.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 7. The Social Service Professional Workforce Code of Conduct

Facilitators say…

We are now going to refresh our memories on the Social Service Professional Workforce Code of Conduct in Rwanda. This was initially covered during Module 2 (professional social service workforce in-service training).

Discussion

In plenary, one facilitator asks participants to discuss:

- What do they understand as the Social Service Professional Code of Conduct?
- Identify any of the standards of professional conduct listed in the Social Service Professional Code of Conduct.
- Have they applied the code of conduct in their daily work? If so, please provide 1-2 examples.

The co-facilitator should make a list on a flip chart of all responses.

Facilitators say…

…and compare the responses…the Code of Conduct provides a unique set of principles and professional standards that guides professional decision making and conduct when ethical issues arise within the workplace. It does not offer a set of rules that recommend how the social service workforce should operate in all situations.

The Code of Conduct underlines the importance of the professional standards required in social service delivery. Implementation of the code ensures that the members of the workforce are familiar with and practice the professional standards of conduct that the public and stakeholders expect of them.

Six professional standards should be implemented at all times:

1. Protect the rights of and promote the interests of children and caregivers;
2. Strive to establish and maintain the trust and confidence of children and caregivers;
3. Promote the resilience and eventual independence of children while providing protection from danger or harm;
4. Respect the rights of children whilst seeking to ensure that their behaviour does not harm themselves or other people;
5. Uphold public trust and confidence in social services by delivering ethical and good practice; and

6. Be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills to best serve your community.

Refer to Participant's Manual for the full text of the Rwanda Social Service Professional Code of Conduct.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.3. Session 3 The importance of family-based care for all children

Timing 90 minutes

PowerPoint slide 8. **Introduction and objectives.**

Objective: *Participants will understand that nurturing family environments are associated with positive outcomes for children's growth and development, and positive interaction between a child and parent or other primary caregiver significantly impacts the development of the brain.*

TO PREPARE: Be familiar with the materials; have copies of the relevant human rights treaties and legislation under discussion; make sure each participant has a copy of the participants manual. Prepare the child descriptions below on separate slips of paper (excluding the text in blue).

PowerPoint slide 9. **The importance of family-based care**

Facilitators say…

International law establishes that all children – including children with disabilities – have the right to live and grow up in a family.

The UNCRC is clear that:

> *"The child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding; the family being the fundamental group of society and the natural environment for the growth and well-being of all its members."*

This is because families are of critical importance to children's healthy growth and development. Research shows that children cared for in families do better than those living in residential care facilities across all areas of development and which supports the view that family-like institutions are still institutions and are no substitute for care by a family no matter the ability of the child.

Article 19 of UNCRPD protects the right of all people with disabilities to live in the community. In General Comment No. 5 the UNCRPD Committee unequivocally states that "for children, the core of the right to be included in the community entails a right to grow up in a family," and that large or small group homes are especially dangerous for children, for whom there is no substitute for the need to grow up with a family.

Group activity

Divide participants into groups of 4-5. In discussion ask them to answer the following questions and to record their responses on flip chart papers:

- What are the risks to children living in residential institutions?
- Why might children with disabilities be more exposed to these risks?

In plenary discuss whilst referring to the content below.

Facilitators say…

[With thanks to Lumos for collating the research.[12]]

Residential institutions for children have many names around the world, including orphanage, children's home and baby home. Regardless of name, size or location, institutional care is defined by certain characteristics:

- Unrelated children live in the care of paid adults.
- Children are separated from their family and often their community. In many cases, they do not have the opportunity to bond with a caregiver.

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[12] https://lumos.contentfiles.net/media/documents/document/2017/03/Factsheet_Lumos_Risks.pdf

- Institutions run according to workplace routines, instead of responding to individual children's needs.

Although some institutions are well-resourced with dedicated staff, they cannot replace a family. Eighty years of research has shown the negative impact of institutionalization on children's health, development and life chances, as well as a high risk of abuse.

PowerPoint slide 10. Risk to health

The Risk to Health

Some children in institutions suffer from poor health due to detrimental physical conditions, a restricted environment or a lack of interaction.

A few examples are given below:

- Malnutrition is a common risk for children who need extra time and support to eat. Young children and those with disabilities often become malnourished when support is not given, even though there is plenty of food available;
- 'Toxic stress' can occur when a young child's anxiety is not relieved by the caregiver, and the brain remains on alert. This reduces neural connections and heightens the risk of poor health in adulthood;
- The immune system cannot develop properly if a child is confined to a limited space, seldom leaving the building, or sometimes even their bed. Sickness also spreads easily where there are many beds in one room;
- Physical and learning disabilities may be caused and/or exacerbated by the restricted environment and lack of stimulation children receive in some institutions; and
- Hearing and visual problems sometimes result from poor nutrition or under-stimulation of the senses. These are often left undiagnosed and untreated

Toxic Stress Centre on the Developing Child Harvard University

Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies prepare us to respond by increasing our heart rate, blood pressure, and stress hormones, such as cortisol. When a young child's stress response systems are activated within an environment of supportive relationships with adults, these physiological effects are buffered and brought back down to baseline. The result is the development of healthy stress response systems. However, if the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened systems and brain architecture, with lifelong repercussions.

It is important to distinguish among three kinds of responses to stress: positive, tolerable, and toxic. As described below, these three terms refer to the stress response systems' effects on the body, not to the stressful event or experience itself:

- **Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunization .
- **Tolerable stress response** activates the body's alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.
- **Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity – such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship – without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

PowerPoint slide 11. The risk to development

The risk to development.

Engagement with adult caregivers generates signals and connections in the growing brain, allowing a child to develop intellectual, physical and emotional skills. The more engagement, the stronger the connections.

Many children who were placed in institutions at an early age show delays in these areas of development. In some poor-quality institutions, children may fail to sit, stand, walk and talk by the age of four.

Research comparing children who were institutionalized at an early age with their peers raised in birth or foster families showed:

- Physical stunting. The Bucharest Early Intervention Project found that Romanian children lost one month of normal growth for every 2.6 months spent in an institution. Other studies in China and Russia found similar results: one-month delay for every 3.0 or 3.4 months.
- Poor social and psychological development. Studies in several European countries found infants showed insecure attachment to adult caregivers. This was linked to behavioural difficulties and 'internalizing disorders' such as depression or anxiety later in life.
- Lower Intelligence Quotients (IQs) and levels of brain activity. Analysed data on the IQ of 4000 children in 19 countries: The average IQ of children raised in birth or foster families was 104. The average IQ of children raised in institutions was 84.

