# EU support for care reform for children in Rwanda in the 2021-2027 period

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hope and homes
for children

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# 1. Introduction

Millions of children around the world live in institutions – including so-called "orphanages", residential special schools and reception centers – that expose them to a catalogue of human rights abuses and enhanced risk of violence, and which cannot meet their needs[1].

The issue of deinstitutionalisation has increasingly gained traction on the EU's global agenda. In 2018, the European Commission gave proof of its commitment towards **promoting the transition from institutional to community-based care for children** globally by including it **in its proposal for the Neighbourhood, Development and International Cooperation Instrument (NDICI)**[2]. The proposal is supported by the European Parliament and the Council[3].

Meanwhile the **Covid-19 pandemic** is having and will continue to have a dramatic impact on the most vulnerable children and families, compounding structural weaknesses in child protection and welfare systems**.** Existing child protection risks are exacerbated, and new ones emerge, as a result of the crisis. Poor families and those with limited resources are bearing the brunt of measures to prevent and control the spread of the pandemic. High stress environments are also leading to an increase in violence at home.

Drawing on learnings from previous epidemics (e.g. SARS, MERS, Ebola, HIV/AIDS)[4] and natural disasters (the 2004 tsunami in Aceh or earthquake in Haiti in 2010)[5] illustrates that child protection services are lifesaving in the immediate and longer-term. Experience shows that **a health crisis requires a multi-sectorial child rights approach** which includes child protection. Yet child protection is chronically underfunded in emergency responses[6].

**As the pandemic unfolds, the economic shocks to children and families globally will be felt for years to come. It is expected that the number of children at risk of separation or in need of alternative care will increase – both during the crisis, where containment measures may lead to separation, as well as a result from the long-term socio-economic impact on caregivers, families and communities[7].**

Despite its geographical size and low-income economy, Rwanda is frequently acknowledged as a **global leader in childcare reform**, and has hosted many exchange visits from other countries in the region and partners from the global north to showcase its advances[8]. Following the 1994 genocide against the Tutsi, institutions quickly proliferated across the country. By 2018, progress in the childcare reform led to around 70% of the children without disabilities being reunited with their families or placed in suitable forms of family-based alternative care[9]. According to internal data from Hope and Homes for Children Rwanda, by 2020, this increased to 87% (3303 children children/young adults).

## Institutionalisation of children

There are numerous definitions of what the term 'institutions'[10] (also known as 'orphanages') means when referring to children. The Common European Guidelines on the Transition from Institutional to Community-based Care refer to a definition of institutions for children "as residential settings that are not built around the needs of the child nor close to a family situation, and display the characteristics typical of institutional culture (depersonalisation, rigidity of routine, block treatment, social distance, dependence, lack of accountability, etc.)"[11].

Over 80 years of research from across the world has demonstrated the significant harm caused to children in institutions who are deprived of loving parental care and may consequently suffer life-long physical and psychological harm[12]. Children who grow up in institutions can experience attachment disorders, cognitive and developmental delays, and a lack of social and life skills leading to multiple disadvantages during adulthood[13]. Long-term effects of living in institutions can also include disability, increased rates of mental health difficulties, involvement in criminal behaviour, and suicide[14].

The term 'orphanage', frequently used in the context of international development, is actually a misnomer. Research consistently demonstrates that the majority of children in institutions are not 'orphans',[15] but are placed there due to reasons such as poverty, disability, marginalisation, migration, a lack of family support services in the community or as a result of trafficking.

**Despite this significant progress, many children are still suffering from institutionalisation - especially children with disabilities[16].** Furthermore, Rwanda continues to have a high rate of child stunting, rooted in poverty and regional disparities, hampering early childhood development and in turn affecting children's learning outcomes[17]. **Research by Rwandese economists on the indicative socio-economic impacts of COVID-19 on Rwanda predicts that, despite the measures taken by the government to curb the spread of the virus and the discipline of Rwandan citizens, external merchandise trade, small and medium enterprises, and agriculture will be negatively affected, though to varying levels[18].** This will have a significant impact on families' livelihoods.

In the long run, the pandemic may lead to a restrictive focus on healthcare priorities and ultimately stall care reform. It is critical to prioritise an integrated child protection response focused on family and community-based care (e.g. kinship care, foster care, etc.). This has proven in previous crises situations to be lifesaving for particularly high-risk groups, such as children in institutions and children in vulnerable families.

