

**REGIONAL
PORTRAIT**

CATHOLIC CARE FOR CHILDREN IN EASTERN AFRICA

A study based
on information
from Kenya, Malawi,
Uganda and Zambia



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Regional Portrait
of Catholic Care for Children
in Eastern Africa

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A STUDY BASED ON INFORMATION
FROM KENYA, MALAWI, UGANDA
AND ZAMBIA

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FOREWORD

CHILDREN! The Holy Father, Pope Francis, reminds us how precious they are. “Children are the joy of the family and of society ... Children are a gift. Each is unique and unrepeatable.”¹

Indeed each child is a gift and each, for his or her full and harmonious development, has a right to a family. The family is where a child first comes to know love and belonging, where he or she first feels the “spark of God’s love.” And yet too many children are deprived of family nurture so vital and foundational to healthy development across the life span.

This regional portrait describes Catholic-sponsored care for children in Eastern Africa using data from Kenya, Malawi, Uganda and Zambia. The first large study of its kind, it focuses on children who are particularly vulnerable—those at risk of or those who have been separated from their families. Many are in institutional care. This portrait also describes growing efforts, led by women and men religious, to ensure children can grow up in safe, nurturing families or family-like environments rather than institutions. Through national associations of religious, Catholic Care for Children programmes are part of and contributing to a much wider global trend in care reform seeking to reduce recourse to institutional care in favour of family- and community-based care for children.

This regional portrait has been a collaborative effort.

- Catholic Care for Children International (CCCI) is a project of the International Union of Superiors General (Rome) that supports Catholic Care for Children—a sister-led, charism-driven movement to ensure children grow up in safe, nurturing families.
- Four national associations of religious in Eastern Africa sponsor Catholic Care for Children (CCC) programmes: the Association of Sisterhoods of Kenya (AOSK), the Association of Women Religious in Malawi (AWRIM), the Association of Religious in Uganda (ARU) and the Zambia Association of Sisterhoods (ZAS). Working with Catholic-sponsored childcare institutions and programmes throughout their respective countries, they are advancing care reform by helping religious institutes read the signs of the times and find new ways to express a charism of care for children in the 21st century. CCCK, CCCM, CCCU and CCCZ teams provided most of the data for this regional portrait.

¹ Pope Francis, General audience, St. Peter’s Square, 12 February 2015; *Amoris Laetitia*, 129.





Catholic sisters in Eastern Africa are emerging leaders in the growing effort to ensure children grow up in nurturing families or family-like environments rather than institutions.

- The Association of Member Episcopal Conferences in Eastern Africa (AMECEA) is the Catholic service organisation for the national episcopal conferences of Eritrea, Ethiopia, Kenya, Malawi, South Sudan, Sudan, Tanzania, Uganda and Zambia. Djibouti and Somalia are affiliated members.
- GHR Foundation (USA) is a hope-fueled global funder of service to people and their limitless potential for good. Through its Children in Families initiative, it supports Catholic Care for Children.

Our thanks to the advisory group who guided the project: Sr. Niluka Perera, R.G.S., the project coordinator of Catholic Care for Children International; Sr. Delvin Mukhwana, D.H.M., CCK project manager who represented CCC groups in Eastern Africa; Rev. Fr. Andrew Kaufa, S.M.M., Coordinator of Social Communications Department, and Mr. Bernard Mberere, Programme Officer, from AMECEA; and Daniel Lauer, Senior Programme Officer from GHR Foundation. We offer a special word of thanks to the CCC teams in Kenya, Malawi, Uganda and Zambia for their considerable efforts to provide up-to-date information. This report was prepared by Nicole Moran from Moran and Associates and Dr. Kathleen Mahoney, Senior Programme Officer from GHR Foundation.

We offer this regional portrait with hopes it will be a resource for those interested in the well-being of children and enliven a deeper commitment to the vision of a family for every child.

Acronyms

AMECEA	Association of Member Episcopal Conferences in Eastern Africa
AOSK	Association of Sisterhoods of Kenya
ARU	Association of Religious of Uganda
ASE	<i>Annuario Statisticum Ecclesiae</i>
AWRIM	Association of Women Religious in Malawi
CCC	Catholic Care for Children
CCCI	Catholic Care for Children International
CCCK	Catholic Care for Children in Kenya
CCCM	Catholic Care for Children in Malawi
CCCU	Catholic Care for Children in Uganda
CCCZ	Catholic Care for Children in Zambia
CCI	Childcare Institution
CCP	Childcare Programme
CCI/P	Childcare Institution and Programme
M&E	Monitoring and Evaluation
NGO	Non-governmental Organisation
UISG	International Union of Superiors General
UNCRC	United Nations Convention on the Rights of the Child
ZAS	Zambia Association of Sisterhoods

Glossary

Alternative Care A formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or duly accredited body or at the initiative of the child, his/her parent(s) or primary caregivers or spontaneously by a care provider in the absence of parents.

Case management The process of providing assistance to a child and their family through support and referral to other services by professionals, such as social workers.

Child A person under the age of 18 years.

Gatekeeping The systematic assessment, rigorous screening and shared decision-making by authorised bodies to ensure that a child is admitted to alternative care only when necessary.

Transition The stages and process that occur as a child changes placement and/or a child leaves formal alternative care.

Glossary entries from https://trackingprogressinitiative.org/dashboard_bcn/troubleshooting/glossary.php

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PART ONE

A Global Trend: Care Reform

CARE REFORM IS GAINING MOMENTUM GLOBALLY. Over the course of decades governments, civil society organisations and communities of faith have mounted efforts to ensure all children can grow up in safe, nurturing families or family-like environments. Through these efforts the tide is turning away from institutional care for children and toward family- and community-based approaches to care designed to keep children with their families. Quite simply: children need families, not institutions.

The case for reforming care is clear and strong. Eight decades of social science research has documented the benefits of family care and risks of institutional care for children. ***No matter how well run an institution, it can never substitute for the love of a family. To thrive, children need the love and individual attention that families provide.***

BENEFITS OF FAMILY CARE	RISKS OF INSTITUTIONAL CARE
<p>Family nurture is foundational for healthy development across the life span.</p> <p>Early nurture correlates with positive social outcomes later in life.</p> <p>Family life is the richest environment for acquiring cultural knowledge and life skills.</p> <p>Family life promotes a positive sense of identity, security and belonging, and it supports community participation and integration.</p>	<p>Regardless of the circumstances, separation from family is traumatic for a child. It may be in a child's best interest; nonetheless, children experience trauma when separated from their families.</p> <p>Children in institutional care are more likely to experience abuse, neglect or be trafficked.</p> <p>Children in institutional care, especially younger children, are susceptible to psychosocial challenges or cognitive or physical delays.</p> <p>After extended stays, care leavers often have difficulties fitting into communities, establishing their own families and finding meaningful employment. Among care leavers, risks of homelessness, crime, incarceration and suicide increase.</p>

Informed by the social sciences, international and national legal frameworks and policies are turning toward family- and community-based care for children and discouraging institutional care. In 1989 world leaders, including the Holy See, signed the ground-breaking *United Nations Convention on the Rights of the Child* (UNCRC) that unequivocally articulates a child's right to a family.² Twenty years later the United Nations issued important Guidelines for the Alternative Care of Children who have been separated from their families.³ In 1990 the Organisation of African Unity (now the African Union) adopted the African Charter on the Rights and Welfare of the Child that aligns closely with the UNCRC and Guidelines for the Alternative Care of Children.⁴

2 <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>

3 <https://bettercarenetwork.org/sites/default/files/2021-03/GuidelinesAlternativeCareofChildrenEnglish.pdf>

4 <https://au.int/en/treaties/african-charter-rights-and-welfare-child>

The House of Charity facilitates adoptions.



These documents are clear: children have rights ensuring their survival, protection, participation and development. Foremost, a child has a right to a family: for the *“full and harmonious development of his or her personality,” the child “should grow up in a family environment, in an atmosphere of happiness, love and understanding.”*⁵ Efforts should be taken to keep families intact and no child is to be separated from his or her parents except when a proper authority deems separation to be in the best interest of the child. It must be a necessity. Reuniting children with and support for their families is to be prioritised. If reunification is not in the best interest of a child, a suitable, family-like alternative is to be provided. In the case of children with disabilities, they and their families are to receive supportive services that foster a child’s development and optimize self-reliance and social integration. Institutional care is always a last resort.

Thanks to two-plus decades of efforts by governments and civil society actors, these principles and guidelines are increasingly embedded in national policies in countries in Eastern Africa, including Kenya, Malawi, Uganda and Zambia. While particulars differ, there are commonalities.

NATIONAL FRAMEWORKS FAVOUR FAMILIES, NOT INSTITUTIONAL

CARE. The national frameworks and policies for the care of children in Kenya, Malawi, Uganda and Zambia are aligned with the United Nations Convention of the Rights of the Child, the UN Guidelines for Alternative Care for Children and the African Charter on the Rights and Welfare of the Child. All promote family preservation and strengthening. If separated, children are to be reunified with their families if it is the best interest of the child. They embrace a continuum of care for children outside of family care: kinship or community care, domestic adoption, foster care, intercountry adoption and specialized institutional care as needed. Children should be in institutions only if absolutely necessary; the care provided in institutions should be of the highest quality and shortest duration possible.

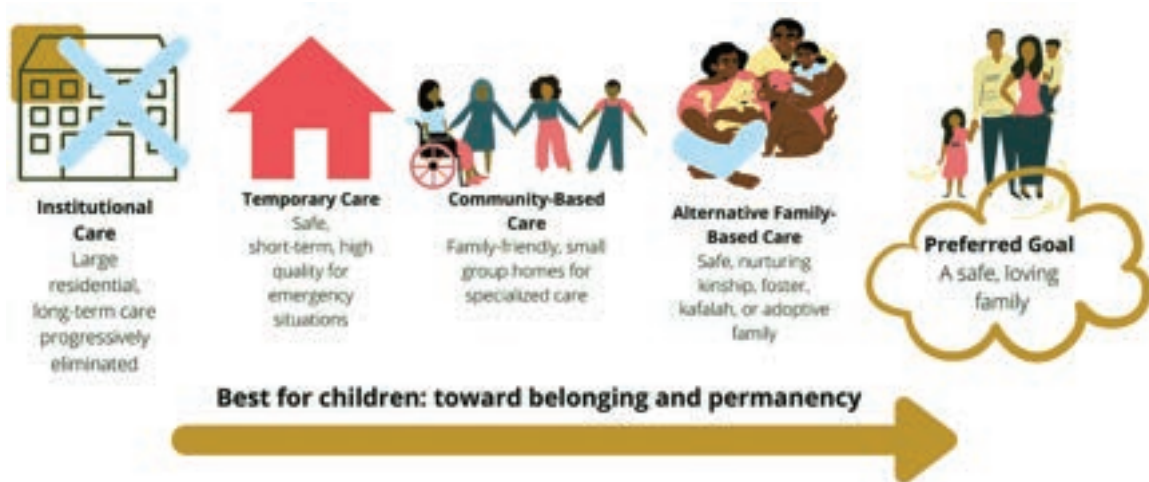
GOVERNMENT REGULATION IS GROWING. Governments expect childcare institutions (CCIs) to be properly registered. To stem the proliferation of CCIs, some are not registering new CCIs. There are legal consequences for operating a CCI that is not registered. Some governments have introduced minimum standards for operating a CCI and have started closing those that do not meet these standards. There are also new laws regulating alternative care, including foster care and adoption, and especially intercountry adoption.



