NATIONAL CHILD DEVELOPMENT AGENCY

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

Operational Guidance on Inclusive Children's Reintegration

Social Service Professionals

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Operational Guidance on Inclusive Children's Reintegration

In partnership with

National Council of Persons with Disabilities

unicef
for every child

USAID
FROM THE AMERICAN PEOPLE

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

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Foreword

The Government of Rwanda endorsed the Strategy for National Child Care Reform in 2012 and since then has been implementing the "Tubarerere Mu Muryango" (TMM) Programme ('Let's raise children in families) led by the then National Commission for Children (NCC), now National Child Development Agency, with an aim to ensure that all children living in institutional care in Rwanda are reunited with their families or placed in suitable forms of family-based 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 orphanages that were hosting all children. The 2018 evaluation of the first phase of TMM reported that placement of children with disabilities into families utilizing the existing model was challenging.

To address the challenges identified with alternative care placements for children with disabilities, NCDA in close collaboration with the National Council for Persons with Disabilities (NCPD), and with financial and technical support from UNICEF and USAID DCOF, developed this operational guide in 2019. The operational guide is embedded in the existing TMM guidance documents which have been revised and adjusted to make it more inclusive. The revision is built on extensive consultations with local authorities, the social workforce, implementing partners, community-based child protection volunteers, families including parents and children with disabilities themselves, who all shared their lessons from past experiences.

The operational guide is paired with Facilitators' and Participants' Handbooks, which will help for refresher trainings and capacity development of all staff working on children reintegration and family-based care support, both within the child protection and disability sectors. Equally, the TMM case management forms are revised to account for children with disabilities specific needs at all the 12 steps of reintegration process and family support.

Over and above providing a common approach, national standards and guidance, it sets the tone for all stakeholders who work directly with children and families on reintegration of children including children with disabilities from residential institutions. It is primarily a working tool for Child Protection and Welfare Officers, as well as a knowledge and skills reference tool for professionals working in other local government roles, like District Disability Mainstreaming Officers and Gender and Family Promotion Officers, including people working in non-governmental organizations (NGOs) or community-based systems – mainly the "Inshuti z'Umuryango" – Friends of the Family, but also other community-based volunteers who support children and families, as part of reintegration process or prevention of family separation. It points to the functioning case management system and existing mechanisms for coordination and collaboration, which are important aspects of sustainable family-based care for all children.

The National Child Development Agency is committed to build on this momentum to spearhead the rights of all children to be raised in families, and reiterate the importance of putting efforts together as we embark on strengthening families and communities for the best interest of all children in Rwanda.

We hope that this operational guidance and accompanying training materials will facilitate the work of those entrusted to support the care of children with disabilities and their families, and that it will add value by promoting long-term inclusive family-based care for all children.

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NATIONAL CHILD DEVELOPMENT AGENCY

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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 (ICDR) University of Toronto, Canada http://icdr.utoronto.ca/
- 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 welfare. https://www.crs.org/our-work-overseas/program-areas/health/4children
- 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. https://p4ec.ru/en/project_region_alliance/
- 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. https://learning.nspcc.org.uk/safeguarding-child-protection/
- The 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 https://bettercarenetwork.org/sites/default/files/FamilyCareGuidance_508.pdf

Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CFCS	Communication Function Classification System
DMO	District Mainstreaming Officer
ECD	Early Childhood Development
GMFCS E&R	Global Motor Function Classification System, Expanded and Revised
HIV	Human Immunodeficiency Virus
MACS	Manual Ability Classification System for Children with Cerebral Palsy
NCDA	National Child Development Agency
NCPD	National Council for Persons with Disabilities
SPDS	Social and Personal Development Scales
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
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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 practised 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 National Child Development Agency (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 Welfare Officer	A graduate social worker or a graduate psychologist working for the NCDA who uses his/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." The 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 etc. 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, audiology and other services that are offered in both clinical and community settings. [3]
Inclusion	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.

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 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.

4 See RI Global, above
5 See 'United Nations 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

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 of Persons with Disabilities (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 the United Nations Convention on the Rights of Person with Disabilities (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, whilst '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 disabilities '.[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 NCPD.

NCPD has developed recommended terminology to replace culturally based insulting usage that is considered as a contributing factor to negative attitudes towards persons with disability in Rwanda. The table below 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, ikibu-rabwenge, 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

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

Introduction

Purpose

This operational guidance describes how the Government of Rwanda conducts case management for reintegration of children from residential institutions to family-based care, including children with disabilities. It contains all the information needed for a Child Protection and Welfare Officer to carry out their case management tasks so that children can live safely and thrive with their own family or in family-based alternative care.

Who is this Operational Guidance for?

This operational guidance is primarily for Government of Rwanda 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.

This operational guidance will help these workers to understand the reintegration process for all children, including children with disabilities who may require more support than children without disabilities.

Rationale

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]

This operational guidance is embedded in the TMM programme and has been adjusted in 2019 to make it more inclusive. Inclusive design is more appropriate than development of a stand-alone and parallel system which can contribute to further stigmatization and discrimination. The operational guidance also constitutes the guiding framework for the adaptation of the accompanying in-depth training modules. 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.

Content overview

This Operational Guidance is organised in four parts:

- **Part 1: The context of case management for reintegration in Rwanda,** including legislative background, the importance of inclusion, guiding principles of case management and code of ethics.
- **Part 2: Standard operating procedures for case management for reintegration,** with a focus on inclusive practices which will ensure that children with disabilities are provided with family care.
- **Part 3: Job aids,** tools and resources which provide just the right amount of task guidance at the moment of need as part of work. They are there to support performance in the workflow. They provide additional information for Child Protection and Welfare Officers at specific stages of the reintegration process.
- **Part 4: Case management forms.** These are the core documents in a child's case file. They relate directly to the Standard Operating Procedures for Case Management for Reintegration in Part Two of this operational guidance.

7 Previously referred to as 'social workers' or 'psychologists' 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 TMM programme, 3,216 children and young adults have been placed in family-based environment 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.

Part One.

The context of case management for reintegration in Rwanda

1.1 The Government of Rwanda's commitments to children

The Government of Rwanda has committed to **international standards** for protection of children's rights including children with disabilities **(Table 1)**.

Table 1. Ratification status relevant to United Nations treaties, Rwanda

United Nations Treaties	Ratification date
CEDAW – Convention on the Elimination of All Forms of Discrimination against Women	1981
CESCR – International Covenant on Economic, Social and Cultural Rights	1975
CRC - Convention on the Rights of the Child	1991
CRC-OP-SC – Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography	2002
CRPD – Convention on the Rights of Persons with Disabilities	2008

Source: Office of the High Commissioner for Human Rights (OHCHR) United Nations Treaty Body Database [11]

The government's actions and initiatives are further informed by the **African Charter on the Rights and Welfare of the Child** which safeguards the special rights of children with disabilities through Article 13, "Every child who is mentally or physically disabled shall have the right to special measures of protection in keeping with his physical and moral needs and under conditions which ensure his dignity, promote his self-reliance and active participation in the community."[12]

In October 2019 the Government of Rwanda became the fifth signatory State to the **Protocol on the Rights of Persons with Disabilities in Africa.**[13] The purpose of this protocol is "to promote, protect and ensure the full and equal enjoyment of all human and people's rights by all persons with disabilities and to ensure respect for their inherent dignity" (Article 2).

The **Constitution of the Republic of Rwanda 2003,** revised in 2015, is founded on principles of equality and social inclusion, and includes provision for protection from discrimination, protection of the family and protection of the child,

The Seven-Year Government Programme National Strategy for Transformation (NST 1) 2017–2024, identifies social inclusion and disability as a cross-cutting area, and makes specific reference to the inclusion of children with disabilities in education, (Priority Area 4, Strategic Intervention 65). In its strategic intervention 77, TMM is emphasized and the public awareness on the programme should be increased.

The Rwandan **Law No. 71/2018 relating to the Protection of the Child** reinforces the universality of rights of all children irrespective of their birth status, highlights the right of all children to be raised in a family environment and provides specific protections to children with disabilities .[14]

The revised **Special Needs and Inclusive Education Policy** 2018 aims to remove barriers to learning and participation in the ordinary school system. This policy defines disability largely in line with UNCRPD. The policy appears to be particularly effective in adapting to the Rwandan socio-cultural context whilst maintaining a rights-based approach.

Rwanda is committed to achievement of Agenda 2030 and is working towards achievement of the **Sustainable Development Goals (SDGs).** The Government of Rwanda Voluntary National Review Report 2019 reiterates the commitment to 'leaving no one behind' and to the inclusion of disabled people.[15]

For an inclusive society, the Government of Rwanda, through NCPD has published **Disability Mainstreaming Guidelines** to ensure that the organization's programmes and services are inclusive, equitable and non-discriminatory, and do not create barriers or reinforce the negative effects of the issue.

11 https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=145&Lang=EN
12 http://www.achpr.org/instruments/child/
13 See https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-persons-disabilities-africa for the full text in English, French, Arabic and Portuguese and for the Signatory Status List.
14 National Child Development Agency and UNICEF Rwanda, 20 Years and Beyond. Advancing Child Rights in Rwanda, 2014. http://NCDA.gov.rw/fileadmin/templates/document/20_yrs_beyond_advancing_child_rights_in_rwanda.pdf
15 https://sustainabledevelopment.un.org/content/documents/23069Rwanda_Main_Messages_VNR_Rwanda_Revised_with_word_limit.pdf
16 National Council for Persons with Disabilities, Disability Mainstreaming Guidelines, 2014.

In 2018, NCPD also published and disseminated **National Guidelines for Community-Based Rehabilitation** to ensure that people with disabilities are fully included in all aspects of community life, build their capacity and have full access to all facilities and services as other persons without disabilities.

At a national level, the Government of Rwanda is committed to revising the **Law No. 01/2007 Relating to Protection of People with Disabilities in General,** updating definitions and to introducing a National Policy on Persons with Disabilities. A full compendium of legislation (Laws and Ministerial Orders) is available in Part 3.

The **National Integrated Child Rights Policy** and accompanying strategic plan adopts a multi-sectoral approach and contributed to the establishment of NCDA. A consequent Cabinet **Brief – Strategy for Child Care Reform, 2012,** contributed to the initiation of the TMM programme which strengthened the capacity of government agencies to manage and coordinate child protection systems development and to the development of a robust professional and volunteer workforce.

Since 2016 the Government of Rwanda through NCDA established a **community-based child and family protection group of volunteers known as Inshuti z'Umuryango** (Friends of the Family) composed of one man and one woman in each village with responsibility for supporting families, promoting child rights and protecting all children from violence, abuse, and exploitation. In addition, Inshuti z'Umuryango work to protect children from being separated from their families and contribute to community reintegration of those who are living in residential institutions. There are 29,674 volunteers across Rwandan villages who report to their respective village chief/leader and to their representative in the cell and sector.

Job Aids

- For a comprehensive listing of pertinent legislation refer to Job Aid 3.1
- For a more detailed commentary on understanding disability refer to Job Aid 3.2
- For a more detailed commentary on types and effects of disability refer to Job Aid 3.3

1.2 The importance of family-based care

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."*[17]

This is because families are of critical importance to children's healthy growth and development.[18] Research shows that children cared for in families do better than those living in residential care facilities across all areas of development.[19]

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. 'Family-like' institutions are still institutions and are no substitute for care by a family."* [20,21,22]

Responsibility of the State for protection of the family is clearly articulated in Article 18 of the Constitution of Rwanda.

1.3 The importance of permanency planning

The United Nations Guidelines for the Alternative Care of Children are clear that:

> *" Frequent changes in care setting are detrimental to the child's development and ability to form attachments, and should be avoided… Permanency for the child should be secured without undue delay through reintegration in his/her nuclear or extended family or, if this is not possible, in an alternative stable family setting." (Article VI. 60.)*[23]

17 United Nations, United Nations Convention on the Rights of the Child, Resolution 44/25, 1989.
18 Williamson, J. and Greenberg, A., Families not orphanages, New York: Better Care Network, 2010, https://bettercarenetwork.org/sites/default/files/Families%20Not%20Orphanages_0.pdf and USAID, 'Early Childhood Development for Orphans and Vulnerable Children: Key Considerations', Technical Brief. USAID: Arlington VA, 2011. https://aidsfree.usaid.gov/sites/default/files/aidstar-one_ovc_ecd.pdf
19 Berens, A.E. and Nelson, C.A., 'The science of early adversity: Is there a role for large institutions in the care of vulnerable children?' The Lancet, 386, 388-398; 2015. https://www.academia.edu/36231330/The_science_of_early_adversity_is_there_a_role_for_large_institutions_in_the_care_of_vulnerable_children ; Nelson, C., Fox, N., Zeanah, C. & Johnson, D., Caring for orphaned, abandoned and maltreated children: Insights from the Bucharest Early Intervention Project. Washington, DC, 2007. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5607636/ ; Better Care Network; and Browne, K.,

Wherever possible the child should be reintegrated to their family of origin to be cared for by their mother and/or father. Where this is not possible, they should be placed with a relative in the extended family (with siblings aged 18 and over, or with grandparents, or with aunts, and uncles, among others). In case the family of origin cannot be located, or refuse to accept the child, or live in conditions which do not support the child's best interests, a family-based alternative care placement should be identified, which can be adoption or foster care. Throughout this document we refer to family-based alternative care and foster care, while acknowledging that permanency planning is preferable and that foster care can be a first step to adoption.

1.4 Defining reintegration

There 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:

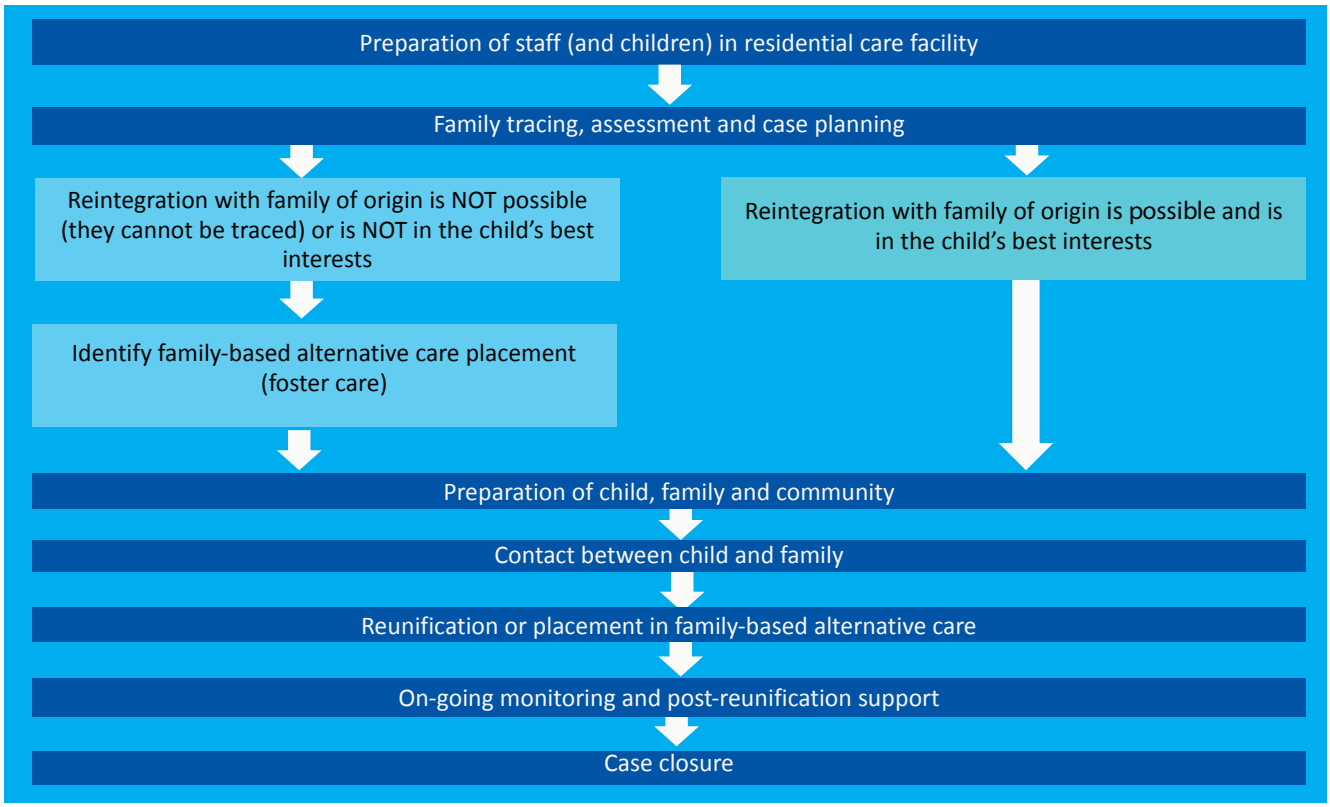
- Reintegration is a process consisting of several steps or phases;
- Reunification is a single action or step taken during the reintegration process.

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".*[24]

The reintegration process consists of several phases, one of which is reunification, the physical act of returning the child to their family of origin **(Figure 1).** In cases where the child cannot be reunified a placement in a family-based alternative care should be considered.

Figure 1. The process of reintegration



Source: Authors, adapted from Inter-agency Group on Children's Reintegration, 2016, Guidelines on Children's Reintegration.

The risk of harm to young children in institutional care, 2009. https://bettercarenetwork.org/library/particular-threats-to-childrens-care-and-protection/effects-of-institutional-care/the-risk-of-harm-to-young-people-in-institutional-care

20 Eric Rosenthal, 'The Right of All Children to Grow Up in a Family Under International Law: Implications for Placement in Orphanages, Residential Care, and Group Homes', 25 Buff. Hum. Rts. L. Rev 1 (2019) cited in United Nations 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

21 United Nations Secretary-General, 'General Comment No. 5 on living independently and being included in the community', U.N. Doc. CRPD/C/GC/5 (Oct. 27, 2017), para. 37, 2017. https://bettercarenetwork.org/sites/default/files/CRPD.C.18.R.1-ENG.pdf

22 'Key Recommendations for the 2019 UNGA Resolution on the Rights of the Child with a focus on children without parental care'; call to action endorsed by more that 209 organizations as of 28.09.2019

1.5 The importance of equity and inclusion

Equity and inclusion are fundamental principles of the Constitution of the Republic of Rwanda 2003, revised in 2015.[25]

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.

