Country Care Profile

Rwanda

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This report was prepared under the leadership of the Better Care Network (BCN) and UNICEF, with support from the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID). It seeks to document significant child-care reform work being carried out in Rwanda, involving legislation, policies and programmes.

Two other countries were reviewed for the country profile study – Ghana and Liberia. All three country profiles and the general summary report are available on the BCN website: <www.bettercarenetwork.org>. The reports are intended to promote information exchange and learning within the region, and to reinforce and encourage care reform in other countries.

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Country Care Profile

Rwanda

Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
CBO	community-based organization
CHF	Cooperative Housing Foundation, now known as Global Communities
CRC	Convention on the Rights of the Child (also UNCRC)
DCOF	Displaced Children and Orphans Fund
DHS	Demographic Household Survey
ECD	early childhood development
ECD&F	early childhood development and family
FARG	The Genocide Survivors Support and Assistance Fund
FIDESCO	organisation catholique de solidarité internationale
FBO	faith-based organization
GDP	gross domestic product
HCIA	1993 Hague Convention for the Protection of Children and Co-operation in Respect of Inter-country Adoption
HHC	Hope and Homes for Children
HIV	human immunodeficiency virus
ICRP	Integrated Child Rights Policy
IMS	information management system
IRC	International Rescue Committee
IZ	*Inshuti Z'Umuryango* (Friends of a Family)
MDGs	Millennium Development Goals
M&E	monitoring and evaluation
MIGEPROF	Ministry of Gender and Family Promotion
MoF	Ministry of Finance
NCC	National Commission for Children
NCPD	National Council for Persons with Disabilities
NGO	non-governmental organization
OVC	orphans and vulnerable children
PCT	Program Coordination Team
P.E.A.C.E Plan	**P**romote reconciliation, **E**quip servant leaders, **A**ssist the poor, **C**are for the sick, **E**ducate the next generation
TMM	*Tubarerere Mu Muryangyo!* Let's Raise Children in Families!
ToR	Terms of Reference
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VUP	Vision 2020 *Umurenge* Programme

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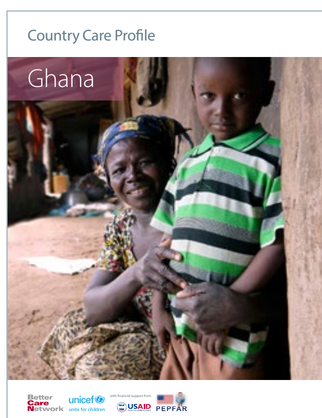
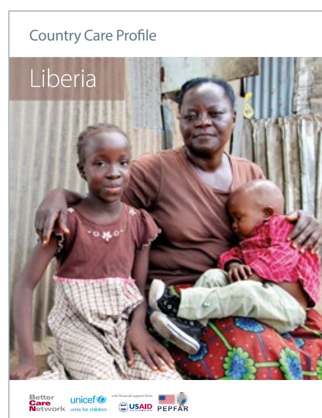
Executive Summary

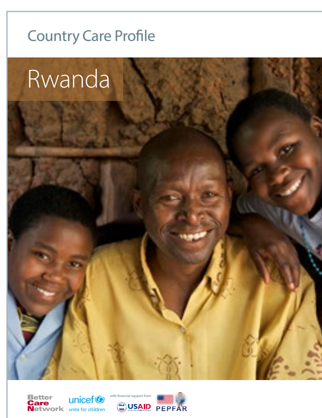
1 Introduction

1.1 Purpose and objectives

The Better Care Network (BCN) and UNICEF, supported by the President's Emergency Plan for AIDS Relief (PEPFAR)/ US Agency for International Development (USAID), commissioned Maestral International LLC to document significant child-care reform work being carried out at country level in three African countries, to promote information exchange and learning within the region, and reinforce and encourage care reform in other countries. These reforms involve legislation, policies and programmes, including service delivery, advocacy and networking. The three countries reviewed for the country profile study were: Ghana, Liberia and Rwanda. All three country profiles and the general summary report are available on the BCN website: <www.bettercarenetwork.org>.







The country profiles document efforts to support care reform within these countries. Based within a framework reflective of the 'Guidelines for the Alternative Care of Children',[1] the profiles provide an overview and analysis of key areas in alternative care services provision and reform efforts. The key areas are:

- National enactment and implementation of the legal and policy framework;
- Preventive and family support services;
- Availability and range of family-based alternative care services;
- Residential care and deinstitutionalization efforts;
- Supporting children exiting or leaving alternative care arrangements;
- Domestic and inter-country adoption;
- Information management systems; and
- Social welfare workforce.

The profiles provide an overview of key lessons learned, including successes, challenges and areas for progress, and gaps in learning and best practice.

The goal of the country profiles is to inform the strengthening care-reform efforts in the sub-Saharan Africa region. It is envisaged that they will build on the positive momentum generated by recent regional conferences, child-protection systems strengthening initiatives, deinstitutionalization efforts, and country-level child protection and care networks. The profiles can contribute to the exchange of information between and among countries on successes and challenges in implementing care-reform efforts, facilitate the development of a community of practice in Africa, and harness reform and political will among donor, government and non-governmental actors. Ultimately, these care profiles can increase collaboration between national and regional actors who are supportive of care reform, strengthening child-protection systems and promoting family-based care options for children.

1.2 Methodology

The international and regional child rights-based instruments that framed the documentation of the care profiles included: the UN Convention on the Rights of the Child (CRC), the 'Guidelines for the Alternative Care of Children' (UN, 2009), the African Charter on the Rights and Welfare of the Child,[2] and the 1993 Hague Convention on the Protection of Children and Co-operation in Respect of Inter-Country Adoption. All definitions of the range of alternative care options were informed by these key international and regional framework documents. Additionally, efforts were made to ensure that the literature review and in-country research included active involvement of children and caregivers in order to gain a deeper understanding of the views of these key stakeholders.

Sound ethical research design, such as ensuring consent, referrals where appropriate and following child participation guidelines, was used to ensure the safeguarding of participating children and their caregivers. Detailed information on the process and steps taken to collect information is included in Annex 1.

1.3 Structure of the country profile

Following the country field visits, a detailed profile was developed for each country documenting, summarizing and analysing the core components of the alternative care system and care-reform initiatives. The country profiles are based on documents reviewed and the field visits in April/May 2013.

The content of each of the country profiles addresses the following topics:

- Overview of country context, including the population of children living outside of family care or at risk
- Description of child-protection and child-care system, including national care-reform initiatives
- Child-care legal and policy framework for the country
- Preventing the need for alternative care, including analysis of national deinstitutionalization strategies and interventions
- Analysis of formal alternative care
- Analysis of informal alternative care
- Domestic and inter-country adoption
- Care during an emergency
- Public awareness and advocacy
- Conclusion
- Reference materials for the country

2 Overview of national care-reform initiative

2.1 Country context

Rwanda is a small, densely populated country in East Africa with a population of approximately 11.5 million inhabitants[3] living within 10,169 square miles (26,338 km^2).[4] Rwanda is divided up administratively into 30 districts, which are further divided into 416 sectors, 2,148 cells and 14,843 villages.[5]

Since 2008, Rwanda has made significant gains in health, education and economic growth. In 2012, the gross domestic product (GDP) grew by 8 per cent.[6] It is projected to grow 7.5 per cent in 2014.[7] Over a five-year span from 2005–2011, poverty declined by more than 10 percentage points from 55.7 per cent to 44.9 per cent,[8] but children still bear the brunt of poverty with 60 per cent of Rwandan children living below the poverty line.[9] There have been significant reductions in infant, child and maternal mortality and a universal health insurance scheme has been set up. These improvements have put Rwanda on track to achieve many of the Millennium Development Goals (MDGs). Despite these gains, Rwanda is still one of the poorest countries in the world, ranking 167th out of 187 in the 2012 Human Development Index.[10]

Textbox 1

Key child-protection indicators for Rwanda: [11]

- 1.1 per cent of Rwandan children under 15 years of age living in a household have lost both parents and 9.1 per cent have lost one parent.
- 64.5 per cent of children under 15 years of age live with both parents.
- 11.2 per cent of children between the ages of 5 and 14 years old are engaged in child labour; 8 per cent of children aged 8–14 work for someone who is not a family member; the rate for orphans is higher.
- 63 per cent of births are registered (children under five years of age).
- Rwanda has a strong tradition of informal child-care practices. Statistics from 2008 found that registered child-care facilities were only caring for approximately 0.5 per cent of all single and double orphans in the country, with the vast majority of orphans growing up in informal care settings.

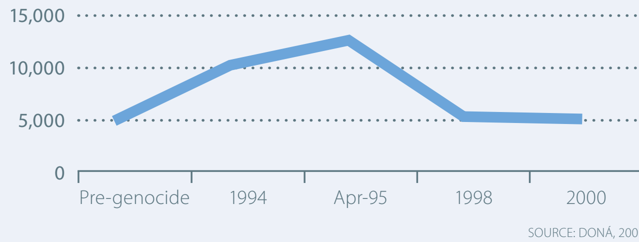
Food security and nutrition remain serious issues in Rwanda, affecting a large proportion of children. The 2010 Demographic Household Survey (DHS) showed that 44 per cent of Rwandan children under five had moderate to severe stunting, with 55 per cent of children aged 18–23 months being similarly affected.[12]

Rwanda has gone through different child-care reform phases over the past several decades, and this most recent effort shares some similarities with, and builds upon successful components of, past reforms – including the emphasis on traditional family-based care. The 1994 genocide led to one of the most notable responses, when organizations such as the International Rescue Committee (IRC), International Social Service (ISS) and Save the Children were actively engaged in processes to help identify, trace and reunify separated and unaccompanied children.

This was juxtaposed with a significant increase in new residential child-care facilities. Before the genocide there were 37 residential care facilities (referred to as 'centres' or 'orphanages' in documentation of this period) caring for 4,800 children. This number increased to 55 centres caring for 10,381 children soon after the end of the genocide, reaching a peak with 77 centres caring for 12,704 children in April 1995.[13] Due to tracing and reunification efforts, as well as an expansion of foster care for children who could not be reunified, this number decreased to 38 centres caring for 5,343 children in 1998; by April 2000, 37 centres had fewer than 5,000 children (see Figure 1).[14] The reunification work, which included

Figure 1

Number of children in residential care facilities



children living in residential care as well as other children living in refugee centres or foster care, was deemed quite successful, with approximately 56,000 children being reunified over a six-year period (1994–2000).[15]

The most recent child-care reform process was initiated in 2010. This phase was prompted by several key developments between 2010 and 2012. These included: the strengthening of a strong child rights-based legal and policy framework through the passage of the landmark Law 54/2011 on the Rights and Protection of the Child; accession to the 1993 Hague Convention for the Protection of Children and Co-operation in Respect of Inter-country Adoption (HCIA); a successful pilot deinstitutionalization effort and a National Study on Residential Care; the establishment of the National Commission for Children (NCC) through the passage of Law 22/2011; and children's voices advocating for family-based care for children at the 2011 National Children's Summit.

The pilot deinstitutionalization project implemented by the non-governmental organization, Hope and Homes for Children (HHC) in 2012, with the support and oversight of the Rwandan government authorities at the national and district levels, played a critical role in providing convincing evidence that deinstitutionalization processes were possible in Rwanda. Furthermore, the findings from the National Study on Residential Care conducted at around the same time greatly informed and helped impel the current care-reform process. Both the residential care study and the pilot deinstitutionalization project helped to inform and provide additional support towards the care reform initiative sparked by the 2011 National Children's Summit.

The 2012 national assessment on institutional care for children found 3,323 children and young adults living in 33 registered residential care facilities.[16] More than a quarter of all residents were over 18 years of age. Approximately 30 per cent of all residents had lived 10 years or longer in the facility, illustrating that exit plans and case management were weak.[17] The four main reasons for placement of the child (covering approximately 81 per cent of all cases) were: deaths of both parents, death of mother, abandonment and poverty.[18]

While, according to institutional records, abandonment was the main recorded reason for entry in 68 per cent of cases, it is important to note that 'abandonment' is a broad term and does not provide concrete reasons or risk factors. A further compilation and review of evidence from detailed child and family assessments[19] showed that the root causes of placement in residential care facilities included: unwanted pregnancies; the circumstances of female domestic workers; lack of knowledge concerning the damaging effects of institutionalization; family conflicts or marriage breakdown; death of parents; and lack of family cohesion.[20]

Another of the root causes identified was the perceived attractiveness of services offered by institutions,[21] i.e. the 'pull' factor of institutional care. This was an especially influential finding that impacts on current practice. The study noted, *"the very existence of an institution increased the likelihood of a child from that neighbourhood to be placed in an institution."*[22] Anecdotal evidence provided by various stakeholders also noted that in the limited number of locations without residential child-care facilities, very few, if any, children from there were placed in facilities in other locations. Thus when there are no residential care facilities nearby, it seems that families find other care options such as kinship or informal foster care.[23]

Textbox 2

How children entered into residential care:

- 60 per cent of children entered through local authorities and local leaders, with a recommendation letter from the district or sector;
- 32 per cent of children entered the institution through a direct request from adults or the child themselves, without following official procedures; and
- 8 per cent were abandoned in maternity wards following birth, and entered directly from there.

One important element of the care-reform process, which differs from previous efforts, is that it is grounded in a holistic vision that is clearly documented in the Strategy for Child Care Reform (2012)[24] and further detailed in the *Tubarerere Mu Muryangyo!* (Let's Raise Our Children in Families! – or TMM as is it commonly known). Led by the government, with active support from UNICEF, non-governmental organizations (NGOs) and faith-based organizations (FBOs), the TMM is the guiding framework for the reform process. The TMM includes five key focus areas of the reform process:

1. Operationalizing the legislative and policy framework for child-care reform;
2. Strengthening the human and technical capacities of structures at the national and district levels to administer childcare and protection and oversee the system;
3. Creating a national framework for care;
4. Building a strong professional social welfare workforce; and
5. Developing efficient information management systems (IMS) on child protection and monitoring and evaluation (M&E) systems.

Table 1

Key Rwanda child-care reform stakeholders

	Stakeholders	Responsibilities
Government	Ministry of Gender and Family Promotion (MIGEPROF)	MIGEPROF houses the NCC (below) and is involved in, and supportive of, activities led by NCC. The governing body of the NCC comprises a Board of Commissioners, an Executive Secretariat and an Advisory Council.
	National Commission for Children (NCC)	The NCC is a mandated government body responsible for overseeing the care-reform process including deinstitutionalization, expansion of alternative care and strengthening of the child protection system.
	Other line ministries or government entities	National Police, Rwanda Defence Force, Rwanda correctional facilities, Ministry of Education, Ministry of Health, Ministry of Local Government, Ministry of Finance and Economic Development, Local Government Authorities, Imbuto Foundation, National Institute for Statistics.
	Program Coordination Team (PCT): NCC, UNICEF, HHC and Cooperative Housing Foundation ([CHF], now Global Communities)	The PCT's main objective is to promote cohesion and coordination in the child-care reform effort. It is chaired by the NCC and co-chaired by UNICEF.
Networks and Committees	Children's Forums	Formal structures at the cell, sector, district and national levels where children are able to share their concerns, opinions and suggestions on issues that directly affect their lives.
	Child protection committees	Community-based groups involved to different degrees in the identification of vulnerable children and families, service provision, gatekeeping and monitoring. Also *Malaika Mulenzi* (Guardian Angels, i.e. foster parents) and *Inshuti Z'umuryango* (Friends of a Family); these are community based para social work volunteers that form part of a new government initiative to identify, prevent and respond to child protection concerns within the community. They also have the responsibility of following up cases of reintegration.
Faith-based organizations	P.E.A.C.E. Plan[28]	A network of Christian faith-based organizations working to encourage and advocate for the active engagement of faith-based communities and actors in advocating for family-based care in support of the larger reform effort.
Social work institutions	Universities and training programmes	The National University of Rwanda, Tulane University, Catholic University, Byumba Polytechnic University
UN and NGOs	UNICEF, HHC, CHF, Catholic Relief Services, Imbabazi Foundation, residential care facilities	UN and NGOs provide technical assistance in system strengthening, child-care reform, deinstitutionalization, prevention, household economic strengthening and other service provision in support of family strengthening, alternative care and deinstitutionalization.
Donors	USAID, Displaced Children and Orphans Fund (DCOF), European Union (EU), Global Fund	Donors support care reform, early childhood education, prevention and economic strengthening.

The National Strategy for Child Care Reform ('the Strategy') has an ambitious timeframe of two years for the first phase (2012–2014), given that it includes deinstitutionalization, strengthening of the workforce, building capacity of key players and expanding alternative care. On the one hand, this desire to reach the end objective of a Rwanda with a strong family-based care system is admirable. On the other, the limited timeframe allotted within the Strategy has elicited some concerns regarding the potential risks of reforming too quickly. The Committee on the Rights of the Child noted in the 2013 Concluding Observations for Rwanda, *"the Committee is further concerned that there are cases of 'spontaneous reintegration' of children without adequate preparation or proper assessment, monitoring and follow-up."*[25] The CRC Committee recommended that Rwanda, *"review the National Strategy for Child Care Reform, with a view to expanding the timeframe for its implementation, introduce monitoring mechanisms with clear indicators to measure the outcomes and provide follow-up procedures."* The Committee further recommended that, *"the State party increase the number of professionals working with or for children, and provide them systemic education and training and supervision."*[26]

The reform process recognizes deinstitutionalization[27] and alternative care reforms as entry points into larger child protection system strengthening, thus viewing it through a broader lens and as an approach/catalyst to a more comprehensive reform effort. The Strategy for National Child Care Reform includes the engagement of the actors listed in Table 1.