The 2021-2027 Multi-Annual Financial Framework constitutes an important opportunity to strengthen social and child protection systems in the context of developing countries. This paper calls on the European Commission Directorate-General for International Cooperation and Development (DG DEVCO), the European External Action Service and the EU delegation in Kigali to ensure that the **Neighbourhood, Development and International Cooperation Instrument (NDICI)[19] supports comprehensive childcare system reform in Rwanda**. Furthermore, the EU should ensure that orphanages and other institutions are not used as a response to the crisis, in line with the UN Resolution on the Rights of the Child (2019), and given the additional risks to congregate care setting in infectious disease outbreaks.[20]

> *"By 2018, progress in the childcare reform led to around 70% of the children without disabilities being reunited with their families or placed in suitable forms of family-based alternative care. According to internal data from Hope and Homes for Children Rwanda, by 2020, this increased to 87%."*

# 2. The EU's leadership in securing child welfare and protection

**The EU is already a global leader in this area, recognising the harm that institutionalisation causes to children and ensuring that no further investment goes to harmful institutional settings within its borders[21].**

## Care reform – progressing towards the 2030 Agenda, leaving no one behind

Some of the most vulnerable children around the world continue to be left behind. Amongst them are children deprived of parental care. Globally, poverty in all its forms continues to drive family separation. As the former European Commissioner for International Cooperation and Development Neven Mimica stated, "the implementation of the 2030 Agenda and global care reform are therefore intrinsically connected"[22]. In particular global care reform and ending the institutionalisation of children supports the implementation of the following Sustainable Development Goals (SDGs):

- **SDG 1– End poverty in all its forms everywhere:** Poverty in all its form is one of the main underlying reasons for children being placed in institutions. Care reform plays a key role in ensuring that the most vulnerable families get access to basic services in the community including social protection.
- **SDG 3 – Good health and wellbeing:** Institutionalisation has a devastating impact on children's physical, cognitive and social well-being. In certain cases, institutions fail to provide sufficient nutrition to children leading to malnourishment and under-development. In the face of the current pandemic, the congregate care environment in institutions exposes children and workers to a high risk of virus transmission. Children with disabilities and especially those with underlying health conditions are especially vulnerable.
- **SDG 4 – Ensure inclusive and equitable quality education:** Lack of access to education is a key driver of institutionalisation, especially for children with disabilities. Institutions are not a solution: growing up in so-called 'residential schools' and 'special schools' while being separated from their community and peers can significantly affect children's health, learning and psychosocial wellbeing.
- **SDG 10 – Reduce inequalities within and among countries:** Children from poor and vulnerable families, children with disabilities and children belonging to ethnic minorities are the most affected by institutionalisation – showing a clear pattern of systemic discrimination.
- **SDG 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children, and SDG 8.7 – Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour.** Institutions put children at increased risk of violence, abuse, and neglect, from peers and adults, and expose them to various forms of structural violence. Children in institutions are also at increased risk of being trafficked or fall victim of other forms of modern-day slavery.

The EU has introduced an ex-ante conditionality on social inclusion 9.1. in the European Structural and Investment Funds Regulations for the 2014-2020 programming period, with a dedicated investment priority on the transition from institutional to community-based care[23]. By doing this, it has played a leading role in supporting vulnerable children and driving care reform across a number of EU countries. This commitment has been further reaffirmed with the introduction of enabling conditions in the draft Cohesion Policy Regulations for the 2021-2027 programming period[24]. In the past, the EU has also made child protection reform and de-institutionalisation conditional in the enlargement processes (e.g. Bulgaria and Romania).

The issue of children in institutions has increasingly been put on the EU's global agenda[25]. In particular, the European Commission showed high political commitment towards deinstitutionalisation globally by introducing for the first time ever a **reference to the transition from institutional to community-based care for children in its proposal for the Neighbourhood, Development and International Cooperation Instrument (NDICI)**[26]. This proposal is supported by the European Parliament and the Council[27].

The EU also supported the development of the Global Study on Children Deprived of Liberty, which recognises that '*institutions, by their very nature, are unable to operate without depriving children of their liberty*'. Institutions in some cases may lead to trafficking of children and their exploitation through commodifying care and linking it to tourism[28].

The **UN Resolution on the Rights of the Child**, adopted in December 2019 and co-drafted by the EU, expresses a concern that millions of children continue to grow up deprived of parental care, states that family- and community-based care should be promoted over placement in institutions and urges States to '*take effective action to provide support to families and to prevent the unnecessary separation of children from their parents, including through investment in social protection services and social services*' [29].

The recent **EU Action Plan on Human Rights and Democracy 2020-2024**[30] also prioritises the development of quality alternative care and the transition from institution-based to quality family- and community-based care for children without parental care.

The coming five years present a unique opportunity for the European Commission to **renew its commitment and global leadership to ensure that children grow up in loving and supported families,** in line with President Ursula von der Leyen's prioritisation of children's rights.