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 (Box 1).

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.

Box 1. A fair chance for every child

Source: UNICEF, n.d., *A Fair Chance for Every Child* https://www.unicef.org/equity/

"All children deserve the chance to be happy and healthy, explore their world safely, and reach their full potential. Yet the rights of millions of children are blocked by deprivation and discrimination based on factors beyond their control – their gender, ethnicity, socio-economic status, place of birth or whether they live with a disability, for example. When children do not have a fair chance in life, significant inequalities emerge between those who have the most and those who have the least. Those inequalities are passed from generation to generation in a vicious circle that has significant economic, political and social consequences – leading to an unequal and unfair world."

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, because it is thought to be too difficult, because the prevailing social norms do not consider that children with disabilities have equal rights with all children.

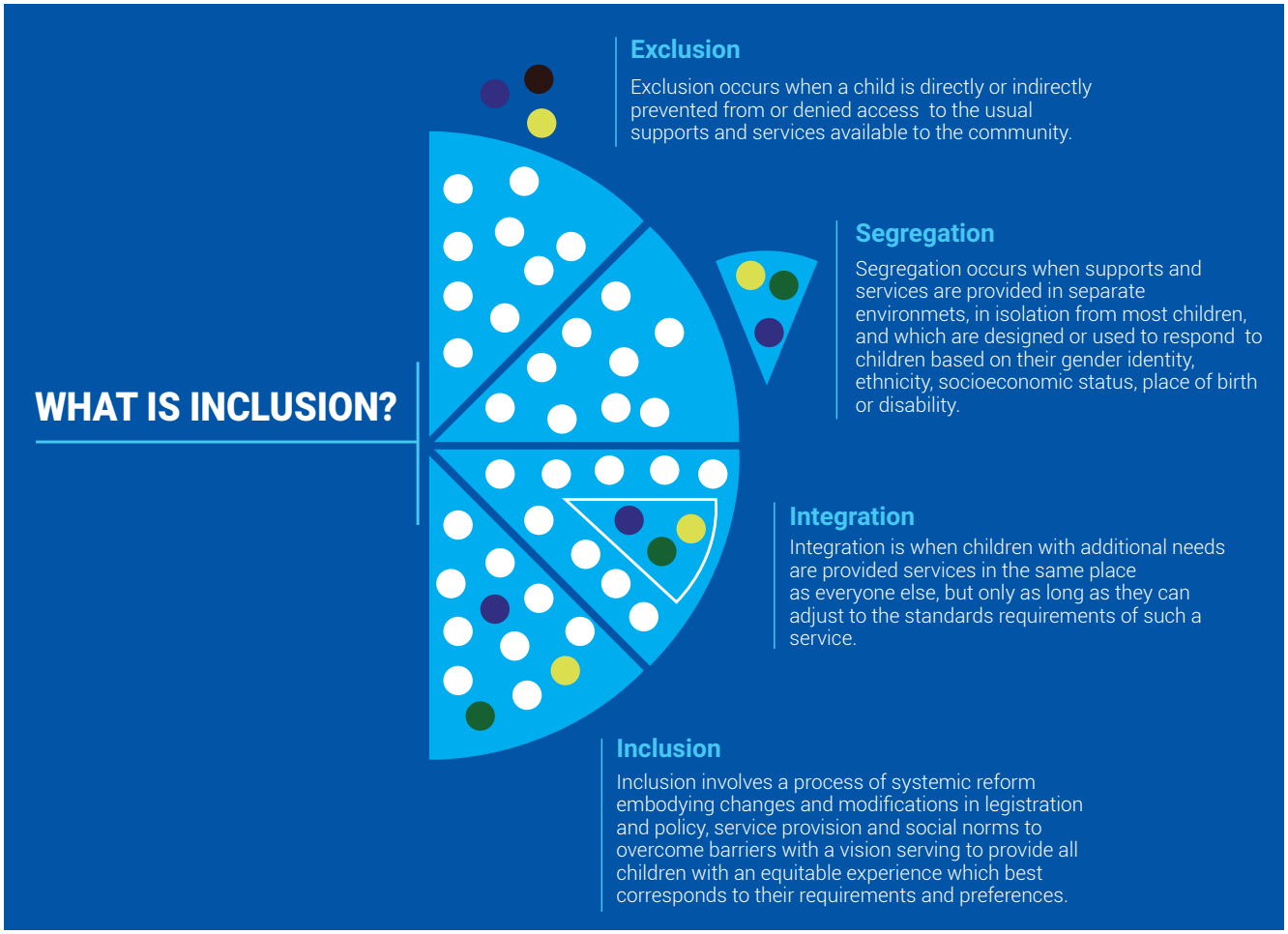
However full and effective participation and inclusion in society is a fundamental principle of both UNCRC[26] which says that children with disabilities have the same rights as all children, and of UNCRPD[27] which says that all persons with disabilities should have full and effective participation 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 and so on.

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.

23 United Nations General Assembly, Guidelines for the Alternative Care of Children, 24 February 2010. https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf
24 Adapted from Inter-agency Group on Children's Reintegration, Guidelines on Children's Reintegration, 2016. https://familyforeverychild.org/our-impact/guidelines-on-childrens-reintegration/ and Rescue Dada Centre, Child Reintegration Guide, Rescue Dada Centre: Nairobi, 2014.
25 Available from the Republic of Rwanda Ministry of Infrastructure http://www.mininfra.gov.rw/index.php?id=rwandaconstitution
26 UNCRC was ratified by Rwanda in 1991.
27 UNCRPD was ratified by Rwanda in 2008.

Figure 2. What is inclusion?



Source: Adapted from Instituto Alana, 2016, A Summary of the Evidence on Inclusive Education. https://alana.org.br/wp-content/uploads/2016/12/A_Summary_of_the_evidence_on_inclusive_education.pdf

Inclusion involves:

- Getting fair treatment from others (nondiscrimination);
- Making products, communication, and the physical environment more usable as many people as possible (universal design);
- 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).

When planning to make sure that children with disabilities are treated fairly (and are not discriminated against) in the care reform process, Child Protection and Welfare Officers should think about how they can make sure that:

- The physical environment does not constitute barriers to child's inclusion
- The services that children need are adapted to their needs; and
- That harmful beliefs and stereotypes in the community are challenged.

1.6 Guiding principles for inclusive case management

Case management for reintegration **does not discriminate** against individual children for any reason. For example, children who have been abandoned, children with disabilities, children from minorities should all be treated equally because they all have the same rights.

Case management should **focus on the individual needs** of the child and their family and respect the evolving capacities of the child[28].

Case management is **a collaborative process involving individuals, groups of people and institutions in the community (Figure 3).** Successful reintegration will require the case worker to coordinate the available support from, for example, government organizations, volunteer groups, community-based rehabilitation programmes, non-governmental organizations (NGOs) and community-based organizations (CBOs), schools, faith-based organizations and churches, and hospitals and health centres.

All children have a right to express opinions about their experiences, and to participate in decisions that affect

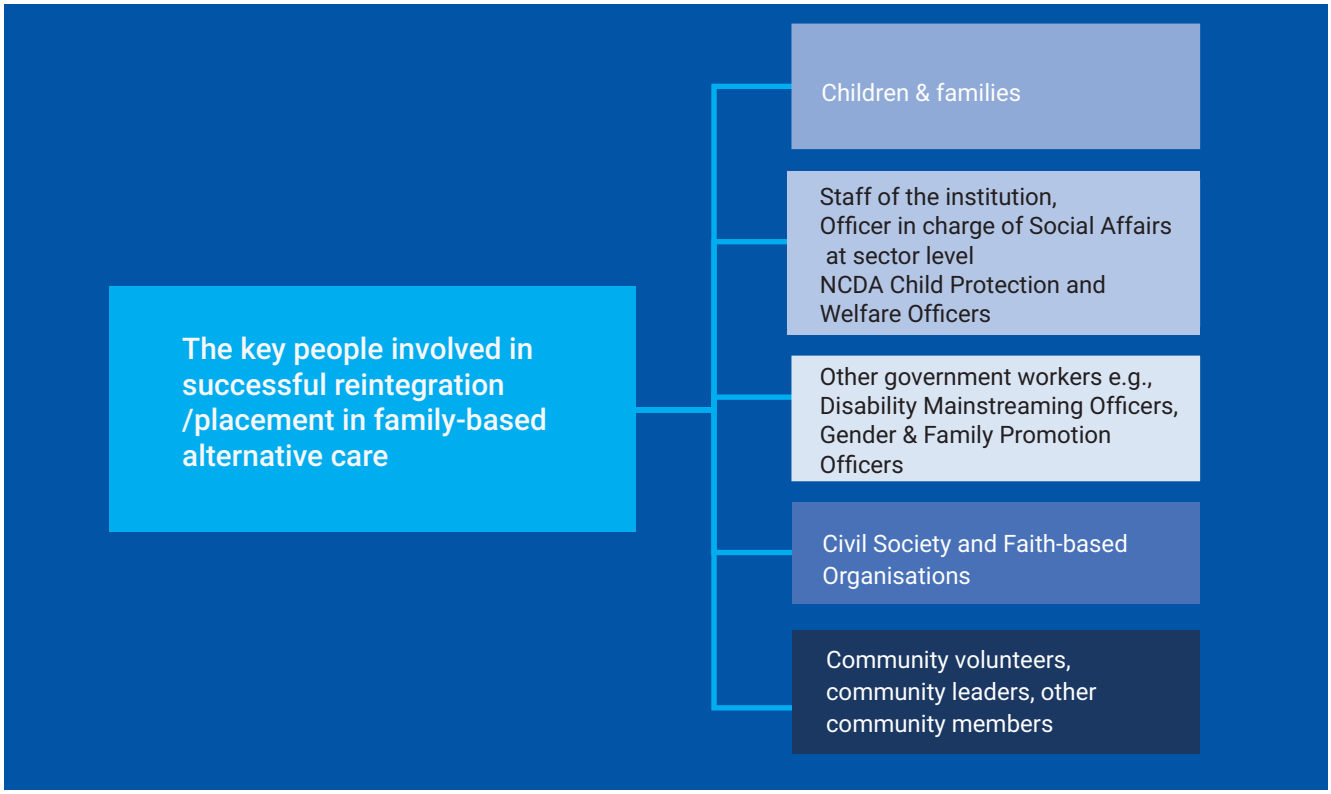
28 "Children in different environments and cultures, and faced with diverse life experiences, will acquire competencies at different ages", Lansdown, Gerison, 'The Evolving Capacities of the Child', Innocenti Insights No. 11, 2005. https://www.unicef-irc.org/publications/384-the-evolving-capacities-of-the-child.html

their lives. There should be active efforts to **create opportunities for children with disabilities to participate** in the decision-making process about where and with whom they should live. See also Section 1.7 on consent and assent.

Case management should be **provided through an established process** with clearly defined steps and systems for accountability **(Figure 3).** However, the timelines can be different, depending on the child's needs, and sometimes steps may need to be repeated if the child's needs or circumstances change.

A lead case worker or case management supervisor is responsible for making sure that **decisions are taken in best interests of the child** that the case is managed in accordance with the established process, and that action is coordinated across all service providers.

Figure 3. Who should be involved in case management for reintegration?



Source: Authors

1.7 Consent and assent

Informed consent is fundamental to the participation of children and adults in the decision-making process about reintegration. An informed adult family member or foster carer should understand the implications of the process they are taking part in. Consenting is a process where the Child Protection and Welfare Officer clearly communicates with the adult and child to make sure they understand what can be expected to happen. It is a conversation and the case management documents will record that this conversation has taken place and that explanations have been provided and consent has been given.

Consent may only be given by individuals who have reached the legal age of consent which is typically 18 years old. Assent is the agreement of someone not able to give legal consent to participate in the activity. Work with children or adults not capable of giving consent requires the consent of the parent or legal guardian and the assent of the subject.

The registration form and the family assessment forms used during the reintegration process contains a section for recording consent and assent.

1.8 Code of ethics for Child Protection and Welfare Officers/case workers[29]

A code of ethics defines the core values and broad ethical principles which are fundamental to a case worker's role and responsibilities:

- A case worker's primary goal is to help children in need and to address social problems.
- Case workers respect the inherent dignity and worth of the person. Case workers treat each child, including children with disabilities in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity.
- Case workers recognize the central importance of human relationships. Case workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of children and families.
- Case workers behave in a trustworthy manner. Case workers act honestly and responsibly to promote ethical practices and maintain impartiality.
- The relationship between a case worker and the child and family is based on mutual trust and respect which is embedded in informed consent and assent, and respect for confidentiality. The case worker must make sure that the child and family understand what is happening at each stage of the reintegration process, and that they agree to each step. The case worker should protect the confidentiality of all information except when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a child or others.

1.9 Establishing a plan and timeline to prepare the staff in the residential institution

While case management for reintegration of children from residential institutions follows the steps of the usual case management process, it begins with preparation of the staff working in the residential institution. This is important to secure their cooperation and make sure the process is successful for children.

Residential institution managers, administrators and care workers will play an important role in helping with identification and assessment, preparing the children for reintegration and in some cases, providing support after the reunification. This is important because the staff know the children and will have established relationships with them. Even if physical records do not exist, they will have knowledge about the child's needs, strengths and wishes and will have skills in communicating with children. They will be an important source of information for case workers as they begin the process of reintegration.

However, they may be unwilling to cooperate. There are many reasons for this which the case worker should be aware of. They may have a genuine loving and caring relationship with the children in their care and are unhappy that the child will be moved. They may believe the care they are providing is the best possible for the child and cannot be matched in the community. If the child has a disability, and the residential institution offers special support services such as physiotherapy, speech therapy or access to assistive devices, there may be concerns that the child will lose access to these supports. The staff may also be afraid that they will lose their job if the residential institution reduces its capacity or closes, or because they have relationships with local companies and suppliers who may lose business if this happens.

By spending time with the staff and preparing them the case worker responsible for reintegration can make sure the process is smooth and effective. This collaboration can be strengthened if the case worker communicates effectively and is open, transparent and honest about what is happening. The case worker should also plan individual or group learning sessions with the staff using this operational guidance to inform them why this care reform process is happening and what the steps in the process are. Involving the staff in the case management process, and particularly the planning for support services, can reassure them that it is in the child's best interests to be reintegrated.

Preparation of the staff should be the first phase in the reintegration work-plan (Figure 4). At this stage it is also important to let children know, as far as possible and without raising their hopes, what is happening to reduce anxiety levels. This is an important step which must include a detailed and thorough orientation of institutional staff to ensure that they fully understand the entire process and the rationale behind it before drawing up the plan and timeline.

29 Adapted from National Association of Social Workers, Code of Ethics, 2017. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Figure 4. Reintegration workplan template

	Month 1				Month 2				Etc.			
	Week1	Week 2	Week 3	Week4	Week1	Week 2	Week 3	Week4	Week1	Week 2	Week 3	Week4
Prepare the staff												
Initial staff meeting												
Individual interviews												
Learning workshop												
Regular staff meetings												
Register the children												
Appoint initial lead caseworkers for each child												
Review existing files and documents												
Collect additional data from the staff												
Hold conversations with the children												
Conduct child assessment												
Review existing files and documents												
Collect additional data from the staff												
Hold conversations with the children												
Arrange and hold meetings with other relavant information sourses, child's doctor, therapists, teachers, etc												
Initiate care plans												
Complete care plans												
Collect additional data												
Collaborate with multi-sector service providers												
Conduct family tracing/ identification of family-based alternative care												
Confirm families of origin												
Identify family-based alternative care placements												
Identify supported independent living placements												
Conduct family assessment												
Complete case management report												
Complete case management meetings												
Placement decision												
Child and family preparation												
Reunification / placement												
Follow-up support												

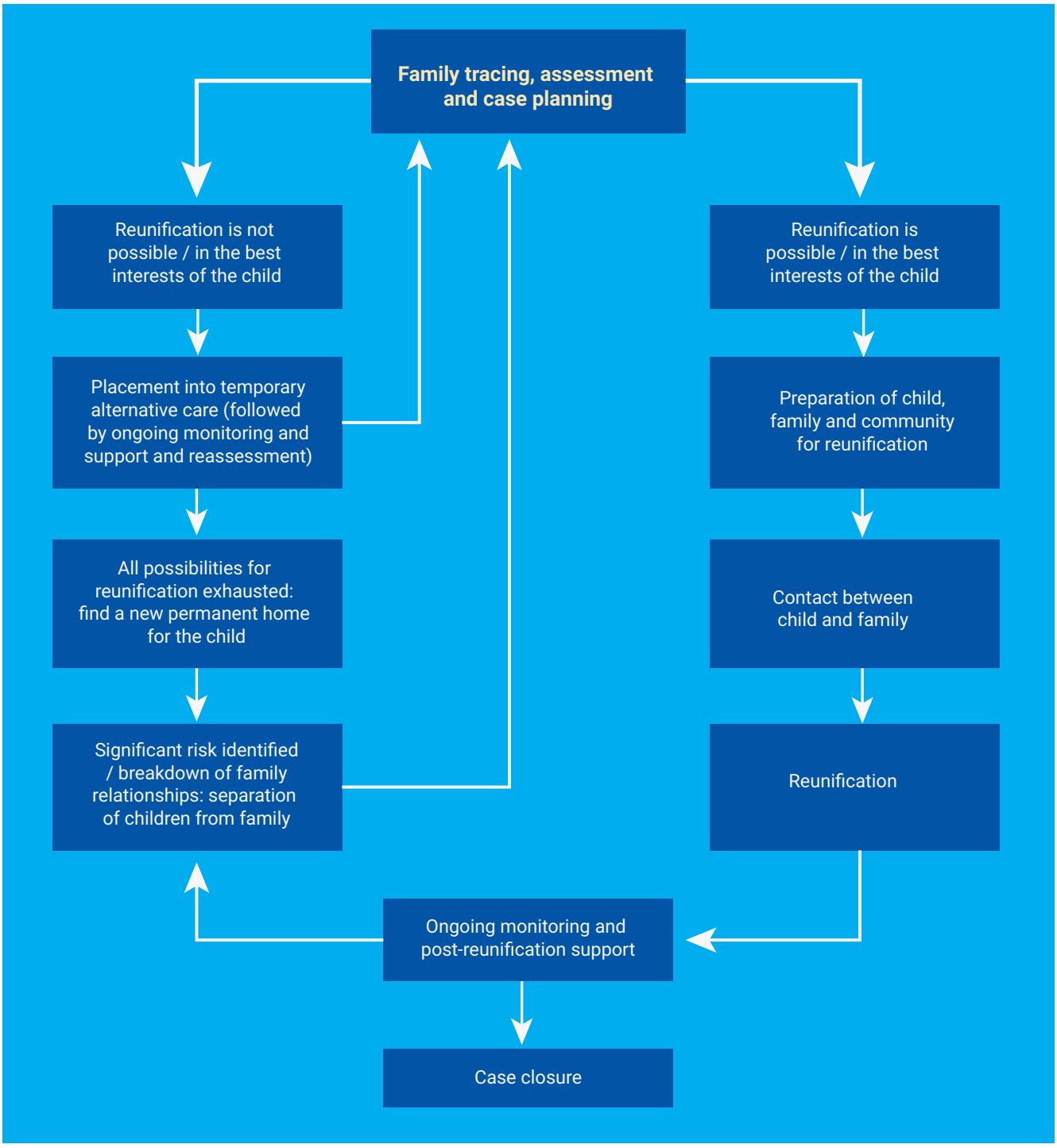
Part Two.