2.2 Care-reform results and promising practices

Strong government leadership, together with the active engagement of civil society (including NGOs, community-based and faith-based organizations [CBOs and FBOs]), is a core component of the child-care reform process (for a more detailed description of the key actors involved in care reform,

Table 2

Key milestones in child-care reform in Rwanda

Year	Milestones
1994–1998	• Foster care, reunification and reintegration efforts take place on large scale, in response to high numbers of unaccompanied children and orphans post-genocide.[29] • Rapid establishment of residential care facilities in response to genocide.[30]
1996	• The Government of Rwanda declares a 'One Child-One Family' Campaign on the Day of the Child to promote family-based care for unaccompanied children and orphans post-genocide.[31]
2010	• Hope and Homes for Children signs a Memorandum of Understanding (MoU) with MIGEPROF to begin pilot deinstitutionalization work in *Mpore Pefa* residential child-care facility.[32] • Integrated Child Rights Policy approved.[33]
2011	• Approval of Law 22/2011, establishing the National Commission for Children. • Approval of Law 54/2011 on Rights and Protection of Children. • National Children's Summit • Adoption of the Strategic Plan for the Integrated Child Rights Policy.[34]
2012	• 1,051 children leave residential care. Several different actors are involved in this process, and it includes both 'spontaneous' reintegration as well as planned reintegration – such as that involved in the pilot project of *Mpore Pefa*.[35] • (January) President makes public remark about commitment to close 'orphanages'. • (March) Cabinet approves National Strategy for Child Care Reform.[36] • (July) The 1993 Hague Convention for the Protection of Children and Cooperation in Respect of Inter-country Adoption enters into force.[37] • (November) National study on institutions for children published.[38] • (November) Development and approval of child-care reform framework (TMM).[39]
2013	• National-level coordination team established, Terms of Reference (ToR) developed/approved.[40] • Government and NGO actors support the deinstitutionalization of 477 children using different methods.[41]
2014	• MIGEPROF/NCC endorsed the IZ (Friends of a Family) concept that encompasses the establishment of community based para social work volunteers with clear roles and responsibilities and reporting channels. • National Council for Persons with Disabilities (NCPD) becomes an official member of the PCT. • The reintegration and closure of residential care facilities continues. Between July 2012 to the end of 2014, 1696 children have left residential care for family-based care or independent living. Eight out of 33 residential care facilities have completed the deinstitutionalization process.

see Section 4 of the Country Profile). Such leadership and engagement are clearly articulated in the TMM, as voiced by key actors involved in child protection, including children, caregivers and communities. Table 2 highlights key milestones in child-care reform efforts from 1994–2013.

Data provided by NCC in March 2015 illustrate the results of the deinstitutionalization component of the care-reform effort for the period of July 2012 through to March 2015. A total of 1,696 children in three types of formal care (residential child-care facilities, centres for street children and children in detention centres with their mothers) were reintegrated or placed in alternative forms of care. The breakdown was as follows: [42]

- 986 children from residential child-care facilities;
- 667 children from street children's centres; and
- 43 children living in detention centres with their mothers.
- Eight out of 33 residential child care facilities have been completely closed.

In March 2015 the NCC reported that between 2011 and March 2015, 750 children had been diverted from placement in residential care through gatekeeping mechanisms and family strengthening interventions.[43]

Although the care-reform process in Rwanda is relatively nascent, several notable elements of this process have helped propel the reform process forward. These include the following:

Strong legal and policy framework

Rwanda has a strong, child rights-based legal and policy framework that has been strengthened and enhanced since 2010 to include a focus on the primary role of the family and family strengthening, family-based alternative care and poverty reduction. This includes the passage of two laws, the Child Rights and Protection Policy, and three national strategies encompassing child-care reform, family promotion and poverty reduction. Together these form a holistic, family-centred framework that includes preventive and response components in support of the care-reform effort. There is also strong support for social protection and early childhood development – this will further reinforce the care-reform effort by supporting the prevention of separation, and helping build the resilience and competencies of Rwandan families.

Clear strategy to guide the process

The Strategy, detailed in the TMM, is the guiding framework through which all elements of the reform process are developed, implemented and assessed. From key informant interviews it appears that the majority of stakeholders involved in child-care reform – from national level government down to the lowest community level – understand and are familiar with key tenets of the child-care reform strategy, suggesting that there exists significant buy-in and a sense of ownership by those involved in the process.

Government leadership

Since 2011 the reform process has, through passage of Law 22/2011, established the National Commission for Children under the Ministry of Gender and Family Promotion (MIGEPROF), whose mandate it is to protect and promote the rights of children in Rwanda. The NCC comprises a Board of Commissioners, an Executive Secretariat and an Advisory Council.[44] Specifically related to the child-care reform process, the NCC is responsible for overseeing the creation of a system of alternative care options and the strengthening of the national child-protection system. This includes developing, coordinating and monitoring new regulations related to childcare. Furthermore, the NCC has an oversight role in domestic and inter-country adoption processes.[45] The NCC works at the national level and coordinates closely with provincial, district and sector-level officials.

Coordination of key actors

An important development within the child-care reform process has been a tripartite approach, established and utilized by key actors involved in the process. The establishment of the Program Coordination Team (PCT) involves government (the National Commission for Children), UNICEF and NGOs (Hope and Homes for Children [HHC][46] and Global Communities,[47] formerly known as CHF International). In 2014 the National Council for Persons with Disabilities was also included as a core member of the PCT. Its main objective is to promote cohesion and coordination in the child-care reform process. The PCT is chaired by the NCC and co-chaired by UNICEF. There are clear Terms of Reference (ToR) for the PCT, as well as a compact (agreement) signed by all members (See Annex 4).[48] The ToR allow for participation in the PCT by other organizations or government bodies committed to and involved in the reform process. This strong working relationship between the four key stakeholders leading the child-care reform process facilitates the sharing of ideas, use of a common language and vision, and coordinated and standardized approaches.

"We understand that all actors have a role in the reform process. Everyone cannot be good at everything so we try to identify the strengths of each member and build onto that."

Member of the Program Coordination Team

Gatekeeping mechanisms

Gatekeeping is new in the Rwandan context and, although still in the very nascent stage under the current reform process, it is recognized as an important component of the system.

Gatekeeping mechanisms have been developed and piloted in several districts and sectors across the country. The pilot deinstitutionalization project of HHC established child-care networks to function as gatekeeping mechanisms, and this model is being replicated – although it is likely to be named differently and address not just care issues but also child protection concerns. Beginning in 2014, the government has launched community based child protection structures (*Inshuti Z'Umuryango* (IZ)) that include para social work volunteers with the responsibility of safeguarding the rights of all children at village, cell and sector levels and paying particular attention to those at risk of separation and children whom have been reintegrated. Although volunteer in nature the IZ are linked with the formal sector[49].

Supportive environment for, and participation of, civil society

The recognition of and support for the role that NGOs play in the care-reform process is demonstrated by the government funding provided to organizations offering services to children and families (e.g. the *Ubumwe* Community Center for People with Disabilities and the organisation *catholique de solidarité internationale* [FIDESCO] transition home for street children). These organizations receive various amounts of financial and in-kind support from the government for specific components of their programming. Examples of the use of government funding provided to NGOs include food support, educational materials and donations of land.

The role of the faith-based community is especially relevant. Faith plays a significant role in the lives of Rwandans and getting key messages about care reform, including the importance of family and family-based care incorporated into sermons, discussions and dialogue is a significant contributor to ensuring that elements of the reform are understood and expanded to the community level. Child-care reform is a recognized national priority, and the importance of family in children's lives and the benefits to their development are key messages that are working their way into the daily lives and understanding of Rwandan communities via their faith leaders.

The participation of children is considered to be an essential component of the care-reform process. Utilizing the establishment of children's forums at the district, sector, cell and village levels, and holding National Children's Forums, is an important tool to ensure that children have a valid voice and an appropriate forum in which to express their views.

Transformation of residential care facilities

Several key informants mentioned that the plan was to have funds currently provided to residential care facilities redistributed to support children in families and family-strengthening efforts once the facilities are closed or are transformed to provide other services.[50] The strategy describes how the redistribution of funds and reorganization of existing child-care facilities will occur:

- Partnerships are created with residential care facilities' managers, their donors, and community and district representatives to plan transformation.
- Government reallocates its funds gradually from institutions to family-based care services, including awareness raising, and support to emergency foster care and to community-based prevention services.
- Government provides clear legislation prohibiting the establishment of new residential care facilities.
- Efficient reallocation of government and private donors' funds from residential care facilities to family-based care and community-based family support centres is planned. Possibilities include: early childhood development; day-care; and after-school programmes for youth.
- New and the existing staff are trained and integrated to implement this strategy and to be involved in the new family- and community-based services.[51]

2.3 Challenges identified and lessons learned

The current care-reform process, although positive in many aspects, has not been without its challenges. The transition from residential care to family-based care has faced some expected obstacles. Key informants mentioned that some private facilities have been resistant to their eventual closure, and some have even had their own public awareness campaign stating the potential harm this may cause.[52] Many stakeholders mentioned the ongoing challenge of changing the mind-set of key actors involved in childcare, and the need to take time and be strategic in how to gain their interest and commitment to the reform process. One of the key lessons learned from the Rwandan care-reform process is that it requires significant time to change attitudes and practice, enabling a transformation of focus and approach to services from residentially based to family-centred ones. This should be considered in the planning and assignment of resources towards public awareness and advocacy.

However, there are also examples of other private child-care facilities that have started this process and are seeing positive results. For example, the *Imbabazi* Foundation[53] stated in a newsletter to supporters the following: *"It was with mixed emotions that we embarked on this reunification journey – although we are sad to see the children leave the orphanage and had some initial doubts about the process, we have so far been amazed with the positive results! Reunification has allowed children to be more in touch with their roots, their communities and their culture. In addition, being in a home environment has given them more time to focus on important things like studying and helping their families."*[54]

Data collection, especially for certain populations of children, has been challenging and efforts to better collect key information about children are ongoing. For example, national statistics on the number of children placed in domestic adoption are not available. Statistics are kept at the sector level and not aggregated to the national level. Furthermore, information about the status and well-being of children in kinship care is limited. Most stakeholders agreed that family-based care and traditional, informal care options are an important option within the continuum of care, but more evidence on how this is practised and outcomes for children would be useful and could help inform future policy and practice. One positive development that responds to this identified gap is that In 2014, the NCC collected data on Most Vulnerable Children. That data will be entered into the MVC database, will be analysed and will help to generate useful information that will be used by partners/Government to address the needs of the vulnerable children[55].

One issue that does not appear to have been specifically addressed within the current deinstitutionalization process is that of children with disabilities. Currently, some children with disabilities reside within residential care facilities targeted for closure, but it appears that the vast majority of such children are in other facilities – some not officially registered – specifically for persons with mental and physical disabilities, including adults. These are under the mandate of the Ministry of Health, Ministry of Local Government and National Commission for Persons with Disabilities. As a result, children with disabilities are not included in the current deinstitutionalization process. The number of children residing in these other facilities is unclear. For children with disabilities that reside in the facilities involved in the deinstitutionalization process, key stakeholders did mention that there are efforts to recruit and train specialized foster families to care for them. For example, the *Ubumwe* Community Center[56] in Rubavu is being included in discussions, as it could provide necessary support such as vocational training and day-care facilities. Given that disability is a priority action area for UNICEF and others, this has been identified as an important area to review in the near future.[57] Integrating the National Council for Persons with Disabilities into the PCT was also a critical step in ensuring that children with disabilities are included within the larger care reform process.

Linking key elements of the care-reform process, especially deinstitutionalization and care for families at risk of separation to existing services, interventions and programmes, is an element that could use greater attention. The current prioritization by government and donors to roll out and expand early childhood development centres, purposefully[58] linking them to the care-reform efforts, could potentially be an excellent model for how cross-sector engagement might occur and be fostered. This could provide important models of and lessons for other sectors, such as health and social protection.

1 Overview of country context

1.1 Country context

Rwanda is a country in East Africa with a population of approximately 11.5 million inhabitants.[59] It has an area of 10,169 square miles (26,338 km^2), making it one of the most densely populated countries in Africa.[60] Rwanda is considered a low-income country;[61] and in 2012, the country was ranked 167 out of 187 on the Human Development Index.[62] Since 2008, the country has seen notable improvements in health, education and economic growth resulting in a significant leap in the standard of living. Over a five-year span from 2005–2011, poverty declined by more than 10 percentage points from 55.7 per cent to 44.9 per cent.[63] Significant gains in reducing infant, child and maternal mortality, combined with national social protection measures such as health insurance schemes, have helped put Rwanda on track to achieve most of its Millennium Development Goals (MDGs) targets.

Despite these impressive gains, poverty still remains an issue in Rwanda; 44 per cent of the country's population lives below the poverty line. Children make up half of the population, but bear the brunt of poverty with 60 per cent of children living below the poverty line.[64] The estimated adult prevalence rate of HIV is 2.9 per cent.[65] The 1994 genocide, as well as other issues, has resulted in a large segment of the population – approximately 500,000 (5 per cent of the total population) – living with disabilities.[66] Poor nutrition and food insecurity negatively impact children. The Demographic Household Survey (DHS) from 2010 showed that 44 per cent of Rwandan children under five had moderate to severe stunting.[67] The highest level of stunting was found in the 18–23 months age group, where it is prevalent in 55 per cent of children. There are also gender and geographic differences, with stunting in 47 per cent of boys and 41 per cent of girls, and in 47 per cent of children in rural areas compared to 27 per cent in urban areas.[68]

1.2 Population of children living outside of family care or at risk

Although notable improvements have been made in the health and education status of Rwandan children, they still face significant obstacles, including high poverty rates. The 2010 DHS study statistics compiler showed that 16.8 per cent of households were caring for a 'foster' child. A 'foster' child in this case is defined as a child living in a household without mother or father present.[70] The 1994 genocide in Rwanda increased the percentage of children under 15 who lost both parents – from 0.7 per cent in 1992 to just below 5 per cent in 2000. For many years, Rwanda also had one of the highest numbers of child-headed households in the world, resulting both from the 1994 genocide and HIV and AIDS,[71] although most of these children have now reached the age of 18.[72] By 2010, the prevalence of children who had lost both parents had decreased to 1.1,[73] demonstrating the significant changes in family life that have occurred over the past two decades. The number of Rwandan children living in a household who have lost one parent is 9.1 per cent[74] (see Figure 2).[75]

A regional comparison shows that Rwanda still retains an average double orphan rate. Neighbouring countries, Ethiopia and Mozambique, have rates of 0.6 per cent and 0.4 per cent respectively, while Zimbabwe and Zambia have the highest double rates at 4.7 per cent and 2.7 per cent.[76] Rwanda's percentage of children under 15 living in a household who have lost one or both parents (10.2 per cent) is about average,

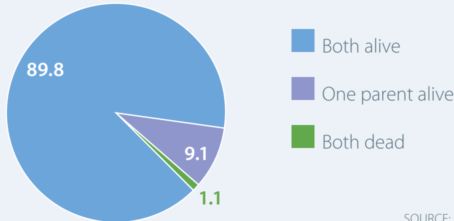
Textbox 1

Key child protection indicators for Rwanda: [69]

- 1.1 per cent of Rwandan children under 15 years of age living in a household have lost both parents and 9.1 per cent have lost one parent.
- 64.5 per cent of children under 15 years of age live with both parents.
- 11.2 per cent of children between the ages of 5 and 14 years old are engaged in child labour; 8 per cent of children aged 8–14 work for someone who is not a family member; the rate for orphans is higher.
- 63 per cent of births are registered (children under five years of age).
- Rwanda has a strong tradition of informal child-care practices. Statistics from 2008 found that registered child-care facilities were only caring for approximately 0.5 per cent of all single and double orphans in the country, with the vast majority of orphans growing up in informal care settings.

Figure 2

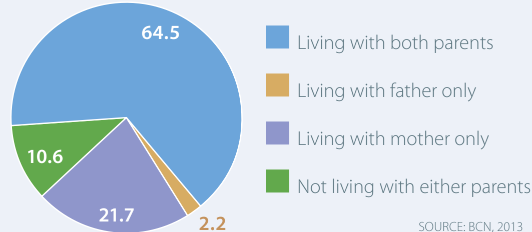
Rwanda: children under 15 living in a household by survival of parent status



SOURCE: BCN, 2013

Figure 4

Rwanda: children under 15 in a household living with or without their parents



SOURCE: BCN, 2013

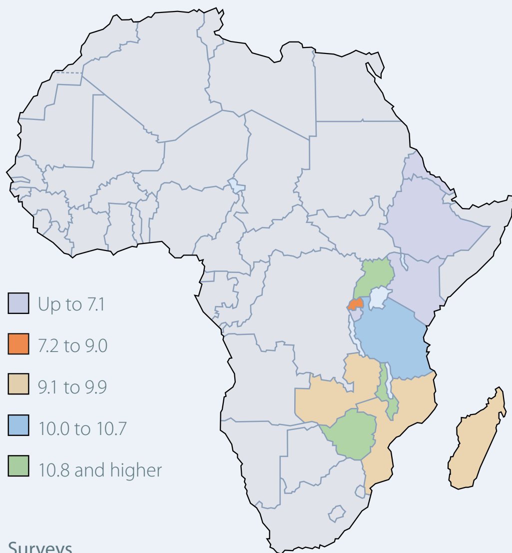
significantly higher than Madagascar (6.2 per cent) and Ethiopia (7.8 per cent) which have the lowest rates, but well behind Zimbabwe (18.4 per cent), Uganda (13.4 per cent) and Zambia (13.1 per cent), which have the highest.[77]

In terms of family living arrangements, 64.5 per cent of children under 15 live with both parents (see Figure 4).[78] This is higher than the regional average: on the lower end of the spectrum, Zimbabwe has 44.6 per cent of children under 15 years of age living with both parents, while Eritrea, at the top, has 76 per cent.[79] Nonetheless, a significant percentage of children under 15 in Rwanda live with their mother only (21.7 per cent) and 2.2 per cent live with their father only.[80] In addition, 10.6 per cent of children under 15 do not live with either parent. There is also a notable geographic difference within Rwanda, with the Southern region reporting 59.2 per cent of children living with both parents, Kigali with 64.1 per cent and the Northern region with the highest, 67.6 per cent.[81]

An interesting finding is that 75 per cent of children aged 0–2 live with both parents, decreasing to 54 per cent of children 10–14 years old.[82] One possibility is that this is reflective of the need for children to move from home to access education, although research needs to be conducted to find conclusive data as to why this number decreases so much for this age group. Finally, since 2005 there has been a steady increase in children in households who do not live with either parent although both are alive, with 7.3 per cent of children under 15 in this category (see Figure 5). Children in rural areas were a percentage point higher (7.4 per cent) compared to children in urban areas (6.4 per cent) in this respect.[83] This could be due to urban migration of parents for labour purposes, but additional evidence identifying reasons for this difference is needed. Therefore, parental death is not the only reason for children living outside of parental care and further research could enhance understanding of the other causes.

