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CARE REFORM IN RWANDA

A VIRTUAL STUDY TOUR

Changing THE WAY WE care

The National Child Development Agency

HOW TO TAKE PART IN THE VIRTUAL STUDY TOUR

This virtual study tour aims to provide you with a strong understanding of care reform in Rwanda from the comfort of your own home. To take part, you will need to:

1.

Read the snapshot and timeline of care reform and follow the link to watch a short presentation which will give you an overview of care reform in Rwanda.

2.

Take a look at the promising practice examples, reading the case studies provided or following the links to watch short videos. You can explore all of the examples or just take a look at those that interest you the most.

3.

Take part in a live webinar to ask a panel of experts from Rwanda any questions you still have. The webinar will be held at the end of April 2021. To register your interest and receive further details, complete this short form. A recording will be made available here after this event.

4.

Let us know what you think of this virtual study tour by completing this short form.

HOW TO TAKE PART IN THE VIRTUAL STUDY TOUR

Still want to know more?

There is a list of resources at the end of this document, including useful legislation and guidance from the Government of Rwanda.

Confused by all the jargon?

There is glossary of key terms at the end of the document.

Too much information?

You will see some colour coding in the document to help you quickly find the information of most interest to you.

Bold black	is for information on the structures and mechanisms needed for care reform, and cross-cutting issues such as care for children with disabilities.
Orange	is for information on family strengthening and reintegration.
Purple	is for information on kinship care.
Red	is for information on residential care.
Blue	is for information on foster care.
Green	is for information on adoption.
Brown	is for information on supervised independent living.

SNAPSHOT OF CARE IN RWANDA

Population of country	12.6 million[1]
Child population	Approximately half the population or around 6 million children.[2]
Kinship care	11 per cent of children, or around 660,000 children.[3]
Residential care	Currently 447 children and young adults in residential care, plus 2,040 children and young adults with disabilities.[4]
Foster care	From 2013 to 2021, 533 children were placed in foster care.[5]
Domestic adoption	From 2013 to 2020, 66 out of 3,335 children in residential care were adopted domestically.[6]
Inter-country adoption	Since 2017, when the suspension of inter-country adopted was lifted, four children from Rwanda have been adopted internationally.[7]

A TIMELINE OF CARE REFORM IN RWANDA[8]

BEFORE 1994

SITUATION

37 **residential care** facilities caring for around 4,800 children.

Foster care occurs only informally and in small numbers.

1994

SITUATION

Genocide against the Tutsi leading to the death of an estimated one million people and the separation of many children from their families.

55 **residential care** facilities with over 10,000 children.

RESPONSE

Foster care becomes more widespread and a greater priority for government.[9]

1995

SITUATION

77 **residential care** facilities caring for 12,700 children.

RESPONSE

Mass efforts to **reunify children with their families** begin.

A TIMELINE OF CARE REFORM IN RWANDA

1996

SITUATION

57 **residential care** homes with 6,620 children.

POLICY / LEGAL FRAMEWORK

A government committee is established with the task of drafting guidelines on **foster care**.

RESPONSE

Government launch the national 'One child, one family' campaign to promote family-based care.

1997

POLICY / LEGAL FRAMEWORK

Government produce guidelines to regulate **residential care**.

1998

SITUATION

38 **residential care facilities** with 5,343 children.

POLICY / LEGAL FRAMEWORK

Government produce guidelines on foster care and **family reunification**.

A TIMELINE OF CARE REFORM IN RWANDA

2000

SITUATION

Over the past four years, 56,000 children have been **reunified with their families** from residential care or refugee camps

2001

POLICY / LEGAL FRAMEWORK

Law No. 27/2001 focuses on the rights of the child and the protection of children against violence. This law states that every orphan must have a guardian or **adoptive** parent.

2003

SITUATION

There are around 3,600 children in 25 **residential care** facilities.

POLICY / LEGAL FRAMEWORK

Two key policies relating to **care reform** are introduced. The Constitution of Rwanda enshrines the rights of children to be raised and protected in a family-based environment.

The National Policy for Orphans and other Vulnerable Children outlines principles and strategies required for the protection of orphans and other vulnerable children.

RESPONSE

Government works to reduce the number of **residential care** facilities and the number of children in these facilities.