Standard Operating Procedures for Case Management

Case management is the process of helping individual children and families through direct social work-type support and information management;[30] It is a process practised by social service workers that support or guide the delivery of social service support to vulnerable children and families and other populations in need.[31]

In general, the steps in the case management process can be applied during children's reintegration from residential institutions to family care, or family-based alternative care (Figure 5).

Figure 5. The case management for reintegration process



Source: Inter-agency Group on Children's Reintegration, Guidelines on Children's Reintegration, page 14, 2016.

30 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
31 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

The process steps for reintegration of children through the TMM programme are informed by universal case management process steps and principles (Table 2).

Table 2. Overview of case management for reintegration process steps

# No.	Process Step	Actions	By whom and to whom?	Documents	Job Aid
0	Prepare the staff in the residential institution	Develop a reintegration plan and timeline; communicate effectively; involve staff in the planning and case management process.	NCDA Child Protection and Welfare Officer and the Disability Mainstreaming Officer at district level)	Reintegration work plan template; Operational Guidance on Reintegration	3.2 Understanding disability 3.3 Types and effects of disability
1	Registration	Collect basic biographical information of children eligible for reintegration.	NCDA Child Protection and Welfare Officer and involving the staff of the residential institution and the child	Registration form	3.9 How to talk to a child with disabilities 3.7 Child safeguarding
2	Child assessment	Written record of key information related to the child including the child's wishes and needs captured through review of existing documentation; interview with child, caregivers and others familiar with the child; application of specific assessment tools e.g. Portage and Social and Personal Development Scales (SPDS); and observation.	NCDA case worker/Child Protection Officer (social worker/psychologist); involving the child, the staff of the residential institution and other individuals familiar with the child and who are concerned with the child's well-being and protection	Child assessment form Teachers' Guide for Special Educational Needs Assessment and Individual Education Plan published by the Rwanda Education Board, Ministry of Education in 2019	3.4 Completing a child assessment
3	Case plan	Describes the needs of the child in different areas, including health, education and care; formulates objectives and actions to address those needs when the child is reintegrated; identifies proximal services for which referral is required.	NCDA case worker/ Child Protection Officer (social worker/ psychologist); involving the child, the staff of the residential institution and other individuals familiar with the child and who are concerned with the child's well-being and protection e.g. physiotherapist, occupational therapist, teacher etc.	Case plan form	3.5 Completing a case plan

4	Family tracing	Collect information about family ties gathered from records, staff at the residential institution, the child, or through field research; can assist in making decision on eligibility for reunification or placement in family-based alternative care.	NCDA Child Protection and Welfare Officer and DMO with local government in the child's district/sector, cell/ village of origin; Inshuti z'Umuryango volunteer, Malayika Murinzi	Family tracing form; proof of no trace document	
5	Family assessment	Assess the capacity of the child's family of origin, extended family or identified adoptive/ foster family to receive the child.	NCDA/Child Protection and Welfare Officer with local government in the child's district/ sector/ cell/ village of origin	Family assessment form;	3.11 How to conduct a home accessibility audit
6	Case management report	Prepare the case management report that provides a brief overview of the case and is drafted in preparation for the case management meeting (see below) in order to present the case to other Social Welfare Officers.	NCDA/Child Protection and Welfare Officer	Case management report form	
7	Case management meeting	Organize the case management meeting with all the people responsible for the care and protection of the child to discuss and agree on the best option for the child or adolescent. The individual responsible for handling the case will present key information using the case management report and other information available.	NCDA Child Protection and Welfare Officer, DMO and involving the child, the staff of the residential institution, and other individuals familiar with the child and who are concerned with the child's well-being and protection e.g. in charge of social affairs at sector and cell levels, physiotherapist, occupational therapist, teacher etc.	Case management meeting report form	
8	Placement decision	Record the details of the placement decision for the child in this form; it includes the preparation and placement schedule.	NCDA Child Protection and Welfare Officer and DMO	Placement decision form	

9	Child, family and community preparation	Assess whether both parties are in agreement with the placement decision and to assess whether there could be a match. Once both the child and receiving family are in agreement with the placement decision, further sessions with both parties will take place and the community will be prepared.	NCDA Child Protection and Welfare Officer; child, family and community	Child, family and community preparation form	3.6 Child family and community preparation process 3.8 How to talk to parents and family of a child with disability 3.10 How to talk to siblings of a child with disability
10	Child's reunification with the family or placement in family-based alternative care/ independent living	Record the details on where the child is placed, including address and contact details of the family and whether the child is linked to existing community resources/ service providers.	NCDA Child Protection and Welfare Officer DMO	Child placement form	
11	Post-placement support and follow-up	Written record of the ongoing support for the child and family, and when/how the follow-up was conducted. Each case management file can have multiple of these forms.	NCDA/Child Protection and Welfare Officer, DMO, social affairs in-charge at sector and cell levels; child and family; Inshuti z'Umuryango volunteer	Post-placement support and follow-up form	
12	Case closure	Whenever a child and/or family does not require any more support from the Social Protection and Welfare Officer and when the child lives within a safe and protective environment and when the family is linked to existing community inclusive initiatives, the case can be closed.	NCDA Child Protection and Welfare Officer, DMO, Social affairs in-charge at sector and cell levels, Community Health Worker, Inshuti z'Umuryango; child and family	Case closure form	

2.1 Registration form

Purpose of Registration

- To collect basic biographical information of the child eligible for reintegration.[32] The registration form is the first form of the set of case management documents, and is intended to register the child's personal details, current care arrangements and details of family, friends and other people who are important to the child.

Guiding Principles

- The initial biographical data should come from a review of existing files and documents and conversations with residential institution administrators and staff.
- Children's right to participation means that they should always be respectfully included in the data-gathering process, with their consent/assent. There are no exclusions, for example a child with severe disabilities which affect their cognitive understanding can be included by being present during the discussion.[33]
- Follow the child protection and child safeguarding policy/regulations.[34]
- When speaking with children, ensure this is done in a safe and welcoming space. If the child has communication difficulties, ask the staff of the residential care institution to help you, for example using sign language translation, or making sure the child has access to any assistive devices. Consider the age of the child when you are talking to them and make sure the language and tone that you use are appropriate to their development.
- Do not make promises to children that you cannot keep, for example do not tell them they are going to live with their family if it has not yet been deemed suitable.
- You may need to take your time and have more than one session with the child in order to build a relationship.
- Always think about what a child can do, instead of what they cannot (strength-based approach).
- Throughout the process consider the anxiety a child may feel if they are worried about possible change in their lives, for example moving to live with different people, saying goodbye to staff and friends.

Consent and Assent

- Have you explained to the child and their adult caregiver the purpose and process of the data gathering? Are you assured that they have understood and wish to continue?
    - The adult caregiver providing consent on behalf of the child should be the child's legal guardian, or their official delegate. For children living in residential institutions this should be the director of the institution or their appointed responsible person.
    - This person should explain to the child (if the child's age allows) in your presence in order to obtain their assent.

Section 1: Child's Personal Details

- A unique registration number is given to each child: this registration number should also be written on each page of the CM forms (at the bottom). This is to prevent pages from different files getting mixed up. Also, when discussing or communicating on a case (e.g. through e-mail), it is better to use the registration number instead of the child's name. This makes it easier to maintain confidentiality.
- "Name of institution and district the child is currently residing in (if applicable)"
    - When a registration is done for a child that is living outside of an institution (e.g. with parents or other caregivers), this does not have to be filled in.
- "Current address where the child is living"
    - In case the child is living in an institution, this is the address of the institution.
- "Name of Inshuti z'Umuryango active in the village where the child is living/integrated"
    - This can be filled in at a later point, when you know in which village the child will be reintegrated.

32 Children may be ineligible for reintegration if they are placed in the residential institution temporarily for respite care, if they are attending a boarding school for educational purposes and have existing close family times, or if it is less than six months until their 18th birthday.
33 Guidance on communication with children with disabilities and their families is included in Job Aid 3.9
34 Guidance on child safeguarding is included in Job Aid 3.7; please also see the National Child Development Agency child protection and safeguarding policies when available.

Section 3: Details of Persons of Importance to the Child (family and non-family)

- "Provide details of persons that the child is living with. This can either be parents, extended family, siblings, caregivers in an institution, other adults, etc."
  - In this section, contact details are written down of all persons that are living with the child in the same household. For a child in an institution, this will most likely be caregivers from the institution that are in daily contact with the child.
- "Provide details of family members or other important adults in the child's life, but who the child is not living with"
  - It could be that the child has other family members or adults that are important to the child's life or that have a role in the child's upbringing, but do not live in the same household as the child (e.g. other family members, supportive neighbours, etc.).
- "Does the child have any siblings that are in the same or different institution"
  - If this is the case, the relationship between siblings should be assessed, and placement of siblings in the same family/community should be considered during the different case management steps.

Section 4: History of Separation

- This section provides further details on how the child has been separated from family members or people who were responsible for providing care to the child.
- This does not only apply for children in institutions only: e.g. a child that is working as a domestic worker in another district or a child that is living in the streets is also separated from his/her caregivers.
- "Date of separation from family/primary caregiver" and "Date of placement in institution" can be two different dates
  - For example, a child started living on the streets in 2014, and it took a year before they were placed in an institution.
- "Causes of separation"
  - You can tick more than one box if there are multiple reasons for separation; a check box is included for disability as a possible reason why the child has been separated from their family.

2.2 Child assessment

Purpose of the Child Assessment Form

- The child assessment form has as an objective to note down key information related to the child, including information on the level of education, health status, behavioural characteristics and the level of development or functional independence level (using Portage, SPDS, GMFCS, MACS, CFS, and other authorized tools).
- It provides an opportunity to engage with the child to get to know more about the child's history and future perspectives, and their relationships – with related or unrelated adults and with peers. This will give an initial idea of what kind of placement could be possible.
- It is important during this step that a holistic assessment of the social, medical, psychological and developmental functioning[35] of the child is conducted using standardized tools by a qualified professional or team. The assessment is conducted to understand the *"problems, needs and rights of a child and his/her parent(s) or primary caregivers in a wider context of the community."*[36] This is important to determine placement opportunities and to develop a permanency plan and case plan for the child or adult with disabilities.
-  More information is provided in Job Aid 3.2

35 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf

36 Ministry of Gender, Children and Social Development and UNICEF, Toolkit and National Standards for Best Practice in Charitable Children's Institutions. p.13, April 2013. https://bettercarenetwork.org/sites/default/files/National%20Standards%20for%20Best%20Practices%20in%20Charitable%20Children%27s%20Institutions.pdf

Guiding Principles

- The child assessment is conducted by a multidisciplinary team using different techniques:
  - Review of existing documentation (institution's files, medical files, previous assessments, etc.).
  - Conducting interviews and structured discussions with the child, caregivers and other individuals familiar with the child and who are concerned with the child's well-being and protection.
  - Use of specific professional assessment tools (Portage, SPDS, GMFCS, MACS, and CFCS.
  - Through a series of observation sessions carried out in different environments and during different activities.
-  A selection of tools for assessment of children with disabilities are included in Job Aid 3.4
- Since a child assessment can take several days, you should note down the start and end date of the assessment
- Diagnosis of a chronic health condition, for example Human Immunodeficiency Virus (HIV) status, cannot be a requirement for or condition of reintegration. It is unethical and should not be a condition to require that a child has an HIV test before they are reintegrated.

Section 1: Health

- For the health assessment, it is not expected that Child Protection and Welfare Officers have all medical documents to do the assessment. However, the form is filled in using whatever information and documentation is available and provided.
- Whenever possible and available, copies of health documents (e.g. vaccination cards, rehabilitation services provided) should be included as an annex
- "Provide further details on disability"
  - This information can be filled in or updated according to information gathered throughout the Case Management process.
- "Does the child have a chronic health condition"
  - Health conditions can only be verified through medical tests, for example, tuberculosis, asthma, epilepsy, Cerebral Palsy, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), HIV etc. Confirmation of a diagnosed condition and treatment regime shall be contained in the child's medical records. There is no requirement for children to be tested, for example to determine their tuberculosis or HIV status, if this is not a pre-recorded condition for which treatment is being provided. A family member or the child's legal guardian may provide consent for testing based on family medical history; however, the outcome of such medical tests or medical assessments can be used to only to determine the child's treatment and support/rehabilitation plan. Diagnosis of a chronic health condition, for example HIV status, cannot be a requirement for or condition of reintegration. It is unethical and should not be a condition to require that a child has an HIV test before they are reintegrated.
  - In cases of suspected rape or sexual abuse of a child, testing and treatment for sexually transmitted infections should form part of the investigative and treatment plan, along with counselling.

Section 3: Education

- Please refer to the Teachers' Guide for Special Educational Needs Assessment and Individual Education Plan published by the Rwanda Education Board, Ministry of Education in 2019.

Section 4: Child Development

- This section on Child Development and its five sub-sections (autonomy/self-care, gross motor skills, fine motor skills, cognitive development, and emotional/behavioural development) is completed based on analysis coming from the (i) Portage, (ii) Social and Personal Development Scale (SPDS) (iii) Global Motor Function Classification System (GMFCS), Manual Ability Classification System for Children with Cerebral Palsy (MACS), Communication Function Classification System (CFCS), or other assessment tool (iv) direct interaction and observations with the child and (v) information from individuals that are in regular contact with the child.

Section 5: Child's General Welfare and History

- This section provides space to provide more details on the child's wellbeing, their history and wishes for the future. Completing this section of course depends on whether conversation with the child is possible (depending on age, level of development of the child, etc.). If conversation is not possible with the child directly, gather information from other resources and through observation.

Section 6: Protection Concerns and Related Follow-up Action Required

- Any questions on harm suffered must not be asked in a direct manner to the child, but rather through dialogue and indirect questions.
- In case the child is being harmed at the time of the child assessment, or if there are any indications that the child will suffer serious harm in the future, the primary objective is to ensure that the child is in a safe environment protected from any further harm and has received or is receiving appropriate services.
- "Child Safety Assessment"
    - Are there any other immediate actions required (e.g. by social workers, intervention of the police, legal support etc.)? What action specifically, and by who? For example, it could be that the child has health conditions which the caregivers in the future placement have to be aware of, but it could also be that during the time of the child assessment, it became clear that the child required immediate medical attention. Ensuring that the child then has access to health care services would be considered an immediate action.
- Are there any middle or long-term actions required (e.g. follow-up by professional social welfare worker, monitoring by sector and cell social affairs or a village chief etc.)?

Section 7: Wishes of the Child

- During the child assessment, depending on the age, child's stage of development and emotional condition among others, it is important to take into account the wishes of the child, as this can inform any future steps/ possibilities to address the child protection issue.
- A child's wishes should not result in harming the child or result in keeping the child in a harmful situation. The principle of 'best interest of the child' should therefore be taken into account
    - For example, it would not be in the best interests of the child to remain in a household where they are being sexually abused by a household member, even if the child expresses a wish to remain.
- "In case the child could benefit from referral to a service provider, does the child's guardian provide consent/ assent?"
    - In case there is consent for the child to access a particular service provider, make sure the child understands any consequences that can arise from this, as well as the process, and make sure there is an appropriate caregiver available to accompany the child.
    - In case the child does not provide consent for a referral to a service provider think about whether the child is able to make this judgement and foresee any possible consequences, and whether they understand the ways in which this can affect their level of safety, protection or care situation.

Section 9: Recommended Placement

- The recommended placement in this section is preliminary and based on the child assessment (taking into account the child's wishes where appropriate etc.).
    - There can be several recommendations which will be finalized following the more in-depth assessment, including family and household assessment and the subsequent decision-making process.

2.3 Case plan

Purpose of the Case plan Form

- The child assessment helps the case worker to understand the child's needs relative to their history, level of development, behavioural characteristics, disability and general well-being. The case plan outlines how these needs can be met when they are reintegrated through the provision of support services including health, education and social care.