Credit:HHC

## How can the EU support third countries to transform their care systems?

**The EU should help Governments to strengthen families and communities and provide/oversee quality family- and community-based alternative care in line with the UN CRC, the UN CRPD and the UN Guidelines for the Alternative Care of Children.**

**Actions may include[31]:**

- ✓ Supporting governments in responding to the needs of the most vulnerable children (including children in institutions), families and communities in their **response plans to the Covid-19 pandemic**, integrating care reform and child protection systems strengthening in the medium- and long-term strategies for recovery.
- ✓ Improving **governments' knowledge of and control over systems of informal and unregistered care provision (and providers)** prevalent in their countries, closing existing data gaps, developing national and global baselines, and investing in quality, accessible, timely and reliable disaggregated data related to children living without parental or family care in all settings and situations;
- ✓ Analysing and addressing the **push factors leading to the separation of children from their families**, with a focus on helping to make vulnerable families more resilient (e.g. family planning, pre-natal care, mother and baby units, universal birth registration, parenting programmes focusing on creating safe and protective home environments, social protection, conditional cash transfer, income-generating activities, etc.), while also combating stigma and discrimination.
- ✓ Ensuring that all children and families have **inclusive access to social programmes and quality services and programmes in the community** (e.g. water and sanitation, housing, energy, garbage collection, safe environment, early childhood education and care, inclusive education and health services, etc.), including in rural areas – whenever possible, transferring resources from institutions to the new services in order to ensure long-term sustainability.
- ✓ Measuring whether existing EU programming focusing on parenting, children rights, and livelihoods is not only making families more resilient to shocks, but also less likely to separate.
- ✓ Researching and addressing the **'pull' factors leading to the institutionalisation of children**, including financial incentives, orphanage tourism/volunteering, and institutions' recruitment practices (e.g. parents being coerced or deceived into giving up their children under the false pretence of access to better education and healthcare). Exploring and addressing the **relationship between institutionalisation of children, exploitation and trafficking**.
- ✓ Ensuring that **policy, legislation and regulations** are revised, developed and adopted to support vulnerable families, alternative family-based care and the transition/closure of residential institutions;
- ✓ Strengthening **inclusive local and national child protection systems** to address children's needs, establishing effective 'gatekeeping' mechanisms, preventing family separation and promoting effective regulation;
- ✓ Identifying and implementing long-term integrated strategies for the holistic and systemic transformation of care systems;
- ✓ **Raising awareness** among families and communities on the rights of the child and the importance of providing them with a stable nurturing environment; countering perceptions that institutional placement is necessary and raising awareness of the harm caused to children by institutionalisation; **reducing communities' stigmatisation of, and discrimination against, children** on the grounds of disability or ethnic or minority background;

- ✓ Preparing and implementing **family- and community-based solutions** for the reintegration of children taken out of institutions, providing access to essential services to support children within their families and communities, with special attention to deprived and remote areas and to children facing discrimination (on grounds of disability, ethnic or minority background, etc.);
- ✓ Assessing individual children's needs **and providing comprehensive quality care to children until they can be reunited with their families and communities**, prioritising the development and/or strengthening of kinship and foster care, supporting foster parents' networks, etc. In very specific cases where it may be necessary to provide care in a small group setting, provide quality, temporary, specialised care organized around the rights and needs of the child in a setting as close as possible to a family, and for the shortest possible period of time;
- ✓ **Promoting children's and young people's meaningful participation** in care decisions, service delivery reviews and national debates on care reform, making sure their voices are heard and acted on;
- ✓ **Building the workforce** (direct informal carers, care professionals and those in related social services) at national and subnational levels, in terms of training (conducting child and family assessments, case management systems, follow-up monitoring after reintegration, forms of alternative care, training of trainers, special care for children with disabilities), status and working;
- ✓ Raise awareness and develop the capacity of **private service providers** (e.g. NGOs, Faith Based Organisations, and Foundations) that provide the institutional care services (with or without State resources) to transform their programs – focusing on strengthening families and communities and developing specialized support programs for children at risk (e.g. school reinforcement, development of specific skills, conflict resolution, consumption of psychoactive substances, etc.).

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The EU's financial assistance could be delivered via different aid modalities. This includes budget support to governments – in the form of Sustainable Development Contracts or Sector Reform Performance contracts –as well as direct/indirect management of grants.

Experience shows that achieving comprehensive care reform requires complex and multi-sectorial transformations that are often best delivered in partnership between governments, non-governmental organisations and/or UN agencies. This is particularly evident in countries where private actors (NGOs, faith-based organisations, etc.) are engaged in providing a significant portion of child protection and care services and are therefore essential stakeholders for the transition. Therefore, the EU should promote partnership with civil society organisations and support CSOs' programmatic interventions and advocacy initiatives to promote child protection and care reform through EU thematic and geographical programming.