PowerPoint slide 12. Risk of neglect, abuse and exploitation

Risk of Neglect, abuse and exploitation.

The United Nations World Report on Violence against Children showed corporal punishment, and abusive 'treatments' including physical restraint and electric shock used on children in institutions.

One report of a psychiatric facility in Mexico found children with self-harming behaviour (such as banging their head against a wall) were ignored for long periods or permanently held in physical restraints.

Studies in Europe have shown similarly abusive conditions, especially for children with disabilities.

Children in residential care are six times more likely to be exposed to sexual abuse than children of the same age in the general population.[13]

PowerPoint slide 13. Risk to long-term life chances

Risk to long-term life chances.

Children living in institutional care often do not develop social networks or skills that are essential in adulthood. It is harder for them to find employment and they are more likely to have behavioural, physical and mental health problems, including high risk behaviours, sexually transmitted infections, alcohol or drug misuse and violence. They are also more likely to be dependent on the State.

Children with disabilities often remain in institutions for their entire lives, with no opportunity to appeal the decision.

Survey data in Russia showed outcomes for children who grew up in institutions:

- 1 in 3 became homeless
- 1 in 5 had a criminal record
- 1 in 7 became involved in sex work
- 1 in 10 committed suicide

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

Group activity

In advance, prepare the child descriptions below on separate slips of paper (excluding the text in blue). Divide participants into pairs. Give each pair one of the child descriptions below. Ask them to consider the risks the child might face, growing up in a residential institution and why. After 10 minutes ask pairs who are discussing the same child to come together and compare answers.

Feedback in the facilitator-guided plenary.

Ruth is 4 years old. She came to live in the residential institution six months ago because her mother who was a single parent could not cope any longer. Ruth hardly speaks anymore. Most days she needs someone to help her to get dressed. The staff often see her looking out the window and rocking back and forth. Sometimes she doesn't seem to notice when her name is called.

For example, Ruth can be experiencing separation anxiety because she is no longer with her mother; she may have stopped speaking because no one listens, because they do not understand her and do not respond, or because they are busy and do not have time to talk. She is losing her skills – she can no longer dress herself and her development is slowing down. Rocking can be a repetitive stereotypical behaviour which she has adopted to provide her with stimulus and the comfort she lost when she was separated from her mother.

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[13] Timmerman, G. and Schreuder, P., 'Sexual abuse of children and youth in residential care: An international review', Aggression and Violent Behavior 19(6) November 2014.

Patrick is 14 years old. He cannot remember living anywhere except the residential institution. He's seen a lot of people come and go and he does not bother to make friends anymore because they all leave in the end. He used to think about being a photographer when he grows up but since he's become older, he thinks that was just a dream. He spends most of the time lying on the floor because he cannot walk and because he does not have a wheelchair or crutches. He is not sure if he ever had any treatment for his condition.

For example, because Patrick has not had any physiotherapy his condition has become even more disabling. He is not able to join in with the activities in the institution as much as he would like and he has lost opportunities for growth, development and learning. Now he is losing his dreams too. He may tend to keep out of the way of other people because he is worried, that they will hurt him since he is on the floor and they might not notice he is there. Patrick is probably very lonely and at risk of depression and other mental health conditions.

Eugene is 17 years old. He thinks he came to live here about four years ago because he was too big and heavy for his parents to manage at home anymore. Because they live far away, he has not seen them for a while. The staff here do not understand him when he speaks, not like his family did; this makes him frustrated and he sometimes gets angry.

For example, because he is large and aggressive, Eugene may be confined for much of the time – this could include being locked in a room by himself or tied up. He is probably lonely too, which can trigger depression, he may not eat properly because staff do not want to go near him. If he gets sick, he might not get the treatment he needs because no one cares to examine him. Eugene may lose the self-care skills he learned while he was living at home. This can lead him to be considered more profoundly disabled.

Winny is 6 years old. She is pretty, cute and compliant, and everyone loves to cuddle her. There are a couple of carers in the residential institution who take special care of her and make sure she gets extra treats. She has learned to be extra good when they are around. She cannot hear very well and no one in the residential institution knows sign language. Sometimes she misses what's going on and people think she is not very clever because she doesn't respond.

For example, Winny may have insecure attachment – because she has not experienced the socio-emotional support from a parent/single caregiver, her attachments may be disorganized. She knows what behaviours are attractive – she will likely greet strangers with hugs and smiles (unlike other children her age who can be shy meeting strangers); as she grows older this can leave her exposed to exploitation including sexual exploitation.

Hosea is 12 years old. He has Down syndrome and was abandoned when he was a baby. He has lived in the residential institution all of his life. Hosea is quite overweight, and this makes it difficult for him to move around and the staff make fun of him and call him names. Because he has Down syndrome the staff decided that Hosea did not need to go to school. To keep him occupied they used to give him simple chores to do, but because he often got things wrong and there was no one with enough time to supervise him, they soon gave up.

For example, Hosea has poor nutrition, he has been neglected and the impact of his condition has been worsened by the neglect. Hosea has missed opportunities to grow and develop and live a productive life.

Facilitators say...

This session has been about the importance of family-based care for all children. This means that all children should have the opportunity to grow and develop in their families, or in a substitute family. This includes children with disabilities. The risks to a child's health, development and long-term outcomes are too serious to ignore. This is why the government has initiated this programme of care reform.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.4. Session 4: The importance of permanency planning

Timing 60 minutes

PowerPoint slide 14. **Introduction and objectives.**

Objective: *Participants will be familiar with the key content of the United Nations Guidelines for the Alternative Care of Children and will understand the importance of ensuring a secure environment with lifelong bonds that will support the child into adulthood.*

TO PREPARE: Be familiar with the materials.

Facilitators say…

Children and young people deserve stability – somewhere safe that they can come home to every day, relationships that are nurtured and developed over time, and a sense of security and belonging. We know that this stability is one of the things that helps children to achieve good outcomes, and for those who come into the care of local councils, it is why working towards permanency from the very start is so important.

For some, permanency will mean returning home to their birth family after a period of time. For other children, adoption may be the best option, or perhaps living with a relative or someone else known to them under a special guardianship order. Similarly, long term fostering arrangements can offer a stable home without cutting links to the birth family. A very small number of young people might not want to live with another family, or may not be suited to it, and so will stay in residential care until adulthood.