With the child’s best interests always in mind: Is separation of the child from his or her family necessary? If so, is the alternative suitable and most conducive for his or her well-being?

5. Preamble to UNCRC.

Continuum of Care for Children



Despite legal frameworks favouring family- and community-based care and the well-documented risks associated with institutionalisation, there are still many, many children living in institutions. Inadequate and inconsistent monitoring by governments makes enumerating the number of children in institutional care difficult. But based on an extensive literature review published in *The Lancet*, it is safe to assume **there are at least five million children in institutional care globally.**⁶

Eighty percent of children in institutional care have a living parent. Loss of one or both parents does not correlate strongly with institutionalisation, as most children who have lost one or both parents are living with immediate family or kin. For example, 96% of children in Kenya who have lost a parent are living with kin.⁷

A variety of factors related to survival, development and protection push and pull children into childcare institutions. Poverty often drives institutionalisation; families and others turn to institutions to provide food and shelter for children. Childcare institutions provide some with access to education not available within the family setting. Abandonment, abuse and neglect fuel institutionalisation. These factors are

often more acute for children with disabilities, for whom social stigma is often a compounding factor.

Of course, institutions do meet immediate needs for some children. There will always be a need for temporary, emergency care. But too often institutional placements become long-term responses to address children's short-term needs. While legal frameworks and policies favour family- and community-based care, systems too often still favour institutional care. Ministries, government offices, local officials and communities turn to what is readily available and familiar. Moreover, many donors are prone to support children in institutions, not children in families. This occurs even though it costs more to support children in institutions than in families and the well-documented, but perhaps not well-known, risks associated with institutional care.⁸

6 [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(20\)30022-5/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30022-5/fulltext)

7 <https://rethinkorphanages.org/school-university-groups/information-about-orphanages-facts-about-orphanages-statistics#:~:text=Globally%2C%20over%2080%25%20of%20children,of%20violence%2C%20trafficking%20and%20exploitation.;> <https://bettercarenetwork.org/compare/without-bio/kenya>

8 John Williamson and Aaron Greenberg, "Families, Not Orphanages," Better Care Network working paper, 2010, p. 6f.

The Catholic Church, Care and Care Reform

GIVEN THE CENTRALITY OF THE FAMILY within Catholic life, as well as the immense global footprint of Catholic-sponsored care for children, care reform favouring families over institutions is especially relevant for Catholic communities.

For Catholics, the family is fundamental. Children and families figure prominently in the Scriptures. God loves humanity as a loving parent tenderly nurtures a child (Dt 1:31; Is 49:15; Ps 103:13; 1 Jn 3:1). Children are a blessing for their parents (Ps 127:3-5). Jesus was born into a family and knew the love of his parents Mary and Joseph. Their love for him was steadfast even as the Holy Family experienced early travails (Mt 2:13-23).

In his ministry, Jesus warmly welcomed children and treated them with dignity not common for the time. “Let the children come to me,” Jesus said, “and do not hinder them.” He embraced children and blessed them. With tenderness, he put his arms around a child and told his followers: “Whoever welcomes a child such as this for my sake welcomes me. And whoever welcomes me welcomes, not me, but him who sent me” (Mk 10:13-16; 9:36-37).

A social worker checks in on a child reunited with his family.



Struggling families need support.

Familial love is foundational for the fullness of human development. Often called the “domestic church,” the family is where a child first experiences the nurturing graces of human connection, learning they are loved and to love. In *Amoris Laetitia*, Pope Francis speaks to the importance of family life for a child: “Children, once born, begin to receive, along with nourishment and care, the spiritual gift of knowing with certainty that they are loved. This love is shown to them through the gift of their personal name, the sharing of language, looks of love and the brightness of a smile. In this way, they learn that the beauty of human relationships touches our soul, seeks our freedom, accepts the difference of others, recognizes and respects them as a partner in dialogue... Such is love, and it contains a spark of God’s love!”⁹



“
Too often we
forget our
responsibility
and close our
eyes to . . . these
children who
don’t have a right
to play, to study,
to dream. They
don’t even enjoy
the warmth of
a family. We
can no longer
allow them to
feel alone and
abandoned—
they are entitled
. . . to feel the
love of a family.

—POPE FRANCIS,
Nov. 3 2022

Yet many families are strained by human frailties or adversely affected by external circumstances. Family illness or death can fray family ties. Mental illness or addiction can test familial resilience. Domestic violence, war, natural disasters, migration, extreme poverty—all can undermine family bonds.

Faith compels Christians to care for the vulnerable, including “widows and orphans” (Jas 1:27; Is 1:17; Ps 82:3-4). Struggling families need support.

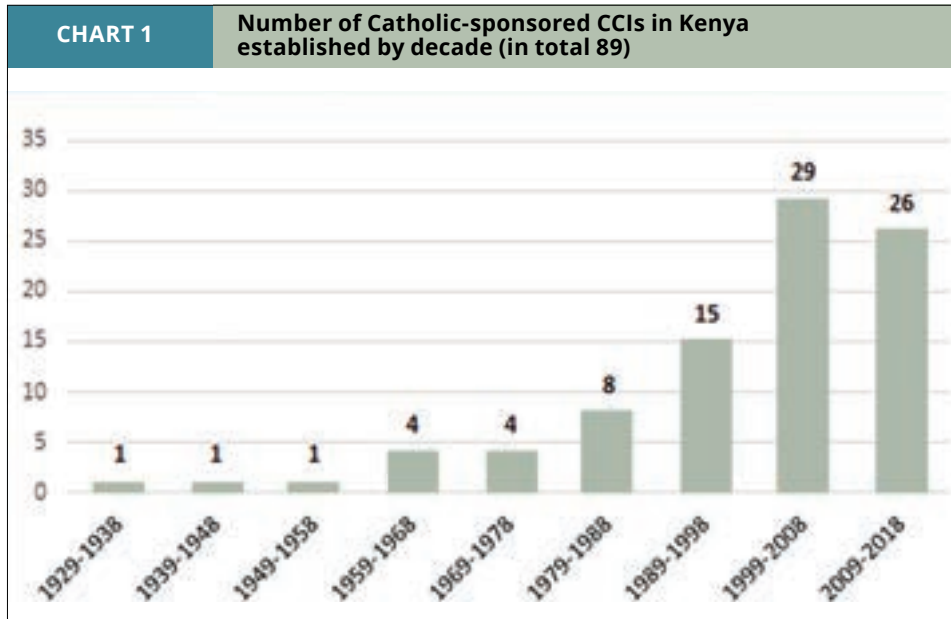
Institutions are important expressions of the Christian mandate to care for those in need. The Catholic Church in all its diversity and through myriad entities, sponsors immense numbers of social welfare institutions globally, a commitment enlivened by the scriptural mandates to care for the vulnerable. These institutions are manifestations of Catholic social teachings that speak to the dignity of all people, a preferential option for the poor and the right of each person to participate fully in society and community. Many are animated by the charisms of religious institutes whose members have played an outsized role in the care of persons in institutional settings.

According to the Vatican’s most recent *Annuarium Statisticum Ecclesiae* (ASE), there are over 100,000 Catholic-sponsored social welfare institutions around the globe. Catholic hospitals, clinics, counseling centers and the like are sprinkled across the world. This includes over 9,000 Catholic-sponsored “orphanages”¹⁰ and 15,000 “homes” for the elderly, people experiencing chronic illness and those with disabilities.

⁹ *Amoris Laetitia*, 172.

¹⁰ Given that most children in childcare institutions have at least one living parent, the terms “orphan” and “orphanage” have fallen out of favour.

Most Catholic-sponsored CCIs are in the Global South. This is due, in part, to the significant impact of the HIV/AIDS pandemic in this region. According to the ASE, in 1980 there were about 390 Catholic-sponsored “orphanages” in Africa. The number doubled in two decades and tripled within three. The impact is clearly seen in Kenya, for example, where, in a sample of 89 Catholic childcare institutions, almost all were established after 1978 (Chart 1).



Catholic efforts to reduce recourse to institutions and foster family- and community-based approaches are underway. Catholic Relief Services and Caritas groups have undertaken efforts to strengthen the economic position of families and in so doing have prevented family separation. Through its Changing the Way We Care project, CRS has helped the Kenyan government adopt family-friendly legislation and begin to reunify children with their families. Most notably, four national associations of religious have organised to champion care reform: the Association of Sisterhoods in Kenya (AOSK), the Association of Women Religious in Malawi (AWRIM), the Association of Religious in Uganda (ARU) and the Zambia Association of Sisterhoods (ZAS). Each national association sponsors a Catholic Care for Children programme. Together they comprise the first sustained, organised Catholic effort to participate in and contribute to care reform in Eastern Africa.



A child is reintegrated with his family through the efforts of CCC in Eastern Africa.

A Regional Portrait of Catholic Care for Children

THE FOLLOWING IS A REGIONAL PORTRAIT of Catholic-sponsored care for children in Eastern Africa based on information from Kenya, Malawi, Uganda and Zambia. The next section profiles aspects of Catholic care, including descriptions of childcare institutions and programmes, the children who are in care, care services and practices, as well as resources—human and financial. The final section considers gaps and identifies opportunities for improving Catholic-sponsored care for children.

The regional portrait is based on documentation from Catholic Care for Children programmes sponsored by AOSK, AWRIM, ARU and ZAS. Each CCC programme has collected substantial data. Researchers delved into their records and consulted with CCC teams to ensure information is as up-to-date and complete as possible.

Each CCC programme started with a rapid assessment or study of Catholic-sponsored childcare institutions and programmes, along with a situational analysis. To get started, researchers in each country identified as many Catholic-sponsored CCI/Ps as possible and were successful in identifying the vast majority. Information about various aspects of Catholic care, obtained via desk research, surveys and field visits, was compiled, analysed and used to develop work plans to promote family- and community-based care.