## Example of EU-funded project supporting family care in the region – Protecting mothers and babies in Sudan[32]

In Sudan, the social stigma suffered by mothers who give birth outside marriage and their children means that around 100 new-born babies are abandoned on the streets and in the hospitals of the capital Khartoum, every month. The babies that survive are admitted to the Myigoma baby institution, the largest orphanage in the country. Many of the babies who do survive suffer severe developmental delays as a result of the physical and emotional neglect they suffered in the crucial early years of their lives. Others developed chronic illnesses due to poor nutrition and the lack of appropriate care.

Since 2018, Hope and Homes for Children together with their local partner Shamaa have been using EU funds to roll out further community-based services to support vulnerable women and their babies and prevent abandonment and institutionalisation. The EU funding is training and empowering child protection professionals to respond to the needs of vulnerable women, set up new prevention and quality alternative care services and reduce the stigma and discrimination towards single mothers, pregnant women and women who give birth outside wedlock.


Credit: HHC

# 3. Structural conditions for care reform in Rwanda

Replacing institutions with a sustainable system focused on providing care for children within families and communities is a complex process, which requires a number of structural conditions to be in place.

**Political will** is key to initiate the transition. The strategic vision owned by key champions in government needs to be complemented by a strong legislative and policy framework, accompanied by measurable and timebound action plans. This should be based on a set of **reliable data** on children in alternative care. Another critical factor is the availability of **local know-how and capacity** within the social workforce to actually deliver the reform and, once it is complete, to sustain prevention and alternative family and community-based care services. In this process, the existence of **an active and organised civil society** - including groups of self-advocates – has proven to be essential to ensure that the strategies are adequately implemented and continue to promote the highest human rights standards. Last, but not least, without **funding for the transition** care reform cannot progress. Additional resources are needed during the phase of transformation, when the old and the reformed systems are still running in parallel and until the resources locked in institutions can be transferred to support children in their families and communities.

**All of these elements are present today in Rwanda**. The last decade has seen growing momentum for child protection system reform, with remarkable progress across all the critical areas outlined above. Nevertheless, change is not without concerns. **The following sections illustrate the steps taken by Rwanda in its journey towards establishing a modern and rights-based child protection system, while also highlighting the pivotal role that the EU could play to sustain and strengthen the care reform efforts within the country.**

## 3.1. Political will to transform child protection and care systems

Strong national leadership and long-term vision are indispensable to move away from institutions and develop child protection and child welfare systems that protect children and families within their homes and communities. Political commitment at the highest level will help tackle vested interests and resistance and sustain the process beyond the life span of political and electoral cycles.

**Family and community-based care is at the heart of Rwanda's child protection and care initiatives, with President Paul Kagame providing high level political support to the process.** The Ministry of Gender and Family promotion (MIGEPROF), through the National Commission for Children (NCC) and the National Council for Persons with Disabilities (NCPD), is leading the process of care reform. The First Lady's office and Unity Cub – an advocacy platform composed of current and former cabinet members with their spouses – also strongly support deinstitutionalisation.

This commitment has led to a robust legal and policy framework to protect children. Rwanda ratified the UN Convention on the Rights of the Child and The African Charter on the Rights and Welfare of the Child (1991) and **embedded the protection of the rights of the child and the family in its Constitution**[33]. Since 2011, the National Integrated Child Rights Policy (ICRP) sets a comprehensive and multi-sectorial approach to child rights[34] with the following priorities: Identity and Nationality; Family and Alternative Care; Health, Survival and Standard of Living; Education; Protection; Justice; and Participation. The ICRP is complimented with the following legislative initiatives relating to care reform; Law n°71/2018 of 31/08/2018 relating to the protection of the child,[35] Law n°32/2016 of 28/08/2016 governing persons and family[36].

**Child protection system reform began in earnest in 2012 through the first phase of the Strategic Plan (2012-2018)**[37]. The strategy was followed by the development of the **Tubarerere MU Muryango (TMM) program,** which sought to ensure that all children living in institutional care in Rwanda are reunited with their families or placed in suitable forms of family-based alternative care[38]. By 2018, progress in the childcare reform led to around 70%[39] of children being reunited with their families or placed in suitable family-based alternatives (see section 2.2). Another particularly significant step is that the country no longer registers institutions for children without disabilities. Through the care reform initiative, robust steps have been taken to eliminate the harmful practice of institutionalisation of children. **In 2019, Rwanda approved the second phase of the Strategic Plan (2019-2024)**[40] **which, among others, prioritizes deinstitutionalisation of children with disabilities**. Standards for centers for children with disabilities have been developed by the Ministry of Local Government (MINALOC) and are key to improving conditions of residents before their placement into families and family-based alternative care services[41].