Support for children and their families – both their birth families and carers – shouldn't stop when a placement is made. Some children will have been through very difficult, potentially traumatic experiences before coming into care, and will need extra help to come to terms with that and go on to fulfil their potential.

Discussion

Permanency arrangements vary for different children, according to what their needs are and what is in their best interests. In plenary, facilitator asks participants to consider the different types of permanency. These can be listed on a flip chart. In follow-up discussion in plenary facilitator refers to the types of permanency planning described below.

PowerPoint slide 15. **Types of permanency**

Return to birth parents

For many children, a return to their birth family is possible after those issues that led to a period in care have been dealt with.

Kinship (family and friends) care

Kinship care is where a child lives with a relative, friend or other 'connected' person. Many children in kinship care are in informal arrangements, which do not involve the local authority (for example, where a parent asks the child's grandparents to take on full-time caring responsibilities).

Adoption

For some children permanence is achieved through adoption, in which full parental responsibility is legally transferred to the adoptive parents. This is most likely to happen for younger children; But adoption can be an excellent route to permanence for children of all ages and should not be discounted purely on the basis of age. Where adoption is considered the best option for a child, avoiding delay is key. Research has shown that a child's chances of being adopted reduce by half for every year of delay, while the age at which the child comes into their adoptive family has a significant impact on adoption outcomes.

Special guardianship

In some countries special guardianship provides an alternative form of legal permanence to adoption and can be used, for example, in cases where children, social workers or the courts feel it would be beneficial to retain links with their birth families. It should:

- Give the carer parental responsibility for all aspects of caring for the child and for taking the decisions to do with their upbringing. The child will no longer be looked after by a local authority.
- Provide a firm foundation on which to build a lifelong permanent relationship between the child and their carer.
- Be legally secure.
- Preserve the basic link between the child and their birth family.
- Be accompanied by access to a full range of support services, including, where appropriate, financial support.

Long-term foster care

Children living in stable, long-term foster care can have similar outcomes to adopted children, and this is a positive permanency option for those children who still identify with, and wish to maintain links to, their birth families. It can also be a positive option for children with complex care needs [who have a disability] or who are harder to place for adoption, such as sibling groups or older children, providing them with long-term stability and ongoing care and support.

Residential placement

Living within a family setting will be the preferred permanency option for most children, including those for whom residential care is a positive short-term option. However, for a small number of children and young people a long-term residential placement could equally be the best option. In particular, this can be useful for older children who are unable or unwilling to participate in family life due to previous experiences or the emotional demands of family living.

Fostering for adoption

Where the preferred form of permanency for a child is adoption, they may be placed with approved adopters who are also approved foster carers while social workers continue to investigate all options for the child. Where the court decides that the child can be placed for adoption, the foster family will then be granted an adoption order, provided social workers and the court are satisfied the child's needs will be met in that placement. Fostering for adoption can limit the number of placement moves for a child and allows them to begin building a relationship with potential adoptive parents from an early stage.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

Facilitators say…

Finding alternative families for children with disabilities can be challenging. However, there are things you can do.

PowerPoint slide 16. Finding alternative families for children with disabilities

You can build support for alternative family care by making people aware of the needs, and the rights of all children to grow up in a family.

You can talk to the professionals working in existing programmes for foster care and adoption to build disability awareness.

Recruitment, preparation, training and support for foster carers and adoptive parents needs to focus on the specific support needs of children with disabilities. It can require intensive input in the immediate and longer-term to make sure that the child is safe and cared for and that the family is supported financially and emotionally. This can include specialized training programmes at the outset and during the child's placement, to make sure that families have the correct information and skills to support the child in different stages in their life.

PowerPoint slide 17. United Nations Guidelines on Alternative Care

CRC seeks to protect children who are unable to live with their parents or remain in a stable family setting (notably, though not only, in Article 20). However, CRC does not describe in any depth what measures should be taken.

Therefore, the United Nations Guidelines on Alternative Care were developed. The core message in the guidelines is that children must never be placed in alternative care unnecessarily, and where out-of-home care must be provided it should be appropriate to each child's specific needs, circumstances and best interests.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.5. Session 5: Defining reintegration

Timing: 60 minutes

PowerPoint slide 18. **Introduction and objective**

Objective: *Participants will understand the difference between reintegration, reunification and placement in family-based alternative care; be familiar with the steps in the planning process and know how to monitor and follow up with all children and families post reunification/ placement.*

Group activity

Divide participants into two groups; without letting each group know what the other's task is, ask the first group to develop a definition for reintegration; the second group are tasked with developing a definition for reunification.

Feedback in plenary and compare these definitions with those given by the facilitator (see below)

Facilitators say…

PowerPoint slide 19. **Reintegration and reunification**

TThere is not yet a globally accepted definition of reintegration; however, it is generally agreed that this is a process rather than an individual action. Sometimes reintegration and reunification are used interchangeably but these are separate and different terms:

- Reintegration is a process consisting of several steps or phases;
- Reunification is a single action or step taken during the reintegration process.

In Rwanda reintegration through TMM includes transition of a child from a residential institution to live with their family of origin or to live in family-based alternative care.

> *"Reintegration is the process of a separated child making what is anticipated to be a permanent transition back to their family of origin and community or to live in family-based alternative care, where they can have their rights fulfilled and receive the support and love needed to reach their future potential.*

Reintegration is the process of a separated child making what is anticipated to be a permanent transition back to their family of origin and community or to live in family-based alternative care, where they can have their rights fulfilled and receive the support and love needed to reach their future potential.

Reunification is the physical act of returning the child to their family; it is one step in the reintegration process.

PowerPoint slide 20. **Steps in the reintegration process**

The reintegration process consists of several phases, one of which is reunification, the physical act of returning the child to their family of origin. In cases where the child cannot be reunified a placement in family-based alternative care should be considered.

Discussion

In plenary the facilitator goes through the steps of the reintegration process with participants, focusing on children with disabilities.

Children with disabilities need particular assistance during all phases of the reintegration process. During the preparatory phase, it is important to properly assess children with disabilities using a qualified expert and to work to rehabilitate children as appropriate (providing physiotherapy or teaching children how to use aids for mobility, bathing, feeding, dressing etc. and for performing daily task as independently as possible).

It is also crucial to identify ongoing support needs and to determine how these will be met, mapping existing services and support and connecting with local organizations working to support children with disabilities in their home communities.

Social workers may need to:

- Access physical aids and assistive devices (such as wheelchairs or hearing aids);
- Train family members in children's care and support or teach them how to effectively communicate with children;
- Ensure that schools and homes are accessible/ adapt home environments; and
- Work to tackle discrimination and promote integration into local schools.