Figure 3

Residence and survival status of parents: Living with neither, both alive



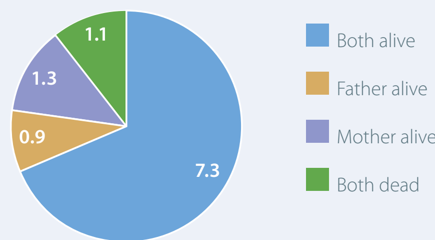
Surveys

Survey	Value	Survey	Value
Burundi 2010 DHS	4.3	Mozambique 2011 DHS	9.5
Comoros 1996 DHS	15.2	Rwanda 2010 DHS	7.3
Eritrea 2002 DHS	2.8	Tanzania 2010 DHS	10.6
Ethiopia 2011 DHS	6.5	Uganda 2011 DHS	11.8
Kenya 2003 DHS	6.5	Zambia 2007 DHS	9.4
Madagascar 2008–09 DHS	9.5	Zimbabwe 2010–11 DHS	12.5
Malawi 2010 DHS	10.8		

SOURCE: ICF INTERNATIONAL, 2012; MEASURE DHS STATCOMPILER. WWW.STATCOMPILER.COM ACCESSED 25 SEPTEMBER 2013

Figure 5

Rwanda: children under 15 in a household not living with their parents by survival of parent status



SOURCE: BCN, 2013

The number of residential care facilities has changed over the past three decades, with increases and decreases occurring depending upon the context and situation. Significant increases occurred post-genocide; later the numbers decreased during a concerted effort to reduce the number of children in residential care. In the early part of the new millennium, new residential care facilities opened in response to HIV and AIDS, with many funded and/or administered by faith-based organizations.[84] Before the genocide, there were 4,800 children in residential care, increasing to 12,704[85] by April 1995. Five years later the number had decreased to fewer than 5,000,[86] due to extensive reintegration efforts by multiple actors.

Textbox 2

How children entered into residential care:

- 60 per cent of children entered through local authorities and local leaders, with a recommendation letter from the district or sector;
- 32 per cent of children entered the institution through a direct request from adults or the child themselves, without following official procedures; and
- 8 per cent were abandoned in maternity wards following birth, and entered directly from there.

A 2012 national assessment on registered residential care facilities for children found that 3,323 children and young adults resided in 33 such facilities, 11 per cent of whom were children under three years of age and 37 per cent aged 0–3 at the time of placement.[87] Thirty per cent of the children living in the institutions at the time of the study had already spent more than 10 years there. This study also found that one third of children in residential care were placed there by a relative or other legal guardian, with only 11 per cent placed there by their parents.[88] The main reasons for placement of children in residential care, provided by the directors of the facilities, were noted to be: death of both parents, death of mother, abandonment and poverty.[89]

While, according to institutional records, abandonment was the main recorded reason for entry in 68 per cent of cases, it is important to note that 'abandonment' is a broad term and does not provide concrete reasons or risk factors. A further compilation and review of evidence from detailed child and family assessments[90] showed that the root causes of placement in residential care facilities included: unwanted pregnancies; the circumstances of female domestic workers; lack of knowledge concerning the damaging effects of institutionalization; family conflicts or marriage breakdown; death of parents; and lack of family cohesion.[91]

Another of the root causes identified was the perceived attractiveness of services offered by institutions,[92] i.e. the 'pull' factor of institutional care. This was an especially influential finding that impacts on current practice. The study noted, *"the very existence of an institution increased the likelihood of a child from that neighbourhood to be placed in an institution."*[93] Anecdotal evidence provided by various stakeholders also noted that in the limited number of locations without residential child-care facilities, very few, if any, children from there were placed in facilities in other locations. Thus when there are no residential care facilities nearby, it seems that families find other care options such as kinship or informal foster care.[94]

The recent reform efforts have resulted in a significant reduction in children in residential care. Statistics provided by a key informant in March 2014 showed that the original number of children in care had been reduced from 3,323 (in 2012) to 1,457 in March 2014.[95] There are no clear government statistics on the number of children in informal family-based care. However, as mentioned in the previous section, the 2010 DHS study statistics compiler highlighted that 16.8 per cent of households were caring for a 'foster' child, which can help shed light on the situation of children in informal care.[96]

Data from August 2013 show that a total of 1,196 street children in Rwanda are being served by 25 organizations.[97] According to FIDESCO, the largest group of street children are migrants from rural areas of the country to the capital of Kigali. The main push factors leading children to the streets were identified to be: abuse, violence, poverty, HIV and the lasting effects of genocide.[98]

2 Child protection and child-care system

2.1 Stakeholders and groups

The child protection and child-care system in Rwanda involves the engagement of a wide range of actors including government, civil society, parents and caregivers, and children. Child-care reform has been prioritized by the highest level of government (i.e. by the President and Prime Minister), beginning with a National Children's Forum where the issue of residential care was prioritized by children (see below Children, as well as Section 9). Awareness of and involvement in the process by key actors has been identified as being critical to the success of the reform effort.

Government

Rwanda has a clear government administrative division. The country is divided up into 30 districts (see map in Section 1), which are further divided into 416 sectors, a total of 2,148 cells and 14,843 villages.[99]

An important tool utilized by the Government of Rwanda (GoR) is performance contracts (*'Imihigo'* in Kinyarwanda).[100] All levels of government – the ministry, NCC, district, sector,

cell and village levels – are expected to be involved in and support care-reform efforts, and each level of government has targets and performance plan indicators related to the reform. As indicated by key informants within government, there appears to be a clear understanding of all levels of their own roles within, and targets related to, care reform. There also seems to be a growing awareness that other national-level government initiatives – such as early childhood development, health insurance schemes and cash transfer programmes like the Vision 2020 *Umurenge* Programme (VUP) – need to work closely with the reform effort to ensure better linkages. Although this realisation is still relatively nascent, key informants did mention that creating such linkages is on their agenda and this has started to gain momentum.

Since 2006, local government authorities have utilized the tool of *Imihigo* contracts to develop and monitor performance indicators related to specific national priorities and, in the case of child-care reform, specific goals taking into account identified national priorities. During the research, key informants mentioned that both government officials at the local level and individual families have been given indicators related to child-care reform. These contracts typically focus on actions related to family preservation or kinship care and are viewed as a way of keeping local officials and families accountable within larger care-reform efforts.[101]

The NCC has made significant progress in building its capacity and taking a strong leadership role in the child-care reform process.[102] There appears to be strong commitment by all staff, a growing technical ability of key personnel, and a strong understanding of the NCC's mandated role in coordination and oversight of the process. Stakeholders recognize that the NCC is the ultimate driver and owner of the reform process, but also feel that the involvement of civil society is recognized and appreciated. The NCC utilizes the TMM as the child-care reform framework, clearly articulates how this is to occur and helps define the roles of all stakeholders in that process. The UN Committee on the Rights of the Child has recognized the importance of the establishment of the NCC, although it did express concerns in the Concluding Observations (2013) about the lack of decentralized coordination structures at district and sector levels.[103] The CRC Committee recommended increased human, technical and financial resources to strengthen this aspect.[104]

According to government sources, the Rwandan government was due to commit 335,110,109 Rwandan Francs (equivalent of 503,522 US dollars [USD]) towards care-reform efforts in 2013–14.[105]

Civil society

Civil society, including non-governmental organizations (NGOs) and faith-based organizations (FBOs), has a prominent role in the child-care reform process, as noted in the National Strategy for Child Care. For instance, NGOs such as HHC and Global Communities (CHF) continue to play a significant role in the process. That being said, the NCC is very clear in wanting NGOs working in the area of child protection or childcare to only work within the framework of the TMM.

There are also many organizations, both international and local, that are involved in family strengthening, food security, vocational training and income-generating activities, and savings and loans initiatives – all activities that work to address the inequities of poverty and strengthen livelihoods and families. Although not directly involved with or linked to the current care-reform process, these groups are important to the prevention side of the reform effort.

Many residential care facilities are run by NGOs or FBOs, and the reform process recognizes that these activities will need to be realigned to support family-based care. This is likely to cause some resistance; some informants admitted to having concerns and challenges around this aspect of the reform process, but most recognize that it is something that needs to be done. In 2013, the Government of Rwanda launched a national early childhood development and family (ECD&F)[106] programme, and there are initial discussions between key parties about how former residential care facilities and staff can be potentially transformed and utilized within the ECD movement.[107] This again demonstrates interministerial collaboration and the importance placed on the current care-reform effort.

Faith-based organizations

Faith-based organizations are a significant part of Rwandan culture and community, and are recognized as necessary actors in the reform process. FBOs are also prominent in the support and management of residential care. The National Study on Residential Care found that more than half of the 33 residential care facilities were founded by faith-based organizations.[108] Key informants noted that churches were significant entry points for the identification of vulnerable children, support for families, and recruitment of foster or adoptive families, while also playing a role in monitoring.[109] P.E.A.C.E. Plan in Rwanda is one of the major players within the faith-based community and understands its role in supporting national child-care reform. P.E.A.C.E. Plan utilizes its role as a network organization supporting churches in Rwanda and developing key topics and messages, discussing and sharing them with faith-based leaders (i.e. priests and pastors). The religious leaders then go back to their communities and share the messages as part of their services. According to key informants from the organization, services are offered to those in need, regardless of religious affiliation, at the community level.

Textbox 3

Case study – Faith-based community in support of reunification efforts

Four years ago, twin boys were placed in residential care during their first week of life as their mother died in childbirth. The case came to the attention of P.E.A.C.E. Plan. The grandmother is still alive, as is the boys' father. They live near an extended group of family members including aunts and cousins, but are living in poverty. It was clear to those involved that the family, especially the father, wanted the boys to be reintegrated. P.E.A.C.E. Plan identified the church that the family members went to and through its relationship with the local pastor, encouraged the family to have the children returned to the family environment. The church community offered to support the family in this effort. The boys are now living with the family, and although they have some developmental delays they are slowly forming close attachments with family members.[112]

The key role of the faith-based community was illustrated in discussions with several key informants. While the faith-based community has contributed significantly to the care-reform efforts, there remain pockets of resistance from some faith leaders, especially those with particular relationships to residential care facilities. P.E.A.C.E. Plan defined its understanding of the child-care reform process as, *"We believe that the child-care reform has three components: retain, reunite and regain. We would like to see children remain in their families (prevention) first and foremost. Secondly, we would like to see children in institutions reunite with their families of origin. Finally, we would like to see children in institutions who cannot be reunified regain new families."*[110] The last point emphasized the role of adoption, especially domestic adoption, within the range of care options. Several stakeholders mentioned the importance of inter-country adoption as an option, while recognizing that they wanted to proceed slowly to ensure best practice.[111]

> *"Every country is made up of families. The condition of families reflects the condition of a nation, so we want strong families in Rwanda."*
> P.E.A.C.E. Plan

Academia

University-based social work programmes have continued to expand since 2010, with three universities now offering degree programmes.[113] The university faculties and departments of social work are involved in the child-care reform process through the provision of training to university-level social workers, as well as certificate-level cadres. According to information provided by the Rwanda Association of Social Work, approximately 1,000 social workers, from the National University of Rwanda and Byumba Polytechnic University, completed a university degree in social work between 2003 and 2013. The Catholic University was due to graduate its first class in 2014.[114] Additionally, social work professors from the National University of Rwanda[115] and Tulane University are involved in developing training, overseeing data collection and analysis of the rapid assessment study on reunified children. Key informants mentioned their hope that there will be continued collaboration with academia for future research related to the reform process.[116]

Although additional child-focused research led by academic institutions in the area of child-care reform was not identified through this assessment process, the PROSOWO project, a regional research initiative by the School of Social Work of the National University of Rwanda, is notable.[117] This joint initiative involving schools of social work in four East African countries, is funded by an international donor, with the objective to promote social work education and the profession with a specific focus on social development and poverty reduction to meet the regional Millennium Development Goals. It also aims to promote the establishment of South–South partnerships and to foster networking with the Association of Schools of Social Work in Africa. A regional conference highlighting this project and poverty reduction and social development research was due to be held in March 2014.

Social welfare workforce

The social welfare workforce in Rwanda is still rather nascent, with social work as a profession only recently entering into national discussion. During the Social Welfare Workforce Conference in Cape Town in 2010, the Rwanda delegation described the situation in Rwanda as, *"lacking a national concept of 'social welfare' or its workforce."* It also noted the following:

- Low value placed on community psychosocial workers;
- Limited number of Bachelor of Social Work programmes, no Master of Social Work programmes and no professional associations; and
- Extensive reliance on volunteer, community-based cadres who receive a range of training, supervision and ongoing support.[118]

Currently, there are three universities that offer social work training, the National University of Rwanda, the Catholic University of Rwanda and Byumba Polytechnic University, which offer bachelor-level programmes. There are no master's programmes in the country. Stakeholders mentioned that many social work graduates stay in urban areas and work with government or in large NGOs. They do not fill positions that are community-based and directly in contact with children and families. A trained workforce placed at the cell and sector levels (i.e., community level) and whose function it is to identify, assess, refer and monitor children and families is a critical component of any reform process, including that

Textbox 4

Promising practice: interministerial collaboration in sustaining components of the reform process

As part of the sensitization process undertaken by the NCC, the Child Care Reform Strategy was shared with other ministries, including the Ministry of Finance (MoF). According to the NCC, they felt it was important that all ministries be aware of the strategy given that children were involved and that the holistic view taken by the strategy dictated the involvement or support of other ministries. When the NCC and UNICEF developed a funding proposal to support aspects of the strategy, they shared it with colleagues at the Ministry of Finance. They did this to ensure that: 1) the MoF was well-informed about the process; 2) that it was in agreement with what was being proposed; and 3) that the MoF understood the importance of sustaining key elements of the reform process, such as the social welfare workforce, after the end of the funding cycle. This awareness building and active engagement of colleagues at the Ministry of Finance not only resulted in support for the contents of the proposal but, perhaps more importantly, the ministry understood the importance to the larger national effort to promote family-based care and a strong child protection system. The MoF committed government funds to cover salaries for 68 social workers and psychologists placed at the district level after the funding ended.

in Rwanda. At present, there are many volunteers working on behalf of and trained by various NGOs, CBOs and FBOs, but they all receive different training, different support and supervision and possess different skills.

The National Strategy for Child Care Reform recognizes the lack of an adequate social welfare workforce and places significant emphasis upon the role that the workforce has within the reform process. Two of the five objectives of the strategy focus on strengthening human resource capacity in this respect, specifically mentioning the following: 1) strengthening the human and technical capacities of structures at the national and district levels to administer childcare and protection and oversee the system; and 2) building a strong professional social welfare workforce.[119] The strategy understands that the workforce includes volunteers at the lowest level upwards to the sector, district and national levels. The role of supportive supervision is also recognized and addressed through training, development of job descriptions etc.

At the time of writing efforts were primarily focused on preparing a cadre of 68 social workers and psychologists to work at the district level, with the population of a district ranging from 284,860 to 530,907.[120] These staff will be placed in pairs (social worker and psychologist) in each of the 30 districts, integrated into existing district local authority structures and will report to the Gender and Family Promotion Officer, the focal point of MIGEPROF at the district level. The number of new staff was calculated based on the number of districts. It was also calculated utilizing the team approach and caseload size used by HHC during the pilot deinstitutionalization and reintegration process in 2011–2012. The social workers and psychologists will be trained and placed in a phased approach, prioritizing districts where residential care facilities are being or will soon be closed. Their primary mandate will be to oversee care-reform efforts in that district including deinstitutionalization, prevention of separation and alternative care for the first three years. The plan is that over time they will begin to take on new responsibilities within social welfare, including addressing issues of other vulnerable populations like the elderly and people with disabilities, in addition to the deinstitutionalization and alternative care work.[121] In addition, eight pairs of social workers and psychologists will be placed in the district where Orphanage Noel de Nyundo[122] is located, to support that large caseload (566).[123]

Pre-service and in-service training is being provided for the social workers and psychologists.[124] UNICEF, the NCC, Tulane University and HHC have jointly developed the training curriculum.

These staff will also be responsible for providing training and support to the cadres at the sector and village levels (i.e. a cascade approach will be employed to build the capacity of different cadres). A key informant highlighted this commitment by stating, *"the NCC is committed to social work making a change in Rwanda."* Similarly, another informant mentioned, *"social work is taking root, because people are better understanding the role that social workers play in society."*

Committees and networks

Rwanda has a strong tradition of community-based networks and committees. These include faith-based initiatives, child protection committees and community savings groups. Child protection committees are typically made up of local authorities and the chair of the village's executive committee.