In parallel, **Rwanda has undertaken numerous efforts to strengthen its wider social protection system**. Embedded in the Social Protection Strategy 2012 (revised in 2020)[42] is the Vision 2020 Umurenge Programme – a major programme focussed on accelerating poverty eradication, rural growth and social protection through cash transfers. The National Social Protection Strategy also commits to providing all people with disabilities with a disability pension that guarantees a minimum standard of living, and financial support to caregivers. Numerous key policies to support families and prevent separation were also introduced, such as the Early Childhood Development Policy (2011)[43] and the Revised Special Needs and Inclusive Education policy (2018)[44].

**Significantly more should be done to strengthen access to inclusive education. The national education system has been characterized by a lack of systems and facilities that respond to the needs of children with disabilities**. Firstly, there is an insufficient number of qualified teachers to teach children with special educational needs. Secondly, negative attitudes from the community towards children with special needs, including those with disabilities, still persist. Thirdly, there is a lack of early identification, assessment, placement, enrolment, and intervention criteria and procedures for children with special educational needs. Lastly, there is a lack of assessment centres which would facilitate for appropriate referrals and placements for children with special educational needs.

In mid-2011 Rwanda enacted a comprehensive health insurance reform ('mutuelle de sante'), extending access to healthcare to about 90% of the population[45]. Additionally, Rwanda has put in place a fund for Genocide Survivors, 'Genocide Survivors Support and Assistance Fund', which makes up 5% of the national budget and supports more than 300,000 victims of the 1994 genocide[46]. Through this fund, many families at risk of separation receive a monthly economic allowance, livelihood support, educational scholarships and/or medical assistance. Rwanda also seen a steady rise of individual income from USD680 in 2012 to USD780 in 2018[47].

Despite all this progress, the current child protection system and domestic resources (see sections 3.3 and 3.6) remain unable to respond to the needs of many children and families. As highlighted across various studies and submissions, including Rwanda's 2019 Voluntary Country National Review for the SDGs[48], the UN Convention on the Rights of the Child's 2020 concluding 2020 observations[49] and the UN Convention on the Rights of Persons with Disabilities' 2019 Concluding observations on the initial report of Rwanda[50], children continue facing severe deprivation and violence. **More than half (55%) of under-5 children and 32% of children aged 5-17 suffer from at least three simultaneous (overlapping) deprivations[51].** The nutrition, health and sanitation dimensions were identified as having the most significant overlap for children aged 0-23 months (26.6%), whereas children aged 24-59 months face significant simultaneous deprivations in the areas of health, water and sanitation (19.9%)[52]. Children with disabilities are mostly at risk.

### Early childhood Development

Early childhood, and in particular the period from pregnancy to age 3, is when children are most susceptible to environmental influences.[53] That period lays the foundation for health, well-being, learning and productivity throughout a person's whole life, and has an impact on the health and well-being of the next generation.[54] In these earliest years, the health sector is uniquely positioned to provide support for nurturing care[55]. Early childhood development is threatened by extreme poverty, insecurity, gender inequities, violence, environmental toxins, and poor mental health. An enabling environment is needed: policies, programmes and services that give families, parents and caregivers the knowledge and resources to provide nurturing care for young children.[56]

## 3.2. Available evidence on children in alternative care

A key element of a State's ability to protect and promote children's rights is the availability of reliable data to develop strategies corresponding to the needs and characteristics of the population. Before 1994, Rwanda had 37 institutions caring for 2,800 children. Following the 1994 genocide against the Tutsi, institutions quickly proliferated across the country. By 1995, there were 77 facilities caring for some 12,700 children. Despite this devastating event, there was a strong determination for Rwanda to heal and develop.[57] Sustained efforts to reunite children with their families reduced the number of children in institutional care to about 5,380 in 1998[58].

**In 2012, Rwanda held 33 institutions accommodating 3,323 children without disabilities[59]. By 2018, progress in the childcare reform led to around 70% of the children without disabilities being reunited with their families or placed in suitable forms of family-based alternative care[60]. According to internal data from Hope and Homes for Children Rwanda, by 2020, this increased to 87% (3303 children children/ young adults).** Internal data also shows that 52% of children without disabilities in households are living with their biological parents, 32% in foster care, 14% children in kinship care, and 2% were adopted[61]. To date, children who remain in the institutions are those who live in the 4 SOS Children's Villages. According to the SOS Children's Villages Rwanda website, there are still 273 children remaining across 4 locations (Gikongoro, Byumba, Kayonza and Kigali)[62].

In 2016, Rwanda carried out a national assessment of the centres caring for children with disabilities[63]. The results showed that 59 institutions for children with disabilities still exist across the country. The number of children with disabilities living in institutions is currently 4,339. Data from the first pilot closure of an institution for children with disabilities shows that 73% of the children from the institutions could be placed with a biological parent, 1% with the extended family and 19% with specialist foster carers[64].