A TIMELINE OF CARE REFORM IN RWANDA

2007

POLICY / LEGAL FRAMEWORK

The Strategic Plan of action for Orphans and Other Vulnerable Children is put in place.

RESPONSE

The Imbuto Foundation – a charity set up by Rwanda's first lady – establishes the Malaika Mulinzi (Guardian Angel) programme. This rewards **kinship** and informal **foster** carers and sets up a network of these caregivers.

2010

POLICY / LEGAL FRAMEWORK

Inter-country adoption (ICA) is suspended to allow measures to be put in place to ensure that Rwanda is in line with the Hague Convention on ICA.

RESPONSE

The start of a new phase of **care reform**.

Start of a pilot to close down the Mpore Pefa children's home and **reunify 51 children with their families**. This pilot runs for two years and is managed by the NGO Hope and Homes for Children with government oversight.

A TIMELINE OF CARE REFORM IN RWANDA

POLICY / LEGAL FRAMEWORK

The National Integrated Child Rights Policy and accompanying strategic plan includes provisions on **care reform**. It states that every child has the right to be cared for by a family, and commits the government to **providing support for families** and alternative care when needed. Care by **extended family members** should always be explored as the first option, and children should only be placed in institutional care as a last resort.

Ratification of the Hague Convention on **ICA**. Law 54/2000 passed relating to the rights and protection of the child.

RESPONSE

Children advocate for family-based care at the 7th National Children's Summit, strengthening government resolve on **care reform**.

2011

A TIMELINE OF CARE REFORM IN RWANDA

2012

SITUATION

Survey of **residential care** by Hope and Homes for Children and the government shows 3,323 children and young adults in 33 residential care facilities – a 5% rise since 2007. The survey also reveals poor standards of care in many facilities.

POLICY / LEGAL FRAMEWORK

The Cabinet Brief: Strategy for National **Child Care Reform** provides a detailed action plan which includes building **social work capacity**, awareness raising on family-based care, the development of **foster care**, the transformation of **residential care facilities** and the mass **reintegration** of separated children.

2013

POLICY / LEGAL FRAMEWORK

Phase one of the USAID-funded, government and UNICEF-managed Tubarerere Mu Muryango (TMM) programme (2013–2017) begins. This programme leads to the closure or transformation of over 30 **residential care** facilities and the **reintegration** of children. 1,440 **foster carers** are recruited and **gatekeeping** is strengthened.

The USAID-funded Ishema Mu Muryango Programme (2013–2015) begins to **reintegrate** children from two districts of Rwanda.

A TIMELINE OF CARE REFORM IN RWANDA

2016

SITUATION

The Cabinet Brief: Strategy for National **Child Care Reform** provides a detailed action plan which includes building **social work capacity**, awareness raising on family-based care, the development of **foster care**, the transformation of **residential care facilities** and the mass **reintegration** of separated children.

POLICY / LEGAL FRAMEWORK

Law 32/2017 of 28/08/2016 is adopted which governs persons and family and provides terms, conditions and requirements for **kinship care**, guardianship and the **adoption** of children.

RESPONSE

Survey of **residential care** by Hope and Homes for Children and the government shows 3,323 children and young adults in 33 residential care facilities – a 5% rise since 2007. The survey also reveals poor standards of care in many facilities.

A TIMELINE OF CARE REFORM IN RWANDA

2017

POLICY / LEGAL FRAMEWORK

The government lifts the ban on **ICA** having met the conditions of the Hague Convention.

RESPONSE

Phase 2 of the TMM programme begins, focusing on **strengthening the workforce** and government agencies, violence reduction, and the reintegration of hard to reach groups, including **children with disabilities** and **street connected children**.

2018

SITUATION

By the end of phase 1 of the TMM programme, 522 children have been placed in **foster care**, and only a small number remain in **residential care**. 46% those formerly in residential care are living with **extended families**, 20% **with parents**, 17% are in long term **foster care** and 2% have been **adopted**. The remainder are young adults in **supervised independent living**.

POLICY / LEGAL FRAMEWORK

Adoption of Law No. 71/2018 relating to the protection of the child, which provides legal safeguards on care, including around **foster care** and standards in **residential care**.

RESPONSE

UNICEF and the government further strengthen child care reform related to children with disabilities, enhancing the provision of **family support** and piloting the closure of one **residential care** facility.

A TIMELINE OF CARE REFORM IN RWANDA

2019

POLICY / LEGAL FRAMEWORK

Development of government guidance on inclusive **reintegration**.