In general, the focus should be on making the environment accessible and inclusive, not on trying to 'fix' children with disabilities to make them fit into society. Social workers should link with any community-based expertise and resources, in particular disabled people's organizations, which are run by and for persons with disabilities. When raising the possibility of reintegration, staff are advised to discuss openly any concerns with children and families, and to stress the commitment of the NCDA to continue to support access to rehabilitation services, medical treatment (if needed) or other required services once home. Here it is important to stay positive and to focus on children's ability to live independently rather than on loss or deficit. It may be possible to link parents of children with disabilities together and peer-to-peer support can also be valuable for children with disabilities. It may also be important to offer respite care to provide caregivers and children a break.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.6. Session 6 Children with disabilities

Timing: 210 minutes (3.5 hours). Facilitators may introduce breaks at their discretion.

PowerPoint slide 22. Introduction and objective

Objective: *Participants will have enough information to be more confident when meeting children with a disability and their families, and when talking to other professionals.*

TO PREPARE: Be familiar with the materials; make sure participants have a copy of the participants handbook.

Group activity

Divide participants into groups of 4–5; based on their knowledge and experience, ask them to answer the following question: Why is it important to include children with a disability?

The groups should list reasons on a flip chart paper, and feedback in plenary, guided by the facilitator who can refer to the information below.

PowerPoint slide 23. A fair chance for every child

Facilitators say…

Children with disabilities should be included because it is their human right.

Children with disabilities are children first, with their own needs, strengths, wants and rights. As for all children, children with disabilities have the right to thrive, not simply survive. This means that they have the right to participate fully in their families and communities, including going to school, and to access the services needed to help them achieve their full potential. These rights are protected and advocated for by the United Nations Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities. Equity and inclusion are also fundamental principles of the Constitution of the Republic of Rwanda 2003, revised in 2015.

Child Protection and Welfare Officers have the responsibility to ensure that all children have a fair chance, including those who experience deprivation and discrimination because of their gender, ethnicity, socio-economic status, place of birth or disability status.

Equity is the fair treatment, access, opportunity, and advancement for all people, while at the same time striving to identify and eliminate barriers that have prevented the full participation of some groups.

Inclusion is the act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate.

Limited knowledge about disability and related negative attitudes can result in the exclusion of children with disabilities within their families, schools and communities. In cultures where guilt, shame and fear are associated with the birth of a child with disability they are frequently hidden from view, ill-treated and excluded from activities that are crucial for their development. As a result of this discrimination, children with disabilities may have poor health and education outcomes; they may have low self-esteem and limited interaction with others; and they may be at higher risk for violence, abuse, neglect and exploitation.

Children with disabilities can be excluded because their families have been advised by medical professionals to place them in residential care facilities, or because they have not had the right support to take care of the child at home. They can also be excluded from care reform processes, for example, because they are forgotten, or because it is thought to be too difficult, or because the prevailing social norms do not consider that children with disabilities have equal rights with all children.

However full and effective participation and inclusion in society is a fundamental principle of both UNCRC which says that children with disabilities have the same rights as all children, and of UNCRPD which says that all persons with disabilities should have full and effective participation and inclusion in society (Figure 2).

Inclusion of children with disabilities and their families in all aspects of daily life is important because it supports their rights. However, reintegration of children with disabilities from residential institutions does not guarantee the transition from segregation to inclusion. This requires accompanying services and systems such as rehabilitation, inclusive education and others to be in place and for changes in infrastructure, changes in attitudes to adjust social norms among others.

Children with disabilities do not require different activities or experiences for learning to occur. However, they may need specific, individualized support to benefit from the positive experiences that children without disabilities have access to. For example, adaptations to the built environment/infrastructure (wheelchair ramps), access to assistive devices (a computer with special software for communication), a personal assistant (to help them in the classroom, or to use the toilet at school), habilitation and rehabilitation therapy to support delayed development (physiotherapy, speech therapy, occupational therapy), change in attitude and behaviour of the people around them so that they can be involved in day-to-day life, among others.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

Written exercise

Ask participants to write down three things you think about when you picture a child with a disability.

Ask each person in the group to read out what they have written and put it up on the board/flip chart/screen.

PowerPoint slide 24. Defining disability

Facilitators say…

Disability is complex. It can be understood differently and described differently depending on the cultural context. However, there is a general agreement that the definitions provided in global conventions are a good place to start.

UNCRPD says that;

> *"Persons with a disability include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".*

Let's discuss…

Is this the same or different to what you wrote down? Why do you think this is?

Facilitators say…

Disability is the complex relationship between the mind, the body and the environment in which a child lives.

Sometimes people think that disability is an illness, that it is something which can be treated or cured, or in the negative, something that can be spread to others, like an illness that can be caught. This is called the medical model of disability. It only considers what people assume is wrong with a child; something to be fixed. When people think like this, they do everything they can to get help from doctors and other medical professionals. Sometimes this can help, for example if a child has epilepsy and they experience seizures, they will need to take medicine to control it. But only dealing with the medical or health-related challenge and forgetting about the other ways that disability impacts life can mean that a child with a disability does not get all the support they need. For example, a child who has Down Syndrome may have surgery to correct a heart defect they are born with, but if they do not get the extra support they need for learning and development they may not be able to go to school because they have not learned to dress themselves or to socialize with other children; or another child with cerebral palsy may receive injections to relieve muscle spasms but if the infrastructure is not suitable for their wheelchair they may not be able to move around easily.

An alternative view is that children are 'disabled' by barriers in society, not by their lack of ability, impairment or difference. This is called the social model of disability. Barriers can be physical, like buildings not having accessible entrances or toilets. Or they can be caused by people's negative attitudes to difference, like assuming disabled people cannot do certain things or that a disability can be 'caught' like a disease.

For example, if a child cannot see very well but wants to read the latest best-selling book so they can chat about it with their friends, the medical model takes them to a clinic to see if the doctors can do anything to improve their eyesight. The social model solution makes a full-text recording available when the book is published.

This child has an impairment (poor eyesight) which can limit their activity (reading books) until the participation restriction is lifted (by recording the text).

Let's discuss…

Can you think of other examples?

Facilitators say…

Sometimes choosing the medical model over the social model, or the social model over the medical model can mean we don't seek out all the solutions which can assist the child to realize their rights.