Since the initial rapid assessments were completed, monitoring and evaluation (M&E) staff in each country have collected information about programme activities and results for various stakeholders, including GHR Foundation, which has a trove of grant reports available to the researchers. Furthermore, CCCU completed a major external mid-term evaluation in 2020-21; a mid-term evaluation for CCCK has recently been published.¹¹

Through Catholic Care for Children International (based at the International Union of Superiors General in Rome), CCC programmes in Kenya, Malawi, Uganda and Zambia (along with a new programme in Sri Lanka) are collaborating on monitoring and evaluation (M&E) efforts. During 2022 they developed a common M&E framework, agreeing on common indicators. During 2023 the M&E framework will be piloted; the first inputs have been provided. Going forward, information will be routinely updated.

¹¹ A summary of the CCCU mid-term evaluation is available at <https://catholiccareforchildren.org/catholic-care-for-children-in-uganda-findings-from-a-midterm-evaluation/>

T I M E L I N E

2016	—	Catholic Care for Children in Uganda Association of Religious in Uganda
2017	—	Catholic Care for Children in Zambia Zambia Association of Sisterhoods
2018	—	Catholic Care for Children in Kenya Association of Sisterhoods of Kenya
2020	—	Catholic Care for Children International International Union of Superiors General
2023	—	Catholic Care for Children in Malawi Association of Women Religious in Malawi

Given the large number of CCI/Ps included in the initial assessments and ongoing M&E, it can be assumed with reasonable confidence that the findings are reliable and generalisable. Yet there are limitations. Data has been collected at different points by different research teams. While researchers and M&E staff collected information about similar aspects of Catholic care, they did not begin with standardised instruments. There are still gaps in data collection as CCC is still building its M&E capacity. Moreover, country to country, there are differences in nomenclature. The CCCI M&E effort has mitigated some of these differences and researchers will note when they are relevant to results and findings.

S O U R C E M A T E R I A L

	INITIAL ASSESSMENTS	GRANT REPORTS	EVALUATIONS	CCCI MONITORING
KENYA	Rapid assessment completed in 2019	Yes	Mid-term evaluation completed in 2023	Yes
MALAWI	Rapid assessment completed in 2022	Not yet	Not yet applicable	Not yet
UGANDA	Rapid assessment completed in 2016	Yes	Mid-term evaluation completed in 2021	Yes
ZAMBIA	Study of Catholic-sponsored care completed by CRS in 2016	Yes	Midterm evaluation completed in 2022	Yes

Despite methodological limitations, CCC documentation is rich. It provides the basis for a first-of-its-kind overview of Catholic care for children in the region. Given that Catholics have a long history in the region and sponsor a significant portion of care within these countries, results from this regional portrait are relevant for better understanding care in general in Kenya, Malawi, Uganda and Zambia and may be suggestive for Catholic-sponsored care in nearby countries.



PART TWO

Catholic Care for Children in Eastern Africa

GLOBALLY AND LOCALLY, the Catholic Church plays an immense role in fostering family integrity and prospects for children’s well-being. It has nurtured families and in so doing, strengthened the environment wherein children first experience what Pope Francis has described as the “spark of God’s love.”

But family life is not always easy. Some families struggle mightily with human frailties; others are beset by dire circumstances. Each can fray family bonds and lead to separation of children from their families.

When families have struggled, faith-inspired efforts have kept many families intact. Much is to be said for the personal and informal responses of families, neighbours, small Christian communities and parishes. Look closely and you will quickly see myriad examples. Heeding the gospel mandate to care, a neighbour supports another through a difficult time. The parish offers marital counselling. A small Christian community provides moral support. At a more organised level, a Caritas economic strengthening programme brings needed resources to families.

Yet many children have been separated from families and alternative care becomes necessary. Here again personal and informal efforts inspired by faith are quite significant. Take note of a grandmother caring for grandchildren or a couple caring for nieces and nephews. Appreciate couples who adopt or those who foster children.

The Catholic community also cares for children through more formal, organised efforts undertaken by dioceses, religious institutes, parishes, lay associations, volunteers and social welfare organisations. There are many and varied community-based programmes that create safe places for children. Programmes serve children who live on the streets. Day-care programmes ensure the well-being of children while their parents work. Children with disabilities are cared for in ways that promote social integration and self-reliance.

“

I lost my own mother at the age of one and a half years and instead of being taken into an orphanage, my grandmother welcomed me to her own home so much so that I never knew that my grandmother was my grandmother, but I knew her as my mother up to the age of 15. To have a family is a very important thing. It changes the whole attitude towards love and acceptance. I have wondered: what would my life have been like if I had been raised in an orphanage instead of a family?

—SR. MARGARET KUBANZE, LSOSF, FORMER SECRETARY GENERAL, ARU

Some care occurs in institutional settings. Abandoned children, for example, have been cared for in institutions providing short-term emergency care. Many other children have been cared for in long-term residential care.

As care reform gains momentum globally, institutional approaches to caring for children are giving way to family- and community-based care. Efforts are keeping families intact. Other endeavours are reuniting children with families or finding them long-term, family-like settings that improve prospects for their healthy, psychosocial development. While there will always be a need for some institutional care, especially short-term emergency care, long-term residential care is now discouraged.

This section of the regional portrait focuses on care for children separated from their families and growing efforts to ensure more children can grow up in safe, nurturing families or family-like environments. As noted, the data herein derives primarily from Catholic Care for Children programmes in Kenya, Malawi, Uganda and Zambia.

The *first section* looks at Catholic-sponsored care for children through an *institutional and programmatic* lens. This section provides information about the numbers and types of Catholic-sponsored childcare institutions (CCIs) and childcare programmes (CCPs), along with information pertaining to ownership and management.





The *second section* focuses on **children in Catholic care**. It contains information about the current number of children in care, as well as recent census declines stemming from CCC efforts and the impact of COVID-19. This section also provides basic demographic information about children in care and reasons driving separation of children from their families.

The *third section* focuses on the **practice of care and care reform**. It describes the types of services provided for children in care (for example, health and education). It includes information about the registration status of CCI/Ps. This section provides some information about case management, as well as staff qualifications and training.

The *fourth section* explores **partnerships and resources**. It describes how women and men religious are working together, along with the ways in which CCC is working with government and local officials, church leaders and NGOs. This section also provides some information about funding sources and some of the challenges securing revenues needed for effective care reform.






While the first four sections are organised topically, the *fifth section* is organised geographically, providing readers with **country-specific profiles** of Catholic-sponsored care for children in Kenya, Malawi, Uganda and Zambia.

This regional portrait of Catholic-sponsored care for children in Eastern Africa reveals deep investments in the care of children and a growing commitment to forego institutional care in favour of family- and community-based care. It illuminates the complexity of care and care reform. It also sheds light on

areas for improvement—to ensure every child receives the highest quality of care and as many as possible grow up in safe, nurturing families or family-like environments.

Note: Unless otherwise indicated, charts and tables refer to Catholic-sponsored childcare institutions or programmes.

Catholic care for children is situated within larger ecosystems of care that are shaped, in large measure, by national approaches to and investments in care as well as demographic realities. To better situate Catholic care for children, Table 2 provides basic information from Kenya, Malawi, Uganda and Zambia, along with information about the Catholic population.

TABLE 2		National Profiles: Kenya, Malawi, Uganda and Zambia			
COUNTRY	KENYA	MALAWI	UGANDA	ZAMBIA	
					
COUNTRY POPULATION	49.6M	17.6M	44.2M	18.9M	
CHILDREN IN INSTITUTIONAL CARE	45,000	6,203	40,000-50,000	6,517	
CHILDCARE INSTITUTIONS	850	126	600	190	
CATHOLIC POPULATION (2022)	11M	3.5M	19M	3.2M	
CATHOLIC DIOCESES	26	8	19	11	
RELIGIOUS INSTITUTES FOR WOMEN	167	46	78	46	
WOMEN RELIGIOUS	7,000	1,510	4,135	1,753	
RELIGIOUS INSTITUTES FOR MEN	88	30	34	26	
MEN RELIGIOUS	2,656	325	1,200	788	

Source: ■ UNICEF 2021 ■ Catholic data provided by AMECEA

Institutional profile of Catholic Care for Children

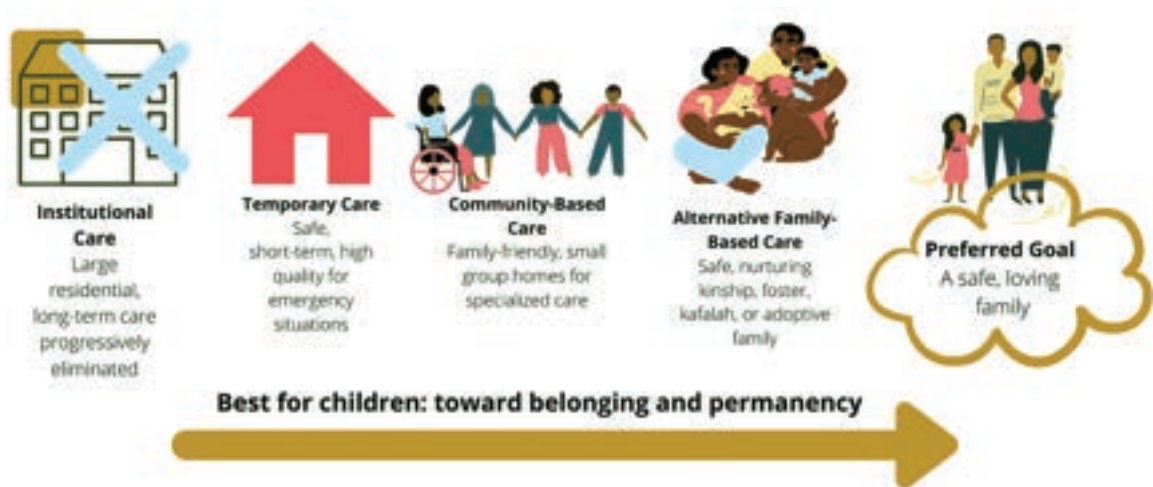
Numbers and types of Catholic-sponsored childcare institutions and programmes

THROUGH INITIAL RAPID ASSESSMENT studies and ongoing field work, Catholic Care for Children teams have identified almost all Catholic-sponsored CCIs and CCPs within their respective countries (Table 3). Given inconsistent nomenclature, it is not possible to determine the precise scope of the Catholic footprint of care, but data suggests that Catholics are significant providers of care within each country.

TABLE 3 Number of Catholic-sponsored CCIs and CCPs identified through Catholic Care for Children			
KENYA 145	MALAWI 32	UGANDA 43	ZAMBIA 33

These Catholic-sponsored CCIs and CCPs align with a continuum of care—ranging from long-term residential, to short-term emergency, small group homes, adoption and fostering programmes and community-based care. There are also programmes for children who live on the streets. A significant portion of care is provided via special schools or annexes for children with disabilities.