2020

SITUATION

The TMM programme has seen 17 **children with disabilities** **reintegrated** into families.

RESPONSE

Capacity building of child protection and welfare officers on supporting **children with disabilities** through the TMM programme.

Introduction of remote **case management** and temporary support to families affected by COVID-19 lockdown to prevent **family separation**.

AN INTRODUCTION TO CARE REFORM IN RWANDA

Follow this link for a presentation by James Nduwayo, Manager of the TMM programme, National Child Development Agency, Government of Rwanda. The presentation provides a short overview of the care reform process in Rwanda.

PROMISING PRACTICE EXAMPLES AND LESSONS LEARNT

BUILDING THE STRUCTURES AND MECHANISMS FOR CARE REFORM

The 2012 Cabinet brief: Strategy for National Child Care Reform provides the over-arching framework for care reform in Rwanda. The ambitious Tubarerere Mu Muryango (TMM) programme has led care reform efforts (see Example 1). Building the professional and volunteer social workforce has been the cornerstone of Rwanda's child care reform. Importantly, using care reform as an impetus for strengthening the workforce has helped to enhance the entire child protection system (see Example 2).

PROMISING PRACTICE EXAMPLES AND LESSONS LEARNT

EXAMPLE 1

The Tubarerere Mu Muryango (Lets raise children in families) programme[10]

The TMM programme was established by the government of Rwanda in collaboration with UNICEF. Phase one of the programme ran from 2013 to 2017, and phase two started in 2017. The programme has led to a dramatic fall in the number of children in residential care, and in government spend on institutional care. Families were supported to care for children at home, and many residential care facilities were transformed to provide community outreach services. The programme enhanced the capacity of government bodies responsible for care reform and led to the recruitment of the first professional social workforce in the country.

Professional social workers were supported by around 30,000 community volunteers, who were trained through the programme to monitor and assist vulnerable families. The programme led to the expansion of foster care and is currently focusing on the harder to reach children in care, including those with disabilities. Some lessons learnt from the programme include the following.

1. Government ownership and commitment is essential for successful child care reform: The TMM could not have happened without the strong government support that mobilised resources and provided the impetus and authority to close down institutions and develop family-based care.

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2. Partnership is vital to transform the system of care and protection for children: Care reform is complex. It requires expertise across sectors including child protection and care, social protection, health, services for children with disabilities, and education. It necessitates the countrywide mobilisation of human and material resources. A range of partners were needed to meet all of these needs, including different government agencies and NGOs. During the TMM programme, the Programme Coordination Team brought together partners to share learning, encourage the utilisation of further resources, and avoid the duplication of activities.

3. Building government institutional capacity is crucial for sustainability: TMM is managed by a team within government consisting of a programme lead, a communications specialist, a monitoring and evaluation specialist, and an accountant. Having a team that is part of the civil service has been important for ensuring ownership and has provided an opportunity to strengthen government departments responsible for children, with wider benefits for the achievement of all child rights.

4. It is important to have an initial awareness-raising phase: The process of ensuring that every child lives in family care has met considerable resistance from both the general public and staff employed in residential care facilities. An awareness-raising phase, including sensitizing journalists, was found to be important for the success of subsequent reform efforts.

5. Building on local models and values leads to appropriate, sustainable interventions: The TMM programme sought to identify and build on existing models and cultural values that support family-based care. For example, Rwanda has a

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long history of collective responsibility for enhancing community wellbeing including through community volunteers. The TMM programme used these values to establish the IZU, a cadre of community volunteers, who play a crucial role in monitoring the wellbeing of children returned to family care.

6. A professional social workforce is essential for the success of all areas of child care reform: Training professional psychologists and social workers and incorporating them into the civil service has proved to be instrumental in many of the achievements of TMM.

7. It is important to 'think big' in child care reform and develop a comprehensive programme: The scale of the TMM programme ensured that a large number of facilities could be closed in just a few years. This meant that children could not simply leave one facility to enter another. Working on prevention as well as reintegration stemmed the flow of new entrants into institutional care.

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EXAMPLE 2

Building the professional and volunteer workforce[11]

Prior to the TMM programme Rwanda had no professional, government employed frontline social service staff. The programme led to the recruitment and training of 68 professional social workers and psychologists, around half of whom have since been absorbed into the civil service. These staff have been heavily involved in child care reform, including in the following tasks.