Instead, there is a third model which says that we should try and balance the social and medical model by looking at the whole person, the whole child. It means we think about their physiological (health or body) needs and their social needs, including their interpersonal needs – that is the way we relate to them – and support them to relate to the world and the people around them. This is sometimes called the biopsychosocial model of disability.

It means we should relate to the child on a number of different levels when assessing their needs, and where necessary adjusting our own behaviour to meet those needs. For example, the child with poor eyesight who has had healthcare to improve his eyesight as far as possible, and who has access to audio books, may still be isolated from his peers because he needs help to move around or because other children his age are afraid of him because he is different. This boy may need support to go to places where other children his age meet, to learn to get around by himself (become independent); and the other children may need support to learn the facts about disability and to understand the person behind the disability. In this way all of the boy's needs can be met so that his rights to participate equally are realized.

Let's discuss…

How does this relate to the answers you gave when you are asked to write down what you think about when you think of a disability. How many of these ideas and descriptions are about something you can see or immediately experience? For example, a child who cannot walk, or has some other restricted movement; a child who cannot see, hear or talk; a child who displays unusual behaviour such as hand-flapping, or rocking back and forth rhythmically?

Facilitators say…

Sometimes a disability is not obvious. A hidden disability may not be immediately noticeable except under unusual circumstances or because the person or other someone close to the person tells you about it. Some examples of hidden disability include arthritis, mental health difficulties such as depression, and Human Immunodeficiency Virus (HIV). Not being able to read and write can also be a hidden disability because although there is no physiological impairment, a person who cannot read and write experiences activity limitation and participation restriction. They may not be able to find a job, they may be considered a bad parent because they do not help their children with homework, they may miss out on benefits because they cannot fill in the forms…

Children who have an autistic spectrum disorder may look like all other children around them, but they may become disturbed by an outside influence which causes their behaviour to become unruly or antisocial. To many people watching this can seem like a temper tantrum and blame bad parenting. This can mean that they, or their parents do not want them to go out in public and so they can become isolated and cut off from learning, social and human development experiences.

In conclusion, understanding disability can be complex; a child may experience impairment, an activity limitation or a participation restriction or all three, and these may change at different times in the child's life. For example, the behaviour associated with autism described above can be perceived differently in a 6-year-old and a 17-year-old. It is also important to know that children can be born with a disability, or they can acquire it, for example, as a result of a road accident.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 25. Types and effects of disability (I)

Facilitators say…

Everyone is an individual: a disability can affect children in different ways, even when one child has the same type of disability as another person

By being thoughtful you can find ways to reduce activity limitations and participation restrictions

PowerPoint slide 26. **Types and effects of disability (II)**

Facilitators say…

A disability can affect children in different ways, even when one child has the same type of disability as another person. Some children have more than one type of disability. There are many types of disabilities, such as those that affect a child's:

- Motor skills
- Sensory ability
- Behavioural skills
- Intellectual functioning
- Communication skills

These difficulties can affect a child's ability to:

- Sit, crawl or walk
- Hold or manipulate objects
- Use the toilet, dress or feed themselves appropriately
- Learn from their environment
- Manage their emotions and demonstrate age-appropriate behaviour
- Learn, understand and apply complex information
- Use words to communicate, express their thoughts and feelings, or to understand others
- Speak clearly and be understood
- Understand simple directions
- Be with, play and relate to their peers or adults

However, if we think about the definition of disability, we can see that an impairment can be moderated by lifting the activity limitation or participation restriction so that not being able to see well becomes less disabling for the child. For example, if a child with poor vision can play football using a ball with a ringing bell inside (lifting the activity limitation), they can participate in 'ringing bell' football with other children if a few safety rules are devised and agreed to (lifting the participation restriction).

A child may also be extremely sensitive (hypersensitive) or not responsive (hyposensitive) to the environment. This means they may have an acute reaction to a minor environmental stimulus such as being distracted by common sounds like the humming of a refrigerator; or they can be unresponsive to the world around them and need additional sensory stimulation to feel content, such as touching things excessively, always turning the volume very loud, or constantly putting objects in their mouth.

Let's discuss…

How do you think activity limitations and participation restrictions could be lifted in this case?

Facilitators say…

Children with disabilities may also show unusual or uncontrollable behaviour. Sometimes this behaviour can be caused because the child is sick or in pain and cannot communicate this. It can also be related to emotional issues if the child is sad or unhappy, or to being hypersensitive or hyposensitive to their environment. There can be many causes and it is important to ask a doctor or other specialist in case the behaviour is linked to an illness or injury or other physical cause.

Because each child is unique, disability can affect individual children in different ways, even among children with the same type of disability. Children can also be affected by more than one type of disability, for example, their movement and sight, thinking and understanding can all be affected.

Following the biopsychosocial model of disability, and because individual children develop at different rates, disability is assessed and described in terms of what a child can do, how a child 'functions' rather than a description of a condition. For example, each child with Down Syndrome will have capacities and difficulties in different areas. Their disability is not defined by the condition itself but rather by how their functioning is impacted, by the opportunities they have to learn and develop skills and to have the same experiences as their peers.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 27. **Inclusion involves…**

Facilitators say…

Inclusion of children with disabilities and their families in all aspects of daily life is important because it supports their rights.

Children with disabilities do not require different activities or experiences for learning to occur. However, they may need specific, individualized support to benefit from the positive experiences that all **typically developing children** have access to. For example, adaptations to the built environment/infrastructure (wheelchair ramps), access to assistive devices (a computer with special software for communication), a personal assistant (to help them in the classroom, or to use the toilet at school), habilitation and rehabilitation therapy to support delayed development (physiotherapy, speech therapy, occupational therapy), change in attitude and behaviour of the people around them so that they can be involved in day-to-day life, etc.

Inclusion of children with disabilities in everyday activities involves practices and policies designed to identify and remove physical, communication, attitudinal and other barriers that hamper children's ability to have full participation in society, similar to typically developing children. Inclusion involves:

- Getting fair treatment from others (non-discrimination);
- Making products more user-friendly, communications more understandable and the physical environment physically accessible to as many people as possible;
- Modifying items, procedures, or systems to enable a person with a disability to use them to the maximum extent possible (reasonable accommodations); and
- Eliminating the belief that people with disabilities are unhealthy or less capable of doing things (stigma, stereotypes).

Let's discuss...

Can you think of any examples of inclusion you have noticed in your environment?

PowerPoint slide 28. What is inclusion?

Facilitators say...

Exclusion occurs when children are directly or indirectly excluded from the life of the family, school or any part of community life.