**It is necessary to considerably improve data collection for children without parental care.** It is welcome that data on children in alternative care and institutions are gathered annually by the National Commission for Children on its website. However, there is no law supporting the gathering of statistics on children in alternative care. Currently, the national data system does not count children in foster care or kinship care arrangements. **Data collection methodologies should be improved and be sufficiently disaggregated to cover all of Rwanda's child population[65].**

## 3.3. Capacity to implement

The lack of know-how and professional capacity for the provision of social services to children and families can be an obstacle for the implementation of care reform. In Rwanda, a National Commission for Children (NCC) coordinates and implements child protection, supported by professional social workers and psychologists, Inshuti z'Umuryango (or 'Friends of the Family')[66] and child protection/development networks.

**Rwanda is one of very few countries in Africa to have a dedicated national social workforce focused on child protection and family strengthening, and equipped with the expertise to close institutions.** As mentioned above, under the leadership of the NCC, the Tubarerere MU Muryango (TMM) programme put into place a range of mechanisms to prevent children from entering institutional care and plan the progressive closure of institutions, including a two-year mass media campaign, the development of emergency foster care, projects to support teenage parents, and closely monitoring of the remaining facilities to ensure they were not allowing new children to enter.

**Before the TMM programme was introduced, there were no professional (government employed) frontline staff working on child protection in Rwanda**. The TMM programme enabled the NCC to recruit 34 social workers and 34 psychologists to support the reintegration of children and the closure of institutions, as well as staff at the central level to manage the programme. Thirty of these professionals have been absorbed into the civil service to become a permanent part of the government child protection system.[67]

At the same time**, it is essential to note that the workforce dedicated to support the social protection mechanism (e.g. social workers) is insufficient and thus unable to properly assess children and families and provide tailored support** (e.g. there is only 1 social worker per district). The Inshuti Z'Umuryango – IZU (Friends of families) volunteer workforce has been mobilized as frontline child protection workers at the community level, but this remains an unpaid position with few resources flowing to it. This makes interventions less transformative, and results in the most vulnerable groups, like children with disabilities, teen mothers or care leavers, being left out.

Several services and programmes are available in the community to prevent the unnecessary separation of children from their parents. These include family planning[68], pre-natal consultations[69], Baby-friendly Hospital Initiative and the Baby Friendly Community Initiative[70], the social protection program[71], community health workers[72], and the Inshuti z'umuryango[73] or 'Friends of the Family'. However access to and development of family and community-based services remains a challenge, particularly for children disabilities. Additional measures should be taken to ensure that children with disabilities are able to remain with their families through the development of family-based care and community-based services (e.g. day care centres, adapted accessible infrastructures, etc.).

### The role of community hubs in supporting children and families in Rwanda

Hope and Homes for Children has developed a Community Hub model to provide integrated child protection and family strengthening services in Rwanda. A Community Hub is a child friendly community resource centre that serves children, parents and communities through a range of diversified services which aim to strengthen communities, prevent family breakdown and abandonment. It also provides oversight and monitoring for vulnerable children returned from institutions and cared for in families. The exact nature of services run from each Community Hub is determined by a community assessment. Core services typically provided in a Community Hub include: early childhood development and day care, livelihoods support and income generation programmes, community education workshops, counselling, healthcare, after-school programmes and child rights education, child protection, and outreach services. To ensure sustainability, the Community Hubs are owned and managed by the community via a local Management Committee. Each service is developed in partnership with the local government (e.g. the land is donated by local authorities) and planned with exit and financial sustainability in mind, for example through income generation channels and small service fees.

## 3.4. Know-how and pilot projects

In the last decade, many innovative projects were implemented to replace institutions with a range of prevention and quality alternative care services in the community. **The experience from these pilots can be key to build the capacity, know-how, skills and expertise of the professional workforce and implement reform at regional or national scale.**

In addition to the TMM program – whose implementation was supported by UNICEF and Hope and Homes for Children Rwanda - a number of successful pilot projects are underway in the frame of child protection system reform, including:

- **"No Child Left Behind" project (2018-2021)[74]:** This DFID/ UK AID-funded project is implemented by Hope and Homes for Children, the National Council for Persons with Disabilities and the National Commission for Children. It aims to support the closure of two institutions for children with disabilities, the first to ever be closed in the region; support the placement of children into family-based care; and develop community strengthening services. This project is implemented in two distinct national contexts (Rwanda and Uganda[75]) and two distinct settings (urban and rural).
- **Early Childhood Development programme:** Led by the Ministry of Gender and Family Promotion, the plan is set to eradicate child malnutrition and calls for all partners to work in a harmonized and integrated manner.[76]

These locally developed know-how and promising practices are great foundations to continue the reform at scale.