- Instigating the transformation of institutions, persuading managers to transform facilities to provide support to families and communities rather than residential care.
- Supporting the reintegration of separated children and young people.
- Recruiting, assessing and monitoring foster carers.
- Working to identify and address factors that lead to family separation, such as teenage pregnancy.

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Professional social workers are supported by around 30,000 community volunteers, known locally as the IZU. These volunteers work in pairs to identify especially vulnerable families and carry out home visits, making referrals to professionals where necessary. They also carry out awareness raising on the importance of family-based care and support the recruitment of foster carers. The IZU are well organised with clear linkages to government personnel. They produce monthly reports which are compiled by coordinators at the cell and sector levels and then shared with professional social workers at the district level, who respond to any problems identified. Over a 10-month period, the IZU recorded 65,000 cases of violence, abuse or neglect.

Lessons learnt from workforce strengthening in Rwanda include the following.

- Members of the workforce must have clear roles and responsibilities.
- It is important to value the contributions of both professionals and volunteers.
- For sustainability, the workforce must be embedded in or linked to the civil service.
- There need to be enough workers to keep caseloads manageable. A shortage of staff can affect child wellbeing and lead to staff burnout.
- Both volunteers and professionals should receive specialised training, developed to ensure local relevance, and delivered in a highly participatory manner using real-life scenarios.

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- Unpaid volunteers are more effective if well supported, including the provision of mobile phones, mentoring and refresher training.
- The workforce must work closely with local leaders and volunteers and professionals from other sectors.
- Both volunteers and professionals benefit from clear, easy-to-use systems of case management, which support referrals and reporting.
- It is vital to have measures in place to protect children from abuse by the workforce, including proper vetting of workers, whistle-blowing procedures, and well-advertised mechanisms to enable children to report abuse.

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REINTEGRATION

Both the TMM and Ishema Mu Muruyango (IMM) programme provide vital lessons about effective reintegration processes (see Example 3 and 4). These programmes have also worked to reintegrate children and young adults with **disabilities** (see Example 5).

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EXAMPLE 3

Lessons learnt on reintegration from the Ishema Mu Muryango programme[12]

The USAID-funded Ishema Mu Muryango (IMM) programme was implemented between 2013 and 2015 by the NGOs Global Communities and Hope and Homes for Children with the support of UNICEF and the Government of Rwanda. The programme worked to sustainably reintegrate children from residential care in two districts. Key lessons about reintegration learnt from the programme include the following.

1. **Reintegration is not always possible and children need a range of care choices.** Not all children could return to their families or communities, and some needed to be supported to live independently or with foster carers. Particular efforts were needed to enable children with disabilities to live in communities.

2. **Creating community support networks is vital.** The programme used community volunteers to deliver training and develop support networks. This approach had several advantages. Families in crisis are often isolated and being part of a group ensures that they no longer feel alone. Families reported that they could relate to community volunteers who understood the challenges they faced. Engaging the community in reintegration efforts created a sense of social cohesion and collective responsibility. Locally-based community volunteers could regularly monitor vulnerable families and report concerns back to case workers.

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3. **Both mothers and fathers must play a role in supporting reintegrating children.** Culturally fathers tend to play a limited role in children's upbringing in Rwanda. The programme successfully challenged these stereotypes, promoting the more active engagement of fathers in parenting.

4. **Professional social workers are needed for successful reintegration.** Social workers linked families with services and community supports. They monitored and coached families and helped them stay strong through the challenges of the reintegration process.

5. **Successful reintegration takes time to address the root causes of separation.** To avoid repeat separation, it is crucial to address factors such as gender roles, social stigma affecting unmarried mothers, poverty and physical and mental health issues that lead to the break-up of families. This takes time and reintegration should be seen as a long term process rather than a one-off event.

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EXAMPLE 4

A 12-step reintegration process for children in institutional care[13]

As part of the TMM programme, government social workers instigated a 12-step programme to support the reintegration of children from residential care.

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

1. Engage care home managers and gain their commitment to the reintegration process.

2. Do an initial assessment of children, through interviews and care home records.

3. Carry out a series of sessions with children – in groups and individually – to explain the reintegration process and explore the possibilities for their reintegration.

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4. Develop a care plan to address any issues that may inhibit reintegration, such as challenging behaviours or health problems.