Segregation occurs when services for children with disabilities are provided in separate environments designed or used to respond to a specific impairment or set of impairments, in isolation from typically developing children.

Integration is when children with disabilities are provided with services in the same place as everyone else, as long as they can adjust to the standard requirements of such a service.

Inclusion involves full reform which means that children with disabilities can participate fully in the life of the family and community; this means making changes to the environment, to the way we all communicate, to our attitudes and belief systems, and to the way we provide services so the service adapts and not the child.

Although the research is still limited there is emerging evidence that there are strong economic benefits for the whole community to adopting a disability-inclusive approach. Economic benefits are clearest and have been most commonly highlighted in programmes that supported disabled people's livelihoods and employment or access to credit or finance. Some inclusive education programmes also make explicit links to economic benefits. The theory is plausible that if we include people with disabilities, we increase the pool of productive citizens who can contribute to reducing poverty.

For example: Let's think about Ana and Henry who live with their families in the same village.

Ana and Henry both have disabilities. Because their parents are afraid of what other people will think about this (they might be scared, or superstitious, or want to hurt the children) they keep Ana and Henry at home, in the house or compound where no one can see them. They do not see visitors, they do not go shopping with their parents or siblings and they are not enrolled in school. They are invisible to almost everyone. This is exclusion.

One day Ana and Henry's parents learn that there is a residential institution for children like them in a remote place 50 kilometres away. The doctor says it is a good place where the children will be cared for. The village leader/head of the local council also tells the children's parents that it is a good place for them. A car comes and takes Ana and Henry to the institution, where they start their new life. This is segregation.

After some time, the government decides that these isolated institutions are not good for children and so they decide to close them. They slowly move the children to live with other children with disabilites in a smaller 'family-type group home' in the village they came from. They go to the local school and sit in the classroom with other children, they do not have any extra help in the classroom, and they do not make much progress. This is integration.

PowerPoint slide 29

Facilitators say...

Step-by-step changes start to happen in the village – when new buildings are constructed the architects and builders have to think about how children and other people with disabilities can access them; when professionals in health or education are trained, there is a special module on how to include children with disabilities so they can get the proper services at the ordinary health and education facilities; the village leader/head of the council talks about the importance of including people with disabilities in the life of the community and dispels myths. Henry and Ana and their families are supported so that they can live together again. Because Henry and Ana are able to grow up in an inclusive society, as adults they can get jobs and contribute to society. This is inclusion.

In your day-to-day work it is important to remember that involving children and their families in service planning and design from the start creates better services. 'Involving' means both listening to and acting on what you hear. This is because the services which are designed to meet the needs of the people who will use them will be more accessible and useful. It also allows service planners to communicate openly and transparently about what is possible and feasible, given financial realities, and to plan for evolving design as resources become available.

Group activity

Divide participants into groups of 4–5 to answer this question – What do you think needs to happen to make this a reality in your community? What should the first steps be?

Feedback in the plenary discussion guided by the facilitator; can include discussing with community leaders, talking to educators in school, visiting the local clinic to speak to health personnel...

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

Ask participants to take a few minutes to write down some of the words people in Rwanda use when referring to children with a disability (use the local language). Put a √ (tick) against the words which seem to you positive and respectful. Put a X (cross) against those words which seem to you negative and disrespectful.

Ask each person in the group to read out what they have written and put it up on the board/flip chart/screen.

PowerPoint slide 30. Overcoming stigma and discrimination

Facilitators say...

It is really important that the language used to describe disability is respectful to people with disabilities and in line with the way they describe themselves. The words we use to talk about children with disabilities can reinforce stereotypes, stigma, segregation, exclusion and discrimination.

Each country and even individual communities within each country can have a different context and history that may also affect how people think about disability. The way we talk about disability and the words we use can reflect this context but can sometimes be disrespectful and reinforce the label applied to the child as having little or less value than other children. This is not a rights-based approach and because of this the child and their family can experience stigma, discrimination, exclusion and isolation.

Stigma refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different. **Discrimination** happens when individuals or institutions unjustly deprive others of their rights and life opportunities due to stigma. This lack of understanding can have serious consequences for people with a disability and their families.

For example, some people with a disability do not like it when someone says they are 'vulnerable' and need 'care'. They prefer to think of themselves, and to be thought of by others, as capable, and want the focus to be on the barriers to their inclusion and independence that have been created by society.

Sometimes the words used to describe people with a disability can also be used as terms of abuse. For example, in the past, in the United Kingdom the words 'idiot' and 'moron' were used as official classifications for a person with an intellectual disability. These words are now used as disapproving words of abuse. In the United States of America 'mental retardation' is an official classification of limitations in intellectual functioning, and many young people use the word 'retard' when they want to say something nasty about a peer.

In some countries the laws reflect the medical model of disability using words such as, 'with limited health opportunities' to describe disability.

Let's discuss...

At the beginning of this session we asked you to write down some words used in your country to describe disability. Are these words positive or negative? Facilitator reviews the words on the flip chart and in plenary discusses and puts a √ (tick) against the words which everyone agrees are positive and respectful and puts a X (cross) against the words which everyone agrees are negative and discriminatory.

Facilitators say...

In many countries organizations and individuals like to use what is called person-first language. Person first language emphasizes the person first and not the disability. For example, when referring to a child with a disability, refer to the child first by using phrases such as: 'a child who ...', 'a child with ...' or, 'child who has...'. This helps us to remember that they are all children, first and foremost. However, in other countries some people describe themselves as a disabled person in preference to a person who has a disability, because they believe the disability is a part of their identity.

It is a good idea to talk to people with a disability, perhaps members of a disabled persons' organization in your country, to find out what words they would prefer you to use.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.7. Session 7: Engaging with children, families and communities

PowerPoint slide 31. Introduction and objectives

Objective: *Participants will know how to encourage participation and self-advocacy to make sure children, their families and communities as well as residential institution staff and local administration staff are fully included in the reintegration process.*

TO PREPARE: Be familiar with the materials.

PowerPoint slide 32. What is participation?

Facilitators say…

Participation is the right to be listened to and taken seriously. Article 12 of UNCRC says that children and young people have the human right to have opinions and for these opinions to matter; Article 12 applies everywhere and to everyone;

It is about being able to speak up – even if you have a different opinion from other people or want to complain; It is also a child's right to refuse to give an opinion.

The right to participation applies to all children everywhere.

Written exercise

Ask participants to take a few minutes to write down three reasons why they think participation is important for children with disabilities.