Continuum of Care for Children



KENYA

- 8 babies' homes
- 39 children's homes
- 30 rehabilitation centres for children connected to streets
- 19 rehabilitation centres for children with disabilities
- 1 rehabilitation centre for children in conflict with the law
- 20 small homes
- 11 rescue centres
- 17 community-based programmes

MALAWI

- 16 long-term residential childcare institutions
- 5 short-term residential childcare institutions
- 5 annexes for children with special needs
- 15 community-based programmes

UGANDA

- 8 babies' homes
- 4 children's homes
- 4 residential rehabilitation centres
- 3 boarding annexes
- 8 schools for orphans or vulnerable children
- 8 annex schools for children with disabilities
- 2 community-based rehabilitation centres
- 6 community-based programmes

ZAMBIA

- 13 homes for orphans and vulnerable children
- 3 facilities for girls at risk
- 5 centres for children connected to streets
- 7 facilities for children with disabilities
- 4 boarding schools for children with disabilities
- 1 school for children with disabilities and rehabilitation services

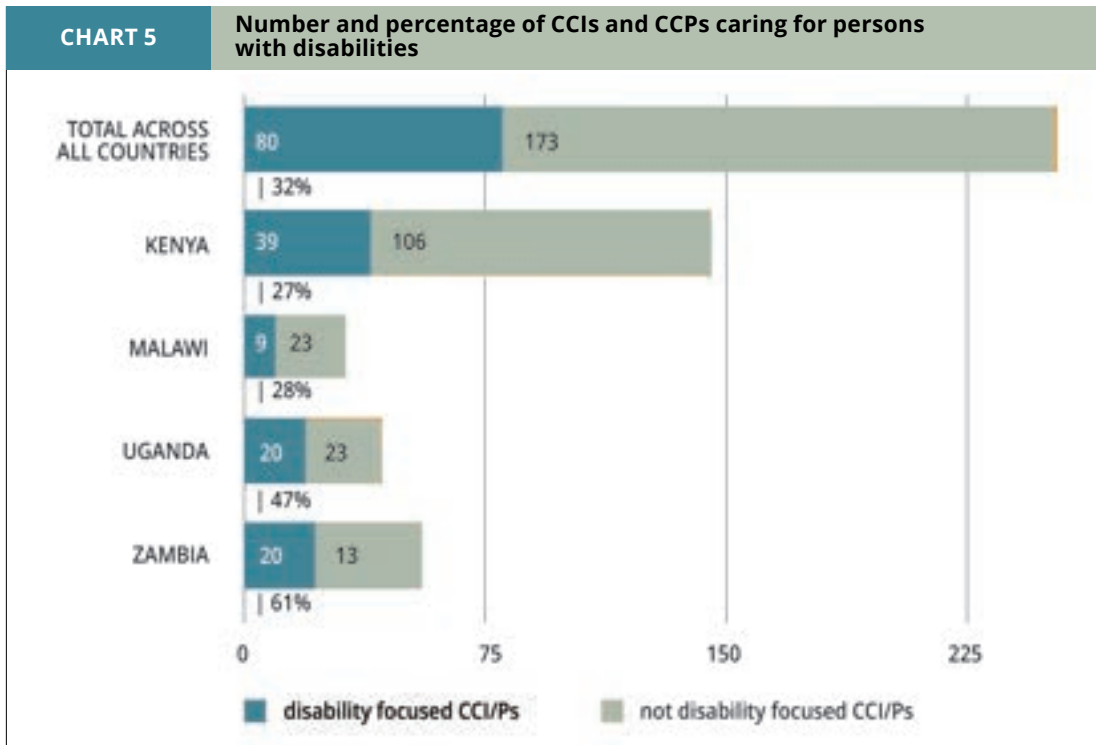
Children outside of families are supported in *residential* childcare institutions and *non-residential* childcare programmes, that is, community-based or outreach programmes. Residential CCIs significantly outnumber non-residential CCPs (Table 4). Note: most residential CCIs also engage in some community-based programming or outreach.

TABLE 4**Percentage of residential CCIs v. non-residential CCPs**

	RESIDENTIAL CCIs	NON-RESIDENTIAL CCPs
KENYA	88%	12%
MALAWI	63%	37%
UGANDA	79%	21%
ZAMBIA	97%	3%
ACROSS 4 COUNTRIES	84%	16%

Note: Of the 33 CCIs CCCZ is with, only one is a fully non-residential, community-based programme. Of the remaining 32 CCIs, 20 offer residential services as well as outreach/community-based services.

Whether residential or non-residential, **about one-third of Catholic-sponsored childcare institutions and programmes serve children and some adults with disabilities**, ranging from 27% in Kenya to 47% in Uganda (Chart 5).

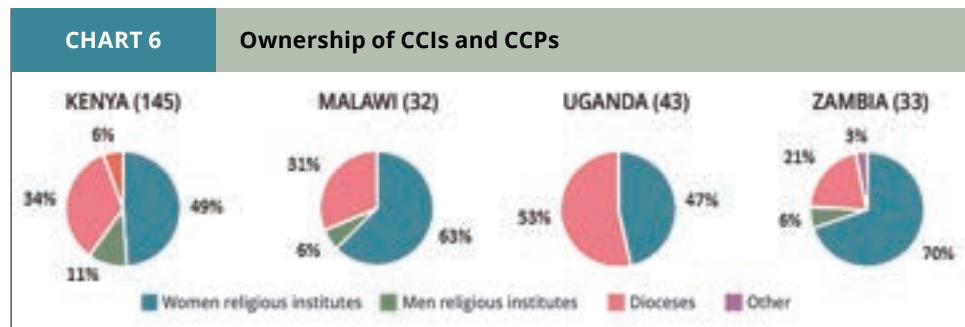


One-third of Catholic-sponsored childcare institutions in Eastern Africa serve children with disabilities.



Ownership and Management of Catholic-Sponsored Childcare Institutions and Programmes

CATHOLIC CHILDCARE INSTITUTIONS and programmes are either owned or sponsored by religious institutes or dioceses; the exceptions are in Kenya and Zambia where a handful are owned by other entities. Ownership by religious institutes is generally more common than ownership by dioceses. In Kenya, 60% of CCI/PPs are owned by women’s and men’s religious institutes; in Malawi, 69%; in Uganda, 47%; and in Zambia, 76%. More CCIs and CCPs are owned by women’s religious institutes than by men’s (Chart 6).



While dioceses own a significant number of CCIs and CCPs, they manage far fewer (Table 7).

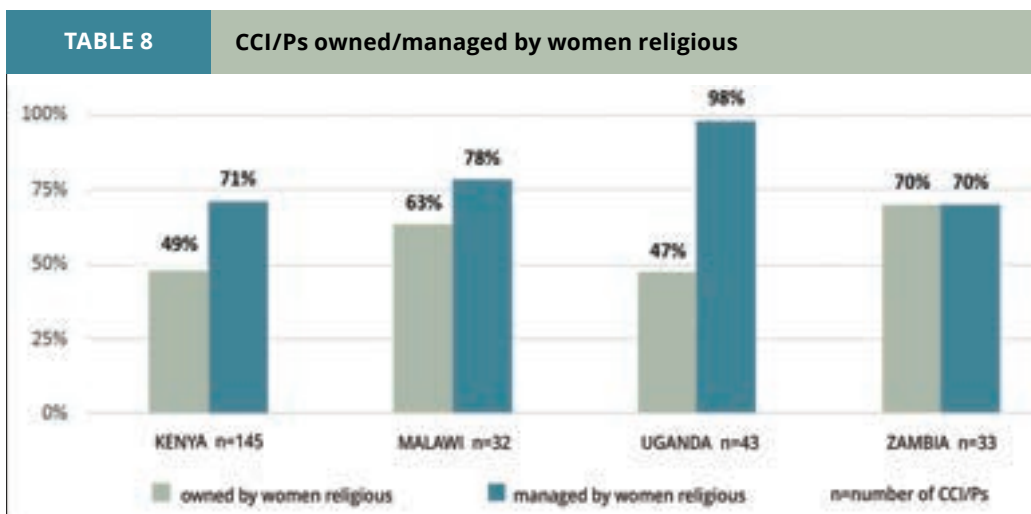
TABLE 7 Ownership and management of CCIs and CCPs

	KENYA		MALAWI		UGANDA		ZAMBIA	
	Own	Manage	Own	Manage	Own	Manage	Own	Manage
Women religious	71	103	20	25	20	42	23	23
Men religious	16	15	2	2	0	1	2	2
Dioceses	50	22	10	5	23	0	7	7
Other	8	5	0	0	0	0	1	1



Catholic sisters manage most of the Catholic CCI and CCPs in Eastern Africa.

Women religious manage most CCI/Ps. Regardless of ownership, most CCI/Ps are managed by women religious. In Kenya, for example, in addition to managing the CCI and CCPs that they own (71), sisters also manage 27 of 50 (54%) of CCI/Ps owned by dioceses and few more owned by other groups. In Malawi, sisters manage their own CCI and CCPs (20) as well as half (5 of 10) of the diocesan-owned CCI/Ps (Chart 8).



Children in Catholic Care

The number of Children in Care

ACCORDING TO THE MOST RECENT DATA available (late 2022/early 2023), there were **at least 22,446 children served through Catholic-sponsored childcare institutions and programmes**. While residential CCIs outnumber non-residential CCPs several times over (Table 4 above), **more children are cared for in non-residential CCPs than in residential CCIs** (Table 9).

	KENYA	MALAWI	UGANDA	ZAMBIA	TOTAL
Residential CCIs	4,741	1,279	2,315	1,555	9,890 (44%)
Community-based/ Non-residential CCPs	5,125	4,296	1,888	1,265	12,574 (56%)
TOTAL	9,866	5,575	4,203	2,820	22,464

Note: 60% of CCIs/PPs (87 of 145) in Kenya reporting; 100% reporting from Malawi; 98% from Uganda, and 79% from Zambia.

Since the advent of CCC programmes and more recent COVID-19 regulations, the number of children served through CCIs has declined. *Admission rates have slowed and more than 3,650 children have been reintegrated with their families or placed in alternative care.* Most have been reunited with biological families or kin (Table 10).

	KENYA	UGANDA	ZAMBIA
Biological parents	66%	83%	96%
Kinship care	12%		
Guardianship	17%	4%	
Foster care	2%	10%	4%
Adoption	3%	1%	
Independent living	1%	2%	

Note: In data collection, CCCU and CCCZ have not distinguished between reunification with biological parents and placement with kin.

KENYA Since 2018 at least 2,322 children from 53 CCI have been reunited with their families: 143 from babies’ homes, 744 from children’s homes, 960 from rehabilitation centres for street-connected children, 315 from rehabilitation centres for children with disabilities and 160 from rescue centres.