5. Carry out family tracing and identify relatives who could care for the child. These may be parents or other relatives such as grandparents or aunts and uncles.

6. Assess the family and explore their willingness and capacity to care for the child.

7. If reintegration is deemed to be in the child's best interest, begin the reintegration process. If reintegration is not possible or advisable, seek a suitable foster or adoptive family for the child.

8. Prepare the child and family for reintegration. Support the family to overcome issues that may have led to the original separation (such as conflict in the family or extreme poverty). Ensure regular contact between the child and the family during this period.

9. Reunite the child with the family. At this point, the parent comes to the institution and receives a briefing to remind them of their responsibility and to prepare them for some of the initial challenges of caring for a child who has been institutionalised. For example, parents are told that the child may be withdrawn and that they may not know how to carry out simple tasks or chores that have been done for them in the institution.

10. Have the parent sign a contract to show that they are taking responsibility for the child.

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11. Provide a reintegration package, which may include material support such as bedding or clothing, assistance to enrol in the national Ubudehe social protection programme, support to generate income, counselling and help with school fees.

12. Provide follow-up monitoring. Social workers usually visit two weeks after children return to families, then after a further month, then after a further two months, and finally after a further six months, though this timeframe may be adapted according to need. IZU community volunteers are involved in monitoring children's safety and the reintegration process. Social workers and psychologists sometimes also provide telephone support.

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EXAMPLE 5

The reintegration of children with disabilities[14]

As part of the IMM programme, children and young adults with disabilities were reintegrated into communities. In some cases, these young people were supported to live independently. Others were placed with caregivers, who were sometimes former staff of residential care facilities closed down as part of the deinstitutionalisation process. Although it was a challenge to initially match children and young people with caregivers, with perseverance it was generally possible to find suitable support. Child and young people with disabilities greatly benefitted from day care facilities such as the Ubumwe Community Center.

The centre provides private schooling, using the fees to fund schooling and other services for those with disabilities. Caregivers report huge changes in the children and young people who have moved to live in the communities. They have developed new skills and independence, built friendships and are happier. Having children with disabilities in the community rather than hidden in an orphanage has also reduced stigma.

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TRANSFORMATION OF RESIDENTIAL CARE

Part of the TMM programme included the transformation of residential care facilities to provide much needed services to vulnerable families (see Example 6).

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EXAMPLE 6

The transformation of the Gisimba Memorial Center[15]

The Gisimba Memorial Center was opened in 1980 by the parents of the current manager. The founders began by taking vulnerable boys and girls into their own home, gradually expanding until they were caring for 75 children at the time of the genocide against the Tutsi in 1994. During the genocide, the residential care home became a refuge for children and families in the neighbourhood, and many children who had been orphaned continued to live in the facility afterwards, leading to the facility growing to care for over 300 children. By 2012, there were 126 children being cared for in a large site on the outskirts of Kigali. Despite having dedicated his life to the care home, the manager was enthusiastic about the changes proposed under the TMM programme.

As he explained, he strongly believed in the value of family care, and saw residential care as something alien to Rwandan culture:

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

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The manager had experienced the challenges and risks of poorly supported reintegration in the aftermath of the genocide against the Tutsi. He knew that children who were returned to families without proper assessment or follow-up could face discrimination and abuse. The TMM programme enabled the manager to fulfil his dream of safely returning all of the children in the facility back to their families or into foster care. Now the Gisimba Memorial Center supports extremely poor families from the surrounding neighbourhood, teaching them about basic nutrition. The centre runs after-school clubs, helping 41 children with their homework and instilling beliefs in the value of education. It also provides a holiday play scheme and feeding programme.

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KINSHIP CARE

Kinship care is the most common form of alternative care in Rwanda, with around 660,000 children being looked after by grandparents, aunts, uncles, older siblings, other relatives and friends of the family. Research and testimonies highlight the experiences of caregivers and children in kinship care (see Examples 7 and 8).

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EXAMPLE 7

Testimonies from kinship and foster carers

This short video introduces the TMM programme, including testimonies from extended family members and foster carers supported by the programme to care for children who used to live in residential care. The video shows how it is possible to enable children with **disabilities** to be placed in communities.

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EXAMPLE 8

Research on kinship care in Rwanda[16]

Research on kinship care across six African countries including Rwanda shows the following.