In plenary, the facilitator asks each person to read out what they have written and put it up on the board/flip chart/screen.

Facilitators say…

One of the things UNCRC makes clear is that human rights apply to children and young people, just as they do to adults. This is as true in Kenya, Guatemala or Moldova as it is anywhere else in the world.

For example, Article 12 of UNCRC says that children and young people have the human right to have opinions and for these opinions to matter. It says that the opinions of children and young people should be considered when people make decisions about things that involve them, and they should not be dismissed out of hand on the basis of age. It also says children and young people should be given the information they need to make good decisions.

Article 12 applies everywhere and to everyone.

The opinion of a child and young person should be considered everywhere, including in their home, in their workplace and at school. This is true no matter how young a child or young person is, although the weight their opinion is given should change as they grow up and become more mature.

Article 12 applies to everyone, and care should be taken to make sure it can be exercised by everyone in reality. For example:

- special materials should be produced for children and young people with disabilities if they need these to participate;
- special consideration should be given to children and young people in vulnerable situations, such as those in care or refugees;
- care should be taken to make sure girls' opinions are respected just as much as boys are.

Being able to speak up

Article 12 is also concerned with making sure children and young people feel able to express their opinions. It says that they should not feel their opinions will be dismissed or regarded as invalid because of their age. It also says that children and young people need to know about this right so that they can exercise it, and that adults need to know about this right, so they do not dismiss it out of hand.

Additionally, children and young people should be able to complain about any aspect of their lives as easily as adults can. They should have ways to complain about those in a position of power over them – such as parents, guardians or teachers – without an adult knowing, and complaints procedures should be easy for them to access.

Being able to refuse

Article 12 does not mean children and young people have to express an opinion if they do not want to. They can refuse to give their opinion for any reason, and Article 12 should not be used to pressure them into giving it.

PowerPoint slide 33. What does UNCRPD say about participation?

Facilitators say…

UNCRPD also mentions participation of persons with disabilities. This international agreement on the rights of disabled people is clear that countries must make sure that disabled people have the right to find out and give information and to say what they want, just like everyone else.

This includes:

- Providing information in different ways – EasyRead, for example, or using sign language, Braille and audio – firstly, people should ask disabled people how they would like to get information;
- Telling other services to make their information accessible;
- Getting the media, including the Internet to provide accessible information; and
- Supporting the use of sign language.

UNCRPD also talks about the right of disabled people to vote and to participate in politics, and in sport and leisure, as well as to be included in all aspects of community life.

Let's discuss…

Can you think of a child or adult with a disability that you know who finds it difficult to participate and be involved? Why do you think this is?

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 34. What is advocacy?

Facilitators say…

Advocacy is when a person gets the support they need to speak up.

Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to:

- Have their opinions heard on issues that are important to them;
- Defend and safeguard their rights;
- Have their views and wishes genuinely considered when decisions are being made about their lives.

In other words, advocacy is a process of supporting and enabling people to:

- Express their views and concerns;
- Access information and services;
- Defend and promote their rights and responsibilities; and
- Explore choices and options.

PowerPoint slide 35. An advocate will…

Facilitators say…

An advocate is someone who provides advocacy support to a person when they need it. An advocate might help them to access information they need or go with the person to meetings or interviews in a supportive role. A child with a disability may want an advocate to write letters on their behalf, or to speak for them in situations where they do not feel able to speak for themselves.

An advocate will talk to a child with a disability to find out what they want and how they feel. An advocate will listen, find the information to help the child to make choices, can talk to other people or groups on behalf of the child (with their permission) and can help the child say what they think about their reintegration process, or any other issue that is important to them.

During the reintegration process an advocate will talk to the local authorities, meet teachers and go to the local health centre to make sure they are prepared for the child and can offer appropriate services and support.

A child or person with a disability who is supported to speak for themselves is a self-advocate.

Group activity

In pairs, discuss what you can do to act as an advocate for the children with disabilities with whom you work. Think specifically about what you can do as an advocate during the reintegration process.

In plenary, discuss your responses guided by the facilitator, and write-up on flip chart/board/screen.

PowerPoint slide 36. Three important terms

Facilitators say…

We have learned three important terms today which may seem to be saying the same thing, but which have nuances in the context we are using them. To be clear:

- Participation is a human right;
- Advocacy is the support provided to children and families to realize that right;
- Self-advocacy is when the child has the knowledge, skills and support to advocate on their own behalf.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 37. What is involving children and their families important?

Facilitators say…

The importance of participation is reflected in both UNCRC and more recently in UNCRPD.

Despite this, children with disabilites and young people have fewer opportunities to participate in decision making than their non-disabled peers.

Research tells us that many children with disabilites and young people are still being excluded from participation and decision-making opportunities. In many cases decisions are taken without even the involvement of their families. Basic access needs to support disabled young people's participation are not being met, and children and young people with higher support needs and communication impairments face significant additional barriers to participation.

As the services children with disabilites and young people use change, it is important that we ensure they have opportunities to shape and influence them. Involving children and young people and their families, hearing what they have to say, is key to successful projects and ensures that your work meets their needs. Projects or services for children, young people and their families that incorporate participation will be:

- Improved;
- Better informed;
- Better targeted; and
- More effective.

By asking, listening and responding to the views of children and young people and their families right from the start, your projects will be on the right track from the beginning.

Let's discuss…

Can you think of one example when the children and families you work with have been excluded from the decision-making process? How would you do things differently in the future, and how do you think this would improve things?

In plenary, discuss your responses guided by the facilitator, and write up on flip chart/board/screen.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 38. Henry, Irina and Daniela and participation

Facilitators say…

This is the story of Daniela, Henry and Irina, who live in different countries. They are young people who cannot see very well but who all want to read the latest best-selling book such as (insert name of a book read in your country), so they can chat about it with their friends.

Daniela's family was advised by their doctor to take Daniela to a special clinic to see if the doctors can do anything to fix her eyesight, but there is no improvement and Daniela still cannot read the book.

Henry has a similar problem with his eyesight, but he lives in a country where the audio recording of the book was made available by the publishers at the same time as the written text. Henry loves listening to the book but is sorry he cannot meet his friends to talk about it.

Irina also has poor eyesight, but she lives in a country where not only did she get the audio book, but she gets support to go to an inclusive school. Because this school is inclusive, the girls and boys in her class have had special training on how to understand and help a person with very poor eyesight. A girl that Irina goes to school with who lives nearby learns how to help and guide Irina so that she is as independent as possible and safe; she calls for Irina on her way to meet up with their friends, so that they can go together.