MALAWI As CCCM started in 2023, no change-over-time data is available.

UGANDA Since 2016 at least 1,443 children from 19 CCIs have been reunited with their families: 655 from babies’ homes, 656 from children’s homes and 132 from rehabilitation centres.

ZAMBIA CCCZ is part of a collaborative that includes the Zambian Ministry of Community Development and Social Services, international NGOs and local service providers. From two pilot projects, 70 children have been reunited with their families. Three additional CCIs have recently started reunification efforts.

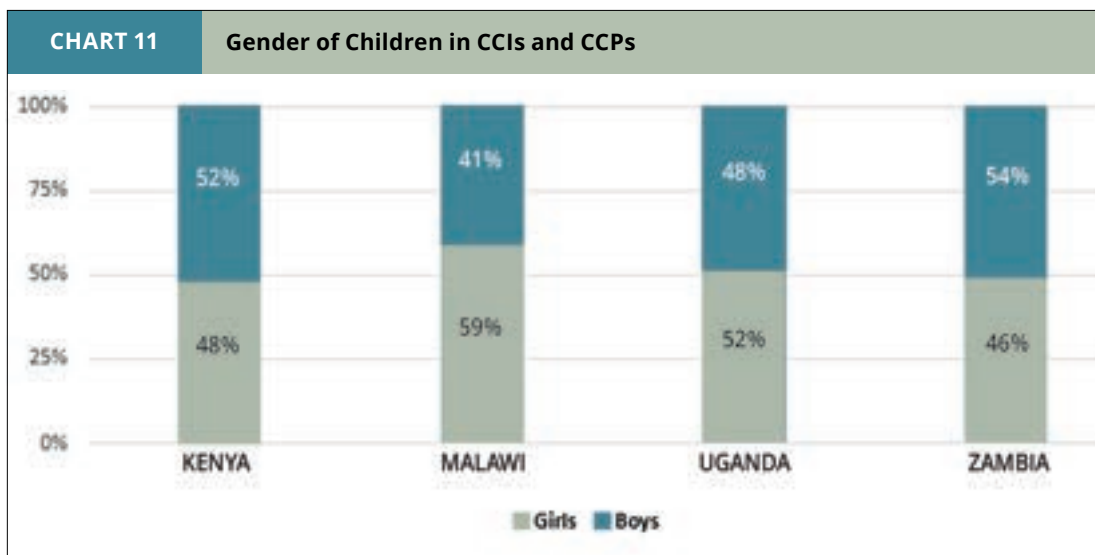


The gate to get in is nearly closed and the gate to get out is wide open.

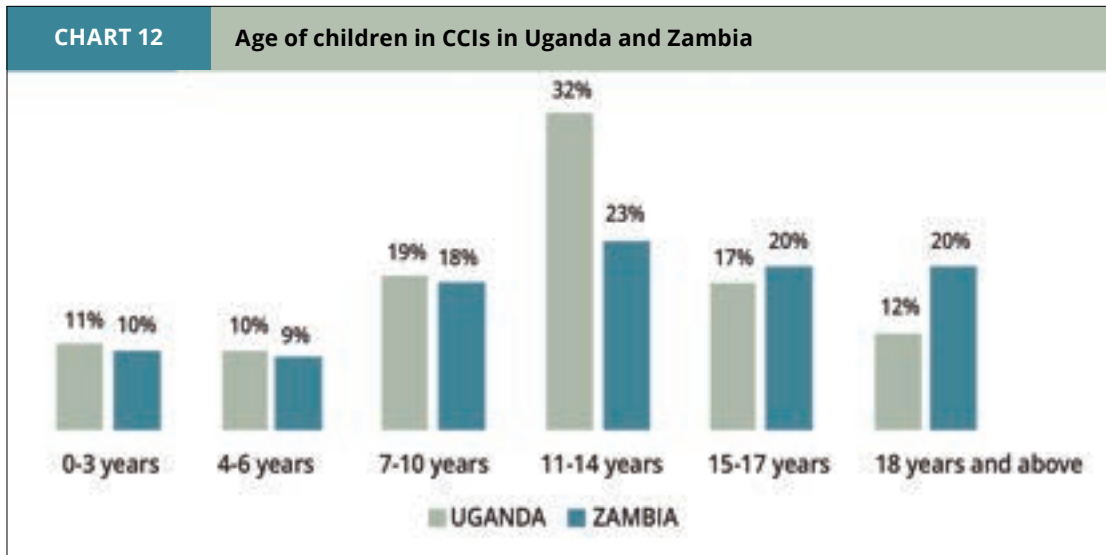
—SISTER FROM UGANDA

Demographics

Gender Overall, gender does not play a major role in determining which children are in institutional care. Boys are slightly more likely to be in care in Kenya and Zambia, while girls are slightly more likely in Malawi and Uganda (Chart 11).



Age In Uganda and Zambia relatively few children under the age of 6 are in care. The vast majority of those in care are over the age of 7; most are teenagers (Chart 12). Older youth may be highly represented in care as prospects for reunification with family or placement with kin diminish with time.



HIV/AIDS
 Chronic Disease
 Human Trafficking
 Family Breakdown
 Poverty
 Parental death
 Abuse
 Disability
 Neglect
 Access to Services
 Teenage Pregnancy
 Mental Illness
 Abandonment

Why are children in care outside of their families?

It is well-documented: most children in residential care have at least one living parent. While CCC teams have not tracked parental status, national-level data suggest that *parental loss is far from the only driver of institutionalisation*. Many children who have lost a parent are not in institutional care (Table 13).

TABLE 13 National data: Parental status of children not living with biological parents

	% of children who are not living with biological parents	Parental status of children not living with biological parents—in kinship care, foster care, residential care, in an adopted family, living alone, in child-headed households, etc.		
		Both parents living	One parent living	Neither parents living
KENYA	13%	66%	18%	8%
MALAWI	20%	68%	21%	10%
UGANDA	20%	78%	17%	6%
ZAMBIA	16%	68%	23%	9%

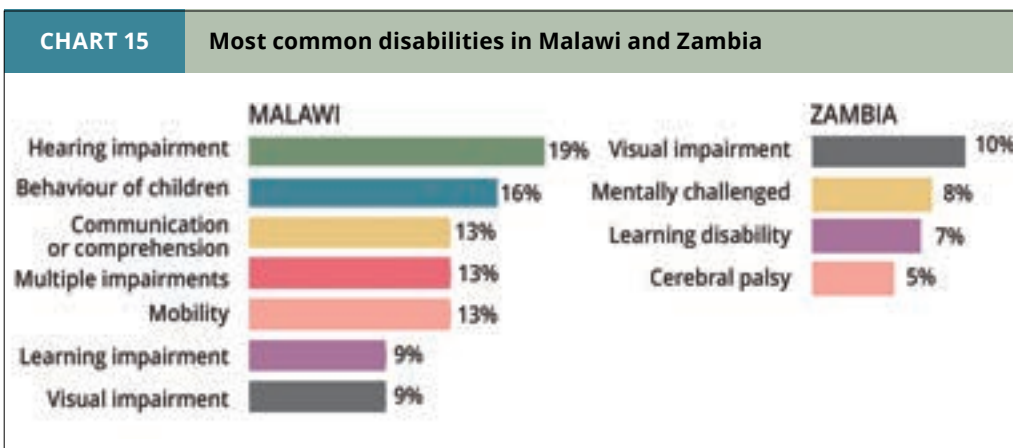
Source: <https://bettercarenetwork.org/regions-countries/africa/eastern-africa>

While parental death creates vulnerability, CCC programmes note other push-and-pull factors leading to separation of children from their families. Some are related to children’s survival, development and protection, others to parental capacity to provide or care for children. Parental loss, poverty and disability are mentioned most often.

Disability plays an important role. In Eastern Africa a significant percentage of those in Catholic-sponsored CCI/Ps have a disability. The population includes children and some adults (Table 14).

TABLE 14	Percentage of persons (children & adults) in care with a disability			
	KENYA	MALAWI	UGANDA	ZAMBIA
% with a disability in CCIs	25%	53%	44%	49%
% with a disability in CCPs	9%	10%	68%	47%

The categories of disabilities experienced by persons in Catholic care include cognitive, behavioural and physical. Some children/persons have multiple disabilities (Chart 15).



Mental and physical challenges are a significant cause for children living outside the home.



ADMINISTRATION BLOCK

KITCHEN

**OCCUPATIONAL
THERAPY ROOM**

HALL

PHYSIOTHERAPY ROOM

DORMITORIES

VOCATIONAL ROOM

WASH ROOMS

PRIVATE CONVENT

Care and Care Reform

Services provided: a holistic approach

Catholic-sponsored CCIs and CCPs provide holistic care for children. A holistic approach aligns with Catholic social teachings, especially those that underscore the dignity of every person and the right to full participation in society.

Rapid assessments conducted for CCC programmes found virtually all Catholic-sponsored CCIs and CCPs provide one or more auxiliary services. These include:

- education
- healthcare and nutrition
- family counselling and psychosocial support
- coordination of alternative care
- rehabilitation for children with special needs
- family strengthening
- linkages with other service providers

Familial bonds and social integration are important for all children. Most CCIs providing education and health services for children with disabilities (such as small homes, rehabilitation centres, annex schools, boarding annexes and OVC schools) provide opportunities for children to visit their families, especially during the holidays. In other CCIs (such as children's homes), home visits designed to foster family bonds are part of the reintegration process. The number of CCIs providing routine opportunities for home visits for all children is limited (Table 16), but the number is reportedly growing since CCC started.



We try our best that no separation is done. When a child comes in, we ensure that we deeply look at the case and decide whether the child is for admission or not. Currently we have 76 children in outreach. This means that we sent them back home. The outreach programme staffed with two social workers links us to the community.

—CHILDREN'S HOME STAFF,
KENYA

TABLE 16

Number and percentage of CCIs providing routine home visitation opportunities (holidays and/or weekends)

	Total residential CCIs reporting	Number/percent
KENYA	128	39 (30%)
MALAWI	26	6 (23%)
UGANDA	35	20 (57%)
ZAMBIA	32	9 (28%)



Now empty, a CCI facility can be repurposed and used in new ways to support children and their families.

As mindsets change and fewer children are in care, **care providers are beginning to transition their services.** In Kenya, some CCIs are beginning to reimagine how the charism of care might find new expressions; they are considering outreach work, schools, nurseries and income generating activities. Having reunited children in their care with their families, several CCIs in Uganda are now exclusively used for community-based childcare programmes. Twenty-six CCIs have augmented services with community outreach. In recent years two CCIs in Zambia have transitioned from residential care to family care.