Guiding Principles

- The case plan is informed by the child assessment, but also through interactions with individuals close to the child. The case plan can therefore be amended throughout the case management process.
- The case plan also takes into consideration whether the child has siblings and existing networks of support.
- The case plan should be specific to the individual and include the following[37]:
  - Goals for the personal growth and development of the child/adult
  - Activities/steps to achieve those goals
  - Timeline for achieving the goals
  - The team members involved in and responsible for the activities
- Case plans need to be developed and reviewed by qualified professionals. As noted in the Cabinet Brief for the National Child Care Reform Strategy, case plans can be developed "*in partnership with the caregiver and community partners to ensure that future monitoring and support needs can be measured and adjusted as needed …*".[38]
-  For more information see Job Aid 3.5

Section 1: Minimum Requirements for Responding to the Needs of the Child

- In this section, the case worker details in which areas the child requires additional support or considerations in the area of:
  - Education
  - Health and physical, cognitive and emotional development
  - Child protection
  - Behaviour, socialization and communication skills
  - Living conditions, including accessibility and availability of carer
  - Employment and household economy
  - Other considerations, for example, livelihoods in the case of adolescents who are about to finish school
- For example, when a child has a physical disability, it is a minimum requirement that the future family/placement of the child receives parenting support, lives close to a day care rehabilitation centre and/or has access to postural or mobility assistive device.
- Other considerations
  - Does the child have a strong protective environment or linkages in their neighbourhood? This question is an important consideration when designing the case plan for the child. For this question however, the concept of 'best interest of the child' should be taken into consideration. For example, the child might be enrolled in a school, and if the child is happy there then ideally the final placement decision should allow the child to continue going to the same school (whenever this is possible). Keeping the child in the same school is of course not advisable when the child is not happy in the school environment or when for example abuse has occurred there.
  - "Which existing government or decentralized services/stakeholders should/could be accessed to help fulfil minimum requirements, capacities and resources?" It could be that the child can benefit from services provided by the government, NGOs or other actors. In this case, this should be mentioned here. For example, when a child has a chronic health condition one of the minimum requirements could be that the child needs regular access to medical/health care services. In that case, it could be beneficial for the child to be linked to a specific health care facility, health care NGO, rehabilitation centre, etc.

37 Jenny M. Romanens-Pythoud S., International Social Service (ISS). A Better Future is Possible: Promoting family life for children with disabilities in residential care. Manual for Professionals, Geneva: Switzerland p. 40, 2016. https://www.iss-ssi.org/images/Publications_ISS/ENG/ISS-ManualEnglish.pdf

38 Cabinet Brief: Strategy for National Child Care Reform (Rwanda) (p. 4) http://www.NCDA.gov.rw

2.4 Family tracing

Purpose of Family Tracing Form

- Family tracing is the search for family members, including parents and extended family members, or former caregivers of children living in residential institutions, with the aim of ensuring the restoration of family links and the right of family unity. The form provides information about the child's family ties.
- This information is either provided by the child, institutional managers or through field research.
- Because of family tracing, the family can be:
  - Located and willingly agree to consider supported reintegration;
  - Located and agree to receive the child but with conditions;
  - Located and reject supported reintegration; or
  - Cannot be located.

Guiding Principles

- No parent or family member should be forced to acknowledge the child or accept the reintegration process. It may be difficult to trace the family of a child with disability if the child has been placed in a residential institution anonymously (abandoned), or in cases where families find they cannot cope with the stigma and discrimination associated with having a child with disability and do not acknowledge the child, or in cases where the family has moved and left no forwarding address. In these cases, an appropriate family-based alternative care arrangement should be planned (adoption or foster care).
- Historical mobility mapping (drawing and flow chart tools), can be used to complement or be used as an alternative to standard documentation interviews, especially for young, traumatized or children with disabilities .[39]

Proof of No-trace Document

- The proof of no-trace document should be signed by the local official at cell level.
- As much as possible, the cell level official should be involved at the start of family tracing in the respective cell.
- Documentation of tracing efforts will also build a case to present to the cell official and serve as proof.

2.5 Family assessment

Purpose of the Family Assessment Form

- The family assessment forms are used to assess the family with whom it is proposed to reintegrate them. This can be the child's family of origin, including extended family or family-based alternative carer (foster care).

Guiding Principles

- Consent for family assessment should be obtained at the outset.
- Depending on the case, each case file can contain multiple family assessment forms.
- The family should be in agreement and considered suitable to receive the child.
- While conducting the family assessment, the case worker should not let their personal perceptions or prejudice influence their decisions or assessment.

Section 2: Relationship between Family and Child

- "if the family is related to the child or knows the child"
  - Most likely, these families will be either the family of origin or extended family, or families that have cared for the child in the past
- "if the family does not know the child"
  - Most likely, this will be a family that is interested in fostering a child.

39 Mobility mapping and flow diagrams: Tools for Family Tracing and Social Reintegration Work with Separated Children, Brigette De Lay, 2003, and Family Reunification, Alternative Care and Community Reintegration of Separated Children in Post-conflict Rwanda, IRC, 2003. https://bettercarenetwork.org/sites/default/files/Mobility%20Mapping%20and%20Flow%20Diagrams.pdf

Section 3: Family Assessment Details

- "Provide analysis on the different factors below"
  - Motivating factors of caregivers to provide alternative care to the child: This analysis is essential, as it gives clarity on some of the (underlying) reasons why families would decide to foster a child. At the same time, families interested in reunifying with their own child or who want to foster a child have certain expectations about the process and how it would impact their life. It is important to talk with the family about what they can expect, but also to address expectations or wishes that might not be realistic and how it will change their lives.
  - Understanding the reasons why a child was placed in residential care can assist with the analysis and preparation of a reintegration support plan; for example, if limited access to services for rehabilitation was a motivating factor, access to such services should be guaranteed.
  -  Conducting a quick accessibility audit within the home environment to analyze barriers that might restrict family and community inclusion and participation. For more information see Job Aid 3.11.

Section 4: Conclusion and Recommendation

- In case the conclusion of the family assessment is 'yes' or 'yes, under certain conditions', a case management report (Form 6) can be drafted with a brief overview of the case

2.6 Case management report

Purpose of the Case Management Report Form

- The case management report provides a brief overview of the case and outcomes of the initial case plan, family tracing and family assessment analysis. This report is prepared to summarize the information so that it can be presented during the case management meeting and the placement decision taken.

Guiding Principles

- The report should honestly and concisely reflect the key points of the case.
- The case worker should advise that consent for the process has been received from the family and child.

Section 2: Suggested Placement Decision

- "Does this decision require consultation during a case management meeting"
  - In complex cases involving placement of a child with disability who requires additional support, a case management meeting is mandatory. In cases where the case worker would like to seek advice from peers and supervisors to make the decision because the case is complex for other reasons, a case management meeting can also be called.
- If yes, what is the planned date of the case management meeting?
- If no, fill in Form 8 and continue with the child and family preparation.

2.7 Case management meeting

Purpose of the Case Management Meeting Form

- The case management meeting involves the case worker and other professionals responsible for the care and protection of the child (for example the director of the residential institution and/or carers who know the child well, teachers etc.) to discuss and record on the agreed placement decision.
- An advocate or representative of the child with disability should attend the case management meeting.
- The lead case worker or care supervisor will present key information using the case management report and other information available.
- Any discussion points and possible recommendation(s) on placement/solutions to address the issue are noted down.
- A realistic timeline should be developed on needs identified specific to disability access and training.
- If a placement decision is reached, Form 8 must be completed.

2.8 Placement decision

Purpose of the Placement Decision Form

- Based on all previous case management steps, and in agreement with Social Welfare Officers during the case management meeting, details of the placement decision for the child or adolescent is recorded.
- This placement decision allows matching to go ahead, before a final decision on reunification or placement is made.

Guiding Principles

- The consideration of placement needs to be based on the best interest of the child, not what is in the best interest of others, as is the right of the child or adult with disabilities based on UNCRPD Article 7 (2) that states that *"In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration"*. UNCRC Article 3 (1) reinforces this, noting that *"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration"*.
- The determination of best interest requires a case-by-case assessment, consideration of the individual's capacity to participate throughout, input of people supporting the child and consideration of short- and long-term impact on the child.[40]
- This approach will recognize the heterogeneity of disability and supports a holistic approach that recognizes that each person has unique needs.
- This also upholds two critical principles [41,42] of alternative care for children: 1) *the necessity principle* – that alternative care is actually required (United Nations guidelines paras 32 – 56); and, 2) *the suitability principle* – that if required, the alternative care received is appropriate based on the needs of the individual child (United Nations guidelines paras 57–167).
- An important part in the determination of best interest is for the child or adult with disabilities to be involved and participate in making decisions about their care throughout.[43] Importantly, for young children, and for children and adults with special needs, this may require the use of alternative means of communication and different strategies and mechanisms to ensure their needs are met and their rights respected.

Section 2: Justification for Placement Decision

- Add any additional information to that noted down during the case management meeting.

Section 3: Preparation and Placement Schedule

- This section has tentative dates for the matching process. As much as possible, the social welfare worker should adhere to the tentative dates. This will help in planning the matching process.

40 Swales D.M., Geibel R., and McMillan N., Applying the Standards: Improving Quality of Child Care Provision in East and Central Africa, 2006. Retrieved from http://bettercarenetwork.org/
41 Cantwell N, Davidson J, Elsley S, Milligan I, Quinn N., Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children'. UK: Centre for Excellence for Looked After Children in Scotland, 2012. Retrieved from www.alternativecareguidelines.org
42 United Nations, Guidelines for the Alternative Care of Children, 2010. www.alternativecareguidelines.org
43 UNICEF, Making Decisions for the Better Care of Children, 2015. https://www.unicef.org/protection/files/UNICEF_Gatekeeping_V11_WEB_(003).pdf

2.9 Child, family and community preparation

Purpose of the Child and Family and Community Preparation Form

- Preparations should occur at three levels to support the transition of children and adults with disabilities from institutions to the community: 1) the child with disabilities; 2) the family and other caregivers; and, 3) the community.
- The child, family and community preparation process involves individual sessions in which the case worker discusses with the family and with the child the process and the placement decision and obtains agreement from both parties to move the process forward. It also involves the joint visit of the case worker and DMO to the local community to meet sector and cell leaders and other key community stakeholders (churches, schools, ECDs, etc.).
- The form records this process and the agreement.
-  More information on the preparation process is provided at Job Aid 3.6

Guiding Principles

- Agreement with the placement decision is required from both the child and receiving family.
- The timing and number of meetings is guided by the reaction of the child and family to the meetings which should include at a minimum:
  - a family visit to the child in the institution,
  - a child visit to the family, and
  - a child visit to the family – overnight stay.
  - a child visit to the community (school, ECD, church, market, etc.)
- Preparation of the community is required including identifying the appropriate community volunteer, talking to community leaders and other local government officials responsible for disability mainstreaming, social affairs, gender and family.
- Preparation of the community should also involve different sensitization meetings of the community members through existing mechanisms such as Umuganda, Umugoroba w'imiryango, Inteko y'umudugudu, and other existing community level platforms.

Section 3: Group Session(s) with the Child

- Note down here any specific remarks or observations on the child during the group session.

Section 4: Child and Family Visits and Preparation

- This section also includes a record of any interaction of the case worker with families and children by phone or letter/text.

Section 6: Result of Matching Process

- Based on the matching process, indicate whether the matching has been successful, or if another family/solution has to be considered. Once a decision has been made, proceed to Form 10.

2.10 Child's reunification/placement/independent living

Purpose of the Child Reunification/Placement Form

- The placement form has details on where the child is placed, including address and contact details of the family and whether the child is linked to existing community resources/services.

- "Date of placement in the family/independent living"
    - This is the date of the first day where the child is reunified with/placed in the family or in supported independent living (if the child is younger than 18 but within six months of their 18th birthday).

Section 1: Family Composition

- Name of head of household and other household members
    - These persons are now the primary caregivers of the reintegrated child (either the family of origin, extended family, foster family).

2.11 Post placement support and follow-up

Purpose of the Post Placement Support and Follow-up Form

- This form is filled in to register any efforts in supporting the placed child/adolescent and family, and when/how the follow-up was conducted. Each case file can have multiple of these forms.

Guiding Principles

- The case worker is required to conduct the first follow-up visit two weeks after the first day of placement in the family. This initial visit can be made earlier if there is a compelling need. Further follow-up is recommended every three months during the first year and then annually, until the child and family are well adjusted, but for a minimum of two years.[44]
- Follow-up by phone can also be registered on this form.
- Long term follow-up can be required for children with disabilities following their reintegration to reassess and monitor progress, thus a case file can have multiple post-placement/follow-up forms.
- Periodic reviews need to:
    - Consider the child's well-being, health, nutritional status, educational and psychosocial development;
    - Use standardized indicators and assessments;
    - Review and update the case plan;
    - Consider how the family is managing.
    - Identify, document and link to additional support needed.
    - Identify and document reasons why the family is not accessing certain services that are available.
- Case follow-up continues until the case worker, child and family agree that the child is settled within the family and community and receiving the required services to support their reintegration.
- A case worker involves DMO and the staff in charge of social affairs at both sector and cell levels to make sure the family can be eligible for social protection programmes and is linked to other community-inclusive initiatives such as parents' self-help groups, CBR/CBID programme, inclusive cooperatives, etc.

A confidential, impartial and independent complaint process should be established that is accessible to children or adults with disabilities (including physical, sensory, mental), their families and their representatives.

44 Ministry of Local Government and International Centre for Disability and Rehabilitation (ICDR) University of Toronto, Canada, Draft Minimum Standards for Alternative Care and Considerations for Strengthening the Tubarerere Mu Muryango (TMM) Programme for the Inclusion of Children and Adults with Disability, 16 January 2017.

Section 1: Basic Information

- "Is the child still in the family":
    - In case the child is not in the family any more, it is critical to understand why this is the case. If the child is not in the family any more because the family rejected the child after reintegration, it is important to report this to NCDA Kigali and to document what the reasons were for rejection.
    - It is important to trace where the child is located, and to ensure that the child is in a safe environment and has access to basic needs. If necessary, another child assessment has to be conducted and a solution found to place the child in family care.

Section 2: Follow-up of Case plan

- Which objectives under the case plan (Form 3) have been fulfilled?
    - This can form the basis of further engagement with the family and identify gaps where the family or child might need closer support from the Social Welfare Officer or other community actors.
    - Have referrals been made to appropriate support services?
    - Have the child and family received all the support services for which they were referred?
    - Do the parents receive a training on home-based care/rehabilitation through simple therapeutic modalities?
    - What else might need to be done?
- If the child's needs have changed, then a further assessment can be completed, and the case plan revised.

Section 3: Child Wellbeing

- During the follow-up, it is useful to have some private time/space with the child, to see how the child feels in the family, community and new surroundings. In case the child is still very young or unable to express themselves verbally, observing parent-child interaction and emotional and physical well-being is particularly important.

Section 4: Family and Community Re-assessment

- Considering that the family also had certain expectations regarding welcoming a child in the family, how is the family handling the new situation, and where could they receive more support?
- Are the community leaders supportive? Are community attitudes supportive towards children with disabilities? What needs to be done for a more inclusive community?

2.12 Case closure

Purpose of the Case Closure Form

- When it is assessed that the child lives within a safe and protective environment in which their needs are being met and that the child and family no longer require support from the case worker, the case can be closed.
- The case can be reopened if the child or family needs change and additional support is required. All case management data will remain stored electronically and in paper copies.
- In the case of a child with disability it is recommended at a minimum to conduct monthly visits during the first six months and as necessary thereafter up to one year following reunification or placement. Such visits should involve DMO and the officers in charge of social affairs for the smooth transition of the family from the TMM programme to available social protection programmes in that community, or community-based inclusive programmes.

Part Three.

Job Aids

3.1 Compendium of legislation

This runs to 140 pages and is therefore provided as a separate document in pdf.

3.2 Understanding disability

Disability is a complex issue. 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.

The United Nations Convention on the Rights of Persons with Disabilities (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 ".*

Disability is the complex relationship between the mind, the body and the environment in which a child lives. It can manifest in one or a combination of:

- Impairment
- Activity limitation
- Participation restriction

and can change during the child's life course. A disability can be congenital (is present at birth) or can be acquired.

Sometimes people think that disability is an illness, that it is something which can be treated or cured. This is called *the medical model of disability*. It considers disability as a purely physiological impairment. 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 impairment and forgetting about the other components can mean that a child with disability does not get all the support they need.

A by-product of the medical model is the charitable *model of disability*. The base logic is informed by the medical model but expanded into a view of disability as tragic and pitiable.

According to the charity model, a person has a disability. This disability is a 'problem' in their body and good citizens should feel pity for the disabled person's tragedy or inspired by a disabled person's achievements. "Disabled people's lives in the Charity Model are rarely seen as positive or fully-rounded; but as something to struggle against. It is the duty of non-disabled people to help disabled people, as part of their civic and moral obligations."[45]

An alternative view is that children are disabled by barriers in society, not by their impairment or difference. This is called *the social model of disability*. Barriers can be physical, like buildings not having accessible toilets. Or they can be caused by people's negative attitudes to difference, like assuming persons with disabilities cannot do certain things, or that children have a disability because it is God's will and therefore their destiny cannot be changed. The social norms in a community can also affect how children with disabilities are treated, for example if it is believed that disability is contagious and can be contracted by spending time with the disabled person.

Box 2. Models of disability - different approaches

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 (MP3) available when the book is published.

A child who lives nearby learns how to guide the child with impaired sight and calls for him on his way to meet up with their friends.

This child has an impairment (poor eyesight) which can limit their activity (reading books) until the accessibility barrier is lifted (by recording the text) and participation restriction removed (by helping friends understand how to assist appropriately). This is called the biopsychosocial model.

45 For more information see Hans Kretser, 'Understanding Disability: Part 4 - The Charity Model', 20 December 2017. https://www.drakemusic.org/blog/hdekretser/understanding-disability-part-4-the-charity-model/

Sometimes choosing the medical model over the social model or the social model over the medical model can mean we do not seek out all the solutions which can assist the child to realize their rights.

Making sure that we look at the whole person, the whole child means we think about their physiological (health) needs and their social needs, as well as 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 behaviours to meet those needs.

In the case of the boy whose story we tell in Box 2., the biopsychosocial model makes sure the physiological impairment is treated, and that the activity limitation is addressed as well as the participation restriction, for example making sure he has support to attend the book club to discuss the book with his friends.