Textbox 5

Training curriculum for social workers and psychologists

The training curriculum developed for the pre-service training of the social workers and psychologists is based within the child-rights framework and builds upon the training that participants have already received in their university degree courses. The curriculum includes eight modules:

Module 1 – National Frameworks
Module 2 – Child Protection
Module 3 – Child Well-being Assessment
Module 4 – Child-Centred Programming
Module 5 – Professional Identity
Module 6 – Resource Mobilization
Module 7 – M&E/Impact measurement
Module 8 – Professional Productivity (ICT, report writing, negotiation, leadership, time management etc).[125]

Textbox 6

Promising practice

UNICEF, NCC and other key partners used the research as an opportunity to train a new cadre of social workers. University-trained social workers were hired for the district-level positions (identified as a key component of the TMM). Before starting work, the social workers participated in a training provided by Tulane University, acting as data collectors for the rapid assessment of children involved in the deinstitutionalization process. This was a strategic move in terms of providing the social workers with exposure to pre-service training and direct involvement in the data collection process, as well as being more cost-effective than hiring outside data collectors. It is hoped that the social workers gained first-hand experience of the benefits and challenges associated with deinstitutionalization, monitoring and family support, and that this will inform their future work and enable them to assist in other evidence-gathering efforts in future. Additionally, the data analysis and results will help inform future deinstitutionalization efforts and prevention measures that the social workers are directly involved in at the district level.

The committees might also include leaders in the faith community or other important members of the communities. In some instances, the child protection committees have taken on a role in gatekeeping (see Textbox 9). Associated with those initiatives are large cadres of volunteers that perform the functions of community-based health-care workers, community psychosocial workers or social workers. In many cases volunteers are in the frontline of the care-reform process and are responsible for both disseminating information, as well as identifying vulnerable children and families in their communities. In addition, as noted above, beginning in 2014 volunteer members of the *Inshuti Z'Umuryango* have a role in monitoring and following up at risk families in the community and families where a child has been reintegrated[126].

Donor community

The donor community has also been made aware of this priority by the Rwandan government and UNICEF. According to stakeholders, European donors (e.g., the European Union [EU], Swedish International Development Cooperation Agency [Sida] and the UK Department for International Development [DFID]) have been approached and discussions are ongoing. Currently, the reform process is primarily funded through multi- and bilateral organizations such as UNICEF, and the Displaced Children and Orphans Fund (DCOF) at USAID, who have dedicated funds to the care-reform effort and/or to larger orphans and vulnerable children (OVC) and social protection responses that link with or support care reform. The His Chase Foundation,[127] a private foundation, agreed to support ongoing education including secondary and university fees for 241 children from Noel de Nyundo residential care facility once they have been reunified.[128] According to the NCC, the Global Fund will also support 790 families and establish 90 early childhood development centres, with the priority given to children formerly in residential care and residential care centres that are interested in transforming to ECD centres.[129] Identification of funds is an ongoing issue and other potential donors are being approached. For example, the Unity Club, under the stewardship of the First Lady of Rwanda, donated funds to build houses for 20 children who were moving from residential care to independent living.[130]

Children

Children's voices and opinions are one of the main influences of the current child-care reform efforts. The Rwandan government has made a commitment to involving children in policy discussions through the establishment of children's forums, which are in place from the village up to the district levels. At the national level there is an annual children's summit. The children's forums have existed since 2004, while a formal, regulated process for election procedures, as well as guidelines, was officially established in 2012, led by the NCC. At the children's summit in January 2011, 800 children representing all areas of the country said they wanted children in families to be prioritized. This was reaffirmed in a presentation given at the 2013 children's summit, where UNICEF Rwanda Representative Noala Skinner lauded the efforts of the Government of Rwanda to deliver on its promises to children stating, *"Dear children, you speak, and Rwanda listens."*

At the village level there is a general assembly composed of all children aged 6–18 years old living in the village. Its elected executive committee is composed of a president, vice president, secretary, two advisers and a representative of children with disabilities, if possible. This structure is then replicated at the cell level, with the general assembly made up of all of the executive committees of all the villages within the cell along with an elected executive committee. This same process occurs at the sector level and the district level.[131]

2.2 Government commitment

There is a demonstrated commitment to the child-care reform process at the highest government level. This commitment also appears to be backed by allocation and coordination of resources. The NCC has begun to allocate funds previously used to support residential care towards family- and community-based initiatives. Similarly, early childhood development has been recognized as a national priority. It is talked about as a core family strengthening intervention that will help to decrease reliance on residential care and promote stronger families, thus preventing unnecessary separation.

In May 2013, the President of Rwanda explained the commitment to child-care reform during a speech on Rwanda

Day in London. An audience member raised concerns about how the care-reform process will be enacted and suggested it might be worse for some children. The President responded, *"You don't get up in the morning and you say we are closing institutions. It is not a matter of closing institutions as you can imagine. There is a process to this that starts by assessing and then following up each case. We need to see how children will be in families. Behind this what we want is the well-being of children in families. Every step is monitored to ensure the well-being of children."*[132]

2.3 Information management system (IMS)

The NCC has a mandate to collect data related to children's rights and protection. The NCC is also responsible for overseeing the child-rights data gathering and management, together with MIGEPROF and the National Institute of Statistics of Rwanda. The NCC is mandated to develop, in partnership with the National Institute of Statistics of Rwanda, a data management system for regular status reports on children and their rights. Ideally, aggregated data can then be analysed and disseminated to support policy, plans and programme interventions at all levels.[133]

To date, several different mechanisms have been used to collect information related to child protection and care, but these have yet to be collated into one central database. The issue of data collection was noted in the 2013 Concluding Observations of the CRC Committee, which issued the following recommendation: *"Strengthen its data collection system to ensure availability of up-to-date data on children in the most vulnerable situations, including children heading their own households, children with disabilities and living in poverty, children affected by HIV/AIDS and from marginalized Batwa communities. In this regard, the NCC, the Child Rights Observatory and the National Institute for Statistics should coordinate and harmonize their data collection to avoid duplication and discrepancies in data and information on children."*[134]

As part of the care-reform process, a mapping exercise on existing information management systems has been conducted by a UNICEF consultant. The aim of the study was to develop a clear understanding of the current child protection information system in Rwanda, including a comprehensive mapping and analysis for the current or planned case management and information systems across different government departments, NGOs, universities and other key stakeholders. Findings and recommendations were validated in July 2013 and will be used to inform the ongoing process of establishing a comprehensive information management system within the NCC.[135]

2.4 Interface of care and child protection systems

It is clear from the National Child Care Reform Strategy as well as the TMM that child-care reform, and specifically its alternative care component, are viewed as entry points into larger, more holistic strengthening of the child protection system. The NCC, UNICEF and other key partners envisage the reform process as an opportunity to support continued strengthening of the larger child protection system, including strengthening the social welfare workforce and the capacity of government bodies responsible for childcare and protection at all levels, and focusing on supporting parents and caregivers

Table 3

Ratification of key international human rights instruments

Convention or Protocol	Ratification status
Convention on the Rights of the Child (UNCRC)	Ratified 24 January 1991
CRC Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography	Ratified in 2002
CRC Optional Protocol on Involvement of Children in Armed Conflict	Acceded 23 April 2002
International Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)	Ratified 2 March 1981
International Labour Organization (ILO) Convention 183 on the Worst Forms of Child Labour	Ratified 23 May 2000
International Covenant on Economic, Social and Cultural Rights (CESCR)	Acceded 16 April 1975
International Covenant on Civil and Political Rights (ICCPR)	Acceded 16 April 1975
Hague Convention on the Protection of Children and Co-operation in Respect of Inter-country Adoption	Ratified in 2008, Presidential Order acceding to the HCIA in 2010. Implemented in July 2012
Convention on the Rights of Persons with Disabilities	Ratified in 2008
Optional Protocol on the Convention on the Rights of Persons with Disabilities	Acceded 15 December 2008
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families	Acceded 15 December 2008
African Youth Charter	Ratified in 2007
African Charter on the Rights and Welfare of the Child	Ratified 11 May 2001

through creating stronger linkages with existing services. One of the main objectives of the existing work funded by USAID/DCOF is increasing the capacity of the NCC at the national and district levels to coordinate and provide oversight of both the reform process and the larger child protection system.[136] The TMM included a reference to a recent study,[137] which highlighted that child-care reform is understood as an opportunity to utilize the care subsystem as a change agent to support the strengthening of the larger child protection system rather than being seen in isolation.[138]

3 Legal and policy framework

Rwanda has a strong legal and policy framework based upon international instruments and respectful of human rights, including those of children. The national legal and policy framework is also quite robust, with many recent child-rights laws and policies adopted in the last few years helping support the current child-care reform process.

3.1 Ratification of key international instruments

Rwanda has ratified many international legal instruments and has made significant efforts in harmonizing its own national legal framework to reflect the content of those instruments. The National Constitution of Rwanda (2003) makes specific reference to the Convention on the Rights of the Child. Furthermore, Article 190 of the National Constitution provides that international treaties ratified and published in the official gazette are part of the domestic law of Rwanda and can be invoked before the courts of law.[139] Table 3 highlights the main child rights-based international instruments that Rwanda has ratified.

Table 4

National laws and policies pertaining to child-care

National Constitution of Rwanda (2003), Article 28: provides that, *"every child has the right to special protection that his conditions might require from his family, the society and the State."* In its preamble, the National Constitution refers to the Convention on the Rights of the Child.

Law 01/2007 relating to the protection of persons with disabilities

Strategic Plan for OVC (2008–2012)

Presidential Order 24/01 of 2010 acceding to the HCIA

Law No. 22/2011, which establishes the National Commission for Children

Law No. 54/2011 relating to the Rights and Protection of the Child, adopted in June 2012, provides an enabling legal framework which recognizes the family and family-based care as not only necessary but in the best interest of vulnerable children. The law also highlights the development, promotion and expansion of alternative care options for children.

Integrated Child Rights Policy and Strategic Plan (2011)

National Strategic Plan for Family Promotion (2011)

The Economic Development and Poverty Reduction Strategy: a framework for integrating the issue of OVCs in all other sectors

Strategy for National Child Care Reform (2012)

Organic Law No. 01/2012/OL criminalizes child abandonment, in order to prevent and remedy child abuse and neglect[140]

Guidelines on foster care, national adoption, inter-country adoption and residential care (DRAFT as of July 2013)

The National Social Protection Policy (DRAFT)

3.2 Laws, policies, guidelines and regulations

Table 4 highlights key national laws, policies, strategies and guidelines specific to childcare and protection.

Law 54/2011 on the Rights and Protection of the Child includes specific articles relating to prevention of separation, family support, alternative care and the social integration of children, many recognizing the specific rights of children in care. These include the following:

- **Article 26:** Prevention of separation and support to parents
- **Article 31:** Child participation
- **Articles 27, 32, 33 and 34:** Process for determining placement
- **Articles 35, 36 and 37:** Rights/procedures during placement
- **Articles 38, 39 and 40:** Types of alternative care placement

3.3 Reforming the legal and policy framework

The existing laws and strategies provide a comprehensive framework for promoting and supporting the role of the family, prioritization of a family environment for alternative care placements, and the role of different actors involved in the process. The informants expressed pride in the comprehensiveness of Rwanda's legal and policy framework, and many were familiar with the contents.[141] Rwanda also has many mechanisms to ensure the implementation of these laws and strategies. Such implementation will be further enhanced by the approval of guidelines for the different forms of alternative care, although these were still in the process of validation at the time of writing.

3.4 Enactment and Implementation of the legal and policy framework

The 'backbone' of care reform is Law 54/2011 on the Rights and Protection of the Child and the Integrated Child Rights Policy and Strategic Plan (2011). The Integrated Child Rights Policy is the first comprehensive policy addressing all children's issues in Rwanda. Its overall objective is to ensure children's rights to survival, protection and development through improved access to quality services and strengthened institutions and

systems. Government officials and civil society organizations are well aware of the legal and policy framework and utilize it to help guide their work with children and families.[142] There is also vast dissemination and understanding of the legal and policy framework from the highest levels down to community members. As one district official from Kicukiro District in Kigali said, *"We own our policy!"* This commitment to adherence to, familiarization with and utilization of the policy framework provides useful guidance, a common vision, similar language and a place of reference in the child-care reform efforts currently taking place. The alternative care guidelines (in draft form at the time of writing) will be an important addition to the care-reform process generally and the legal, policy and regulation framework specifically, as there remains a need for clear guidance on how to both implement and monitor alternative care.

> *"We don't just want children in families, we want them in good families."*
>
> Permanent Secretary of the Ministry of Gender and Family Protection

4 Preventing the need for alternative care

4.1 Policies and services available to prevent family breakdown and separation

The role of the family and the importance placed on supporting and strengthening the family is made clear in the legal and policy framework of Rwanda, as well as the current child-care reform process that prioritizes family-based care for children, beginning with prevention of separation. The National Constitution of Rwanda specifically mentions the importance of family care for children. As noted in Child Frontiers (2012), the *"civil code and National Constitution reference reunification with family or extended family and specifically mention formalising it as guardianship of children."*[143] Other key legal and policy frameworks prioritize prevention of separation through supporting the family unit. Several national initiatives are in place to promote this, including social protection programmes, strong community-based mechanisms and a new prioritization on early childhood education. The importance placed on family-based care for orphans was significant following the genocide, and that has continued since the 1990s – but with an even stronger and more intense focus in the past couple of years.

One area related to prevention that has raised concern with the Committee on the Rights of the Child is Organic Law No. 01/2012/OL, which criminalizes child abandonment. In its Concluding Observations, the CRC Committee noted that it, *"is concerned about the unintended consequences of criminalization measures on economically and socially disadvantaged parents or families, particularly those living in poverty, and the negative effects that criminalization would have on the efforts to trace parents or guardians for family reunification purposes."*[144] The CRC Committee recommended that the law be reviewed and reformed to ensure that families who are not able to care for their children due to poverty and other reasons are not prosecuted, and that necessary reforms are put in place to facilitate reunification. The CRC Committee also went on to suggest that the root causes of child abandonment, including poverty, be addressed through the provision of specialized services, including *"financial and technical resources, appropriate information and integrated social services."*[145]

Rwanda has been impacted by HIV and AIDS and at the time of writing was ranked twenty-first worldwide in terms of prevalence; 2.9 per cent of the adult population are living with the virus.[146] Prevention of mother-to-child transmission (PMTCT) has significantly increased with 98 per cent of pregnant women receiving antiretroviral treatment (ARTs).[147] This success is both important in decreasing the spread of the virus to children in utero, but is also aimed at keeping mothers healthy and adhering to ARTs – with one of the potential outcomes being reduced family separation for this especially vulnerable group.

4.2 Policies and services available to promote and support family reintegration

The National Social Protection Strategy (2011) specifically references the most vulnerable children as a particularly important category to support, stating:

> *"The most vulnerable children are a particularly important category to support. Many vulnerable children will benefit as members of households receiving cash transfers (including Direct Support and Public Works Programmes), which will enable households to feed, clothe and educate their children, even in times of crisis. They will also benefit through complementary programmes aimed at increasing the ability of households to engage in productive activities. By 2014, we will assess the feasibility of a future child grant. We will also encourage non-governmental actors working with vulnerable children to provide them with a package of minimum support, and we will gradually build our capacity to ensure children are protected from abuse."*[148]

The new Social Protection Policy was being drafted at the time of writing by a multisectoral group and includes children as a primary target group for social protection initiatives. The Social Protection Strategy (2011) notes that children living

with elderly caregivers are some of the poorest and most vulnerable – their poverty rate is 7 per cent above the national average.[149] Female-headed households are also considered especially vulnerable. Therefore these groups are among those prioritized for social protection interventions. Social protection initiatives include the national health insurance plan, covering between 85–96 per cent of the population;[150] 143,000 people were also covered by the cash transfer programme in 2012.[151] Rwanda also boasts an extensive and globally recognized community health worker programme, which has been instrumental in helping Rwanda meet or exceed several health-related Millennium Development Goals (MDGs).

> *"It is better to live with my mom in poverty than it is to live in even the best orphanage."*
>
> **A 17-year old boy who spent seven years in a residential child-care facility and was recently reunified with his mother**

Access to basic services, such as education, is an important part of the continuum of services that need to be available to and accessible by children. In terms of fulfilment of a child's right to education, Rwanda stands out among countries in Africa. Rwanda has the highest rates of enrolment in primary school in all of Africa and is on track to fulfil the MDG goal of universal access to primary education by 2015. The net enrolment rate for primary school is 96.5, with not just gender parity, but girls having higher rates than boys (98 per cent as compared to 95 per cent).[152] Continued efforts focus on not just ensuring access to primary education, but completion of both primary and secondary education and provision of quality education by trained teachers. It has been mentioned that that one group of children that do not access primary education are children with disabilities.[153] Key informants from UNICEF and an NGO mentioned this as an ongoing challenge that required more attention.

There is a specific fund, the Genocide Survivors Support and Assistance Fund (FARG), set up for victims of the genocide that includes both cash and educational support. The existence and budget of the FARG is specifically mentioned in the National Constitution, with 5 per cent of the national budget committed to supporting, in various forms, the more than 300,000 surviving victims of the genocide.[154] Many families at risk of separation due to poverty, disability, unemployment or other factors receive a monthly economic allowance, livelihood support, educational scholarships and/or medical assistance.[155] Several key informants did mention that vulnerable families they worked with benefitted from the FARG. Key findings[156] from a final evaluation showed that support from FARG helped improve the welfare of programme beneficiaries. This was especially true in the case of education, health and shelter, which were noted as having the most impact.[157] Children benefitted most from educational support, including young adults who went to vocational school or university. The study also noted, via self-reports from beneficiaries, 49 per cent of those that received support considered themselves to be *"independent/self-sufficient."*[158] Other outcomes resulting from FARG support were reported as: food security (20.3 per cent of beneficiaries); improved health (16 per cent of beneficiaries); and acquisition of livestock (5.7 per cent of beneficiaries).[159]

Building the resilience of families is a common theme frequently noted in the literature, by the donor community as well as with key implementers. Global Communities (CHF), a key partner in the child-care reform, has significant USAID funding to support the implementation of the following community-based resilience-building efforts to complement and/or link to existing national social protection initiatives:[160]

- Positive deviance hearth groups (a community-based approach to address malnutrition in children under 5);
- Farmer field schools (FFS): FFS is a proven strategy for increasing household food production; and
- Internal savings and lending groups (ISLGs).