Bauleni Special Needs Project and School (BSNP) in Lusaka, Zambia is a Centre of Excellence for inclusive, special needs education. A project of the Sisters of the Sacred Hearts of Jesus and Mary, BSNP supports children with disabilities and their families through community-based programming. According to the Project Manager, “We don’t want to be seen as an orphanage, but as a facility to provide education to vulnerable children.” BSNP’s home-based programmes for severely disabled children have brought hope to families formerly without support. Not long ago it created a support group for parents and guardians. During a recent school holiday, parents, guardians and their children had the opportunity to stay together in small groups at the Bauleni hostel. They met with teachers who offered ideas about how they might further support their children. The experience was rich in peer-to-peer support. (See <https://www.miseancara.ie/2022/12/bauleni-special-needs-project-lusaka-zambia/>)

Registration status

Government regulations in all four countries require childcare institutions and programmes to be registered. While enforcement has not always been rigorous or consistent, in recent years regulations are being enforced more routinely.

Like many other childcare institutions within their respective countries, a fair number of Catholic CCIs have been operating without registration or with lapsed registration. In every instance representatives of Catholic CCIs have indicated their desire to be properly registered and with assistance from CCC programmes, many have been. In Uganda, 100% of CCIs and CCPs are now properly registered. Kenya is making progress and Malawi is getting started. CCIs in Zambia were registered prior to the establishment of CCCZ (Table 17).

TABLE 17 Registration status of CCIs and CCPs			
KENYA	MALAWI	UGANDA	ZAMBIA
50 of 145 CCI/Ps are not registered. Those previously registered may reapply; CCCK has helped 28 to do so. The remainder may only apply to operate as community-based programmes.	As of 2023, 8 of 32 CCI/Ps are registered. Most administrators are aware of the registration requirement. Efforts on the part of some to register have failed due to unwieldy bureaucracies and an absence of guidelines. Almost all CCIs have certificates of recognition from the District Assembly.	When CCCU started, only 2 of 21 CCIs were registered. CCCU helped the remaining 19 CCIs secure registration with the Ministry of Labour and Social Development. The 8 CCPs are registered with the Local Government; 16 schools are registered with the Ministry of Education and Sport.	All 33 CCIs are registered. Registration was secured independently of CCCZ.

Case management

Case management is the process of assisting a child and his or her family that is undertaken by professionals, usually those with training in social work. It entails developing individual case plans and then finding and providing the means to implement them by support, referrals or accessing needed resources. It begins with the initial intake of the child and ends with closure of the case when a child has been successfully reintegrated into family or into alternative care.

Catholic Care for Children programmes in Kenya, Uganda and Zambia have built case-management capacity among member institutions to ensure a safe transition of children back into families or an appropriate alternative. Most childcare institutions now have:

- stronger gatekeeping mechanisms;
- more systematic record keeping;
- a file for each child;
- more robust family tracing efforts;
- greater involvement of parents and guardians;

“

There are significant changes in case management practices, including gatekeeping, documentation, family tracing, reunification of children with families and some have clear agendas of what they want to transform into as they de-institutionalise. The number of children under care has significantly reduced.

—CCCU TECHNICAL PARTNER FROM MAKERERE UNIVERSITY

- increased attention to family strengthening to ensure families are able to care for their children;
- stronger ties with local stakeholders, such as government officials and other community-based organisations.

“

I feel empowered and I challenge social welfare officers if they are not adhering to what they are supposed to do for example if they bring a child without an admission letter.

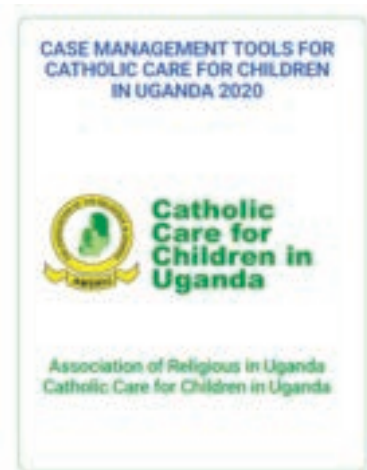
—SISTER IN ZAMBIA

Most CCIs have adopted a more robust approach to gatekeeping. In the past there was little or no screening to admit children or effort to return them to their families. Today children are admitted only if conditions are serious and done in coordination with and approval from government officials. At the same time, once a child has been admitted, plans are developed for the child to leave the institution as soon as possible.

A significant departure from earlier practice pertains to record keeping—ensuring a full record is kept for each child. Besides encouraging CCIs to keep records, CCC programmes have introduced comprehensive, web-based case-management systems aligned with government guidelines.

CCC programmes have also developed guidelines and tools to facilitate the transitioning process (such as the “Case Management Tools for Catholic Care in Uganda”) and introduced CCIs to existing tools developed by their respective governments.

In addition to trainings in case management (described below), mentoring visits by the staff of national CCC programmes to the CCI/Ps are perceived as extremely helpful for the learning process and ensuring that the knowledge gained in trainings is implemented properly.



Child protection and safeguarding

Child protection is integral to Catholic Care for Children and the efforts to help CCIs and CCPs embrace care reform. It looks at the safety of children in care, during the transitioning process and once children are back with their families or in alternative care. Training on safeguarding is grounded in the rights of children and couched within the

Knowledge on how to run the home—formerly it was one person doing the administration and yet not trained as a social worker, so was doing on trial and error. Now we have been trained how to run the homes—record keeping, things should be systematic. In the past was very hard to follow details of the child from when it came in until later. There were no records. Children stayed in the home for a long time especially if the parent didn’t look for the child. Now at least you can put information on TV, radio, especially for the abandoned children, and announce in church.

—BABIES’ HOME UGANDA



Children learn life skills at the Familia Ya Ufariji Children's Home in Kenya, including woodworking, farming and rabbit rearing.

ASOSK started training us about care reforms around 2019 and whatever they were training us on went hand-in-hand with government policies. We are now following the rules. Right now, we only rescue children, 4-7 years old from the streets. Before reuniting them, we have to teach them life skills including how to make their bed, how to clean a compound, how to clean the rooms, how to do farming, how to rear rabbits, and so on. We give them psychosocial support. We also provide them with food, clothing and medical care.

Most of the boys either don't know where they come from, don't remember the names of their family members or they may not give us sufficient information to trace their families. Some of the children's families are street families. When you trace the families, either you find good wholesome families or you might also find broken families. In broken families, the child may not find peace. Depending on the background of a child and the situation of their lives and or family, they may be forced to stay at the children's home for a long period as we try to find a solution.

When a case has progressed and reached the point of reintegration, we do family conferencing where the best interests of a child are discussed. The conferencing involves several entities, including duty bearers responsible for the area where the child will be settled, including the chief, *nyumba kumi* leader, church leaders, the Children's Officer and also extended family members. Each discusses their contribution to the well-being of the child after reintegration has been done. Through this forum, we get to know whether the child will be accepted into a family and a community or would be rejected. This is important because we don't force a child into a family. Leaders take the responsibility of overseeing the wellness of the reintegrated boy including ensuring that the boy remains at home and goes to school. For example, in one area, the chief asked the boy to pass by his office daily on school days to sign a book as evidence that the boy was attending school every day. If you work with all these mentioned people, reintegration works out very well and the boy remains at home in a safe environment.

—FAMILIA YA UFARIJI CHILDREN'S HOME, KENYA

alternative care framework. This comprehensive approach to child protection resonates with those working in CCI/Ps and helps them keep the best interests of the child at the forefront.

As the associations of religious in Uganda, Kenya and Zambia launched CCC programmes, they developed or reviewed their own child-protection policies and then supported their members in developing policies for their own institutions. During this process the CCC programmes have provided technical support and training for religious and lay personnel at all levels from the Superiors to local communities.

KENYA CCK received technical support from a law firm and linked some CCI with the firm where there were specific questions and issues to be addressed. CCK has helped 26 member congregations and 2 CCIs develop their child protection policies. Some congregations have formed child protection committees.

MALAWI AWRIM as well as the Episcopal Conference of Malawi have safeguarding policies. CCCM will support any childcare institution and programme that has not yet developed a child protection policy and will be arranging training for CCI/P staffs.

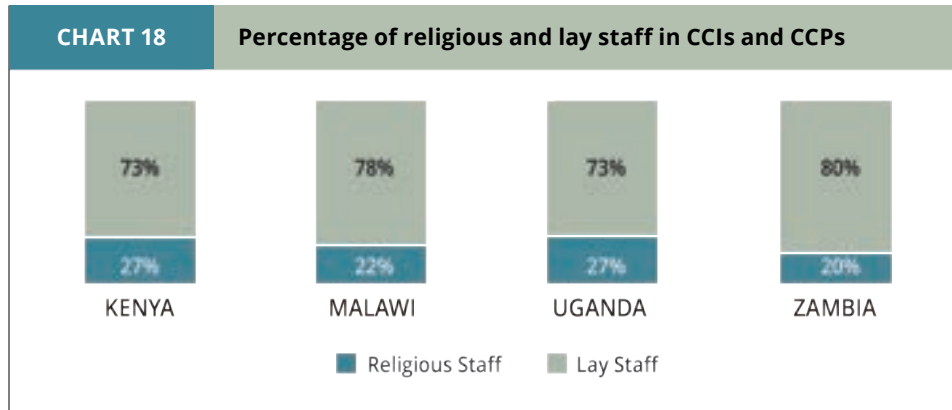
UGANDA Of 15 religious institutes surveyed in 2016, only one mentioned a child protection policy. Now child protection is on the agenda of all the institutes and child protection committees have been formed.

ZAMBIA Religious institutes and CCIs have had child protection policies in place; however, a joint review was done to ensure that minimum standards were being met and the CCIs were supported in their revision processes.



Staffing, training and qualifications

CCIs and CCPs are staffed by women and men religious and lay staff. The percentage of religious staff ranges from 20% to 27% by country (Chart 18).



The quality of care is very much affected by those who work in CCIs and CCPs. There are, of course, intangibles greatly affecting the quality of care—such as compassion and empathy—which are easy to recognize and difficult to document. But training, skills and experience also matter.

Rapid assessments conducted when launching CCC programmes in Kenya, Malawi and Uganda found low levels of training among staff. (Data is not available from Zambia.) Most staff had little formal training in case management or safeguarding; few staff had social work training. For example, in Malawi, 87% of sisters working in CCI/Ps have no formal training in social work. In Kenya, most sisters working in CCIs had tertiary-level education, but



few were trained in social work or child protection. The rapid assessment in Uganda found only 12 sisters trained in social work. In the recently completed rapid assessment in Malawi, researchers specifically asked about training in safeguarding. About one-third of CCI/P staff (146 of 457) had training in child protection (4 religious with a bachelor’s degree; 24 staff, including 2 religious, with diplomas; 9 with certificates and 109 with in-house training)—but two-thirds had not.