Sometimes a disability is not obvious. A *hidden disability* may not be immediately noticeable except under unusual circumstances or because the person or someone close to the person tells you about it. Some examples of hidden disability include intellectual disability, autism, mental health difficulties such as depression, chronic conditions such as diabetes, Human Immunodeficiency Virus (HIV), or arthritis. 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. To many people watching, this can seem like a temper tantrum because of 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 and development experiences.

Understanding disability can be complex, a child may experience:

- an impairment,
- an activity limitation,
- or a participation restriction,
- or all three,
- and these may change at different time in the child's life.

For example, behaviour associated with autism such as crying and screaming when changes occur in the child's routine can be perceived very differently in a 6-year-old and in 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.

3.3 Type and effects of disability

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.

They 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.

Box 3. Types and effects of disability

Source: Adapted from London School of Hygiene & Tropical Medicine, *Global Health and Disability,* 2018

The term developmental disability covers a broad range of conditions, across a broad range of domains, including motor, sensory, cognitive and behavioural functioning. These conditions can be caused by both biological and environmental factors, including genes, toxins in the environment and malnutrition. One condition can result in multiple impairments, for example a child with Down syndrome may experience delays in some or all of the areas identified below.

Below, we will consider areas of a child's functioning that may be affected by a developmental disability and give examples of common conditions associated with each category.

Domain 1. Motor

Motor skills are an essential component of child development, as they promote independent, goal-oriented actions. Typically, children develop gross motor skills (e.g. crawling, walking) and fine motor skills (e.g. pinching, using a pencil). Impairments in gross and fine motor skills may result in clumsiness, slowness and inaccuracy of motor performance, causing difficulties with many daily activities, such as playing, sports and schoolwork. These impairments can also impede a child's ability to feed or practice self-care, such as washing and toileting, and this can impact their long-term health and independence.

Common conditions that can cause delays in the development of motor skills include:

- **Cerebral palsy:** a group of disorders of the development of movement, coordination and posture, attributed to non-progressive disturbances that occurred in the developing fetal or infant brain.
- **Spina bifida:** incomplete development of the backbone spinal cord, causing damage to the nervous system.
- **Muscular dystrophies:** a group of conditions in which muscle fibres weaken gradually over time, creating difficulties in movement, balance and sometimes breathing.
- **Developmental Coordination Disorder:** difficulty coordinating movements means that a child has difficulty in performing everyday tasks, such as tying shoelaces.

Domain 2. Sensory

Impairments to one or more of the senses (sight, hearing, smell, touch, taste) can affect how a child gathers information from the world around them. Sensory impairments can have a number of practical considerations, such as the need for alternative modes of communication with a child with hearing impairment, for instance. Sensory impairments can have a negative impact on cognitive development, as a child may find it more difficult to learn from their environment and form social bonds.

Common conditions that can cause delays in the development of sensory skills include:

- **Congenital cataracts**: clouding in the lens of the eye that can cause blurred vision or blindness.
- **Retinopathy of prematurity:** abnormal development of blood vessels in children born prematurely.
- **Chronic otitis media:** long-term problems with the middle ear, e.g. hole in the eardrum that does not heal, repeated ear infections or the presence of middle ear fluid ("glue ear")
- **Sensory processing disorder:** impaired ability to adequately receive and respond to information from the senses (e.g. related to Autism Spectrum Disorder).

Domain 3. Behavioural
All children will display challenging behaviours when they are tired, hungry or upset, but some children may present with challenging behaviours that are inconsistent with their age and expected development. Challenging behaviours may include extreme and unpredictable tantrums, aggression and impulsivity. These behaviours may impact a child's social development, relationships and ability to interact with their environments.

Common conditions that can cause delays in the development of behavioural skills include:

- **Autism Spectrum Disorder:** covers a wide range of abilities and impairments, but it is generally characterised by impairments in social interaction, behaviour and communication.
- **Attention deficit hyperactivity disorder (ADHD):** high levels of hyperactivity, impulsivity and inattentiveness.

Domain 4. Intellectual
Intellectual impairment is characterised by limitations in intellectual functioning (reasoning, learning, problem solving) and adaptive behaviour (conceptual, social and practical skills). Intellectual impairments will limit a child's ability to learn, understand and apply complex information and skills. These impairments range from mild to severe, and can negatively impact a child across other domains, including behavioural problems and communication difficulties. An intellectual impairment will therefore affect a child's ability to learn in school and find work, and impairments may make it difficult for them to live independently as an adult.

Common conditions that can cause delays in the development of intellectual functioning include:

- **Down syndrome:** caused by an additional copy of chromosome 21, it will commonly result in mild to moderate intellectual impairment. As well as likely intellectual impairments, children with Down syndrome may face delays in motor and communication development.
- **Fragile X syndrome:** as a result of mutations in the FMR1 gene – most males with the condition have mild to moderate intellectual impairments, about one-third of females have intellectual impairments.

Domain 5. Communication
Some children will exhibit difficulties in understanding or producing language and speech, making it difficult for them to express their thoughts and feelings, or to understand others. Impairments may include limited receptive language skills, limited expressive language skills or non-speech. As a result, children with communication impairments will likely find it difficult to communicate, learn and engage in social interactions.

Common conditions that can cause delays in the development of communication skills include:

- **Speech disorder:** difficulties acquiring and producing speech, resulting in pronunciation errors.
- **Speech fluency disorder:** persistent and frequent disruption of the rhythmic flow of speech (stuttering).
- **Language disorder:** difficulties in understanding and using language (spoken and written).

Conditions across these domains can occur in isolation or in tandem with other conditions. For example, many children with cerebral palsy will demonstrate intellectual impairment, as well as motor impairment, children with autism, and related behavioural difficulties, may also present with intellectual impairment, and children with Down syndrome may find it difficult to develop communication skills.

3.4 Completing an initial child assessment

It is important during a child assessment that a holistic assessment of the social, medical, psychological and developmental functioning[46] of the child is conducted using standardized tools by a qualified professional or team (Box 4.). The assessment is conducted to understand the "problems, needs and rights of a child and his/her parent(s) or primary caregivers in a wider context of the community."[47] This is important to determine placement opportunities and to develop a permanency plan and case plan for the child with disabilities.[48]

> *" Children with special needs do not have different needs from those of other children but rather they have additional needs. This should be the starting point for designing adequate services which meet the children's entire set of needs and not just the additional ones. It is also crucial to focus on the person rather than the special need. Too often when presented with a child with disabilities or special needs there is a tendency to focus on the disability rather than the person and to design services accordingly ".*[49]

Why is a thorough assessment important?

- An assessment will ensure that disabilities have been identified and properly diagnosed and will inform the development of "individual programmes to prepare the child for the move to the new placement, as well as providing individual case plans"[50] to meet their needs in the short and long-term.
- The assessments inform the determination of both the direct and indirect costs of caring for the children and adults with disabilities. This will be important when considering and arranging the support that the family may require now and in the future.[51]
- The assessment will determine which referrals are required to other services/programmes and resources in the community.
- If the assessment determines that medical, surgical or therapeutic intervention is required, then it is the responsibility of the government to ensure that the child or adult with disabilities has access to the intervention.[52] This should be arranged as soon as possible.

Education assessment

- It is important to have a qualified professional (for example inclusive education teacher, special needs education teacher) assess the educational needs and abilities of the child and develop an individualized educational plan which addresses any special needs.
- Please refer to the Teachers' Guide for Special Educational Needs Assessment and Individual Education Plan published by the Rwanda Education Board, Ministry of Education in 2019.

Health assessment

- Depending on the nature of the child's disability, it may be necessary to utilize a multidisciplinary team (including a Child Protection and Welfare Officer, psychologist, medical doctor, and/or rehabilitation personnel). It is also important that disability be assessed from a social inclusion perspective and not a purely medical one.
- Measurement and categorization of disability should be congruent with the UNCRPD definition of disability and thus rely on a functional approach to measuring disability.
- It is important to document the history of the disability if known, mention if the disability was congenital or acquired) and any chronic diseases.
- Under the 'child's health needs checklist' describe if the child or adult is currently using and/or requires any assistive or supportive devices such as wheelchairs, prostheses, hearing aids, visual aids, communication board or other equipment. Note that even if the individual does not currently have any assistive devices or aids, they may be required. It is estimated that only 5-15 per cent of people who require assistive devices and technologies have access to them in many low- and middle-income countries.[53]
- Any special feeding needs due to disability must be noted, for example modified diet, modified eating utensils, modified positioning).
- Health insurance used;

Behavioural characteristics

- Try to separate out behaviours which may be a direct result of the child's impairment from those which may be related to other life events, for example the effects of institutionalization, other contextual and environmental factors.

46 European Commission Daphne Programme, World Health Organization (WHO) Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf.
47 Ministry of Gender, Children and Social Development and UNICEF, Toolkit and National Standards for Best Practice in Charitable Children's Institutions. p.13, April 2013. https://bettercarenetwork.org/sites/default/files/National%20Standards%20for%20Best%20Practices%20in%20Charitable%20Children%27s%20Institutions.pdf
48 UNICEF and Department of Social Welfare Lesotho, Guidelines and Standards Residential Care for Vulnerable Children and Youth. p.32, 2006. https://bettercarenetwork.org/sites/default/files/Lesotho%20Guidelines%20and%20Standards%20-%20Residential%20Care%20for%20Vulnerable%20Children%20and%20Youth.pdf
49 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf. p.24.
50 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf. p.61
51 Better Care Network and EveryChild, Reform: Why supporting children with disabilities must be at the heart of successful childcare reform. New York and London: Better Care Network and EveryChild, 2012. https://bettercarenetwork.org/library/particular-threats-to-childrens-care-and-protection/children-with-disabilities/enabling-reform-why-supporting-children-with-disabilities-must-be-at-the-heart-of-successful-child
52 Republic of Rwanda, Ministry of Justice, Law No. 01/2007 of 20/01/2007 relating to protection of disabled persons in general, Articles 14 and 15.

Box 4. Examples of standardised tools for child assessment[54]

Denver Scale

- Appropriate for children from 0 to 10 years old.
- Provides clear indication of the developmental age of the child with respect to language, communication, social, motor, cognitive and autonomy.
- Relatively simple scale to use and requires few materials
- Appropriate to use in initial assessment, for continuous assessment and monitoring
- Can be applied by those with basic training.

Portage Scale

- Appropriate for children aged 0 to 5 years
- More detail of development than the Denver Scale
- More complicated than the Denver Scale but can be used by those who have received training.

Special Needs Evaluation Form

- Appropriate for children with medium to severe special needs
- Adaptive Behaviour Scale (ABS-RC 2) that reflects the needs and experiences of children with special needs.

Supports Intensity Scale - SIS

- A standardized assessment tool to measure the pattern and intensity of supports that a person aged 16 years and older with intellectual disability requires to be successful in a community setting.
- The SIS focuses on skills the individual has and what is required to gain independence.

Social and Personal Development Scales (SPDS)

- For children above the age of 6 with respect to the age and health conditions.
- There are three tools: 1/ SPDS for typical children and adolescents of above 6 to 17 years old; 2/ SPDS for typical adolescents and adults above 17; 3/ SPDS for children and adolescents of above 6 years with disabilities.

Gross Motor Function Classification System, Expanded and Revised (GMFCS E&R)

- For children with neurodevelopmental disabilities affecting gross motor skills such as Cerebral Palsy.
- Considering illustrations for children in the range of 6-12 years, and 6-18 years old.

Manual Ability Classification System for Children with Cerebral Palsy (MACS)

- For children with fine motor difficulties, using either Mini MACS for children below the age of 4 years or MACS for children aged 4-18 years.

Communication Function Classification System (CFCS)

- Fo r children with communication impairments.

The Communication Matrix

- An assessment tool to help families and professionals easily understand the communication status, progress, and unique needs of anyone functioning at the early stages of communication or using forms of communication other than speaking or writing.

Child's general wellbeing and history

- As noted above, it is important that both the communication needs and developmental level of the child are considered so that professionals and others are able to engage with the child in a way that the child may understand, and the assessor is able to comprehend and allow for the child's needs to be recognized.

Protection concerns and related follow up action required

- Children with disabilities are three to four times more likely to experience violence or abuse than those without disabilities.[55]
- Consideration needs to be given to signs that abuse has or may be occurring and behaviour that might

53 http://www.who.int/disabilities/technology/en/
54 A range of free and open source disability measurement tools can be located at http://disabilitymeasures.org/

indicate an issue for a child who communicates in different ways (for example uses communication board, sign language).

- Individual vulnerabilities of the child need to be identified and appropriate protection measures established.
- For individuals who use alternative communication methods, they may need to be given a way to indicate abuse such as appropriate vocabulary or a visual representation of a body to indicate where on their body the abuse occurred.
- Individual may need to be taught what behaviour is appropriate and what behaviour is inappropriate.

Wishes of the child and adult

- It is important that both the communication needs and developmental level of the child or adult with disabilities are considered so that professionals and others are able to engage with the individual in a way that her/his wishes and needs are shared.
- This may also require the introduction of appropriate vocabulary.

Recommended placement

- Placements should always prioritize family-based alternative care (i.e. family of origin, extended family, adoption, foster care).

3.5 Developing the case plan

The following are key tips for good practice in developing case plans:

- **Input from the child**
  - What others like about me and what I like about myself
  - What's important to me
  - What does good support for me look like?
  - The views, wishes and aspirations of the child and her/his family
  - Indicate how views were gathered
- **Identifying Needs**
  - Writing and numbering each need separately makes it easier to match each need with service provision
  - For health needs keep it as simple as possible so that it can be understood by a non-specialist
  - A diagnosis does not describe need, instead it is important to focus and identify the practical implications (e.g., on day-to-day activities) of any health condition or impairment on that individual
  - Information about social care needs (i.e. needs related to activities of daily living, social interaction, inclusion in the community) can come from a range of people (e.g., teachers, community health workers etc.)
  - If a child is 'not known' to social care, it does not mean that there are no social care needs
- **Defining Outcomes**
  - Short-term, service level targets are not outcomes but outputs
  - Outcomes should be linked to the child's aspirations
  - Where appropriate, outcomes should be across education, health and social care.
- Provisions - for all service provision planned (i.e., education, health, social services) it is important to identify:
  - what is going to happen
  - who is going to do it?
  - what skills, qualifications or training they need
  - how often it will be made available
  - when it will be reviewed

3.6 Child, family and community preparation process

Preparation of the Child with Disabilities

- Institutionalized children with intellectual disabilities can be particularly vulnerable and may require individualized strategies to introduce them to their new home including play, musical instruments, therapy, additional time and gradual exposure to the new home and the members of the family, if not already known to the child (Box 5.). [56]
- Some children with disabilities who have lived in an institution for a long time may need basic recuperation work prior to preparing for the move.[57]
- Preparation programmes need to correspond with the level of the understanding of the child with disabilities and her/his preferred communication method must be used.[58]
- A considerable amount of practical and experiential learning over a period of time may be necessary for a child with disabilities to understand new experiences and what will happen to her/him.[59]

56 For more details and good practice refer to: World Health Organization (WHO) Regional Office for Europe, Better health, better lives: children and young people with intellectual disabilities and their families. Transfer care from institutions to the community, 2010. http://www.euro.who.int/intellectual_disabilities

57 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf. p. 104.

58 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. Retrieved from https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf. p.104

59 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, U, 2007.

Box 5. Preparing a child with disability for reintegration - example from Romania[60]

In 2001, an institution with 250 children and young adults with severe intellectual disabilities was closed in Romania. The children and young adults in this institution had rarely been outside the institution *("some did not understand the concepts of 'family', 'home' and 'community'")*, many had severely institutionalized behaviours (for example, self-stimulation) and some were routinely physically or chemically restrained to minimize aggressiveness and self-harm. There were not enough qualified personnel to prepare these children, so the local authorities partnered with a local NGO to develop an individualized preparation programme for each child.

A number of strategies were used to prepare these children and young adults including:

- Use of concrete rather than abstract explanations about what was happening in his/her life including play, special communication methods, photographs and actual experience
- Children were prepared individually, and for those who wanted to live together there were joint activities to develop relationships
- Activities to increase self-esteem and self-identity to strengthen the child's ability to make choices about their future.
- Provision of regular one-to-one therapy with qualified professionals for children with severe behavioural difficulties (e.g., aggression or self-harming)
- Techniques (e.g., intensive interaction) to support alternative methods of communication, minimize self-harming behaviours, and foster healthy relationships.
- Training of institution staff on alternative methods to help children with behavioural difficulties to reduce the use of restraints.

The reported outcomes following the individualized preparation program were minimal 'disturbed behavior' when the children and adults with intellectual disabilities moved into their new homes, and rapid improvements in health, development, behaviour and independence skills.

- Children or adults with disabilities need reassurance that the family will accept and love them.[61]
- It is important the child or adult with disabilities does not believe that the future family will 'heal' their disabilities, but that they will be loved and cared for.[62]
- Make sure that the children have access to any specialised support and assistance needed to enable participation in daily life, for example, assistive devices, mobility aids, communication devices[63]
- Ensure appropriate access to personnel required to assist the individual in their rehabilitation programme.

Preparation of the family and caregivers

Parents, primarily mothers, of children with disabilities in Rwanda, identified a number of challenges that should be addressed during the integration process. These issues were identified during fieldwork in July 2017 and 2019:

- **Lack of access and transport to health care**
    - o There are limited healthcare and disability services available for parents and their children with disabilities, especially in rural areas, that may prevent children from receiving early interventions and treatment.
    - o Disabilities are compounded because of lack of access or delays in receiving care
    - o Healthcare services that are available are difficult for parents and their children to access due to transport barriers (distance, access, terrain, cost)
    - o Nutrition programs and health insurance schemes are designed without the consideration of children with disabilities and their families (e.g., GIRINKA program).
    - o Even with health insurance, many services are not covered (e.g., physiotherapy, orthopaedic, assistive devices) and are beyond the financial means of the family.
    - o Neither children nor their parents are included in the planning, implementation, monitoring, and development of services in the community.
- **Stigmatization and discrimination**
    - o Mothers of children with disabilities face stigma and discrimination within their own families and the community due to prevailing beliefs of the mother and child being 'cursed' by the Nyabingi and other superstitions.