The DCOF-funded *Ishema Mu Muryango* (Pride for the Family) project led by Global Communities and implemented in partnership with Hope and Homes for Children and NCC incorporates these resiliency building interventions into targeted support for families with reintegrated children. *Ishema Mu Muryango* is facilitating the deinstitutionalization process in several residential care facilities through a set of activities including from child assessments, family tracing and assessments, child and family preparation, child placements and post-placement activities. They are also supporting the recruitment, training and support of foster care givers and is integrating positive deviance hearth groups, farmer field schools, early childhood development groups, community based psycho social workers and internal savings and lending groups into their community work to help support families with reintegrated children. For example, the positive deviance hearth groups and early childhood playgroups are particularly useful in helping to integrate recently placed children (i.e., reintegrated) into the community and aims to decrease any potential stigma or discrimination that they might face as a result of having been in residential care. From April 2013 – March 2015 the IMM project has helped to reintegrate 549 children and young adults from two residential care facilities and provided them with important follow up support to ensure that the placement is successful. Furthermore, through their community based activities, they have helped prevent the placement of 4,327 children into residential care through family strengthening approaches.[161]

The focus of CHF's programming is to provide pathways to 'graduation and sustainability', including strengthening

capacity, systems and partnerships across three dimensions: households, communities and local civil society organizations. In addition to these activities, community psychosocial workers (CPWs) associated with the national programme mentioned above will receive additional training provided by the DCOF-funded project to be able to provide basic counselling services to families at established sector- or village-level sites.

HHC is also involved in protection through its Community Hub model.[157]

Key informant interviews raised some concern about limited linkages between deinstitutionalization and prevention efforts, and the social protection mechanisms already in place. Recognizing the challenges associated both with reunification, as well as alternative care placements such as kinship care and foster care, the TMM has ensured that monitoring and evaluation (M&E), assessment and evidence collection are a core component of the reform process. At the time of writing, a rapid assessment of approximately 150 cases of children involved in the deinstitutionalization process was being carried out (see Annex 4). This study is looking at a range of cases including those that: 1) were reintegrated into families with professional assistance and social support[162] provided by HHC; and 2) children from other residential care facilities that were reintegrated into the community without professional assistance or social supports (i.e. 'spontaneously'). The study aims to collect information on the following issues:[163]

- Final placement of children who were involved in the deinstitutionalization process;
- The process involved in reunification (e.g. assessment), including the length of time, steps involved etc.;
- Who was involved in the reintegration process (e.g. trained social workers, staff from the residential care facility, government officials etc.);
- What type of monitoring was provided after placement and how long the monitoring took place; and
- Risk assessment of children in their current placement.

At the time of this report, the rapid assessment study had not been finalized. Key informants recognized the lack of evidence related to deinstitutionalization and outcomes for children, and acknowledged that there were concerns about the 'success' of some placements. The results of the rapid assessment will be utilized to inform the next steps of the deinstitutionalization process.[164] The research instruments that were developed for the rapid assessment will also be utilized to assess subsequent cohorts of children who are reintegrated into families or alternative family-based care during the period 2013–2015. Similarly, the 150 children involved in the initial rapid assessment will additionally be followed up after a period of time to be determined.[165] In addition to this study, key informants mentioned that existing tools such as the Household Resiliency Index developed by Global Communities[162] will also be adapted and utilized to look at the results and impacts of family support interventions.[166]

Other studies looking at the 'success' of reunification/reintegration processes with other populations have been carried out. For example, FIDESCO has conducted a study to assess the success rate and quality of reunifications of street children during the period 2010–2012. The findings of the study will be shared with the PCT.[167]

Textbox 7

Case study – Deinstitutionalization and reunification

Hope and Homes for Children (HHC) first piloted deinstitutionalization in 2010. The HHC pilot targeted one residential child-care facility: *Mpore Pefa*. This was a privately run facility located in Kicukiro district of Kigali, providing care to approximately 50 persons (from infants to young adults) at any given point in time. The pilot project utilized key steps in the process, which began with an assessment and family tracing for children in care, the development of individualized care plans, preparation of the child and family, placement and post-placement support. HHC staff worked closely with local government in the process and linked with existing services including educational support, healthcare and housing. Fifty-one children were placed in community-based care including within the biological or extended family, foster families or were provided with independent living arrangements.[168] All efforts were made to first try and place children with their biological parents or extended family. If that was not possible or was not in the best interest of the child, an alternative family was sought.

The deinstitutionalization process involved the following activities:

- Assessment of children and families, including family tracing;
- Individual care plans, placement decisions and preparation of children and families;
- Recruitment, training and preparation of alternative families (including foster and kinship care);
- Establishing a child-care network to prevent abandonment and institutionalization and to support family-based alternative care;
- Gradual transition of children into family placement or independent living;
- Post-placement monitoring and support; and
- Development of community-based services aimed at family strengthening and child protection, including a Community Hub.

A package of support was provided to assist the placement of each child into family-based care. This support was offered to each family in line with their needs, based on the five elements: living conditions, health, education, family and social relationships, and household economy.[169]

The results of the pilot deinstitutionalization process included: 16 children reintegrated with their birth parents; 10 children reintegrated with their extended family within their communities; 20 children placed in foster families, including one child with disabilities. One of the children was subsequently reintegrated into the birth family from foster care. Four of the children were at the time of writing in the process of a foster care-to-adoption placement, although government adoption guidelines are still being finalized.[170] The remaining five young adults were supported to live independently.

A specific case study of reintegration is included in Annex 3.

5 Formal alternative care

5.1 Formal alternative care data

As in most countries in the region, the number of children in formal alternative care in Rwanda has only recently been enumerated. This is due to limited or fractured information management systems (IMS), as well as a tradition of informal care practices over formal ones. Rwanda has a range of formal alternative care options for children including foster care, guardianship and residential care (including temporary shelter for street children).

Formal foster care was introduced following the genocide when thousands of children were cared for in this manner, although the majority were in informal foster care.[171] Guardianship[172] is also very prominent in Rwanda and existed before the genocide. It is important to note that there is still confusion, especially at the local level, regarding the differentiation between formal foster care, guardianship and domestic adoption. This is recognized by key actors involved in child-care reform and is part of both the public awareness campaign and development of the guidelines.

Data provided by the NCC in August 2013 placed the number of children in formal care as follows:[173]

- 2,504 children in registered residential child-care facilities (this number does not include children with disabilities living in different residential care centres for children, youth and adults with disabilities);
- 1,196 children in 25 centres for street children;
- 117 children in adult detention centres (children living with their mothers in detention); and
- 19 children in formal foster care.

Please note: no updated official data was available at the time of writing this report. For updated data on children reintegrated out of residential care as of March 2015, see page 11.

At present, there are no government data regarding children in formal foster care, although individual organizations delivering foster-care services do keep records. For example, HHC reported 19 children in foster care as part of the deinstitutionalization process. Of the originally 20 children placed in foster care, one child was subsequently reintegrated into their birth family.[174] According to key informants, foster caregivers receive some support for the provision of foster-care services. This can include payment of the universal health insurance, as well as mattresses for the whole family. This is considered part of the 'reintegration package'. An individual assessment is used to determine if other material support is needed.[175]

During key informant interviews, many representatives from NGOs, FBOs and government spoke about foster care as a necessary care option for children, especially for those leaving residential care, as well as a preventative response to placement in residential care. Foster care, when discussed, appeared to be thought of as mainly a long-term placement option and not an emergency or short-term option, primarily because this is how it has been used in the past – specifically post-genocide and with the recent HHC foster-care cases.[176] Because the foster-care guidelines have yet to be finalized, this care option appears to be at a relatively nascent stage and would benefit from more attention and thought around the different models of foster-care placements (e.g., emergency, short-term and long-term) and how those care options will be developed, provided and managed.

Textbox 8

Promising practice: building upon traditional care mechanisms

The *Imbuto* Foundation has supported and promoted the idea of 'treat every child as your own' through highlighting excellent caregivers in the *Malaika Mulinzi* ('Guardian Angel') programme. Beginning in 2007, the programme recognizes exemplary caregivers of orphaned and/or vulnerable children (typically in an informal, long-term foster care and/or kinship placement) and awards a cow to each of two caregivers in each district on an annual basis.[189] This has raised awareness and respect around the importance of positive caregivers. Furthermore, the foundation has helped establish networks of these caregivers in each of the 30 districts. Each network has approximately 120 families. The caregivers have already been included in the reform work and will help to both recruit new formal foster and adoptive families, as well as serve as potential emergency or short-term foster caregivers. Discussions between the *Imbuto* Foundation[190] and the NCC have highlighted this collaboration and involvement of community-based caregivers as an important tool for strengthening alternative, family-based care in Rwanda and building upon already-existing, traditional care mechanisms.

Currently, the Rwandan Integrated Child Rights Policy (ICRP) defines 'alternative care', *"as care for orphans and other vulnerable children who are not under the custody or care of their biological parents, for a variety of reasons including abandonment, imprisonment of parents, detention/imprisonment of children, neglect of children and children who have run away from their homes or have lost contact with their parents due to conflicts/wars and children separated from parents by natural disasters or in refugee camps."*[177] Furthermore, the ICRP in Article 2.6.1 recognizes and prioritizes the following alternative care options:

a: Kinship care (children without parents placed in the care of extended family);
b: Formal adoption within community/country;
c: Placement in foster care within their communities;
d: Inter-country adoption in accordance with international and national guidelines; and
e: Institutional care as a last resort, with continuous effort placed on finding a different option.

The above alternative care options include both formal and informal care. Rwanda does have existing foster-care and adoption guidelines that were developed several years ago; however, these will be replaced by the new guidelines that were being drafted at the time of writing for foster care, residential care, domestic adoption and inter-country adoption.

The 2001 study on fostering practices analysed the different care practices of foster care, guardianship and adoption.[175] The study found that foster care, following the genocide, was widely practised and somewhat formalized (e.g. parents had to sign an agreement with the local authorities), but that it was confusing as this form of care was not specifically mentioned in the legal and policy framework at the time.[179]

This has changed with the ICRP, which recognizes foster care as a valid and formal care option – although the number of children in this type of care is still very small (see above). The draft guidelines were due to be finalized by the end of 2013,[180] whereby additional guidance will be provided and the overall process formalized – with families recruited, assessed, trained, approved and monitored by local authorities.

Textbox 9

Case study – Community-based gatekeeping and alternative, family-based care[181]

A five-month-old infant was left abandoned by a mother who suffered from mental health problems and alcohol abuse. The baby was later placed with his grandmother, but she was frail and unable to care for him on a long-term basis.

Social workers involved in the community-based child-care network[182] in *Gikondo* sector, *Kicukiro* district, were made aware of the child's situation. A social worker made a home visit to the grandmother's house to carry out an initial assessment.

The social worker found the family in a difficult situation; the child's health was in critical condition and he was at immediate risk of being placed into residential care because the grandmother was not able to care for him appropriately. The social worker decided to explore the possibility of placing the child into another type of care placement – i.e. foster care.

The local authorities in *Gikondo* are the leaders of the local child-care network, together with the chairman of the village's executive committee. The network identified emergency healthcare for the child, and also identified a number of families in the local community as potential foster carers. Members of the child-care network worked together to assess the motivations and circumstances of each of the potential foster families. One family was found to be the best match for the child, particularly as they visited him often while he was in the health centre. The decision to place the child in foster care was made by the local leader of the child-care network. HHC provided training for the foster parents. Together with their two young children, the family prepared to welcome the child into their family.

Today, the little boy is healthy and fully integrated into his new family, where he enjoys playing with his two foster siblings. Thanks to the collaboration and services provided by the child-care network, the child is able to live in a family environment with caregivers committed to his well-being. The foster family and child are visited regularly and the placement is monitored to ensure quality of care. The child presently remains in long-term foster care, while the grandmother is receiving support from the local authorities via specific interventions targeting the elderly without family support. The grandmother continues to visit her grandchild regularly.

5.2 Formal alternative care practices

Formal care is still primarily residential care, but this is changing as government encourages other forms of care and some local governments and/or residential care facilities are refusing new entrants. Although there remains confusion about the differences between kinship care, foster care and guardianship, public awareness campaigns, training and capacity building of community social workers and local officials are helping people understand the differences. With recent deinstitutionalization efforts, foster care is now being practised and recognized as a valid formal care option.

Gatekeeping mechanisms are relatively nascent, but have developed in several districts and sectors across the country. The pilot deinstitutionalization project of HHC established child-care networks to function as gatekeeping mechanisms (see case study, Textbox 9) and this model is being replicated. However, it could be named differently and will address more than just alternative care issues – for instance, it will probably also include other child protection issues. There is recognition of the importance of prevention as a critical part of deinstitutionalization and of the larger child-care reform. The National Child Care Reform Strategy and the TMM both mention prevention and/or the role of gatekeeping by community-based multidisciplinary groups at the sector and district levels. Many of these groups currently exist as child protection committees, but to date have not necessarily specified and defined their gatekeeping role. Therefore, training of these groups on the specific function of gatekeeping has been identified as part of the reform process over the next few years.

"We want to revitalize traditional care mechanisms together with development. This is what has helped Rwanda meet its MDG goals."

Executive Secretary of the National Commission for Children

5.3 Reforms to strengthen and expand formal family-based alternative care services

Several of the residential child-care facilities that have closed or are in the process of closing have developed plans to transform their services from residential care to ones that promote family-based care and community engagement. According to key informants, some owners/managers of residential care facilities were concerned or against the idea of transformation due to their own other interests (e.g. financial), but many were open to learning about possible transformation opportunities. During the pilot project involving Mpore Pefa, the staff of the institution was consulted and numerous individual and group sessions were held to discuss the process and its implications for the children, staff and service. Mpore Pefa had a total of 14 staff, with little training in child protection and care. As a result there were serious issues concerning the quality of care provided. As such, six staff immediately left as the process started. Hope and Homes for Children offered training to the staff in hopes that they would be able to find future work within prevention or alternative care services. In other countries where Hope and Homes for Children have implemented similar programmes, many residential care staff members choose to become foster caregivers. This was not the case with Mpore Pefa, which according to key informants from Hope and Homes for Children was surprising.

In other situations, residential care facilities have decided to take the opportunity to redirect their services and resources. One of the initial residential care facilities that closed received funding from the government to set up a dairy, so that the income earned from that project could support children who had been reintegrated into family care from the facility. The amount of support was based on individual needs assessments carried out by social workers managing the case. Another residential care facility that has almost completed the deinstitutionalization process will convert its facility to an early childhood development centre, which will serve the neighbouring community. The facility also has a long-term project of cultivating and selling flowers to help finance the centre. There is also the case of His Chase Foundation,[183] mentioned in Section 2.1 above, which after discussions with government and management of the Noel de Nyundo residential care facility, agreed to continue funding scholarships after the children had been reunified with families, to ensure continuity of education. Supporting this effort, the Rwandan Government (via the NCC) has progressively reallocated funds and identified new funds to support more than 1,449 families.[184]

6 Informal alternative care

Rwanda has a strong tradition of informal child-care practices. Statistics from 2008 found that registered child-care facilities were only caring for approximately 0.5 per cent of all single and double orphans in the country, and that the vast majority of orphans were in informal care settings.[185] The 2010 Demographic and Health Survey (DHS) study statistics compiler showed that 16.8 per cent of households were caring for a 'foster' child (a child living in a household without their mother or father present).[186] Reflecting these numbers, key informants suggested that the vast number of children separated from parents were cared for within extended family or informal foster families. There is a critical need to be able to extract and analyse the relationship to household head data from the 2010 DHS, to better understand the living arrangements of children who are not living with a biological parent.

The National Child Care Reform Strategy recognizes the long-held tradition and benefits of informal caring practices in Rwanda and envisions building on them and creating structures and processes that can support the care, ensuring the protection and best interests of the child.[187]

The *Malaika Mulinzi* ('Guardian Angel') initiative works to promote, support and recognize informal caregivers, and estimates that there are *"thousands"* across Rwanda.[188] As noted above, these caregivers will be used as community advocates or spokespersons in the recruitment campaign for new formal foster caregivers (in this case, foster caregiver refers to long-term caregiving, both kinship and non-kinship). Additionally, they might also be considered to be the first emergency or short-term foster caregivers, given their years of experience.

7 Domestic and inter-country adoption

7.1 Domestic and inter-country adoption data

There are no centralized data on the number of domestic adoptions in Rwanda. To date, formal domestic adoption has been processed at the sector level. Local authorities approve this and then the primary court approves the final legal process. At the time of writing, there was no system in place for collating information regarding the number of domestic adoptions upwards to national level.