- Kinship care is the most common form of support for vulnerable children. It is culturally acceptable, and deeply embedded in historical traditions.
- Kinship care is highly flexible and can provide emergency, short and long term care for children. It has continued to support children through extreme crisis, including the spread of HIV, Ebola and COVID-19 and conflicts and disasters.
- Kinship care benefits both children and caregivers and is the preferred option for many children who cannot live with parents.

> *"When I brought him home, he had studied at five different schools, and was always fighting with his classmates. Currently, he has become stable and is studying very well. He has even improved and is regular at school. Teachers tell me that he is a good child and I feel very proud of him."*
> Female kinship caregiver, Kigali, Rwanda

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> *"I used to have food only sometimes, but today, I have enough food; I never miss any meal. In addition to that, my aunt is a very good adviser to me – I feel very happy."* Boy, 15, Kigali, Rwanda

- Although kinship care is a normal and expected part of childhood for many children, it can place both children and caregivers at risk and support is essential. Caregivers are often elderly and poor, and both children and caregivers are frequently struggling with multiple bereavements and trauma. While many children in kinship care are well cared for, some are discriminated against, abused and neglected.

- Kinship care takes on different forms, each requiring unique types of support. For example, grandparent carers often need economic strengthening, health services and assistance bridging the inter-generational divide. Children cared for by friends of the family or more distant relatives are more likely to suffer from discrimination and abuse.

- Kinship care is usually neglected in care reform efforts, with the assumption that caregivers can manage with no or minimal supports.

> *"I always feel isolated; my kinship carers sometimes show me that they have had enough with me or tell me harsh words."* Boy in kinship care, 13, Kigali, Rwanda

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FOSTER CARE

Through the TMM and IMM programmes, over a thousand foster carers have been recruited in Rwanda, generating important lessons on the establishment of foster care (see Example 9).

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EXAMPLE 9

Lessons learnt about supporting foster care in Rwanda[17]

The TMM and IMM programmes have provided multiple lessons learnt about foster care.

- **Foster care will be more successful if it builds on existing models and cultural values.** The foster care supported through the TMM programme is built on the system of Malaika Mulinzi (Guardian Angels). The Malaika Mulinzi are community volunteers established by the Imbuto Foundation. The TMM programme supported these volunteers to become fully trained and monitored foster carers. The system of Malaika Mulinzi derives its success from long traditions of collective responsibility for child wellbeing in Rwanda, and from the endorsement of Rwanda's first lady.

- **Foster carers need multiple forms of support.** Foster carers in Rwanda are recruited from modest, though not the poorest, backgrounds. They are assessed to make sure they can afford to care for children without additional payments. However, some foster carers struggle, especially if they are looking after children with disabilities or complex health needs. At the very least they need help accessing services and some may also require financial support. Foster carers also benefit from advice and guidance and must be monitored carefully to safeguard the children in their care. Professional social workers are essential for providing this support.

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➔ **Foster carers need help in responding to challenging behaviours.** Children leaving residential care often display challenging behaviours as a result of the trauma of separation, violence and neglect. The IMM programme found that it was vital to train foster carers on the reasons behind these behaviours and to equip them with the skills to respond appropriately.

➔ **Special efforts are required to place some groups of children in foster care.** Social workers report that some groups of children are especially difficult to place in foster care. This includes children older than five years, abandoned children who need emergency care, and children with disabilities. Social workers found that it helped to understand the reasons behind foster carers' reluctance to foster these groups of children, and to address any misconceptions.

➔ **A comprehensive care system means multiple forms of foster care.** There are four forms of foster care in Rwanda:

- emergency foster care for children who need sudden and immediate short term care;
- short term placement for children leaving institutions or emergency foster care whilst efforts are made to reintegrate them with their families;
- long term foster care for children who cannot be reunited with families, and for whom adoption is not appropriate or an option; and
- specialised foster care for children with **disabilities**.