60 World Health Organization (WHO) Regional Office for Europe, Better health, better lives: children and young people with intellectual disabilities and their families. Transfer care from institutions to the community, 2010. http://www.euro.who.int

61 Jenny M, Romanens-Pythoud S, International Social Science, A Better Future is Possible: Promoting family life for children with disabilities in residential care. Manual for professionals. International Social Science Geneva: Switzerland, 2016. https://www.iss-ssi.org/images/Publications_ISS/ENG/ISS-ManualEnglish.pdf

62 Jenny M, Romanens-Pythoud S, International Social Science, A Better Future is Possible: Promoting family life for children with disabilities in residential care. Manual for professionals. International Social Science

- There is a lack of support and care provided by family members and community members to the mother and child, leading to isolation.
- One focus group with 23 mothers with children with disabilities found that the majority of mothers (n=19) indicated that they would prefer receiving mainstream services rather than specialized disability services, as it fosters feelings of inclusion, understanding, and acceptance.
- Mainstream services currently do not have the adequate resources in addressing the specific needs of people with disabilities.
- Children with disabilities experience abuse in the home, school, and community (abandonment, neglect, etc).

- **Education**
  - Parents of children with disabilities do not know or are not provided with information about disabled persons organisations.
  - There is limited access to inclusive education opportunities (e.g. primary, secondary and vocational education) at the local, district and provincial levels.
  - Training is needed on the causes and types of disabilities, and about the services or organizations that are available to people with disabilities and their families, and about their rights.
- **Poverty**
  - Parents of children with disabilities are most likely to experience poverty, as they spend a majority of their time caring for their children rather than being able to work outside the home.
  - Children and adults with disabilities may have greater costs than others due to their special needs (e.g., equipment, specialized transportation, medications, etc.)
  - The work and home time-conflict, especially for mothers, makes it difficult to afford health insurance, medical care, and assistive devices for their children.
  - There are barriers in accessing government programmes designed to alleviate poverty (e.g. Ubudehe categorization)
  - Family conflicts due to the birth of children with disabilities can contribute to couples separating or divorcing.

UNCRPD Article 28 (2, c) notes that States Parties are obligated

> *" To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability related expenses, including adequate training, counseling, financial assistance and respite care".*

The family and other carers need to have the knowledge and where appropriate, specialized skills necessary to address the child or adult's unique needs including, but not limited to: medical and therapeutic needs, risk issues, behavioural issues, disability specific information, behaviour plans, dietary requirements, emotional well-being, and details about their routine.[65]

Identify other families in the village or community that also have a child or adult with disabilities and facilitate the development of a parents' group (or connect family with an existing group) for mutual support. These groups can reduce the sense of isolation, provide opportunities to share experiences, manage stressors associated with caring for a child with disabilities and engage in advocacy to promote the rights of their children and access services. Groups of parents have mobilized services for children with disabilities in many countries.[66]

Funding for assistive devices, adaptations, and income support should be organized as required. This acknowledges that looking after a child or adult with disabilities may prohibit or limit opportunities to earn money and that there may be additional costs (such as transport to access care).

Proactively identify options for planned, short-term respite care (for example specialized foster carers) to relieve pressure on families providing long-term care for a child or adult with disabilities.

If the child is being moved to a residential placement (for example, community-based family home) it is important that the carers and other family members have the opportunity to meet and spend time with the child, that carers are aware of his/her needs and case plan, and that they have received the necessary specialized training to meet those needs.[67]

Community preparedness

An important part of preparation includes strengthening community receptiveness through mobilization and sensitization activities. As noted in the NCPD Disability Mainstreaming Guideline (2014) barriers for people with disabilities integrating within communities are often communication barriers and negative attitudes and/or prejudices.[68]

Geneva: Switzerland, 2016. https://www.iss-ssi.org/images/Publications_ISS/ENG/ISS-ManualEnglish.pdf

63 Better Care Network and EveryChild, Enabling Reform: Why supporting children with disabilities must be at the heart of successful childcare reform. New York and London: Better Care Network and EveryChild (p31), 2012. https://bettercarenetwork.org/library/particular-threats-to-childrens-care-and-protection/children-with-disabilities/enabling-reform-why-supporting-children-with-disabilities-must-be-at-the-heart-of-successful-child

64 SOS Children's Villages International, Quality4Children Standards for Out-of-Home Child Care in Europe. Innsbruck: SOS Children's Villages International. pp 43-44, 2007. Retrieved from https://www.sos-childrensvillages.org/getmedia/67a4237f-3456-4fa9-b6e9-e954075cadd0/Q4C_colour_2.pdf

Mobilization and sensitization would involve local authorities across sectors, local leaders, Inshuti z'Umuryango[69], community health workers and others. Community based programmes such as Umuganda (Community work), Umugoroba w'imiryango, Inteko rusange y'abaturage (community meetings), or community markets, all provide an important space for non-discriminatory messages. Local service providers and protection workers, for example, Inshuti z'Umuryango can be introduced to the child or adult and their family to facilitate links to supports and clarify roles.

It can be useful to prepare guides that could be used for these awareness and sensitization activities to ensure that the messages conveyed do not reinforce stigma, exclusion or the charity model of disability, but are instead empowering and rights-based.

Identify and mobilize available support, address stigma, increase awareness and understanding, reduce isolation, and increase the inclusion of the child or adult with disabilities and their families within the daily life of the community.

3.7 Child safeguarding[70]

Children and young people who have disabilities are at an increased risk of being abused compared with their non-disabled peers. Children and young people who have disabilities are also less likely to receive the protection and support they need when they have been abused. Professionals sometimes have difficulty identifying safeguarding concerns when working with children with disabilities. It is vital that everyone who works with children with disabilities understands how to protect them against people who would take advantage of their increased vulnerability.

Developing child protection and child safeguarding policies can make sure that all children and children with disabilities are safe and protected. Some of the considerations for these policies are described here.

There are several factors that contribute to children with disabilities being at a greater risk of abuse:

- **Communication barriers**
    - Children and young people with speech, language and communication needs (including those who are deaf or have a learning disability or physical disability) face extra barriers when it comes to sharing their worries and concerns.
    - Adults may have difficulty understanding a child's speech so they may not realise when a child is trying to tell them about abuse.
    - Adults may not have the knowledge and skills to communicate non-verbally with a child, which can make it harder for children to share their thoughts and feelings.
    - Communicating solely with parents or carers may pose a risk if the child is being abused by their parent or carer.
    - It can be difficult to teach messages about what abuse is or how to keep safe to children with communication needs. Without this knowledge children may not recognise that they are being abused or will not know how to describe what is happening to them.
- **Increased isolation**

Children with disabilities may have less contact with other people than typically developing children and have fewer people to turn to if they need help or support because they have:

- Fewer out of school opportunities than their peers
- Fewer opportunities for spontaneous fun with friends
- Less access to transport
- Less provision for appropriate toilets and changing facilities
- Difficulty finding out about accessible events
- Need carers to accompany them when they move outside their home
- Have restricted independence because they use a wheelchair or require a sign language interpreter
- Live away from home at a residential institution or boarding school

- **Dependency on others**
    - Children with disabilities may have regular contact with a wide network of carers and other adults for practical assistance in daily living including personal intimate care.
    - This can increase the opportunity for an abusive adult to be alone with a child. If a child is abused by a carer they rely on, they may be more reluctant to disclose abuse for fear that the support service will stop.
    - Caring for a child with little or no support can put families under stress. This can make it difficult for parents to provide the care their child needs and can lead to a child being abused, abandoned or neglected.

65 Department for Families and Communities, Standards of Alternative Care in South Australia an Alternative Care Partnership, p.26, 2008. https://www.childprotection.sa.gov.au/sites/g/files/net916/f/standards-of-alternative-care-booklet.pdf
66 De-institutionalising and Transforming Children's Services: A Guide to Good Practice
67 European Commission Daphne Programme, WHO Regional Office for Europe and University of Birmingham, De-Institutionalising and Transforming Children's Services: A Guide to Good Practice. University of Birmingham: Birmingham, UK, 2007. https://resourcecentre.savethechildren.net/node/5995/pdf/5995.pdf.
68 Republic of Rwanda, National Council for Persons with Disabilities, Disability Mainstreaming Guidelines, May 2014.
69 The Ministry of Gender and Family Protection and the National Child Development Agency endorsed the Inshuti z'Umuryango 'Friends of the Family', in 2014 to establish a community-based para-social work

- **Inadequate support**
    - It can be difficult for any child who has experienced abuse to get the support they need, but children with disabilities may face extra problems. Children with disabilities are less likely to tell someone about experiencing abuse and more likely to delay telling someone than their non-disabled peers. Adults may not understand and respond to a child with disability's safeguarding needs.
    - Communication barriers may prevent adults from fully understanding what the child is telling them. Some adults may not focus on a child with disability's views. If abuse is reported to the police and/or children's social care, the response may be affected if professionals lack skills or experience in working with children with disabilities .
- **Misunderstanding the signs of abuse**
    - It is not always easy to spot the signs of abuse. In some cases, adults may mistake the indicators of abuse for signs of a child's disability.
    - A child experiencing abuse or attempting to disclose abuse may self-harm or display inappropriate sexual behaviour or other repetitive and challenging behaviours. If this is misinterpreted as part of a child's disability or health condition rather than an indicator of abuse, it can prevent adults from taking action.
    - Injuries such as bruising may not raise the same level of concern as they would if seen on a typically developing child. Adults may assume that bruising was self-inflicted or caused by disability equipment or problems with mobility.
- **Lack of education on staying safe**
    - Personal safety programmes about relationships and sex education are not always made accessible to children with disabilities , and not always taught in special schools. As a result, a child with disability may not know how to recognise abuse or who to tell. This can be for a number of reasons:
    - Teachers and parents may not realise they need to teach children with disabilities about relationships and sex education.
    - Parents and professionals may think young people with learning disabilities should not have relationships or sex.
    - Community leaders may not approve of programmes about relationships and sex education being taught.
    - Sex and relationships education may not be taught in a way that makes sense to young people with learning disabilities.
- **Because they may require intimate care**
    - Children with certain disabilities or medical issues may need help and support with intimate personal care including going to the toilet and washing.
    - There should be a separate policy on how intimate case plans are written, carried out and reviewed.
    - Special attention should be paid to the intimate care needs of adolescents with disabilities.

3.8 How to talk to families and caregivers about their child with disability[71]

Becoming the parent or primary caregiver of a child with disability is a unique experience. Parents and family members will each have different and individual feelings. They may not fully understand the situation, they may be angry or scared, or they may feel overwhelmed. This may result in them making a decision to place their child in a residential institution.

When you begin discussing the reintegration process, it may take many meetings before the families listen to you, understand you and come to believe you. Keep emphasising the positive aspects of their children and their connection as a family.

It is useful to remember that life changes come to everyone, and they:

- Can be welcome, anticipated, or unwelcome and unexpected;
- May throw people off balance perhaps momentarily or for longer periods;
- Can create upset, uncertainty or confusion;
- May make people struggle to adapt and cope;
- Are not the same so people will react and feel differently about the same situation; and
- May make people emerge stronger or feeling hopeless.

Talking to a family about reintegration can include discussion about both the emotional and practical demands on the family resources.

When you are talking to families you need to use active listening skills. Active listening skills are among the most important skills that you need to make sure communication is effective and that there is a common understanding of roles, responsibilities and agreements. It will help to build trust, reduce any misunderstandings, and help family members and caregivers to open up.

To be a good listener, you need to focus on and practice being empathetic, non-judgmental, and genuine.

volunteer. There are two volunteers in each village (one man, one woman) to monitor well-being of children in their community including issues related to parenting, gender equality, family conflicts, detection and prevention of gender-based violence.

70 Adapted from the National Society for the Prevention of Cruelty to Children (NSPCC), Safeguarding d/deaf and children with disabilities and young people, 2019. https://learning.nspcc.org.uk/safeguarding-child-protection/

Empathy can help families to feel valued and understood. Empathy and empathetic understanding are:

- The ability to enter into another person's world and to see things as they see them and feel things as they feel them and
- Not the same as sympathy, which is feeling sorry for someone.

A **non-judgmental** approach is essential if you are to be effective. You may not like the attitudes or behavior of the family members or caregivers you are working with but that does not mean they do not deserve your support. If you are judgmental, you may reinforce negative feelings towards the child with disability and it will be more difficult to reintegrate the child. People generally feel more defensive if they think they are going to be criticized. Through being non-judgmental we will reduce defensive behavior and encourage trust. Showing warmth and respect will overcome defensiveness.

Genuineness refers to the ability to be open and sincere. It implies openness in the acknowledgement and expression of other's feelings and attitudes. You can show this characteristic by being straightforward and acknowledging your own strengths and weaknesses.

Your body posture, tone of voice, facial expression, and eye contact are the non-verbal forms of communication that support your listening skills. The willingness to be fully present for the family can be expressed by an open body posture, rather than crossing your arms across your body, for example. Be relaxed, smile, have eye contact, touch someone's arm if you think it will be acceptable.

Try practicing with a family member, friend or colleague. You can make a short video so that you can be more aware of how others see you.

Silence is the most important non-verbal skill of all. Silence can speak volumes at the right moment. It is important to allow others the space and time to experience their deeper feelings. If a family member is speaking, let them finish and pause before you speak, let them breathe and reflect on what they have said, especially if it is very emotional.

Ask yourself:

- Is the family member pausing as they work through an idea?
- Are they experiencing a feeling, and do they need space for this?
- Are they coming to a difficult or embarrassing part in the story, and do they need time to find the words or the courage to share it?
- Has the family member simply finished what she/he wants to say, and is waiting for a response?

Allowing a longer silence than is usual in everyday conversation may feel uncomfortable at first. However, it is surprising that by giving the family member just a few more seconds before you speak, they may be able to share something else with you. So, when in doubt, hold back and stay silent!

3.9 How to talk to a child with disability

Many people with a disability mention the 'golden rule' – treat others as you would like to be treated. When talking to a child with disability, remember that you are interacting with a child and keep the same tone and language as you would with any child of a similar age.

Try particularly not to speak about the child as if they are not in the room. Many people make the mistake of talking in front of a child with disability about them, as if they cannot understand or do not have the same feelings as any other child. They do! Be empathetic, warm and genuine and appreciate that they have a valuable perspective too.

If the child cannot hear, it is important that you don't walk around or move your head while talking with the child. Make sure you are looking at them when you speak, and make sure they are looking at you and can see your face and mouth. Use gestures where appropriate, for example, you can mime holding a glass and drinking when asking the child if they would like a drink. You can ask if there is anyone in the family who can help to interpret for you or find out if there is a person in the local community who uses sign language and who can assist. You should be thoughtful in using whatever communication aids you have. You can draw a picture to describe something, or for a child who can read, write things down.

If you are speaking to a child with an intellectual disability you can first talk to their family for advice on the best methods of communicating, the child's family may also be able to help with interpreting the child's movements or sounds if they cannot speak. You should use all of the guidance above and make sure that you do not speak to the child in a way which makes you appear superior.

Always speak clearly, using short sentences. Use the child's name so they know you are talking to them. It is very important to respond to the child's attempts to communicate, so they understand the effectiveness and importance of communication. If a child points to an object of interest, you can point to it and clearly name it to indicate that you have understood and are listening.

Remember to introduce yourself. This is important when speaking to any child but is especially important for speaking to a child who has difficulties in seeing. This lets them know you are there and helps them to locate your position in the room.

You can also talk to adults with a disability in your community and ask them for their advice. This can

71 Adapted from Sammon, E.M. and Burchell, G., Family Care for Children with Disabilities: Guidance for Case Management Support, USAID: Washington DC, 2018. https://bettercarenetwork.org/sites/default/files/FamilyCareGuidance_508.pdf

involve finding out if there are any disabled people's organizations so that you can get to know them and ask for their support when you need it.

3.10 How to talk to siblings (sisters and brothers) of a child with disability

Siblings are often overlooked and sidelined in discussions about reintegration of a child with disability. Take time to listen to the child's brothers and sisters, be honest with them about the situation and the future and understand that that they may be angry and upset too, as they come to terms with their sibling's disability and the possibility of them moving home. You can encourage everyone in the family to think about what is reasonable for each individual to do to support the child with disability. This may mean that siblings sometimes invite their brother or sister with a disability to join them and their friends for play, but also have time to play separately. Negotiating these new roles is something that you can help families with.

3.11 How to conduct a home accessibility audit

When conducting a home accessibility audit, it is important to remember that types of impairments and associated needs are different. It is also important to keep in mind that accessibility starts outside the home setting. For example, a child with a high level of wheelchair dependence will need to be near the road for easy services access compared to a child with speech and hearing impairments who does not necessary need to be near the road. A child with visual impairment will need good contrast colors and enough lighting inside the house. It is also very important to remember that accessibility does not concern children using wheelchair only, rather a universal design approach aiming at a maximum level of child functional independence when in a family care.

The staff conducting the home accessibility audit, use a simple "home accessibility checklist" designed to audit home environment before the child is reintegrated or placed in the family. The checklist is composed of three main categories: (i) External home environment, (ii) Home compound, (iii) Toilet and washing facility, (iv) House design. During the audit, it is important to have a tape measure with you, to take some measurements. Do not ask family members to tell you but find out yourself.

Please see home accessibility audit/checklist below.