Rwanda has ratified the 1993 Hague Convention for the Protection of Children and Co-operation in Respect of Inter-country Adoption (HCIA), although inter-country adoption is not currently practised in Rwanda as there has been a moratorium in place since 2010.[191] The moratorium is to allow the government time to ensure ethical and transparent processes are in place to ensure the best interests of the child during an adoption process: *"Current suspension on inter-country adoptions will remain in effect until the country has a fully functional Convention process in place."*[192] Prior to the moratorium, inter-country adoption statistics provided by Peter Selman, a global expert on inter-country statistics, showed figures as laid out in Table 5.[193]

Table 5

Rwanda: inter-country adoption statistics

Receiving Country	USA	FRANCE	SWITZERLAND	CANADA	BELGIUM	SWEDEN	NETHERLANDS	ITALY	TOTAL
2003	1	3	3	3	0	0	0	0	**10**
2004	3	7	2	0	0	0	0	0	**12**
2005	0	16	2	2	5	2	0	0	**27**
2006	4	40	2	0	0	1	0	0	**47**
2007	4	4	3	0	0	0	0	0	**11**
2008	17	0	7	2	0	1	0	1	**28**
2009	16	4	4	5	0	0	0	0	**29**
2010	40	5	9	3	0	0	0	0	**57**
2011	58	3	11	8	0	0	1	0	**81**
2003–2011	143	82	43	23	5	4	1	1	302

7.2 Adoption practices

As noted above, there is some confusion around long-term foster care and formal domestic adoption, as it appears that most foster-care situations are long term and therefore considered by many as 'adoptions', although lacking the formal process. That being said, key informants also recognized that formal domestic adoption is growing. Furthermore, anecdotal evidence showed that domestic adoption was not cost prohibitive and many couples found the process relatively straightforward.[194] It is hoped that involvement by faith-based communities and mass media in public awareness campaigns will result in an increasing number of prospective adoptive families. HHC reported that four of its current foster-care families have asked to adopt the children in their care. This is being supported, despite the fact that at the time of this report national guidelines for domestic adoption were yet to be finalized.[195] Key informants familiar with domestic adoption did mention that training and post-placement follow-up will be included within the domestic adoption guidelines.

During the past several years, there have been no noted concerns related to inter-country adoption in Rwanda. It appears that inter-country adoption is considered by Rwandan actors involved in childcare and protection to be a valid care option for a specific group and profile of children, but there is also noted caution in wanting to ensure transparent and ethical procedures once the process opens.[196] This includes having clear guidelines in place for inter-country adoption and limiting the number of approved adoption services providers. There is also discussion around prioritizing international adoptive placement of children with the Rwandan diaspora.

7.3 Reforms to address concerns about adoption practices

With ratification of the 1993 Hague Convention and drafting of the new guidelines on domestic adoption, it is hoped that clearer and more centralized processes and procedures, including relevant data collection on eligible children and families pre- and post-adoption, will occur for both domestic and inter-country adoption. The draft guidelines on domestic adoption (being finalized at the time of writing) outline the responsibilities of the sector, district and national levels. The formal matching process and approval will be carried out at the district level, with information provided about the child and family to the NCC. The NCC will have a centralized database of eligible children, prospective adoptive families and finalized adoptions.[197] As the adoption process is a formal, juridical process it will also involve the court approving an adoption act.

The guidelines for inter-country adoption are also still to be approved, which was noted in the CRC Committee Concluding Observations: *"The Committee notes with concern that despite the ratification of the Hague Convention on Protection of Children and Co-operation in Respect of Inter-country Adoption, the State Party has not yet adopted implementing regulations for the law or established necessary structures and mechanisms to implement the Hague Convention."*[198] The Concluding Observations also recommend that Rwanda, *"ensure strict transparency and follow-up control mechanisms with regard to international adoption and*

ensure regular follow-up of the conditions of adopted children."[199] According to key informants, the NCC will have a primary role in the processing, approval, monitoring and oversight of inter-country adoption, and will act as the designated central authority as per the requirements of the HCIA. Key informants from within NCC also spoke definitively about wanting to be able to ensure that Rwandan children adopted internationally are placed within families that respect Rwandan culture and that will have access to other families that have adopted Rwandan children to ensure a connection with their country of origin.[200]

8 Care during an emergency

As noted above, the 1994 genocide resulted in the expansion of kinship care and the emergence of foster care (both informal and formal) and guardianship arrangements. This process is well documented in Doná, G., *The Rwandan Experience of Fostering Separated Children.* Additionally, family tracing and reunification processes were critical to the post-genocide effort and thousands of children were reunified with extended family or communities.[201] The work also included specific efforts to trace and reunify children associated with armed forces and groups.[202] This early work in tracing and reunification has provided useful lessons for other country contexts.

Currently, Rwanda houses two refugee camps – *Gihembe* and *Kiziba* (the oldest in Rwanda) – which provide shelter for children and families from neighbouring countries. Formal processes are in place for family tracing and reunification. A draft report written by the Child Protection in Crisis Group[203] utilized ethnographic methodology aimed at providing an overview of local beliefs, values and practices related to harms faced by children living in the two refugee camps. Although the study did not look specifically at care issues, it was noted in the research that children without parental care were more vulnerable than those living with parents, especially in terms of sex work, school drop-out and early pregnancy. The research also highlights the community-based child protection response mechanisms that have evolved over time, many of these rooted in the family, clan and neighbours in the camp.[204] This perhaps makes those without family ties less likely to be protected from or responded to when protection violations occur.

9 Public awareness and advocacy

9.1 Awareness-raising campaign

The current public awareness campaign on the child-care reform – as designed, coordinated and overseen at all levels by the NCC (and supported by a dedicated position within the commission) – involves utilization of mass media (i.e. radio and TV), as well as forums, conferences, partnerships with faith-based organizations, and collaboration with children's and women's forums. The campaign is facilitated by Rwanda's strong government administration, while public awareness-raising initiatives from the past, including the 'One Child-One Family' campaign, help inform the process.

The national campaign involves disseminating key messages and building awareness around the negative effects of residential care, and the benefits of family care, positive parenting and the role of the family. According to a key informant directly involved in this, the NCC is using a bottom-up approach – reaching out to communities and then upwards to policy-makers.[205] Additionally, the campaign has trained, and will continue to work with, members of the press to sensitize them to key issues, build common terminology, build interest and increase publication of reform-related coverage.

Rwanda has an established day of collective community work *('Umuganda')*[206] one Saturday every month. Every Rwandan adult is expected to attend and assist with community clean up and maintenance. There is also a community meeting at the end of the event. The public awareness campaign is taking advantage of this existing structure and practice, and is working with community leaders to include child-care reform topics within these discussions.

9.2 Public perception

The public awareness campaign builds upon Rwandan's sense of family and caring for members of the community, and it is not uncommon to hear people talk of the end goal of the reform process as being strong Rwandan families caring for children. Similarly, the First Lady and her *Imbuto* Foundation recognize outstanding caregivers every year, while several awards are presented to community-based caregivers, elevating the status and recognition associated with traditional fostering.[207] The NCC also frequently carries stories related to care reform. An example was a December 2013 article highlighting the deinstitutionalization process at Rwanda's largest residential care facility, Noel de Nyudo. The First Lady helped celebrate the reintegration of 60 children into their families and the building of 20 homes for children who were due to be leaving care and moving into independent living situations.[208]

Although positive strides have been made, some stakeholders did mention concern that the overwhelming attitude is still positive towards residential care and that it will take more time to change this view. Information dissemination and messaging of key points of the reform continue to be important elements in developing a sense of ownership of the process and appear to be a strong asset in changing such attitudes.

10 Conclusion

10.1 Key findings and areas of learning

Rwanda has made great progress in reforming its child-care and protection system, with significant efforts made in the past year (2013). Moving from a residential care model to family-based care, strengthening the legal and policy framework, training and expanding the social welfare workforce, and building upon traditional care mechanisms to develop more formal alternative care options are some of the major actions that have occurred or are currently taking place. The following tables summarize key areas of learning from the child-care reform process in Rwanda. The first table highlights particular components and results of the care-reform process that stand out. The child-care reform process, as noted throughout, requires significant human and financial resources, leadership, coordination and government ownership. Despite the noted positive aspects of this reform process, there are also associated challenges – these are listed in the second table.

Table 6

Results of care reform and promising practices:

1. **In just over four years (2011–2015), more than 1,696 children have left residential care** and been reunified with biological or extended family, foster families or independent living situations.[209] Government and leading NGO actors involved have made financial plans and an ongoing commitment to this effort.
2. **The strong government ownership, leadership and commitment to the process** is evident given the establishment of the new National Commission for Children. NCC is making a concerted effort to increase and strengthen its capacity to successfully fulfil its mandate.
3. **Traditional care mechanisms such as long-term kinship care are being recognized, promoted and built upon as part of the care-reform process.** The use of existing examples and caregivers as inspiration to promote family-based care is recognized by government actors, NGOs and faith-based organizations. Formal foster care has also been piloted and, although limited in number, is providing lessons for how best to expand this formal care option.
4. **The care reform is making great strides in linking with early childhood education programmes and interventions.** Key actors involved in these activities are in regular communication and recognize how these two separate strands can link and enhance one another. Of specific interest is how ECD implementation will use existing residential care infrastructure in the development of new ECD centres.
5. **The coordinated and multisector engagement approach in Rwanda** supports this effort with government, NGOs and FBOs working closely together towards commonly understood and appreciated goals and objectives. The top-level commitment and its effective communication through the various levels is a key part of the reform.
6. **Rwanda has a strong legal and policy framework that provides a solid foundation in support of care reform.** The existence of the National Child Care Reform Strategy has proved essential in providing a guiding framework that leads and directs the work of the different actors involved in the reform process. Prioritization of social protection and early childhood development will further support the care reform by supporting prevention of separation and helping build the resilience and competencies of Rwandan families.
7. **The involvement of the faith-based community in this reform** appears to be a valuable tool to help spread key messages about child-care reform, and has the potential to be a significant source for recruitment of kinship and foster caregivers and prospective domestic adoptive parents.
8. **The training and deployment of a special cadre of social workers and psychologists at the district level demonstrates that there is an understanding of how critical human resources are to the care-reform process.** The additional 68 professionally trained staff will help provide leadership, coordination and support at the district level. This is an important element of the care-reform process, but due attention is also required to address gaps in human resources at the community level.
9. The reform process will require continuing significant work from all of the key stakeholders involved, but there appears to be general agreement that Rwanda can and should do it, and that ***placing the well-being and cohesion of Rwandan families at the centre of the country's development will play a significant role in positive results for the country as a whole.***

Table 7

Identified challenges and lessons from the care-reform process:

1. The deinstitutionalization process was launched quickly in response to the Prime Minister's declaration that all residential care facilities would be closed by the end of 2014. Although positive in demonstrating government commitment to the effort, this did result in spontaneous, **unplanned reunifications that did not involve case planning, assessment or follow up.** There were concerns about the status of children that were placed during the start-up of this process. As noted, a follow-up study is in progress that will utilize results to help inform current deinstitutionalization efforts, specifically those that are planned. Key informants noted the important lesson learned from the initial deinstitutionalization efforts and the recognition that time, professional staff and coordination are key ingredients to successful reunification processes and procedures. Furthermore, the importance of a public awareness campaign with similar key messages about the deinstitutionalization process was noted.
2. **Links between social protection efforts and care reform, specifically in relation to targeting families at risk of separation and/or reunified families, can be strengthened.** Ensuring that actors involved in social protection are aware of, and knowledgeable about, the care reform and understand how social protection interventions could be used to both prevent separation and support reunification is important so that existing resources and opportunities are utilized.
3. **Resistance to reform by some donors, decision-makers and service providers (e.g. residential care staff) remains a constant challenge.** Many stakeholders mentioned the ongoing challenge of changing the mind-set of key actors involved in child care and the need to take time and be strategic in how to gain their interest and commitment to the reform process. This should be considered in the planning and assignment of resources towards public awareness and advocacy.
4. **Confusion remains among caregivers, practitioners, some officials and the general public about the difference between long-term foster care, guardianship and domestic adoption.** It is intended that the draft guidelines on foster care and adoption will remedy this, along with the current public awareness campaign at all levels.
5. **Related to the above, the lack of concrete domestic adoption statistics is notable.** Although statistics are collected at the sector level, these have yet to be collated, analysed and utilized at the national level. One suggestion might be for newly established social workers and psychologists at the district level to work with colleagues at the central level to gather this information to be used as a baseline.
6. **Limited data and dispersed information management systems.** Limited statistics exist relating to children in formal and informal care, and although there have been many initiatives that focus on developing IMS, there is still a notable gap. The NCC has this mandate and, as noted in the CRC Concluding Observations, this coordinated information management system needs to be established urgently. Similarly, a case management system is also necessary and this has been highlighted as a key action relating to the reform process.
7. **Further evidence base is required regarding the 'push and pull' factors that result in children being placed in residential care, kinship care or abandoned.** At the time of writing, there is also limited information about the status and well-being of children in kinship care. Most stakeholders agreed that family-based care and traditional, informal care options are an important option within the continuum, but concrete evidence on how these are practised and the outcomes for children would be useful and could help inform future policy and practice. The National Study on Residential Care (2012)[210] provides helpful information on the push and pull factors related to residential care, but it would also be helpful to have a stronger evidence base for other issues that impact families and care, including domestic violence and early pregnancy.
8. **There is noted concern regarding the law on abandonment and its criminalization.** Given that most abandonment is due to poverty or violence, it is recommended that this law be reviewed and prioritization be placed not on criminalization but on providing services and preventing abandonment in the first place.
9. **Gatekeeping mechanisms are being piloted and the role of gatekeeping has been specifically mentioned as part of the reform process, but these mechanisms should be prioritized to help prevent unnecessary separation and/or placement in residential care.** The pilot studies provide lessons for practice and further roll out. If Rwanda aims to end residential care in a short period of time, having established gatekeeping mechanisms in place, with clear scopes of work, is necessary and should be prioritized.
10. One issue that **does not appear to have been specifically addressed within the current deinstitutionalization process is that of children with disabilities.** Currently, some children with disabilities reside within residential care facilities targeted for closure, but it appears the vast majority of these children reside in other facilities specifically for persons (of all ages) with mental and physical disabilities. Therefore, such children do not fall under the current deinstitutionalization process. Recent data provided by the NCC shows that 2,712 children with disabilities reside in 42 residential care facilities for disabled persons (children and adults).[211] This is an issue that should be prioritized in future efforts, and issues of children with disabilities should be mainstreamed into all existing and future child-care reform efforts.

10.2 Key learning areas for care reform in sub-Saharan Africa

The following are key areas of learning from the child-care reform process in Rwanda. These are examples of positive initiatives around strategy, coordination, public awareness and the role of children.

1. **Having a comprehensive strategy and vision, in the case of Rwanda the *Tubarerere Mu Muryangyo!* (TMM), has provided a clear, mutually understood framework to guide care reform.**

2. **The tripartite approach utilized in child-care reform involving government (the NCC), UNICEF and NGOs (HHC and CHF) promotes cohesion and coordination.** This was facilitated by the formation of a Program Coordination Team (PCT) at the highest level.

3. **The existence of a specific government body to lead and coordinate the child-care reform process is key, as is continued capacity building of that body.** In the case of Rwanda, the NCC has made significant strides in building its capacity and in taking a strong leadership role in the child-care reform process. Stakeholders clearly recognize that the NCC is the ultimate driver and owner of the reform process, but also feel that the involvement of civil society is recognized and appreciated. Having a focal point within the NCC (one person or a team of persons) dedicated to child-care reform has also helped facilitate coordination, communication and has fostered excellent working relationships with stakeholders.

4. **Strong government support and recognition of the role of civil society is a core part of the child-care reform process.** The strategy clearly calls for the active engagement of children, communities, local authorities, FBOs and NGOs in the reform process, and such involvement is evident in current child-care reform efforts. The HHC piloted the deinstitutionalization process, which was instrumental in influencing the care-reform process. This, in combination with its research to advocate for policy change, provides an example of the impactful role that NGOs can play.[212]

5. **The role of children, their voices and engagement (children's forums and children's summits) is essential.** For example, the voices of children have been instrumental in influencing the commitment to care reform at the highest level – as demonstrated in the 2011 National Children's Summit. This is true not just for child-care reform, but other areas such as adolescent development, healthcare and education.

6. **Administrative structures are in place from the national, district, sector, cell and village levels and have helped to communicate the key content of the TMM to all administrative levels.** The existence of performance contracts with specific indicators related to childcare and protection also helps foster accountability and implementation of key elements of the reform process.

7. **Building the technical capacity and sustainability of a social welfare workforce is a core component of the reform process.** The role of supportive supervision is also recognized and addressed through training and development of job descriptions. However, there is still a need **to address the lack of a standardized training curricula, to identify competencies and appropriate supervision structures required for the social welfare workforce** – particularly for volunteers working on behalf of and trained by various NGOs, CBOs and FBOs. The possibility of a standardized certificate programme for this cadre could also be explored.

8. **The child-care reform process has recognized traditional care practices** – for example, kinship, community care and *Malaika Mulinzi* (Guardian Angels) – and has used these as a foundation for deinstitutionalization efforts, as well as for prevention.

9. **Prevention is recognized as being critical to the deinstitutionalization and the larger child-care reform.** In Rwanda, **there is only nascent recognition of what a gatekeeping mechanism is and how it can help prevent unnecessary family separations.** However, by utilizing existing child-care networks, the reform process is training existing structures at the cell, sector and district level child-care networks to provide a gatekeeping mechanism. Pilot projects should also be utilized to help inform the process of establishing gatekeeping mechanisms.

10. **Linking children placed in reunification with existing services and support – such as the social protection sector – is crucial, as is utilizing these to also prevent unnecessary separation and placement in residential child-care centres.** Many organizations are involved in activities around food security, vocational training and income-generation. Although not directly linked to the care-reform process, it should be a priority to engage these groups in strengthening the prevention side of the reform effort.

11. **The National Child Care Reform Strategy views communication and public awareness as a core component of child-care reform – from the village to the national levels.**

12. **From the beginning of the care-reform process and throughout the TMM, data collection, analysis and use of evidence to inform the reform have been included.** Recognizing that this has been a weak area to date, the reform process is prioritizing data collection and use and is working towards developing a centralized information management system.