Credit:Olivier Umukura

## 3.5. Civil society and users' involvement

The presence of an active and organised civil society – including a network of self-advocates with lived experience of the care system – is fundamental to ensure that care reform strategies are adequately implemented and continue to promote the highest human rights standards.

In Rwanda, many civil society organizations (CSOs) such as Save the Children, Plan, Hope and Homes for Children, etc. are involved in supporting vulnerable families and promoting poverty reduction, children rights and child protection. Furthermore, the National Commission for Children leads a Program Coordination Team for TMM composed of key stakeholders working around childcare reform (including HHC, Unity Club[77], UNICEF, Save the Children, AVSI, UNICEF, World Vision, Plan International). Currently, an association of care leavers has started constituting requirements for formal registration. There also exists some isolated initiatives to support youth by civil society organisation (SOS children's villages, Unity Club).

## 3.6. Funding for the transition

Institutionalisation is not a cheap or effective system to support children. Evidence proves that family- and community-based systems of care are more cost-effective and deliver better outcomes in the long run. However, additional resources are needed during the phase of transition, when the old and the reformed systems are still running in parallel and until resources locked in running institutional care can be used to support children in their families and communities.

**Thankfully, political commitment, policy and legislative changes for care reform in Rwanda have been accompanied by financial support.** For the period of 2012-2013, the Rwandan national budget allocated for the first time 900,000,000 RWF (USD 1,426,130) to the National Commission for Children (NCC) to support alternative family care. During the same period, the government also dedicated USD 332,958 to contribute to the achievement of its childcare reform strategy. For the second phase of the strategy plan implementing the National Integrated Child Rights Policy, the national budget allocated for the de-institutionalization of children with disabilities is estimated to 255,720,000 Frw. The budget will facilitate the placement of children, including children with disabilities, from institutions into family-based care.

**It must be highlighted that Rwanda still relies heavily on foreign assistance for the transformation of its social policies.**[78] The use of these funds is facilitated by the *Development Partners Coordination Group*[79]. In fact, institutional donors have played a key role in supporting Rwanda to transition away from institutions towards family and community-based care. The Displaced Children and Orphans Fund (DCOF) at USAID 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.[80] One of the main objectives of the existing work funded by USAID/DCOF before 2015 was to increase 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.[81] As described above, DFID/UK Aid are funding the "No Child Left Behind" project. (see above) for the period 2019-2021.

**Despite these important contributions, considerably more investment is needed to complete the reform, and ensure families and children are provided the conditions to thrive.** This is particular true if additional funds will not be made available once the "No Child Left Behind" project ends.

While EU budget support in Rwanda has not directly targeted children rights[82], Rwanda has benefited from EU funds for the strengthening of the health system and the roll out of the compulsory health insurance scheme[83] - a leading model for healthcare systems in Africa. Most recently, the EU and the government of Rwanda signed an addendum to a financing agreement for €52.87 million (about Frw 55.5 billion) to support the social protection coverage (increased cash transfers and food assistance) in response to the COVID-19 crisis. This grant is part of the EU's €460 million package of support to Rwanda signed in 2014 with European Commission[84]. It is essential for care reform to be mainstreamed under other key priority areas for EU support, such as food and nutrition security, rural development, youth unemployment[85].

# 4. Specific recommendations for NDICI support in Rwanda

By committing to a complete transformation of its child protection system, Rwanda has shown unprecedented leadership on the regional and global stage. Ensuring the continuity of international support – particular in view of the expected socio-economic impact of Covid-19 – is critical to provide the much-needed transitional resources that will allow Rwanda to complete it social protection system reform**. In light of the challenges and opportunities detailed above, we recommend the following to the EU Delegation in Rwanda, DG DEVCO and the EEAS:**

**1. Provide budget/sector support to the government of Rwanda to promote the implementation of the National Integrated Child Rights Policy, and/or mainstream the issue of care reform within other sectoral policies (e.g. social protection, health, rural development and food security, etc).**