THE VOICES OF CHILDREN, CARE LEAVERS AND CAREGIVERS

"In the children's home, there is no family. No one cares about you in the way a parent does. It is their job, they are paid to look after you. Home is different in quality – a parent loves you... The only thing I miss about the home is the football I watched on TV." (A 21-year-old care leaver now living with his family)

"I didn't know the outside life... I didn't know how to live independent, how to be a man." (A 22-year-old care leaver explaining his motivation for wanting to leave residential care)

"Nothing but death will separate us now. I am determined we will stay together." (23-year-old woman, who cares for her three younger siblings who were reintegrated from residential care)

"I understand the meaning of parenting and, even without a wife, I would never let them be taken back." (A father who has been reunited with the two children he placed in residential care following his wife's death)

"Over time he has changed. Now he is good boy... It was a challenge at first. It took time to convince him that he was going to be fine here." (A foster mother of a seven-year-old boy who was placed in institutional care when he was one year old)

RESOURCES

Overviews of care reform

UNICEF and Government of Rwanda (2019) Care reform in Rwanda. Process and lessons learned 2012-2018

Better Care Network (2015) Country care profile Rwanda

Overviews and evaluations of care reform programmes

UNICEF and Government of Rwanda (2019) Evaluation of the Tubarerere Mu Muryango (Let's raise children in families) programme in Rwanda, Phase 1: Summary

UNICEF and Government of Rwanda (2019) Programme brief: Let's raise children in families

UNICEF and Government of Rwanda (2019) Programme brief: Building the social service workforce for childcare reform in Rwanda

Global Communities and Hope and Homes for Children (2015) Key learnings from the Ishema Mu Muryango program

Government policies, strategies and guidance

Government of Rwanda (2012) Cabinet brief: Strategy for National Child Care Reform

Research and surveys

Government of Rwanda and Hope and Homes for Children (2012) National survey of institutions for children in Rwanda.

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

Case studies

Government of Rwanda and UNICEF (2019) Lets raise children in families – programme case study: Thierry

Government of Rwanda and UNICEF (2019) Lets raise children in families – programme case study: Divine

QUESTIONS?

A webinar will be held at the end of April 2021. To register your interest and receive further details, complete this short form. A recording will be made available here after this event.

You can also ask questions directly to:

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FEEDBACK

Please tell us what you think about this virtual study tour and how it could be improved by completing this short form.

GLOSSARY OF KEY TERMS

Alternative Care	The formal and informal care of children outside of parental care. Children outside of parental care are children not in the overnight care of at least one of their parents, as parents are unwilling or unable to care for children.[18] The Guidelines for the Alternative Care of Children outline several different forms of formal and informal alternative care including kinship care, residential care and foster care.[19]
Residential care	Care provided in any non-family-based group setting.[20] A distinction is often made between different forms of residential care. For example: • Institutional care. Large-scale facilities where children are cared for in large groups, usually involving shift-systems, a common set of rules, children sleeping in dormitories, and isolation from wider communities. • Small group homes. Children cared for in small groups, usually with one or two carers, in specially designed and designated facilities.[21]
Family-based care	Care in a family environment. Family-based care includes kinship and foster care (see below for definitions) and care by the child's biological or adoptive parents.
Kinship care	Family-based care within the child's own extended family or with close friends of the family known to the child.[22]

GLOSSARY OF KEY TERMS

Foster care	Foster care is a formal arrangement whereby a competent authority places children in the domestic environment of a family other than the child's own that has been selected, qualified and approved for providing such care.[23] Although global guidance only acknowledges formal foster care, in many countries the term informal or spontaneous foster care is used to describe families taking in unrelated children that are previously unknown to them.
Supervised independent living	Children and young people living alone or in groups in the community but supervised by social workers, caregivers and/or community volunteers.
Gatekeeping	"A recognised and systematic procedure to ensure that alternative care for children is used only when necessary and that the child receives the most suitable support to meet their individual needs."[24]
Case management	Case management is a key means of ensuring that vulnerable children and families get the services they need. Case management uses standardised guidance to support social workers in identifying needs, making referrals to appropriate services, monitoring children and families, and keeping effective records.[25]

ENDNOTES

1. https://data.worldbank.org/indicator/SP.POP.TOTL?locations=RW

2. UNICEF (2018) Situation analysis of children in Rwanda. Rwanda: UNICEF. Defines children as all of those aged under 18 years

3. Martin, F. and Zulaika, G. (2016) Who cares for children? A descriptive study of care-related data available through global household surveys and how these could be better mined to inform policies and services to strengthen family care. Global Social Welfare, 3 (2), p.51-74. This data is from surveys from 2012–2016 and as such some of the data is now quite dated, though it is unlikely that the broad trends in kinship care will have shifted dramatically since data was collected. Data was also only collected on children aged 0-14 years.