Let's discuss.

Which of the three children is fully participating?

In plenary, discuss your responses guided by the facilitator, and write up on a flip chart/board/screen.

PowerPoint slide 39. **Self-advocates**

Facilitators say…

All of the children have an impairment – very poor eyesight, which can limit their participation because they do not have access to the same information as all other children (reading books). When the accessibility barrier is lifted (by recording the text) Henry and Irina can participate a little bit more than Daniela, and when Irina gets help from her friends who understand how to assist appropriately, the participation restriction is lifted completely.

Later on, the doctor who checks Daniela's eyesight introduces her to some other girls and boys of her age who have attended his clinic. His receptionist volunteers to organize a regular meeting for these children. The receptionist becomes their advocate and talks to them about the issues they have in common, she listens to them when they complain that they cannot read the latest best-selling book, she talks to the booksellers and publishers on their behalf, and then helps them to make a video which is sent to the publishers in which they explain their frustrations and what it is they want. Soon the audio book is released in their country.

Henry is fed up because none of the children in his special school have listened to the book and he has no one to talk about it with. His teacher becomes his advocate and talks to him about his frustrations and what it is that Henry wants. The teacher hears that Henry wants to make friends with children his age who are interested in reading and talking about books. The teacher finds out where the nearest youth club to the school is and goes to talk to them about how they can adapt to help Henry to become a member. When Henry joins the club, he realizes that some of the activities on offer could be interesting for more of his friends from school. He asks his youth club friends to help organize a campaign to self-advocate with the adults at the youth club and the teachers at school to make the club more participatory.

PowerPoint slide 40. **Some children have difficulty participating**

Facilitators say…

Some children with disabilities have more difficulty participating than others because:

- In the country where they live it is not culturally appropriate for children to speak up;
- They are discriminated against, for example in some countries, girls are discouraged from speaking up;
- Adults believe they cannot speak up because they have a disability;
- They have profound or multiple disabilities which significantly affect their capacity to communicate.

Let's discuss…

Think of some of the ways you help children to express themselves. These can be your own children, or your nieces and nephews, or children of your friends. For example, for very young children they express themselves through play and interaction, for older children it can be telling you about their day when you are helping with homework…how can you create these opportunities for children with disabilities, especially the children you will be working with during the reintegration process? Where do you think you could start?

In plenary, discuss your responses guided by the facilitator, and write up on flip chart/board/screen.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

3.8. Session 8: Inclusive case management for reintegration

PowerPoint slide 41. Introduction and objectives

Objective: *Participants will be familiar with and know how to use the case management guidance and forms for successful reintegration.*

TO PREPARE: Be familiar with the materials; make sure each participant has a copy of the participants handbook and a copy of the Operational Guidance on Inclusive Children's Reintegration.

Facilitators say…

Each of you has a copy of the revised Operational Guidance on Inclusive Case Management for Children's Reintegration. Today we are going to work through the steps of the process, looking at the forms and the information which is included using a series of real-life case studies.

The information included in the case studies has been anonymized as far as possible to preserve the family's identity and confidentiality. Some of you may be familiar with these families, however, please do not share information unnecessarily. All of the discussion today remains private and not to be shared outside the confines of the training room.

Facilitator briefly guides participants through the contents of the operational guidance.

Group activity

Divide the group into pairs. Each pair has a case study which they are asked to read through and consider. Using the guidance, they should agree on how to proceed and write answers on a flip chart. During this time the facilitators move around the pairs to listen and observe and offer advice. Each pair should discuss each case study for 30 minutes. On completion and in plenary, the group can discuss for 15 minutes…

Let's discuss…

What was done well during the reintegration process? (including follow-up)

What was done less well?

What would you as the child and family social worker do in the future to make the process more effective/ improve the outcomes for the child and the family?

Facilitators say…

Let's move through the case studies taking breaks as appropriate…

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

PowerPoint slide 42. Possible dream

Facilitators say…

Many people consider the reintegration of children with disabilities to be an impossible dream. However, with good planning and support these children can live safely and happily in families and in communities.

Group activity

In working groups of 4–5, referring to the guidance, reflecting on the learning from the case studies, and considering your role (current NCDA worker involved in follow-up or NCDA worker recruited for the De-I process) begin to prepare the implementation plan for reintegration/implementation plan for follow-up. During this time the facilitators move around the pairs to listen and observe and offer advice.

Any questions? Give the participants time to ask questions and seek clarifications before moving on.

WRAP-UP

It is important to have a verbal feedback evaluation session because some of the issues or questions may be relevant to everyone but sometimes people do not feel comfortable raising issues. Each participant should have an opportunity to speak but does not have to.

Facilitators say...

The facilitator begins by quickly summarizing the issues that have been covered during the course.

In the plenary session ask participants:

- If they need clarification on any topic or session;
- To each mention one thing that they felt most useful during the training;
- To each mention one thing that they did not like or were uncomfortable with during the training.

Their responses should be written up on a flip chart for them to see and for the trainer to have as a record.

Remember as facilitators you don't have to have all the answers; but you do need to reassure participants that they do not have to deal with these issues on their own. There is a support network which includes their colleagues at NCDA, NCPD, colleagues in other agencies, NGOs such as HHC and in organizations like UNICEF.

Thank all participants for their active participation in the training and let them know that they are key people in protecting the children in their communities. Wish them all success in their work and let them know that their feedback will be passed on to the relevant people.

END.

(Endnotes)

1. Inter-agency Child Protection Working Group, 2014, Inter-agency Guidelines for Child Protection and Case Management. http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf
2. Global Social Service Workforce Alliance, 2018, Case Management Concept and Principles, GSSWA: Washington DC http://www.socialserviceworkforce.org/sites/default/files/uploads/Case-Management-Concepts-and-Principles.pdf
3. Adapted from RI Global http://www.riglobal.org/projects/habilitation-rehabilitation/
4. See RI Global, above
5. See "UN Disability and Child Rights Groups On Behalf of Children without Parental Care Key Recommendations June 20, 2019, Core Principles: Right to Family Recognized Under International Law https://validity.ngo/wp-content/uploads/2019/07/UNGA-Right-to-Family-2019_06_20.pdf
6. Cabinet Brief: Strategy for National Child Care Reform (n.d.).
7. Primson Management Services, 15 January 2018, Summative Evaluation of the Tubarerere Mu Muryango/Let's Raise Children in Families (TMM) Phase I Programme in Rwanda. NCDA and UNICEF: Kigali