**This includes:**

- ✓ Developing and improving access to/accessibility of **an integrated network of quality mainstream services based in the community** (e.g. health, education, accessible and affordable housing, transport, community hubs, etc.).
- ✓ Developing and improving access to/accessibility of **targeted services aimed at preventing family separation** (e.g. family planning, pre-natal care, mother and baby units, crisis intervention and emergency centres, etc.) or **addressing the needs of particular groups**. For instance, for children with disabilities, this might include technical aids and assistive technologies (e.g. wheelchairs, social alarms, hearing and visuals aids, communication aids etc.), supported living, legal aid, etc.
- ✓ **Developing the education system –** strengthening access to, and quality of, inclusive education and early childhood development for all children – including children with disabilities.
- ✓ **Strengthening the healthcare system** to enhance equal access to affordable, accessible, sustainable and high-quality healthcare with a view to reducing health inequalities, raising health literacy, and supporting health prevention. This should include primary healthcare (e.g. facilities for general practitioners, nurses, prenatal care, early detention and intervention programmes), secondary healthcare (e.g. facilities for specialists, outpatient clinic, physical therapy and orthopaedic), and tertiary healthcare (e.g. acute and long-term care hospitals, emergencies services).
- ✓ **Improving nutrition and food security** – ensuring the availability and access of food.
- ✓ **Promoting income generation activities** – This may include providing at-risk families professional and entrepreneurship training courses, microfinance schemes and mentoring, creating an enabling environment for digital work, designing and rolling-out of employment policies, developing business incubators and investment support for self-employment, micro-enterprises and business creation.
- ✓ **Developing family-based care –** prioritizing family reunification when appropriate and strengthening kinship care and foster parents' networks for when family-based care is not appropriate, providing training for foster parents, child protection workers, etc.
- ✓ **Developing the social workforce**, including increasing the number of social workers per district, and supporting case management in line with deinstitutionalisation and the social protection policy. Strengthening and continuing to mobilize the Inshuti Z'Umuryango – IZU (Friends of families) structures whom are the community-based frontline child protection workers.
- ✓ **Supporting training and capacity building of professionals and carers –** including training for child protection and social welfare staff, school professionals (e.g. teachers), medical staff (particularly on communication skills), re-training of institutional care staff to work in the new community-based services, training for family members, informal carers and foster parents, etc.
- ✓ **Improving data collection mechanisms –** close existing data gaps, develop national baselines, and invest in quality, accessible, ethical[86], timely, disaggregated and reliable disaggregated data related to children living without parental or family care in all settings and situations.
- ✓ **Supporting awareness-raising campaigns and programmes** to promote greater social awareness towards children in institutions and persons with disabilities, informing the general public of their different needs and abilities in society, dispelling myths and superstitions, and affirming their rights and dignity as human beings.

**2. Provide and coordinate technical assistance (international experts, documentation, exchange of experience including from countries in the regions, etc.) on the areas listed above.**

**3. Building on the effective collaboration between the government and CSOs, promote partnership with civil society to implement the National Integrated Child Rights Policy and the care reform strategy, including all the key areas listed above.**

**This may include:**

- ✓ Programmatic interventions to assist the government of Rwanda in the implementation of the reform by a) preventing family separation, b) developing family-based alternative care services to support families, and c) dismantling institutional systems.
- ✓ Advocacy to influence laws, strategies and action plans for the implementation of the reform, identifying gaps in policies and implementation.
- ✓ Programmatic interventions and/or advocacy to establish a baseline and develop a solid information system to record disaggregated data and monitor the wellbeing of children across the alternative care/child protection spectrum.
- ✓ Actions to support, empower and nurture children and young care leavers to become self-advocates and set their own agendas; connecting them with their peers at home and in other countries to make their voices heard in national, regional and global conversations on care reform.

In all of the investments listed above, it is essential to ensure that EU funds' investments in institutions, regardless of the size, are explicitly declared ineligible – including investments for the refurbishing, building, renovating, extending of institutions or improving energy efficiency of the care settings, etc.

**Any investment now from the EU will help ensure that Rwanda becomes the first African state to close all orphanages and return the children to their families and communities, thus generating a formidable momentum for care reform across the region.**

# Endnotes

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9 At the end of TMM Phase 1, 70 per cent of children (2,388 of 3,323) had left institutional care and been reintegrated into families or placed in foster care https://bettercarenetwork.org/sites/default/files/2019-08/TMM%20Summary%20Evaluation%20Phase%20I.pdf

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23 Common Provisions Regulation, Regulation (EU) No 1303/2013

24 Proposal for a Common Provisions Regulation, COM/2018/375 final, Article 11

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27 European Parliament Resolution on the proposal for a regulation on the Neighbourhood, Development and International Cooperation Instrument, T8-0298/2019, Amendment 337 and 481; Council Partial mandate for negotiations 10305/19, Annex II and III

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66 Inshuti z'umuryango are similar to "para-social workers" at the community level and are an integral part of the entire childcare and protection system. Linked with the professional social workforce at the district level, these Inshuti z'umuryango are contributing to strengthen the human resources pillar of the childcare reform and the broader child protection system. Their mission is to prevent any kind of separation and intervening in case separation is happen.

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85 European Union and Republic of Rwanda National Indicative Programme for the 2014-2020 period

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Credit:HHC

hope and homes
for children