11 Endnotes

1 The 'Guidelines for the Alternative Care of Children' were welcomed by the UN General Assembly in 2009. The guidelines are a framework to guide governments and partners to promote, facilitate and guide the progressive implementation of the Convention on the Rights of the Child in this particular area of concern. For more information visit: <http://bettercarenetwork.org/BCN/initiatives.asp>, accessed 2013.

2 UNICEF website, 'African Charter on the Rights and Welfare of the Child', <www.unicef.org/esaro/African_Charter_articles_in_full.pdf>, accessed 2013.

3 The World Bank, 'Data: Rwanda', <http://data.worldbank.org/country/rwanda>, accessed 23 September 2013. Note total population for 2012 was 11,460,000.

4 The estimated population in 2013 was 12,012,589. The Central Intelligence Agency (CIA), 'World Fact Book: Rwanda', <www.cia.gov/library/publications/the-world-factbook/geos/rw.html>, accessed 30 June 2013.

5 Information received from the National Commission for Children.

6 The World Bank, 'Data: Global Economic Prospects', <www.worldbank.org/en/publication/global-economic-prospects/data?region=SST> , accessed 2013.

7 Ibid.

8 The World Bank, 'World Development Indicators: Rwanda', <http://data.worldbank.org/country/rwanda#cp_wdi>, accessed 22 September 2013; *The Third Integrated Household Living Conditions Survey,* as referenced in NCC and UNICEF, *'Tubarerere Mu Muryangyo!* Let's Raise Children in Families!'.

9 National Institute of Statistics of Rwanda (NISR), *The Third Integrated Household Living Conditions Survey* (EICV3), 2010–2011.

10 UN Development Programme (UNDP), 'Human Development Reports', <http://hdr.undp.org/en/2014-report>, accessed 21 June 2013.

11 Sources: National Commission for Children and UNICEF, *'Tubarerere Mu Muryangyo!* Let's Raise Children in Families!', November 2012; National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda] and ICF International, *Rwanda Demographic and Health Survey* 2010, NISR, MOH and ICF International, Calverton, Maryland, 2011, as referenced in The Way Forward Project, *The Way Forward Project Report,* Congressional Coalition on Adoption Institute (CCAI), 2011, <http://www.bettercarenetwork.org/BCN/details.asp?id=31077&themeID=1003&topicID=1020>, accessed 10 September 2012.

12 NISR [Rwanda], MOH [Rwanda] and ICF International, *Rwanda Demographic and Health Survey 2010,* p. xxiii.

13 Doná, G., *The Rwandan Experience of Fostering Separated Children,* Save the Children, 2001.

14 Ibid.

15 Merkelbach, M., *Reunified Children Separated from their Families after the Rwandan Crisis of 1994: The Relative Value of a Central Database,* International Review of the Red Cross, 2000, as referenced in International Rescue Committee (IRC), *Protecting Children and Adolescents Before and After Conflict. Innovative Approaches and Practices. Family Reunification, Alternative Care and Community Reintegration of Separated Children in Post-Conflict Rwanda,* IRC, 2003.

16 Ministry of Gender and Family Promotion, Republic of Rwanda (MIGEPROF) and Hope and Homes for Children, *National Survey of Institutions for Children in Rwanda,* 2012.

17 Ibid.

18 Ibid.

19 Key informant interviews with Hope and Homes for Children.

20 Ibid.

21 Ibid.

22 Ibid. p. 12

23 Key informant interviews with international organizations, non-governmental organizations (NGOs) and government.

24 Government of Rwanda, Cabinet of Ministers, 'Cabinet Brief: Strategy for National Child Care Reform', 2012.

25 United Nations Committee on the Rights of the Child, Concluding Observations Rwanda, CRC/C/ISR/CO/2-4, 2013, <www.crin.org/docs/CRC-C-RWA-CO-3-4.pdf>, accessed 7 July 2013.

26 Ibid.

27 'Deinstitutionalization', as defined by the Better Care Network toolkit, refers to the process of closing residential care facilities and providing alternative family-based care within the community, <http://bettercarenetwork.org/BCN/Toolkit/Glossary/index.asp#d>, accessed 2013.

28 P.E.A.C.E. Plan stands for **P**romote reconciliation – **E**quip servant leaders – **A**ssist the poor – **C**are for the sick – **E**ducate the next generation.

29 Doná, G., The Rwandan Experience of Fostering Separated Children.

30 Ibid.

31 Ibid.

32 Key informant interview with NGO, June 2013.

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100 *'Imihigo'* are contracts between the President of Rwanda and government agencies detailing what the respective institution has set itself as targets on a number of governance, justice, economic and social indicators. The stated objective of *Imihigo* is to improve the speed and quality of execution of government programmes, thus making public agencies more effective. It has been noted that the *Imihigo* is a tool for planning and is utilized to accelerate progress towards economic and developmental goals.
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Annexes

1 Overview of process and steps for collecting information. Data collection matrix.

2 List of key stakeholders interviewed for Rwanda.

3 Case study of reintegration.

4 Terms of reference for consultancy to conduct rapid assessment of children reintegrated from orphanages.

Terms of reference for the Programme Coordination Team for the implementation of the *Tubarerere Mu Muryango* programme.

Annex 1

Overview of process and steps for collecting information

Identifying countries

The first step in the process was identifying countries in sub-Saharan Africa that have implemented significant child-care reform efforts. The consultants first conducted an initial assessment of sub-Saharan Africa and identified 13 countries that are or have been involved in child-care reform initiatives. The team used a four-topic matrix, which included the following components of child-care reform:

1 Presence of legal and policy framework for child protection, childcare and alternative care;
2 Completion of systems mapping or child-care assessments;
3 Presence of networks, inter-sectorial collaboration; and
4 Presence of concrete actions related to child-care reform.

The 13-country list included countries representative of: East and Southern Africa and West and Central African regions, a range of socioeconomic status, emergency and non-emergency settings, and Anglophone and Francophone countries. The matrix was sent to UNICEF East and Southern Africa and West and Central Africa Regional Offices as well as Save the Children Africa Regional Office for review and selection of four to eight countries. Based on feedback from UNICEF, Save the Children and BCN, the consultants narrowed the initial list to seven countries: Kenya, Rwanda, Ghana, Liberia, Sierra Leone, Benin and Cote d'Ivoire.

The second step consisted of a literature review of relevant documentation of the seven selected countries. This included a comprehensive review of:

- Published literature, including peer-reviewed journal articles;
- Grey literature; national and regional policy, standards and legislative documents; and conference materials, presentations and outcome documents (e.g., the 2011 'Way Forward' conference, 2011 US Government 'Evidence Summit on Children Outside of Family Care', 2010 Leiden 'Conference on the Development and Care of Children without Permanent Parental Care',[213] 2009 Nairobi 'Family-Based Care Conference', 2009 'Wilton Park Conference', 2012 'Inter-country Adoption Conference' in Addis Ababa, and the 2012 'Conference on the Strengthening of Family and Alternative Care in the French-speaking sub-Saharan Africa');
- News articles from international and national media outlets; and
- Country child-care and child protection systems assessments conducted by universities, UN agencies, NGOs, the CRC Committee and Hague Secretariat.

The literature review was supported by Internet searches, a call for grey literature via the BCN, OVC Support, the Coalition for Children Affected by AIDS (CCABA), the Inter-Agency Task Team (IATT), Child Rights International Network (CRIN), Child Protection in Crisis Network (CPC) Network, Faith to Action Initiative and other information exchange platforms, and

communication with key actors/organizations working in alternative care including UNICEF country office staff, the BCN Steering Committee and Advisory Group members, NGOs, donors, academics and researchers.

In order to guide the literature review and the process of mapping the child-care reform in each country, the consultants developed a country analysis matrix. The matrix includes over 50 child care-related themes and topics (see below). The matrix helped identify the available information in regards to the country's legal and policy framework, childcare/protection system, preventive services, formal and informal alternative care services, adoption (domestic and inter-country), care during an emergency situation, and public awareness, advocacy, and networking around family strengthening and alternative care.

A general checklist and a brief synthesis were also developed to help in summarizing the care-reform situation in each country. The following core child-care issue areas, which are linked to and influenced by the 'Guidelines for the Alternative Care of Children' (UN, 2009), framed the checklist:

1 Enactment and enforcement of the legal and policy framework;
2 Preventive services;
3 Availability and range of family-based alternative care services;
4 Domestic adoption;
5 Inter-country adoption;
6 Networks and partnership; and
7 Public awareness and advocacy.

Based on the analysis, three countries were selected for the country profiles: Rwanda, Ghana and Liberia. These countries showed the most information and evidence of promising policies and practices in the region. While the three countries were selected as the initial countries to be documented, it is foreseen that additional countries will be documented within the region and other regions in the future.

Collecting country information and data

Once the three countries were identified, a more detailed literature review was conducted, including: published and 'grey' literature; documentation, data and reports from government, BCN, UNICEF and relevant organizational and technical specialists across the three countries; a review of all relevant country laws, policies, standards and regulations; and a review of alternative care tools and training materials. The materials were drawn from BCN, UNICEF, country-level alternative care networks, internet searches, as well as the resources indicated above in use for the global scan. The literature review built upon pre-literature review findings and informed the country field visits. Telephone consultations with key global and regional-level stakeholders and technical experts with in-depth knowledge of the country context supplemented the literature review. Around 70 documents and websites were reviewed for the Rwanda report (see Section 12).

Once the desk review and key informant interviews were finalized, a five-day field visit to each country was conducted in order to meet with key stakeholders and undertake focus group discussions (FGDs) and key informant interviews with country-level child-care actors to expand on the initial information gathered through interviews and literature review. The key informants included representatives from the respective government ministries, foster-care and adoption agencies, non-governmental organizations, faith-based and community organizations, care associations and networks, and academic institutions, as well as children, families and caregivers (see Annex 2 for a full list of key informants interviewed in Rwanda in June 2013).

The objectives of the country visit included the following:

- Confirm information collected during the desk review;
- Collect updated data on specific issues related to child-care reform;
- Review recently published documentation, resources, guidelines, tools, and information on key actors that might not have been included in or were inaccessible during the desk review phase;
- Hold focus group discussions and key informant interviews with key stakeholders to collect their views on specific aspects of the care-reform process, including children and caregivers;
- Create opportunities to hear voices not necessarily represented in the documentation (e.g., care leavers, caregivers, children and families, faith-based groups, community members); and
- Attempt to gather information that was identified as knowledge 'gaps' during the desk review.

Data collection matrix

Description and purpose of the matrix:
Child-care reform process. The questionnaire will help identify the available (as well as missing) information in regards to the country's legal and policy framework, child-care/protection system, preventive services, formal and informal alternative care services, adoption, care during an emergency situation, and public awareness, advocacy and networking around this issue. The starred questions are core questions that we hope to answer for each country.

Sources used to develop the matrix: 'Guidelines for the Alternative Care of Children' (UN, 2009); *The Assessment Tool for the Implementation of the UN 'Guidelines for the Alternative Care of Children'* (Nigel Cantwell, for SOS Children's Villages International, 2012); Child Protection System Mapping and Assessment Toolkit (Maestral International, LLC for UNICEF, 2010).

Availability of reports, research and general information about alternative care

	Question	List and describe	Sources
1*	Are there country-level child protection systems or child-care assessments; reports, studies, research, websites on alternative and childcare available for the country?		
2*	If reports are available what are the main issues, challenges and successes highlighted in the reports about child-care reform in the country?		

Country-level legal and policy framework

	Question	List and describe	Sources
3*	Has the country ratified key child protection human rights instruments (CRC, Hague Convention etc.)? Please list the instruments and dates of ratification.		
4*	Are there laws, policies, guidelines and regulations and standards specific to childcare and alternative care?		
5*	In general, is the country's legal and policy framework in line with the CRC and Alternative Care Guidelines principles (i.e., best interests of the child)?		
6*	Does the legal and policy framework reflect the Hague Convention for the Protection of Children and Co-operation in Respect of Adoption, especially the subsidiarity of inter-country adoption to domestic family-based care options?		
7*	Is there a government-approved strategy for bringing about deinstitutionalization of the alternative care system? — In general — For children under 3 to 5 years — With a target timeframe		
8*	Are there existing efforts to reform the child-care/alternative care policy and legal framework?		
9	Does legislation require the implementation of specific measures and services to prevent family separation?		
10	Does legislation require the implementation of given processes and measures to ensure that the suitability of family-based alternative care for a child is considered before envisioning placement in a residential facility?		
11	Is the process of leaving and aftercare supported in the law?		

Description of child protection/child-care system

Question	List and describe their roles and responsibilities in service delivery, advocacy and networking	Sources
12* Description of the population of children living outside of family care or at risk. This should include description of the particular threats to children and families that lead to children living outside of family care (i.e., HIV, disability, armed conflict, disaster, trafficking, labour, abuse etc.).		
13* Description of the key social welfare workforce groups/cadres and service providers of children in alternative care, including government, NGOs, FBOs, for profit. Also mention if these service providers work together and if there are collaborative mechanisms in place for this type of coordination.		
14* Description of other actors involved in alternative care: alternative care networks; youth or care leavers network; foster parents association; etc.		
15 Are children and caregivers actively engaged in policy and programming that directly affect them and does the legal and policy framework support this?		
16 Description of key donors supporting child protection and alternative care.		
17 Describe the political will and commitment of the government in relation to child-care/alternative care. E.g., Executive Branch leadership; alternative care in national development plans etc.		
18 Does the national budget include line item on child protection and specifically alternative care?		
19 Is there a national information management system specific to child protection, in particular collecting data on children in alternative care?		

Preventive services

Question	List and describe	Sources
20* Describe the range of services and the quality of services that are available to prevent family breakdown and separation, e.g., cash transfers, daycare, respite care, income-generating activities, PSS, etc.		

Formal alternative care services

Question	List and describe	Sources
21* Are there data or credible estimates of the number of children placed in formal alternative care? E.g., residential care, formal foster care, small group homes, etc.		
22* How many children are in residential care versus family-based alternative care (i.e., formal foster care, formal kinship care)?		
23* What is the range of formal alternative care options available to children?		
24* Are there legally recognized alternative care options specifically for: emergency care; short-term care, long-term care?		
25* Are there national reform efforts in place to try to strengthen and expand family-based alternative care service provision?		

Formal alternative care services

	Question	List and describe	Sources
26	In general what is the capacity of government and non-government actors to properly carry out various forms of alternative care service delivery?		
27	Are there trainings and capacity-building initiatives to address capacity/skill gaps for the social welfare workforce and for caregivers?		
28	What are the main reasons/driving factors for placement in alternative care? How and who has documented this?		
29	Are there clear gatekeeping mechanisms and admission policies and procedures in place for residential care? Foster care? Other types of alternative care?		
30	Are children given clear care plans and monitored throughout placement? Residential care? Foster Care? Other types of alternative care?		
31	To what extent are children in alternative care being reintegrated into their families or communities of origin?		
32	Are children/youth provided with preparation and support upon leaving/exiting care? Please include who provides this preparation and support, if known.		
33	Are formal alternative care facilities authorized, registered, inspected, and monitored by authorizing bodies on a regular basis?		
34	Are there standards of care developed, disseminated and utilized in the formal alternative care facilities?		
35	What types of formal alternative care services are available for children with special needs?		
36	What is the quality of formal foster care in general?		
37	What is the quality of residential care in general?		
38	Are there general and widespread concerns about rights violations of children in formal care settings?		

Informal alternative care services

	Question	List and describe	Sources
39*	Are there data or credible estimates of the number of children placed informally outside the parental home? E.g., with grandparents, with other relatives, with local community, in sibling groups (child-headed households) etc.		
40*	Has the state taken any initiatives to establish or improve support or oversight of informal arrangements? E.g., — Voluntary registration of informal carers — Provision of financial allowances — Making available/increasing access to support services — Combating exploitative practices		

Adoption (domestic and inter-country)

Question		List and describe	Sources
41	Are there general and widespread concerns about rights violations of children in informal care settings?		
42*	Are there data or credible estimates of number of children placed in domestic adoption? Inter-country adoption?		
43*	How widely is domestic adoption practised? If practised widely, what are the reasons and good practices? If not practised widely, what are the challenges?		
44*	How widely is ICA practised? What are the main issues and concerns in terms of ICA?		
45*	If there are concerns with adoption practices, are there reform efforts to address these issues?		

Care during an emergency

Question		List and describe	Sources
46*	Has the country recently experienced an emergency? If so, how has it responded in terms of alternative care? Challenges? Successes?		
47*	Has the emergency resulted in child-care reform efforts? If so, please describe.		

Public awareness and advocacy

Question		List and describe	Sources
48*	What are the key child-care advocacy initiatives in place?		
49*	Is there any national awareness-raising campaign specific to childcare? If yes, please describe.		
50*	What is the role of media in childcare and awareness raising? Role of government? Civil society?		
51	Has the government and/or civil society organized conferences or workshops on this issue for key stakeholders?		
52	What is the general public perception on childcare provision, role of residential care, availability and acceptance of other alternative care options, etc.?		
53	Have there been any documented and publicized abuse, exploitation and neglect of children in alternative care?		