CCC programmes have added new capacity in the critical fields of case management, child protection and safeguarding, social work and allied fields (including training specific to working with children with disabilities).

TRAINING IN SOCIAL WORK AND ALLIED FIELDS

CCC programmes have helped women and men religious pursue advanced studies in social work and allied fields—training that helps them express their charism of care (Table 19).

	KENYA		UGANDA		ZAMBIA		TOTALS BY LEVEL	
	Enrolled	Graduated	Enrolled	Graduated	Enrolled	Graduated	Enrolled	Graduated
Certificate		71		88				159
Diploma		14	1	43			1	57
Bachelor	12		5			38	17	5
Master			5	17	8		13	
Total # in studies	12		11		8		31	
Total # graduated		85		148		38		271





A sister certified in special education cares for a child.

WHAT ARE RELIGIOUS STUDYING AND WHERE?

KENYA

- At the behest of AOSK, the Catholic University of Eastern Africa (CUEA) developed an interdisciplinary certificate programme on Sustainable Child Rights Protection and Post-Institutionalised Care (SCRIPPIC). Thirty-seven sisters have graduated.
- Twenty-four sisters graduated with degrees in integrative psycho-spiritual counselling from AOSK's Chemchemi Institute of Formation (affiliated with CUEA).
- Ten sisters graduated with certificates and 14 with diplomas in social work from CUEA.
- Twelve sisters are pursuing a bachelor's degree in social work from CUEA.

UGANDA

- Four sisters and one brother are enrolled at Uganda Christian University–Mukono to pursue a master's degree in social work and social administration.

- Sixteen sisters and one brother have graduated with a bachelor's degree in social work from the University of Kisumu, 41 sisters and two brothers with a diploma and two sisters with a certificate.
- Seventy-three religious and 13 diocesan representatives participated in certificate-level child protection training by Makerere University.
- Four sisters and one brother are studying for a bachelor's degree in special needs education at Kyambogo University.
- One sister is studying for a diploma at the School of Physiotherapy of the Uganda Institute of Allied Health Management Sciences-Mulago, Kampala.

ZAMBIA

- At the behest of ZAS, DMI-St. Eugene's developed a degree programme in social work/counselling; 38 sisters graduated in 2022 with a bachelor's degree and 8 continued for master's-level studies.



CCC programmes have equipped numerous sisters with new skills.

In addition to accruing skills through their studies in social work or an allied field, women and men religious routinely report feeling more competent and confident in their work and in advancing care reform.

The education I got is helping me in serving the children and the community. Initially in our Institute we used to keep children in the CCI for long time, but with the education I have, I have come to value re-integration of children very much, because children develop and grow in a better way. Also with knowledge...I know how to do good family tracing and follow-up visits; I am able to do proper documentation, and I can easily and efficiently do my apostolate without stress.

—A SISTER IN KENYA

With the education I am receiving I am capable of changing and updating many things in our Institution of Care which were not there before. I feel very happy because I am now competent and I have courage to lead the Institution as a professional social worker. I have the knowledge and skills that are helping me do more and good practices, especially dealing with the vulnerable children and the community. I am very confident with what I am doing. —A SISTER IN KENYA

TRAINING IN CASE MANAGEMENT, CHILD PROTECTION AND TECHNICAL SKILLS

Across Kenya, Uganda and Zambia, well over 1,300 persons have been trained in case management and child protection and equipped with technical skills.

- Upwards of 800 people have had training in case management.
- Over 500 have been trained in child protection.

Trainings have developed capacity for ***working with children with disabilities***. Over 120 CCI administrators have taken workshops on caring for children with special needs. SPOON, a US-based nonprofit, has trained CCI staff on how to improve feeding practices and monitor the nutritional status of children with disabilities. Sixteen CCI administrators from Kenya attended a course on Disability-Inclusive Child Development.

As CCIs evolve their approaches to care, ***transitioning donors*** is an important piece. Markempa, a US-based consultancy, has trained 50 people from a handful of CCIs to help each CCI develop a high-quality fundraising plan, create compelling messages about the importance of family care and upgrade their websites (see, for example, <https://stmugagga.org/>). Markempa is slated to expand its work in the near future.

The Social Communications Department from the Association of Member Episcopal Conferences in Eastern Africa (AMECEA) has ***developed capacity for communications*** by training dozens on how to craft and disseminate effective stories that underscore the importance of family- and community-based care for children.

Sustainable Child Rights Protection and Post Institutionalised Care (SCRIPPIC) was initiated by AOSK/CCCK with the support of the **Catholic University of Eastern Africa** which designed the course in 2019 and certified it. Course modules include Social Teaching of the Catholic Church and Child Care Practices, Child Development Theory, Child Rights, Protection and Care, Basic Child Counselling, Family and Community-based Care and Sustainable Management of Child Care Programmes. The course is a foundational course for every sister that pursues a degree in social work. The approach/content of the course is the basis of any training CCCK conducts.



Hundreds of Catholic sisters have been trained in case management throughout Eastern Africa.

SENSITISATION

Through sensitisation efforts, CCC programmes have reached at least 6,000 with information about the nature and importance of care reform.

A sampling of sensitisation efforts:

- Hundreds of religious superiors and congregational leaders in Kenya, Malawi, Uganda and Zambia have attended workshops on care reform.
- Nearly 800 staff in educational and healthcare institutions have learned about care reform and child protection in Kenya.
- The Catholic radio stations in Uganda and Zambia have hosted programmes about care reform.
- Administrators from 13 CCIs in Kenya held forums for 1,700 community members and 45 government officials on positive parenting and care reform.
- CCC programmes have hosted workshops to encourage and support fostering and adoption.

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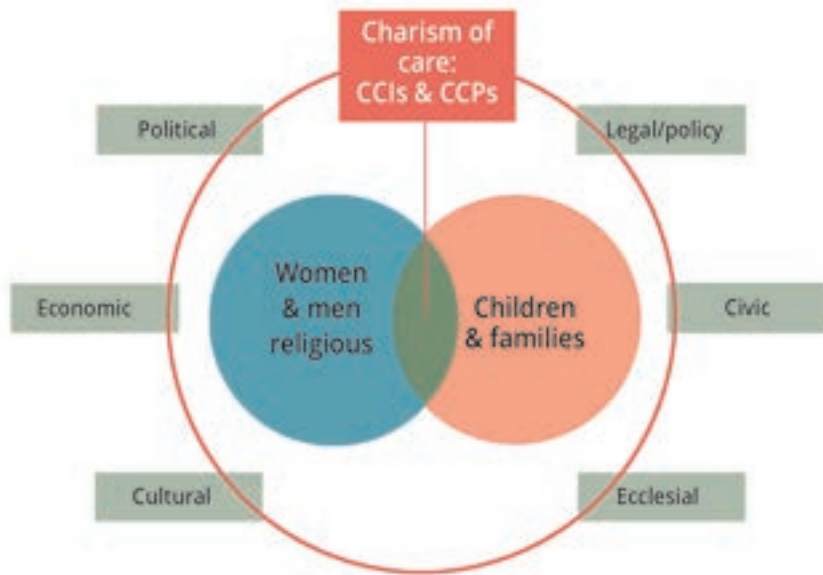
Early in 2023 in Nambale constituency, sisters from AOSK-CCCK, the Deputy County Commissioner, Area County Commissioner, 10 local Chiefs and five Assistant chiefs conducted sensitisation awareness forums for 918 community members on the importance of positive parenting and care for children within families and communities.



Children with physical and mental challenges benefit from CCI administrators' training in special needs care.

Partnerships and resources

CARE AND CARE REFORM ARE COMPLEX. The care a child receives in an institutional setting or through a programme does not exist in a vacuum. Many stakeholders are involved and many factors are at play: legal, ecclesial, cultural, civic, economic and political. The ways in which these knit together determine the kind and quality of care provided, with significant implications for children and their families. Reforming well-established patterns of care requires creating new mindsets, enacting new policies, developing new systems, using new approaches, employing new skills and marshalling new resources. **Collaboration and partnerships are essential.**



As the transition toward family- and community-based care accelerates, women and men religious are collaborating to share learnings, realise efficiencies, marshal resources and advocate effectively. They are deepening relationships and forging partnerships locally, nationally and internationally to improve the quality of care and help ensure that all children can grow up in families or family-like environments.

Working together: women and men religious

The role of the national associations of religious in Catholic care reform cannot be overstated. Before the Association of Religious in Uganda launched Catholic Care for Children in Uganda, there was no sustained, organised platform for Catholics to participate in and contribute to care reform. By bringing women and men religious together, national associations have positioned religious in Eastern Africa as important voices and actors in care reform. As organised

groups, CCC programmes have been able to work with government, civic and ecclesial leaders; engage partners for technical support; and marshal resources.

In sponsoring CCC programmes, the national associations have focused on *religious institutes with a charism of care*. Religious have inspired, encouraged and learned from one another with an eye toward expressing their respective charisms of care in ways addressing contemporary needs.

KENYA Among 255 religious institutes, at least 48 have a charism of care. Forty-eight are involved in CCCK.

MALAWI Among 76 religious institutes, 18 have a charism of care. Thirteen have indicated an interest in CCCM.

UGANDA Among 112 religious institutes, 19 have a charism of care. Eighteen are active in CCCU.

ZAMBIA Among 71 religious institutes, at least 21 have a charism of care. Sixteen have connected with CCCZ.

Connections among religious advancing care reform now extend beyond Eastern Africa. Inspired by the leadership of sisters in Eastern Africa in championing care reform—and aware of the significance of care reform for women religious globally—the International Union of Superiors General (UISG) launched Catholic Care for Children International (CCCI) in 2020. CCCI supports the “CCC family” through regular meetings and cross-cutting efforts, such as a common M&E framework. Through presentations and webinars it is helping women religious across the globe understand the “why” and the “how” of care reform. Here again sisters from Eastern Africa are making a difference. In partnership with the Christian Alliance for Orphans, CCCI has developed training courses for transitioning to family- and community-based care designed especially for religious institutes. During two pilot programmes, which had 48 participants from 10 countries, 3 sisters from Eastern Africa were trained to lead future courses.

CCCI is also liaising with the Gregorian University’s Institute of Anthropology: Interdisciplinary Studies on Human Dignity and Care (IADC) on a research project to develop safeguarding principles for CCC that will inform efforts to ensure children’s safety whilst in care, during transitions and within families.