HOME ACCESSIBILITY CHECKLIST- TO BE USED IN THE TMM PROGRAM

S/N	IBIREBWA / ITEM	Uko bimeze / Rating *Yego cg Oya* *Yes or No*	 *Si ngombwa* *N/A*	Icyo wabivugaho/ Observation
Mbere yo kugera mu rugo / *External home environment*				
1	Urugo ruri hafi ya service z'ibanze umwana ufite ubumuga akenera cyane (irerero, ishuri, ikigo gitanga serivisi ku bantu bafite ubumuga, urusengero/kiriziya, etc) *The house is located nearby fundamental services that a chilld with disability need (for example an ECD service center, school, Rehabilitation center, etc)*			
2	Urugo ruherereye hafi y'umuhanda ku buryo umwana ufite ibibazo by'imigendere (urugero nk'ukoresha akagare cg imbago) atahura n'inzitizi zo kugera kuri serivisi akeneye *The house is located near the street in a way that a child with mobility problems / for example a wheel chair or crutch user) does not face barriers to have access to needed services*			
	Inzira iva ku muhanda kugera ku marembo y'urugo ikoze ku buryo budafite intambamyi, kandi butateza impanuka umwana. *A pathway from the street to the house entrance is made in a way which does not have obstacles and can't cause any harm to the child.*			
Imbere mu rugo (mu mbuga) / *Home compound*				
4	Mu mbuga hararinganiye, nta ntambamyi zihari, umwana wese ashobora kuhakinira, kandi bikamworohera kugera mu nzu, mu gikoni, mu bwiherero no mu bwiyuhagiriro *The house compound is friendly, every child can explore with easy access inside the house, kitchen, toilet and wash facility.*			

Ubwiherero n'ubwiyuhagiriro / *Toilet and bath facility*				
5	Ubwiherero n'ubwiyuhagiriro birahari kandi bikoze ku buryo bworohereza umwana ufite ubumuga kubikoresha wenyine (si ngombwa uburyo buhambaye) *Toilet and nath facility are available and are made in a way that facilitate a child with a disability to use them independently. (Not necessary sophisticated adjustment)*			
Uko inzu iteye / *House design*				
6	Imiryango yose y'inzu ni migari kandi ikoze ku buryo umwana ugendera mu igare ashobora kwinjiramo nta nkomyi (nibura Cm 83 z'ubugari) *All the doors of the house are wide enough, a child in a wheel chair can pass with no barrier (at least 83 Cm ot width)*			
7	Inzu ifite amadirishya manini yinjiza urumuri rukenewe ndetse n'umwuka mwiza wo guhumeka mu nzu *The house has wide windows that facilitate necessary insight lighting and fresh breathing air.*			
8	Ingufuri, aho gucanira amatara (niba hahari), serire z'urugi, ibikoresho byo mu nzu (imeza, intebe) biteye ku buryo butabera inzitizi umwana ufite ubumuga mu kugira uruhare mu bikorwa byo mu rugo *the door facilities (locks, handles) and house interior furniture are disposed in a way which does not constitute barrier to participation in home activities.*			

Done at Kigali.....

Completed on...../...../.....

The person completion the audit cheklist

Names ..... Position ..... Signature .....

Note:
This house accessibility audit checklist is complete and necessary but it needs to think about on financial resources(enough) for house rehabilitation.

Please add Health center among services available in the house location.

Part Four.

Case Management Forms

Case Management Forms
for Professional Social Welfare Workers

Revised September 23, 2019

Case Management Checklist

In order to check the boxes, right-click on the box > properties > "checked"

Before placement	**Date**	**Checked by Case manager**
1. Registration Form		☐
2. Child Assessment		☐
a. Child Assessment: Portage (Excel sheet) b. SPDS		☐
3. Case Plan		☐
4. Family Tracing		☐
a. Proof of no trace found for family (signed by ES at Cell level) ***Inyandiko yemeza ibura ry'umuryango w'umwana uri mu Kigo cy'imfubyi (Attach as Annex)***		☐
5. Family Assessment		☐
a. Refusal of child by the family (if the case) ***Inyandiko y'umuryango wanze umwana wabo wabaga mu kigo cy'imfubyi ugatanga uburenganzira bwo kumurerera mu wundi muryango***		☐
6. Case Management Report		☐
7. Case Management Meeting		☐
8. Placement Decision		☐
9. Child and Family Preparation		☐
Exit form		☐
10. Child's Reunification/Placement into the Family/Independent living		☐
Contract		☐
Acte d'Adoption		☐
After Placement		
11. Post Placement Support and Follow-up		☐
Proof of support to family (financial/material): receipts and/or bank slips		☐
12. Case Closure		☐

1. Registration Form

The registration form outlines the child's personal details, current care arrangements and family/non-family members important to the child

NOTE: the grey areas of the forms are for you to complete without asking directly these questions to the child

NOTE: the word 'caregiver' refers to an adult who is responsible for taking care of the child or adolescent. This can either be a parent, foster parent, extended family member or an individual working in an orphanage

Consent and Assent	**Have you explained to the child and their adult caregiver the purpose and process of the data gathering? Are you assured that they have understood and wish to continue?** **Yes** ☐ **No** ☐		
Name of current caregiver(Third)		**Signature of current caregiver**	
Name of child(Put it on the second place)		**Signature of child and/or caregiver**	
Name of lead caseworker completing assessment(Fourth)		**Signature of lead caseworker completing assessment**	
Start date of child assessment(Date should come first)		**End date of child assessment**	

Registration number (generated by Excel database):
……..
Date of completion of registration form:
……
Named lead caseworker:
……
Name(s) of other case worker(s) directly involved in the case and responsible for the protection/care of the child:
……
……
……

Name of institution and District the child is currently residing in (if applicable):

Date of entry in institution (if applicable)	**Name and contact details of person who brought child to institution (if applicable)**

Name of Inshuti z'Umuryango active in the village where the child is living/(only the IZU of where the child is, either institution or the community needed).	**Position of Inshuti z'Umuryango/volunteer**	**Phone number**

① Child's Personal Details

Name of the child

Place of birth	**Date of birth/age**	**Sex:** Male ☐ Female ☐
Nationality	**Current address where the child is living**	
Phone number of the child/adolescent		

② Current care arrangements
What is the child's current care arrangement?

Family - parent/s or extended family ☐	**Stays with adult that is not family** ☐	**Residential institution**
Institution for children with disabilities ☐	**Centre for street children** ☐	**Supported independent living**
Child headed household ☐	**Lives with other children under 18** ☐	**Other:**

Name of the residential institution (if applicable)	**Address & phone number(s) of residential institution:**

Additional information on current care arrangement and history of any previous care arrangements		
③ Details of persons of importance to the child (family and non-family)		
Provide details of persons that the child is living with. This can either be parents, extended family, siblings, caregivers in an institution, other adults, etc.		
Name(s) of persons that are currently taking care of the child	**Relationship to the child (parent, extended family, siblings, caregivers from institutions etc)**	**Contact details of this person (address + phone number)**
Provide details of family members or other important adults in the child's life, but who the child is not living with		
Does the child have any siblings that are in the same or different institution: **If yes:**	**Yes** ☐	**No**
Name of sibling(s)	**Name of institution:**	**Contact details:**

Additional information:

④ History of Separation
In case the child has been separated from family members or other primary caregivers (e.g. when placed in an institution), provide details below

Date of Separation from family/primary caregiver:	**Address of home before the child was separated:** **District:** …… **Sector:** …… **Cell:** …… **Village:** …… **Contact details:**
Date of placement in institution (if applicable)	

What was the cause of separation:

Causes of separation (Tick all that apply)

Conflict ☐	**Poverty** ☐	**Abandonment**
Death of mother ☐	**Death of father** ☐	**Natural disaster**
Family abuse/violence/exploitation ☐	**Population movement** ☐	**Lack of access to services/support**
Sickness of family member ☐	**Divorce** ☐	**Entrusted into the care of an individual**
Child's disability ☐		

Other:

2. Child Assessment

The Child Assessment form has as an objective to take down key information related to the child, including information on the level of education, health status, behavioral characteristics and the level of development (using potage and other tools).

Furthermore, it provides an opportunity to engage with the child to get to know more about the child's history and future perspectives, and his/her relationships with related or un-related adults. This will give an initial idea of what kind of placement could be possible

Consent and assent	**Have you explained to the child and their adult caregiver the purpose and process of the child assessment? Are you assured that they have understood and wish to continue?** **Yes ☐ No ☐**		
Name of caregiver(Third)		**Signature of caregiver**	
Name of child(Second)		**Signature of child and/or caregiver**	
Name of lead caseworker completing assessment(Fourth)		**Signature of lead caseworker completing assessment**	
Start date of child assessment (Please put it on the first place)		**End date of child assessment**	
①Education			
Level of education completed:			
Does the child go to school?	**Yes ☐**	**No ☐**	**School completed ☐**
If yes, what level (circle)	**ECD**	**vocational 1 2 3**	
	Nursery 1 2 3	**University 1 2 3 4 5 6**	
	Primary 1 2 3 4 5 6	**Special education:**	
	Secondary 1 2 3 4 5 6	**Other**	
Name of school:		**Contact details**	
If child does not go to school, what are the reasons?			
Who pays school fees?		**If no one pays for school fees, what are the reasons:**	
②Health **This section is completed based on discussions and information with care givers, health workers or based on documentation available and observations by the social worker/psychologists. Whenever possible, include copies of health documents as annex**			
Is the child/adolescent suffering from any immediate or visible health issues known to the social worker/psychologist that have to be addressed	**Yes ☐**	**No ☐**	
If yes, provide further details below, as well any action taken (if applicable)			
Has the child been immunized (under 6 years old)	**Yes ☐**	**No ☐**	**Unknown ☐**
If yes, what types of immunization (+ annex a copy of immunization card if available):			
BGC		**OPV/POLIO 0 1 2 3**	**PCV**
DTP (Pentavalent) Hep B – Hib 1 2 3		**Measle ☐**	
Current height		**Current weight**	
Child's weight at birth			
Does the child have health insurance	**Yes ☐**	**No ☐**	**Unknown ☐**
Does the child have a disability (if yes please check all that apply)		**Yes ☐**	**No**
Physical impairment	**Mental impairment**	**Visual impairment ☐**	
Hearing impairment	**Verbal impairment**	**Physical and mental impairment ☐**	

Unspecified: explain			
Provide further details on disability:			
Is it known that the child has any specific health conditions listed below (based on information provided to the social worker/psychologists		**Yes** ☐	**No** ☐
HIV	**Tuberculosis**	**Epilepsy** ☐	
Heart problems	**Cerebral palsy**	**Malnutrition** ☐	
Any other health condition not listed above:			
Does the child receive special treatment as a result of his/her health condition		**Yes** ☐	**No** ☐
Further explain:			
Child's health needs checklist: Tick all that apply			
Special diet	**Dietary supplement**	**Immunization** ☐	
Medical diagnosis	**Treatment for chronic condition**	**Easy access to specialized medical facilities** ☐	
Visual aid	**Physiotherapy**	**Hearing aid** ☐	
Surgery	**Hospice/palliative care**	**Assistive devices e.g. wheelchair, computer assisted speech/voice device, communication board, etc.** ☐	
Please provide details, or add:			
③Behavioral difficulties:			
Indiscriminate affection towards others	**Yes**	**No** ☐	
Consistently aggressive towards others	**Yes**	**No** ☐	
Bedwetting (emotional)	**Yes**	**No** ☐	
Cries for no apparent reason	**Yes**	**No** ☐	
Self-harming	**Yes**	**No** ☐	
Substance abuse	**Yes**	**No** ☐	
Provide further details, including current behaviour management plan:			
④Child Development **In order to assess the child's level of development, the sections below can be completed based on the specialist assessment tools used (Portage, etc.) and general observations and analysis by the person conducting the assessment.**			
Date of assessment:			
Tool used for assessment: (attach in annex)	**Portage** ☐	**Social and personal development scale** ☐	**Other:**
Analysis of the child's development stages			

Autonomy/self-care	
Gross motor skills	
Fine motor skills	
Cognitive development	
Emotional/behavioral development Socialization	

Observations/views/opinions of caregivers familiar with the child on the level of the child's development

⑤ Child's general well-being and history

Engage in a conversation with the child and or caregiver (for children who cannot speaks and express themselves) to get a sense of the child's well-being, psychological state, aspirations and history. Also, who have been/are important persons in the child's life, and what connection does the child/adolescent have with his/her family (if the child knows the family). How does the child get along with his/her siblings (if applicable)? How does the child feel about life in the institution (if applicable)?

⑥Protection concerns and related follow up action required

NOTE: the below must not be asked as direct question but through general dialogue with the child or if they are raised by the child directly

Has the child faced any protection concerns in the past or is there any concern that the child might face a protection concern in the near future?

Physical violence	☐	**Neglect**	☐	**Child abandonment:**	☐
Sexual violence / GBV victim	☐	**Serious Health issue**	☐	**Trafficked/smuggled**	☐
Psychological violence	☐	**Street child**	☐	**Disabled**	☐
Psychological distress	☐	**Refugee**	☐	**Child labour**	☐

Violent disciplining	☐	**Mentally distressed**	☐	**Arrested/detained**	☐
Exploitation	☐	**Mother under 18 years old**	☐	**Other:**	☐

Provide more information where possible:

In case of a child protection issue, has the case been brought to the attention of the social worker/psychologist through a referral?		**Yes** ☐	**No** ☐
If yes, who has the case been referred?	Community member ☐	Village Chief ☐	
	Sector/Cell/District official ☐	Health Center ☐	
	RNP and Rwanda Investigation Bureau(RIB) ☐	NGO ☐	
	Other:		

Is the child/adolescent now safe from violence, abuse, exploitation or neglect, or any other concerns that might negatively impact the child?

Yes, the child is safe ☐	**No, the child is not safe** ☐

If the child is not safe, explain why:

If the child is not safe, provide details below on any referrals made (if applicable)

Referral made? Date:	**Name of service provider (can also be an individual)**	**Contact details of service provider:**

Immediate action required? Yes ☐ **No** ☐	**If yes, what kind of action and by whom (this can also include actions by Child Protection and Wellbeing Officers**
Middle or long-term action required? Yes ☐ **No** ☐	**If yes, what kind of action and by whom (this can also include actions by Child Protection and Wellbeing Officers**

⑦ Wishes of the child

The section below can be completed, taking into account the age of the child and his/her level of development. Also, a child's wishes should not result in harming the child or result in keeping the child in a harmful situation. The principle of 'Best Interest of the Child' should therefore be taken into account. Also the caregiver may provide concerns and wishes for the child they are caring for.

Taking into account the concerns and issues of the child, how does the child view his/her own situation, and what are some of the wishes of the child to address some of the concerns and issues:

Does the child want to trace/reunite with family members? (if applicable)	**Yes** ☐	**No** ☐	**Don't know** ☐

If the child DOES want family reunification, who are the adults the child's wishes to locate:

Name 1st preference: ……

Relationship to the child:	**District:**
	Sector:
Phone number:	**Cell:**
	Village:

Name 2nd preference ……

Relationship to the child:	**District:**
	Sector:
Phone number:	**Cell:**
	Village:

If the child DOES NOT want family tracing/reunification, explain why:

Give any other information of relevance that may assist with tracing for the child (such as key persons/locations in the life of the child who might provide information about the location of the sought family

List details of any documents carried by the child:

⑧Additional notes or observations during the child assessment

⑨ Recommended placement
Preliminary recommendation, based on the assessment of the child and taking into account his/her wishes (if the child has the appropriate age)

Return to mother	**Adoption**	☐
Return to father	**Specialized foster care**	☐
Return to both parents	**Independent living**	☐
Placed in extended family		

Other:

3. Case Plan

The Case Plan outlines what the needs are of the child in different areas, including health, education and care. The needs of the child in the case plan should be addressed:

(i) either immediately through assistance by the Child Protection and Welfare Officer, and/or

(ii) by the future family that will reintegrate the child

The case plan is informed by the child assessment, but also through interactions with individuals close to the child. The case plan can therefore be amended throughout the case management process.

① **Minimum requirements for responding to the needs of the child** **What are the specific interventions required per key area? What are the objectives?**	
Date of developing case plan:	
Education	Does the child have any specific educational needs? Does the child require specialized education/care for children with disabilities?
Child's health & physical, mental and emotional development **Child protection**	Does the child need any specific medication or access to health services? Does the child have a disability? Does the child require any assistive devices or specialized support in their physical development? What is the level of mental development, and would parents needs guidance or support on how to deal with mental development delays? If the child/adolescent has delayed gross or fine motor skills, what steps can be taken to address this? In case the child is suffering from violence, abuse, exploitation or neglect, what intervention is required?
Behaviour/ **Socialization and communication skills**	In case the child shows signs of challenging behaviour, is any specific physiological or parenting support required? Does the child need counseling?

Living conditions	Does the child require basics needs in current living conditions? Does the child require to be placed in a home with specific amenities?
Employment and household economy	Would the child//adolescent need any support in finding employment or require economic support? What is the level of autonomy and self-care of the child/adolescent?
Other considerations	E.g. Civil registration, location, self-care skills

4. Family Tracing

This form provides information gathered from field visits on individuals, who have a relationship to the child or can provide relevant information for further case planning

Information gathered from case files from the institution or other existing documentation:		
Field visits		
Date	Name of individual(s) consulted	Address
Description and comment		
	Name of individual(s) consulted	Address
Description and comment		
	Name of individual(s) consulted	Address
Description and comment		
	Name of individual(s) consulted	Address
Description and comments		
Has the family of the child been traced successfully?		If yes, date:
Yes ☐	No ☐	
If yes, indicate type of family:		
Biological family ☐	Extended ☐	Other
If no, complete 'Proof of no trace' document		
Further provide information:		
Is the family willing to take in the child?		
Yes ☐	No ☐	If no, complete 'Refusal form"

5. Family Assessment

This form is used either to assess the child's family of origin or family-based alternative carer (adoption or foster care)s. Each case file can contain multiple family assessment forms.

Before conducting the assessment, the family should be aware on the purpose of the assessment and the different types of information that will be asked. The social welfare worker should also emphasize that all information is used for professional purposes only, and that the family does not have to any answers any questions they are not comfortable with.