Annex 2

List of key stakeholders interviewed for Rwanda

	Name of informant	Title and place of work
1	Henriette Umulisa	Permanent Secretary, MIGEPROF
2	Damien Ngabonziza	Chair/ NCC Board of Commissioners
3	Zaina Nyiramatama	Executive Secretary, NCC
4	Valens Nkurikiyinka	Policy and Strategy Specialist and Child Care Reform Focal Point, NCC
5	Benilde Uwababyeyi	Adoption and Orphan Officer, NCC
6	Mukashema Alexia	Adoption and Orphan Officer, NCC
7	Annet Birungi	Communication Specialist, NCC
8	Noala Skinner	Country Representative, UNICEF
9	Ramatou Toure	Child Protection Specialist, UNICEF
10	Francesca Morandini	Chief Child protection, UNICEF
11	Gisele Rutayisire	Child and Social Protection, UNICEF
12	Rachel Sabates Wheeler	Social Protection Specialist, UNICEF
13	Esperance Uwicyeza	Gender and Family Promotion Officer, Kicukiro District Office
14	Alphonse Nkusi	Team Leader, Health & Social Welfare Promotion, USAID
15	Bitega Joseph	Director, FIDESCO
16	Twagira Augustin	Administration and Finance, Orphelinat Noel de Nyundo
17	Zacharie Dusingizimana	Executive Director, Ubumwe Community Center
18	Frederick Ndabaramiye	Assistant Director, Ubumwe Community Center
19	Kalinganire Charles	Lecturer in Social Work, National University of Rwanda
20	Nina Shalita	Deputy Director General & Youth Program Director, Imbuto Foundation
21	John Ntigengwa	Health Department Director, Imbuto Foundation
22	Milton Funes	Country Director, Global Communities (CHF International)
23	Innocent Habimfura	IMM Program Manager, Global Communities (CHF International)
24	Michelle Ell	Program Coordinator, Technical Services, Global Communities (CHF International)
25	Juste Kayihura	Program Coordinator, Cross Cutting Activities, Global Communities (CHF International)
26	Victoria Martin	Senior Programme Manager/HQ, Hope and Homes for Children
27	Claudine Nyinawagaga	Country Director, Hope and Homes for Children
28	Epaphrodite Nsabimana	Head of Program Management/ Intuitions, Hope and Homes for Children
29	Vidivi Karangwa Immaculle	Team Leader/ Psychologist, Hope and Homes for Children
30	Christella Bwiza	Team Leader/ Psychologist, Hope and Homes for Children
31	Francoise Murekatete	Social Worker, Hope and Homes for Children
32	Esperence Mukasekuru	Social Worker, Hope and Homes for Children
33	Moise Munyamariza	Social Worker, Hope and Homes for Children
34	Justine Mukandoli	Social Worker, Hope and Homes for Children
35	Eric Munyemana	CEO, P.E.A.C.E. Plan
36	Moses Ndahiro	Trainings Coordinator, P.E.A.C.E. Plan
37	Mary Kamanzi	P.E.A.C.E. Plan
38	Emmannuel karegyesa	Initiatives Coordinator, P.E.A.C.E. Plan
39	Marie Nolle Senyana Mottier	Head of Programs, Catholic Relief Services

Annex 3

Case study of reintegration

One specific examples of a reintegration case occurred as follows. In October 2011, Hope and Homes for Children (HHC), together with local authorities, moved four siblings out of a residential child-care facility and reunited them with their mother and three younger siblings. The oldest of the four siblings said this about the time in residential care: *"We did not know whether we would ever smile again in our lives. The food was very poor and insufficient, and hygiene was very poor. We had no one to ask for help as most of us were children."* He added, *"I made sure that I struggled to get food and clothes for my brother and sisters, especially for my youngest sister."*

In 2006 the father of the family had died. At the time they lived in a town close to the Tanzanian border. Facing economic difficulties, the mother left to travel to Kigali to work. Continued challenges forced the mother to return home, still facing poverty. The mother left her children at home on their own while she travelled to Tanzania, promising to return when she had found a job and could return to provide for her children. At the time, the oldest boy was only 12 years old: *"We had no food in the house. For five nights we survived. We would sleep without eating. Then we were compelled to go around asking for food from neighbours."*

The children were living at home without an adult caregiver. Among his mother's documents, the boy found a phone number for his uncle. The uncle took them in temporarily but soon, unbeknownst to the children, he began to process the documents required for their entry into a residential child-care facility with the local authority, claiming the children had no living relatives who could look after them. After four months with their uncle, his wife and seven children, the siblings were placed in the facility.

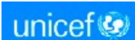
While their mother was away, she heard that the children were with their uncle and so, when she returned to her home, she chose not to contact them – thinking it better to leave their lives undisturbed after so much disruption. When she learned that the children were in fact in a residential care facility she tried to visit them. However, the children's uncle warned her that if she made contact with them, she could be sent to prison as in Rwanda it is against the law to abandon a child. It was at this stage that HHC made contact with the mother.

At the first meeting with the children, they told the HHC social worker that they had no parents or relatives. Although provided with this initial information, the HHC social worker continued with the complicated family tracing process and succeeded in identifying their mother, who by now had three more young children. The first meeting was very emotional. One of the children said, *"You are not our mother."* A series of meetings were facilitated by the HHC social worker aimed at re-establishing the relationship between the mother and her children. The HHC team worked closely with the children and their mother in order to rebuild their relationship and re-establish trust.

However, the children could not immediately return home, as the conditions where their mother lived were precarious. The HHC team worked to ensure that there would be a safe living environment for the mother and her seven children. The mother was also supported in setting up a small business to help provide ongoing support to her children. Although the family still deals with the challenges of poverty, the children are in school. The HHC social worker has regular follow-up visits with the family and recently supported the family while the mother addressed health issues. The HHC social worker also provides regular updates on the children to the local government authorities.

Annex 4

Terms of reference for consultancy to conduct rapid assessment of children reintegrated from orphanages



Background

The Government of Rwanda is committed to reforming the country's national child protection system. On March 16, 2012 the Cabinet of Ministers endorsed the National Strategy for Child Care Reform. The strategy, produced with assistance from UNICEF, seeks to reintegrate into families—biological, kinship, foster care--all children living in orphanages throughout the country.

At the end of 2011, 3,323 children lived in 33 orphanages in Rwanda. In 2011-2012, a National Survey on Institutional Care was conducted by MIGEPROF in partnership with Hope and Homes for Children (HHC) to obtain an accurate overview of the current institutional system and inform policy reform on child care.

The survey found that of the 3,323 institutionalized children, 55 per cent were boys and 45 per cent were girls supported through 600 staff in 19 districts. Thirty-one per cent of the children in orphanages had lost both parents while more than 70% had at least one parent or living relative. Six per cent of the primary caregivers of the institutionalized children had mental health problems and 3% were in prison. At least 1,116 children were in contact with their parents and were regularly visited by relatives. The majority of children in orphanages originated from the areas where the institutions are located, which suggests that orphanages have a "pulling effect." Most institutions were managed by faith-based organizations and/or were funded by international private donors. The amount of their funding is mostly unknown.

Decades of research have documented the harm of institutional care on children globally.[1] There is an abundance of evidence demonstrating serious developmental problems associated with placement in residential care. For the last fifty years, child development specialists have recognized that residential institutions consistently fail to meet children's developmental needs for attachment, acculturation and social integration. A particular shortcoming of institutional care is that young children typically do not experience the continuity of care that they need to form a lasting attachment with an adult caregiver. On going and meaningful contact between a child and an individual care provider is almost always impossible to maintain in a residential institution because of the high ratio of children to staff, the high frequency of staff turnover and the nature of shift work. Children in institutions often live in a peculiar environment with little basic community socialization. As a result, these children have difficulty forming and maintaining relationships throughout their childhood, adolescence and adult lives. There is also evidence that these children have a higher likelihood of homelessness, engagement in criminal activities and suicide later in life. [2] In Africa, mounting evidence consistently supports the cost-effectiveness and long-term child benefits of alternative care mechanisms over institutional care.

The National Commission for Children (NCC) is the government body responsible to oversee and coordinate the deinstitutionalization process. The NCC reported that between January – May 2012, 355 children have been reintegrated into the community.

To date, two groups of children have been reintegrated from orphanages into the community:

a. Children reintegrated into families with professional assistance and social supports from Hope and Homes Center. 51 children from the orphanage Mpore Pefa in Kigali have been reintegrated into their biological families, relatives, and non-kinship foster homes. None was sent to another orphanage

b. Children from other orphanages have been reintegrated into the community without professional assistance or social supports. These include:

    Ste. Elizabeth de Hongrie in Rulindo district. Approximately 60 children have been reintegrated into families in the community.

[1] "Families, Not Orphanages," John Williamson and Aaron Greenberg, September 2010, Better Care Network; "The Development and Care of Institutionally Reared Children," The Leiden Conference on the Development and Care of Children without Permanent Parents

[2] idem

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Centre Girimpuhwe Remera in Gatsibo district. Approximately 50 children have been reintegrated into families in the community.

The rapid assessment will assess the situation of approximately 150 children from these three orphanages or other orphanages selected by NCC in collaboration with UNICEF.

Objective of the consultant

UNICEF, in collaboration with the National Commission for Children, seeks an assessment to determine how the children who have been deinstitutionalized[3] from these three institutions are doing.[4]

In addition, the research instruments that are developed for this rapid assessment will be used to assess subsequent cohorts of children who are reintegrated into the community during the next two years, as well-as to follow-up the children who are part of the rapid assessment. A separate TOR and tender offer will be developed for that assessment.

The analysis would examine and compare two groups of children:

- Children who have been reintegrated with professional support (social work and psychological) with additional assistance to help the child and the family.
- Children who have been reintegrated into the community by staff from the orphanages without additional professional assistance.

The research would answer the following questions:

1. Are the children at risk? How many are living in safe, supportive environments? How many are living in situations in which they are at risk? How many are in intermediary situations? What is the level of risk?
2. For how many children were needs assessments conducted for the children and their families before the children were reintegrated into the community? How were the assessments done and who did them? What is the quality of the assessment?
3. What were the main reasons that children were placed in the orphanage?
4. At each orphanage, and in aggregate, how many children were reintegrated with:
    - Their biological family
    - A relative
    - A non-relative
    - Adoption
    - Another institution (e.g. an orphanage, or a facility for the disabled)
5. What psychosocial supports (e.g. counseling, training, guidance) was/is provided to each child and family? Was a needs assessment conducted? Which organization provided the support? Did the children and families receive the assistance they needed?
6. What financial supports in cash or in-kind ((e.g. material assistance, cash payments, assistance with school, food, housing, clothes, health) was/is provided to each child and family? Which organization provided the support?

[3] Some children may have been placed in other residential institutions. Their situation should also be assessed.
[4] It is possible that other orphanages that have deinstitutionalized children without professional support might be selected instead of one or both of these two based on the recommendation of NCC and UNICEF.

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7. What role did the supports and assistance play in creating a secure and nurturing environment for the child?

8. How long did the reintegration process take for each child and at each orphanage in general?

9. What ongoing monitoring is undertaken for each child and family after the child is placed into a family in the community? Who conducts the monitoring?

The consultant will be responsible for these specific tasks, with regular consultation with UNICEF and NCC and approval of work plan, methodology and research instruments. The work will be conducted in three phases: preparation, field work, data analysis and report writing.

1. Preparation

- Literature review
- consultation with key informants
- design of research instruments
- training of the research team
- planning visits to each orphanage
- In collaboration with UNICEF and NCC determine acceptable conditions for a child living in a family environment following reintegration into families from residential care. Determine the main indicators of inadequate care.

2. Field Work

- Sample selection (all children reintegrated into families from the **three** orphanages, including children who have been transferred to other residential institutions). **It is estimated that 150 children will be in the sample.**
- Data collection teams
- Interviews of informants (children [where old enough], parent(s), neighbours, teachers or other local leaders or officials)
- Review of case records where available

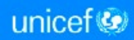
3. Data Analysis and Report Writing

- Quantitative analysis
- Qualitative analysis
- Draft report to be reviewed by UNICEF and NCC
- Final report
- Research informed recommendations

Deliverables

- Research plan and methodology
- Research instruments for this rapid assessment that can also be used to assess the risk and well-being of subsequent cohorts of children who are reintegrated into families in the community
- Draft Report, answering the research questions presented above.
- Final Report.
- The names of children who are in imminent danger will be identified and reported to a representative of NCC for immediate remedial action.
- Families and children at risk of harm will be offered the opportunity to have NCC or other officials notified of their situation so that remedial action can be taken.

Research instruments, data and the final report will belong to both the consultant, UNICEF and NCC. UNICEF will be able to use the data and instruments for subsequent follow-up studies of the children in this rapid assessment or for subsequent cohorts of children.



Profile of the consultant/institution

Applicants must hold an advanced university degree in a field of social science, science or related fields with a minimum 5years experience in social science research and evaluation, particular in the field of child protection and/or child and family welfare.

Applicants must:

- Have experience designing and carrying out assessments in the field of social welfare
- Be able to create a research team to collect and analyse data.
- Be able to produce a report in English using both qualitative and quantitative data
- Knowledge of the child protection system of Rwanda

Management arrangements

The consultant will report to the Chief of Governance and Social Protection in UNICEF who will work in close collaboration with the Social Protection Specialist. The Social Protection Specialist will review the research plan, methodology and research instruments.

The consultant and research team will be based in Kigali with travel to districts in which the orphanages are located and districts in which the children have been reintegrated into families. The consultant will organize all logistical aspects to fulfil assignment. The NCC will facilitate access to the orphanages which will provide initial information about the children in the assessment.

The consultant shall not make use of any unpublished or confidential information, made known to him in the course of performing his duties under the terms of this agreement, without written authorization.

Information about individual children and families will be kept confidential, except for the names of children in immediate danger. Those names will be provided to appropriate officials within NCC for immediate remedial action. With prior approval of the child/and or the family, the names of children and families who are at risk will be provide to NCC for referral for assistance.

The consultant shall respect the habits and customs of the local population and abstain from interfering in the country's political affairs.

Budget and terms of payments

Payment Plan: To be determined.

The consultancy is for a period of five months.

Terms of reference for the Programme Coordination Team for the implementation of the *Tubarerere Mu Muryango* programme

TERMS OF REFERENCE

PROGRAMME COORDINATION TEAM

FOR THE IMPLEMENTATION OF THE

TUBARERERE MU MURYANGO (LET'S RAISE CHILDREN IN FAMILIES)

PROGRAMME

Introduction

The Government of Rwanda is strongly committed to closing orphanages, reintegrating children safely into family-based environments and building a strengthened child protection system.

Rwanda has developed and validated (December 2010) an **Integrated Child Rights Policy (ICRP)** and subsequent **Strategic Plan (2011-16)** as a single comprehensive framework for all thematic areas addressing children. The ICRP is the first comprehensive document to address all children's issues in Rwanda, as opposed to existing policies and strategic plans focusing on specific categories of children. Its overall objective is *to ensure children's rights to survival, protection and development through improved access to quality services and strengthened institutions and systems*. The seven specific objectives of the ICRP are around: 1) recognition of identity and nationality, 2) family and alternative care, 3) universal access to health services, 4) universal access to education, 5) child protection systems, 6) improved access to justice for children, 7) child participation.

The focus of the *Tubarerere Mu Muryango* Programme is on objective 2: family and alternative care and objective 5: child protection systems. Toward carrying out these objectives, on March 16, 2012 the Cabinet of Ministers endorsed the National Strategy for Child Care Reform. The strategy seeks to deinstitutionalize all children living in orphanages and reintegrate them into families. The deinstitutionalization and alternative care activities will facilitate the transition to child care and protection system reform.

UNICEF, in collaboration with the National Commission for Children, submitted a proposal to USAID to provide financial support to carry out the National Strategy for Child Care Reform. The proposal has five strategic objectives which will be carried out over the next three years:

1. Building and enhancing the capacity of the National Commission for Children to lead a national child care reform and coordinate a functioning child protection system
2. Strengthening the capacity to deliver and coordinate child care services at decentralized levels
3. Strengthening the family unit for reintegration, resilience and prevention
4. Ensuring long term sustainability and strengthening the child protection system
5. Enhancing child care policies and practice through data and strategic knowledge management and monitoring and evaluation

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The management plan of the programme designates a Programme Coordination Team to monitor and oversee programme implementation. The management plan identifies representatives of the main implementing partners as the members of the Programme Coordination Team. They are:

- NCC
- MIGEPROF
- UNICEF
- HHC
- CHF

Objectives/Purpose

The Program Coordination Team (PCT) will be responsible for monitoring progress of the *Tubarerere Mu Muryango* Programme, overseeing program implementation, coordinating project activities, and assuring achievement of project outcomes.

The meetings of the PCT will allow for information exchange to ensure that implementing partners are aware of each other's activities in the implementation process.

Membership

The PCT will consist of the following members:

Executive Secretary, NCC
Focal Point, Child Care Reform, NCC
To be designated, MIGEPROF
Chief, Child Protection, UNICEF
Child Protection Specialist, UNICEF
Country Director, HHC
Senior Programme Manager, HHC
Country Director, CHF
Senior Manager, CHF

Responsibilities of the PCT as a Coordinating Body

The PCT will be responsible for coordinating the activities of all implementing partners on the *Tubarerere Mu Muryango* Programme. This will include:

- Ensure that all implementing partners are carrying out their respective responsibilities
- Prepare periodic reports on project implementation.
- Prepare information for liaising with Director of the Cabinet of the Prime Minister's Office, and the Permanent Secretary of MIGEPROF. The Executive Secretary of NCC and chair of the Program Coordination Team, and UNICEF Chief of Child Protection will meet regularly with these representatives.

Responsibilities of Members of the PCT

The representatives to the PCT will have responsibility to:

- Attend regular meetings of the PCT
- Report to their respective organization on the implementation of project activities
- Report to the PCT on the status of project implementation carried out by their organization
- Provide written information as needed on project implementation carried out by their organization.

Chairperson: The Executive Secretary of the NCC will chair the PCT.

Secretariat: UNICEF/NCC will be the secretariat for the PCT, responsible for scheduling meetings, preparing the agenda and preparing minutes of the meetings.

Frequency of Meetings

Initially the PCT will meet every other week as the programme coordination begins. Once the programme is running smoothly, the meetings will occur monthly.

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Network

Better Care Network
777 United Nations Plaza, Suite 3D,
New York, NY 10017
United States

www.bettercarenetwork.org

UNICEF Headquarters
3 United Nations Plaza
New York, NY 10017
United States

www.unicef.org