4. Figures from the Government of Rwanda (figures as of March 2021).

5. Ibid.

6. Ibid.

7. Ibid.

8. Taken from interviews with UNICEF and Government of Rwanda staff and:

Better Care Network (2015) Country care profile: Rwanda. New York: BCN, UNICEF and USAID; Delap, E. and Mann, G. (2019) Documentation of child care reform programme in Rwanda. Processes, lessons learnt, summary and case studies of the "Tubarerere Mu Muryango" child care reform programme in Rwanda between 2012 and 2018. UNICEF and the Government of Rwanda; Government of Rwanda and Hope and Homes for Children (2012) National survey of institutions for children in Rwanda. Rwanda: Hope and Homes for Children; International Centre for Disability and Rehabilitation (2018) Alternative care report and considerations for strengthening the TMM programme for the inclusive of children and adults with disabilities. (unpublished); National Council for Persons with Disabilities and National Commission for Children (2016) Report on the national assessment of centres caring for children with disabilities in Rwanda. Rwanda: Government of Rwanda; Mushimiyimana, D. (2017) Govt lifts ban on foreign adoption of Rwandan kids. AllAfrica, 21 September (https://www.newtimes.co.rw/section/read/220313 and https://allafrica.com/stories/201709210076.html); UNICEF and the National Commission for Children (2012) Tumbarerere mu Muryangyo! Let's raise children in families! Proposal. Rwanda: Republic of Rwanda and UNICEF; UNICEF (2016) Let's raise children in families! Preventing family separation and violence against children in Rwanda – Project description for phase 2. Prepared by UNICEF for USAID.

Figures relating to the genocide are from: http://www.cnlg.gov.rw/index.php?id=80

9. The Ministry of Social Reintegration of Vulnerable Groups began to think about fostering because of the high numbers of separated children in residential centres. Additionally, the Ministry of Work and Social Affairs began to consider, in conjunction with relevant NGOs, the need for the regulation of fostering.

10. Government of Rwanda and UNICEF (2019) Programme brief. Tubarerere Mu Muryango (Let's raise children in families). Rwanda: Government of Rwanda and UNICEF

11. From: Government of Rwanda and UNICEF (2019) Programme brief. Building the social service workforce for childcare reform in Rwanda. Rwanda: Government of Rwanda and UNICEF.

ENDNOTES

12. From: Global Communities and Hope and Homes for Children (2015) Key learnings from the Ishema Mu Muryango program. Rwanda: Global Communities and Hope and Homes for Children.

13. From: Government of Rwanda and UNICEF (2019) Care reform in Rwanda. Process and lessons learnt 2012–2018. Rwanda: UNICEF and Government of Rwanda.

14. Global Communities and Hope and Homes for Children (2015) Key learnings from the Ishema Mu Muryango program. Rwanda: Global Communities and Hope and Homes for Children.

15. From: Government of Rwanda and UNICEF (2019) Care reform in Rwanda. Process and lessons learnt 2012–2018. UNICEF and Government of Rwanda.

16. From: Family for Every Child (2020) Kinship care in Africa. An asset worth supporting. London: Family for Every Child.

17. From: Global Communities and Hope and Homes for Children (2015) Key learnings from the Ishema Mu Muryango program. Rwanda: Global Communities and Hope and Homes for Children; Government of Rwanda and UNICEF (2019) Programme brief. Tubarerere Mu Muryango (Let's raise children in families). Rwanda: Government of Rwanda and UNICEF; Government of Rwanda and UNICEF (2019) Let's raise children in families. Programme case study – Divine. Rwanda: Government of Rwanda and UNICEF.

18. United Nations General Assembly (2010) Guidelines for the alternative care of children, GA Res 142, UNGAOR, 64th session, supplement number 49, Vol.1 (A/64/49 2010). New York: United Nations.

19. Ibid.

20. Ibid.

21. Family for Every Child (2012) Towards a family for every child. Conceptual framework. London: Family for Every Child.

22. United Nations General Assembly 2010.

23. Ibid.

30. Better Care Network (2015) Making decisions for the better care of children. The role of gatekeeping in strengthening family based care and reforming alternative care systems. New York: UNICEF and the Better Care Network.

25. UNICEF and the Global Social Service Workforce Alliance (2019) Guidelines to strengthen the social service workforce for child protection. New York: UNICEF.

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