NOTE: the grey areas of the forms are for you to complete without asking directly these questions to the family

Consent and assent	**Have you explained to the family member the purpose and process of the child assessment? Are you assured that they have understood and wish to continue?** **Yes** ☐ **No** ☐				
Name of family member		**Name of lead caseworker**			
Signature of family member		**Signature of lead caseworker completing assessment**			
Date		**Date**			
① **Basic Details**					
Start date of family assessment		**End date of family assessment**			
Address of family: **District:** **Sector:** **Cell:** **Village:**					
Biological family ☐	**Extended family** ☐	**Foster family** ☐	**Other:**		
Contact details of cell level official (name, phone number):		**Contact details of village chief (name, phone number):**			
Name of head of household	**Date of Birth**	**Educ. level**	**In school yes/no**	**Relationship to the child (parent, uncle, foster parent, etc)**	**Phone number**
Married (if applicable)	Yes ☐	No ☐	If yes, for how long:		
Name(s) of other household members	**Date of Birth**	**Educ. level**	**In school yes/no**	**Relationship to the child (parent, sibling, uncle, foster parent, etc)**	**Phone number**
Other family members not living within the household that are important to the child's life	**Date of Birth**	**Educ. level**	**In school yes/no**	**Relationship to the child (parent, sibling, uncle, foster parent, etc)**	**Phone number**
② **Relationship between family and child** **If the family is related to the child or knows the child:**					

Ask family members to provide more information on the relationship with the child, what the reasons were for separation and if there has been regular contact. How do they view their current family situation, and what does the family think about the TMM programme? Have they ever considered taking in the child back in their family? If yes, what would be their expectations and hopes?

If the family does not know the child:
What does the family think about the TMM programme? What motivates the family to consider taking in another child(ren)? What is their current family situation? How do they think the child will fit within the family? Does the family wish to receive a child of a particular age group? In case a child would integrate in the family: what are their expectations and hopes? Do they foresee any challenges?

③ Family Assessment Details

Family characteristics and relationships (informed by individuals familiar with the household)

Has a member of the household experienced a stressful childhood		**History of childhood abuse by adults reported?**	
Yes ☐	No ☐	Yes ☐	No ☐
Has the family suffered a traumatic crisis in the last 5 years		**Does any of the household members have a history of violence**	
Yes ☐	No ☐	Yes ☐	No ☐
Have any household members been imprisoned?		**Has any household members been suspected of a criminal offence**	
Yes ☐	No ☐	Yes ☐	No ☐
Have there been any suspicions of child abuse in the household?		**Has any household member been suspected of domestic violence**	
Yes ☐	No ☐	Yes ☐	No ☐
Do any of the house members have:			
Poor mental health		Yes ☐	No ☐
Poor physical health		Yes ☐	No ☐
Behaviour problems		Yes ☐	No ☐
Disability		Yes ☐	No ☐
Sensory impairment		Yes ☐	No ☐
Drug/alcohol abuse		Yes ☐	No ☐
Other:		Yes ☐	No ☐

If any of the questions are answered 'yes', provided further information

In case the child has siblings, would the family be willing to take in more than one child?	**Yes** ☐	**No** ☐

Other comments noted by the social worker:

Social relationship and community support

Does the family feel accepted in the community?		**Does the family experience discrimination or harassment?**	
Yes ☐	No ☐	Yes ☐	No ☐
Is the family actively involved in community events?		**Does the household have family members in the same village/cell?**	
Yes ☐	No ☐	Yes ☐	No ☐

Provide further information:

Living conditions

Legal status of shelter:

Owned ☐	**Rented** ☐	**Leased** ☐	**Informal arrangement** ☐	**Family has a loan to pay off the house** ☐

Type of shelter

House ☐	**Apartment** ☐	**Shared house** ☐	**Homeless** ☐

Number of rooms for: **Adults:** **Children:**	The house has: Toilet indoors ☐ Toilet outdoors ☐	Does the home have basic provisions Chairs ☐ Food storage ☐	Beds ☐ Cleanliness	Cooking facilities ☐

Does the accommodation and surroundings pose any security or protection risk for children? Further explain:

Economic factors

Do any of the household members have a regular income		**Are household members enrolled in the VUP programme**	
Yes ☐	No ☐	Yes ☐	No ☐
If yes, which household members	**Profession**	**What is the level of Ubudehe:**	
		1	2
		3	4
		Do all household members have health insurance?	
		Yes ☐	No ☐

Is the family gaining income through - Seasonal Work - Occasional work - Working abroad (which country?) - Working away from home during periods of time - remittances	**Does/could the parent's work adversely impact on childcare?** Yes ☐ No ☐ If yes, explain:

Is the family managing with the income they receive		**Does the family have a debt?**	
Yes ☐	No ☐	Yes ☐	No ☐
Is the family worried about their financial situation		**Does the family own cultivable land**	

Yes ☐	No ☐	Yes ☐	No ☐
Does the family own livestock?		**Is the family involved with other income generating activities?**	
Yes ☐	No ☐	Yes ☐	No ☐

Do children living in the household attend ECD or primary/secondary school/university

Yes ☐	No ☐	Not all children☐	If not, explain:

Would the family have resources to finance an additional child in their education

Yes ☐	No ☐	If not, explain

Total income per month	0 – 20,000	20,000 – 50,000	50,000 – 100,000	100,000 – 200,000	200,000 +
Total value of bills/month					
Total debt:					

Are there any services that the family is currently not accessing, and that could advance their situation?	Yes ☐	No ☐

If yes, provide further information to the family:

Analysis: during discussions with the family, keep in mind the following elements:

Motivating factors of caregivers to provide alternative care to the child	Verify the underlying reasons of why a family considers fostering a child
	What was the reason for the family to place the child in an institution? (if applicable)
	What are the expectations of the family?
Parenting/caregiving capacity	Taken into account the ability of parents/caregivers to protect the child and to respond to their needs
	Assess whether there is any parenting behaviour that could lead to harm the child
	Observe parent-child interactions and assess parenting skills
Community & wider family influences	Consider the presence of other supportive adults, the availability of assistance for the family and the child and other protective mechanisms in the community
Social context	Assess the degree to which the child will be accepted in the community, family and among siblings
Economic factors	Keep in consideration the poverty level of the family and living conditions, options and opportunities for the child(ren) in terms of education/vocational training and income generating activities

Would the family consider taking in a child with mild, moderate or severe disabilities?	Yes ☐	No ☐

If yes, further explain:		
Would the family consider taking in siblings?	Yes ☐	No ☐
If yes, further explain:		
Additional notes to inform the family assessment:		
④ **Conclusion and Recommendation**		
Based on the assessment and analysis above, could this household/family be considered to take in a child(ren)		
Yes ☐	No ☐	Yes, under certain conditions ☐
Further explain your recommendation:		

6. Case Management Report

Date of drafting the case management report:	

① Brief overview
In order to present the case during the case management meeting, provide below a summary of the case, including:

1. **Child's prolife and history**
2. **Brief details on history of separation and any history of violence, abuse or neglect suffered**
3. **Child's needs**
4. **Available options/alternative services**
5. **Wishes of the child (if applicable)**
6. **Household modifications required**
7. **Assistive equipment and aids needed**
8. **Resources and training needed by the family and others in the community**
9. **Other considerations/information**

Together with the case management report, social workers/psychologists can complete the intervention plan in Excel, and attach it to the CM forms

Number (1 - 6)	**Overview**

② Suggested Placement decision
Based on the options described above, which is suggested to be the best option for the child?

Does this decision require consultation with colleagues during a case management meeting? In cases involving children with a disability a case management meeting is mandatory.	Yes ☐	No ☐

If yes: Planned date of case management meeting (see form 7):	**If no** ☐ Fill in form 8: Placement Decision ☐ Fill in form 9: Child and Family Preparation

7. Case Management Meeting

The Case Management Meeting is held with key Child Protection and Welfare Officers responsible for the care and protection of the child to discuss and agree on the best option for the child or adolescent. The individual responsible for handling the case will present key information using the case management report and other information available.

An advocate or representative person who knows the child (who can be the child's case worker in the institution, the Disability Mainstreaming Officer or representative of the NCPD if they know the child) (who is this one? Is this a caregiver in the institution? It will be good if this one would be the Disability Mainstreaming officer and/or NCPD? We need precision? the child with a disability should attend the case management meeting.

Date of case management meeting:		
Attendants of the case management meeting:	**Name**	**Position**
Discussion points and recommendations by attendants of the meeting on this case (including needs assessment of the child and family, required interventions, and recommendation for future placement and services for the child/family)		
If a decision is reached by the attendants of the case management meeting on what the best possible placement option is for the child/adolescent, fill in form 8: Placement Decision		

8. Placement Decision

Based on all previous case management steps, and the agreement by social welfare officers during the case management meeting, a placement decision for the child or adolescent is formulated.

However, the placement decision is only final after the child and family have been successfully matched

Date of when placement decision form was completed:	

Taking into account the individual needs and wishes of the child and the motivation, capacities and resources of the potential foster family, the following family is considered to be the best placement option for the child:

① **Family information**
Provide details below of the family that has been identified as the preferred placement for the child (see the Family Assessment form for more family details:

Biological ☐	**Extended** ☐	**Foster** ☐	**Independent living:** ☐

Other:

Name of head of household – either biological/extended/foster etc	**Date of Birth**	**Sex**	**Phone number**

Address of the family:

District:	
Sector:	
Cell:	
Village:	

Date + name and signature social worker	**Date + name and signature psychologists**

9. Child and Family Preparation

The individual sessions with the child and future caregiver(s) (biological/extended/foster, or independent living) have as objective to prepare the child and family for the placement.
Once both the child and receiving family are in agreement with the placement decision, a second session with both parties will take place

① **Individual session(s) with the child**		
Has individual session(s) taken place with the child:	Yes ☐	No ☐
If yes, write down your observations:		
② **Individual session(s) with the family**		
Has individual session(s) taken place with the family:	Yes ☐	No ☐
If yes, write down your observations:		
③ **Group session(s) with the child**		
Group sessions conducted with the child:	Yes ☐	No ☐
If yes, write down your observations:		

④ **Child and family visits and preparation**

Provide details below on the following activities: a) family visit to the child in the institution, b) child visit to the family, and c) child visit to the family (overnight stay)

Activities:

a) Family visits the child in institution
b) Child visits family (daytime visit)
c) Child visits family (overnight stay)
d) Phone calls conducted by social workers/psychologists

Activity letter (a,b, c or d)	Date	Key observations/feedback from family/child / key talking points

⑤ **Group session with parents/caregivers ready to receive the child(ren)**

Have the parents/future caregivers attended the group session	**Yes** ☐	**No** ☐

⑥ **Result of matching process**

Is matching successful:	Yes ☐	No ☐

In case matching is successful:

1. **Communicate next steps to all parties involved**
2. **Envisioned date of placement:**
3. **Complete and attach exit form**

In case matching is unsuccessful

1. **Consider other placement options**
2. **Explain below why matching was unsuccessful**

10. Child's reunification into the family or placement in family-based alternative care/independent living

Upon placing the child in the family or family-based alternative care or if the adolescent is placed in independent living, the child/family is linked to existing resources in the community

Date of reunification/Placement in the family/independent living:		
Biological family	**Center for children with disabilities** ☐	**Extended Family** ☐
Long-term foster Care	**Emergency Foster Care** ☐	**Special foster care** ☐
Independent Living	**Adoption** ☐	
Other		
① Family Composition		
Name of Head of household	**Relationship to the child (mother/father/uncle/foster parent, etc)**	**Phone number:**
Name of other household members	**Relationship to the child (mother/father/uncle/foster parent, etc)**	**Phone number:**

② Address of placement:			
District:			
Sector:			
Cell:			
Village:			
③ Reintegration package/support provided			
Reintegration package provided:	**Medical insurance** ☐	**School fees** ☐	
	Materials ☐	**Household items** ☐	
	Livelihood support ☐	**Assistive devices** ☐	
	Training/parenting support ☐	**Counselling support** ☐	
	Other:		
Start date of support provided:		**Duration of support**	
Cost of support in RWF:			
④ Family Contract			
Has the family receiving the child and the Executive Secretary signed the Family Contract?		**Yes** ☐	**No** ☐

11. Post Placement Support and Follow-up

The social worker/Psychologist is required to conduct the first follow-up visit 2 weeks after the first day of placement in the family, and another visit a month after the first visit (as a minimum). Follow-up by phone can also be registered on this form.

A case file can have multiple post-placement/follow-up forms.

① **Basic information**				
Date of follow-up				
Type of follow-up	Scheduled ☐		Unplanned ☐	
Follow-up done by: (tick all that apply)	Social Worker ☐		Psychologist ☐	
	Inshuti Z'umuryango ☐		Other	
Location of follow-up	Child's home ☐	Office ☐	By phone ☐	Other ☐
Purpose/aim of follow-up (tick all that apply)	Re-assessment ☐	Monitoring ☐	Support ☐	Other
Person(s) contacted during the follow-up (tick all that apply)	Head of household ☐	Other household members ☐	Village chief ☐	Cell Official ☐
	Sector official ☐	District official ☐	Neighbors ☐	Other community members: ☐
	Other:			
Is the child still in the family?			Yes ☐	No ☐
If not, further explain what the reason is, and where the child is located now:				

② **Follow up of care- and intervention plan**

The following section is aimed to take stock of which objectives under the case plan have been fulfilled (see form 3).

If during the follow-up it is noticed that the case plan has not been implemented by the caregivers, or if there is a deterioration in the wellbeing of the child, it is necessary to conduct a second Child Assessment (form 2) and take appropriate action if needed.

Education	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			

Child's health & and physical, mental and emotional development Child protection	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			
Behaviour/ Socialization and communication skills	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			
Living conditions	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			
Employment and household economy	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			
Other considerations	Have interventions been implemented	Yes ☐	In progress ☐	No ☐
	If no, explain:			

Has the family/foster family/caregiver invested financial resources according to the investment plan? ➔ verify if this is the case, based on the agreed intervention plan	Yes ☐	No ☐
If no, why? And what are the actions agreed upon with the family to ensure resources are invested in the child?		

③ Child wellbeing

Did you have the opportunity to speak with the child individually?	Yes ☐	No ☐
If yes, what was the outcome of the discussion? How does the child feel in the household and community? How does the child perceive the relationship with the caregivers/siblings? If applicable, has the child received any support/materials as part of the intervention plan?		

④ Family Re-assessment

Use form 5 "Family Assessment" as a basis to conduct the family re-assessment

Has there been a change in accommodation since previous assessment:		Has there been a change in family structure since last assessment:	
Yes ☐	No ☐	Yes ☐	No ☐
Has there been a change in family characteristics and relationships (see form 3, point 3)		Has there been a change in living conditions since last assessment (see form 3, point 3)	
Yes ☐	No ☐	Yes ☐	No ☐
Has there been a change in economic factors (see form 3, point 3)		Has there been any other changes in the family that could negatively impact the child?	
Yes ☐	No ☐	Yes ☐	No ☐
If answered 'yes' to any questions above, further explain:			
Availability of community resources/services and accessed by the family:			

	Available		Accessed	
Day Care/ECD	Yes ☐	No ☐	Yes ☐	No ☐
School (primary/secondary)	Yes ☐	No ☐	Yes ☐	No ☐
Day care for children with disabilities	Yes ☐	No ☐	Yes ☐	No ☐
Health center/nutrition centers	Yes ☐	No ☐	Yes ☐	No ☐
Sector level registration	Yes ☐	No ☐	Yes ☐	No ☐
Clubs/cooperatives	Yes ☐	No ☐	Yes ☐	No ☐
NGOs	Yes ☐	No ☐	Yes ☐	No ☐
Inshuti z'Umuryango	Yes ☐	No ☐	Yes ☐	No ☐

How does the family experience the situation now the child is integrated in the family? How does it match their expectations? Have they encountered any challenges? (Questions to be asked not in the presence of the child)

Points of concern/follow up for next contact:

Date of next follow-up:	

⑥Community Re-assessment /Overview of contact/meetings with other stakeholders (village chief, Inshuti z'Umuryango, Civil registration officer at Sector level, etc.) during follow-up of the child

Are the community leaders supportive? Are community attitudes supportive towards children with disabilities? What needs to be done more for a more inclusive community?

Date of when contact was made	Name and designation of person contacted	Method of contact	Position/relation to child	(i) Discussion topics	(ii) Action points/decision

12. Case Closure

Whenever a child, adolescent or family does not require any more support, and when the child/adolescent lives within a safe and protective environment, the case can be closed. However, the case can be reopened if the child or family would require support again.

① Case Closure Checklist		
Date of case closure:		
Fill in checklist for case closure:		
The child/adolescent is in a safe, stable environment, free of violence, harm or abuse		☐
Completed all the case management forms and gone through all the steps of the case management process		☐
Conducted a physical follow-up within 2 weeks of the placement / child protection incident		☐
Ensured that all objectives under the case plan have been completed, or are under the responsibility of a competent individual		☐
Conducted at least one additional follow-up to ensure that the child/adolescent is happy within the home and is accessing appropriate community services		☐
Ensured that financial resources under the intervention plan have been spend according to agreed items, and that the reintegrated has benefited from it?		☐
Ensured that the child has access to appropriate health services (if applicable)		☐
Ensured that child is enrolled in pre-primary, primary or secondary education (if applicable)		☐
Provided the family with counselling and parenting support to address any behavioral characteristics		☐
Registered the child with local authorities		☐
Signed family contract by the family and the Sector Executive Secretary		☐
Engaged with local authorities to ensure that the child has a support network		☐
Adolescents in independent living is self-autonomous and has a regular source of income		☐
For children/adolescents with a disability: ☐ **Linked to all available resources within the community** ☐ **(Foster) parents have the necessary skills to provide support to and interact with the child/adolescent**		☐
Is case not all boxes are checked but the case is still closed, explain why:		
Does the child still require non-specialized support?	**Yes** ☐	**No** ☐
If yes, what kind of support:		

Are there any other individuals/local leaders/organizations that will work / continue work with the child	**Yes** ☐	**No** ☐
If yes: name of individual/organization	**Contact details**	**Kind of support**
Other comments:		
Date + name and signature social worker	**Date + name and signature psychologist**	

Additional comments or remarks related to the case	
Date of comment/remark	**Comment/remark**

5. Endnotes

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