Connecting with government

Catholic Care for Children programmes have developed mutually beneficial relationships with *government bodies and local officials*—from Ministries and local councils and chiefs to police, probation officers and social welfare officers. CCC programmes are helping governments advance their care reform goals by disseminating care reform messaging, ensuring compliance among CCI/Ps with statutes and bringing to bear their lived experience. In turn, officials are helping CCI/Ps to reduce recourse to institutional care for children and keep children in families or family-like environments.

“

I have been able to build a network of people that I know it’s easy to interact with—ministry people, the probation officer that I used to fear, community members. Something I didn’t ever think I would do.

—SISTER FROM
UGANDA

KENYA CCK is part of a stakeholder group on care reform of the National Council of Children’s Services. It has helped Catholic-sponsored CCl with registration renewal. Within some counties, CCl and local officials are working together on sensitisation.

MALAWI During the course of its 2022 rapid assessment, AWRIM made contact with the government and intends to work with relevant parties as CCCM rolls out.

UGANDA CCCU is represented on the National Alternative Care Coordination Task Force and works closely with the Head of the Alternative Care Department. CCCU staff have contributed to trainings and sensitisation sessions for government officials and local duty bearers. The CCCU team supports local officials; for example, an out-of-compliance Catholic-sponsored children’s home was told it faced closure unless it worked with CCCU.

ZAMBIA CCCZ is part of the Children in Families working group which brings together representatives of the Ministry, international NGOs and local service providers. At the provincial and district levels, CCCZ encourages all Catholic-sponsored CCl to engage with local officials to ensure full compliance with regulations for admission and discharge of children.

Engaged with the Church

A partnership with AMECEA has been particularly fruitful. AMECEA’s Social Communications Department has hosted meetings and supported conversations to help bishops appreciate the importance of care reform and learn more about CCC. In the summer of 2022 representatives from CCC programmes in Kenya, Malawi, Uganda and Zambia were honoured to be invited to the AMECEA Quadrennial Assembly where sisters had the opportunity to meet with their episcopal leaders and share more about CCC.

The AMECEA-CCC relationship is poised to deepen. With recent support from GHR Foundation, AMECEA will work more closely with CCC in support of care reform. Initial discussions have noted the importance of bishop/ clergy support and the need for increased investments in safeguarding, programming for children with disabilities, family strengthening and support for youth in care who are moving toward independent living.



KENYA During the course of its rapid assessment, AOSK/CCCK gratefully received encouragement from several local bishops. At the local level, CCCK and CCI/Ps have invited clergy and catechists to participate in and contribute to sensitisation activities.

MALAWI AWRIM has shared the results of its recently completed rapid assessment with the Episcopal Conference of Malawi which expressed its support for CCCM.

UGANDA ARU/CCCU has worked with the Ugandan Episcopal Conference since the start. During the week-long kick-off training in care reform and child protection in 2016, 13 diocesan representatives participated. Since then, CCCU has connected with clergy and Catholic organisations to involve local communities.

ZAMBIA ZAS/CCCZ has had the opportunity to speak about care reform to the Zambia Conference of Catholic Bishops Commission on Integral Human Development. During the annual CCCZ meeting, ZCCB representatives have made addresses. Local churches are involved in sensitisation, e.g., CCCZ is working with a pastoral coordinator from the Diocese of Livingstone who is promoting care reform.

Partnering with non-governmental organisations (NGOs)

CCC programmes have forged connections with NGOs providing technical support and direct services. For example, in the area of family strengthening CCCU is working with Catholic Relief Services and Kulika Uganda while CCCZ is working with Save the Children and the Catholic Medical Mission Board. To improve case management and alternative care options, CCCZ is working with CRS and Alliance for Children Everywhere.

Expenses temporarily increase when CCIs transition children back to families.





CCI/Ps derive revenue from many sources, including keeping livestock or growing vegetables.

Resources

CCI/Ps derive revenues from a variety of sources: governments, donors, local communities, churches and alumni, as well as religious institutes. Many undertake income-generating activities, such as keeping livestock or growing vegetables for their own use and the market. Most benefit from some in-kind contributions, especially from religious institutes whose members staff CCIs and CCPs. Despite multiple revenue streams, most CCI/Ps are thinly resourced. Many are feeling the adverse effects of COVID-19 which have stemmed the flow of some philanthropic funds while driving up the costs of basics like electricity.

When a CCI begins transitioning children back into families or appropriate alternatives, expenses temporarily increase. There are still ongoing expenses for the facilities, programming, staff and overhead. But new expenses surface. There are direct costs related to transitioning, e.g., travel for family assessments/visits, or fees for alternative care placements. Additional staff and training may be needed, and costs sometimes accrue when new family-focused or community-based programmes are launched.

CCC programmes, with their CCI/P partners, note critical funding needs at this time. The pace at which childcare institutions will be able to reunite children with their families or find alternative placements will be determined, in no small way, by available funding.

Countries at a Glance

TABLE 20 KENYA: Catholic Care for Children

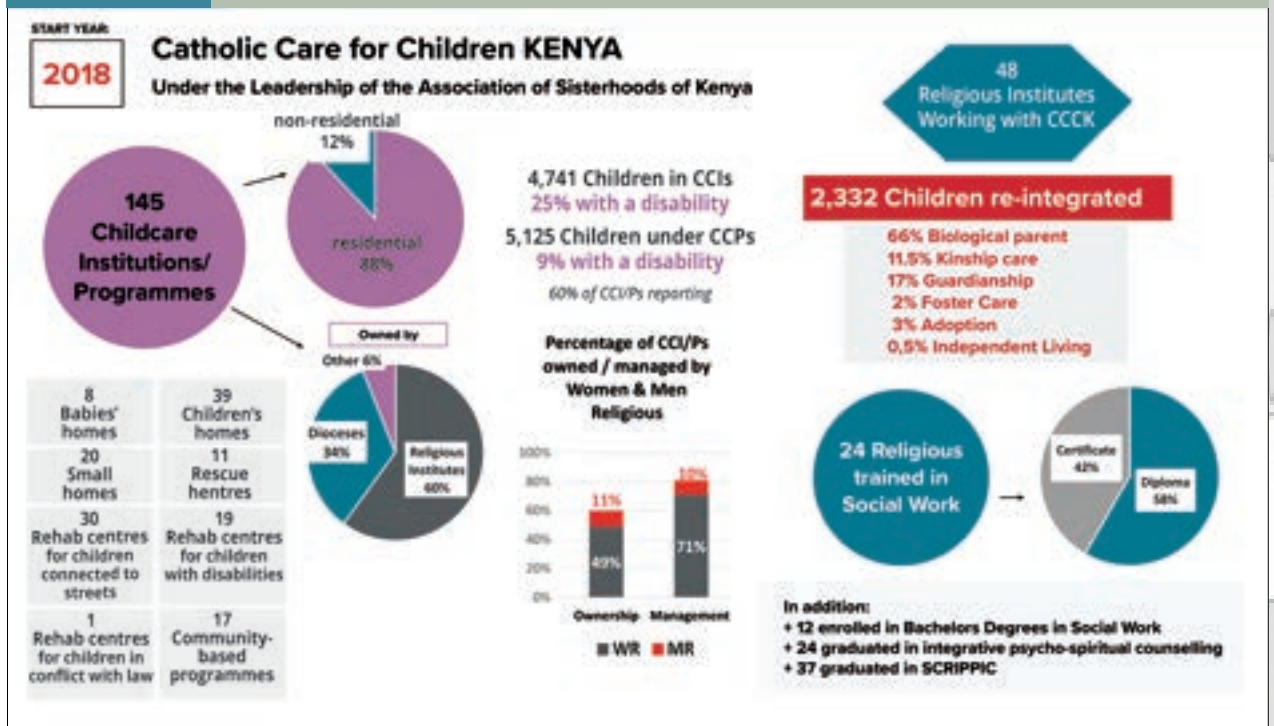


TABLE 21 MALAWI: Catholic Care for Children

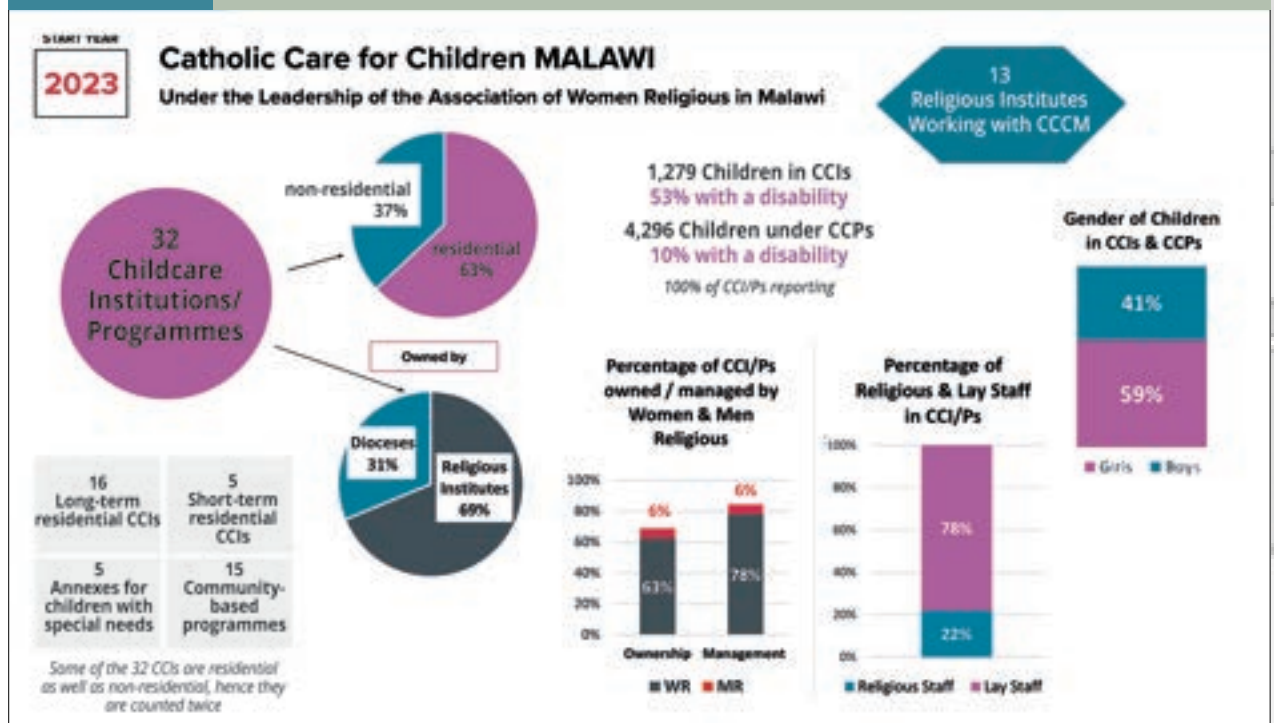


TABLE 22

UGANDA: Catholic Care for Children

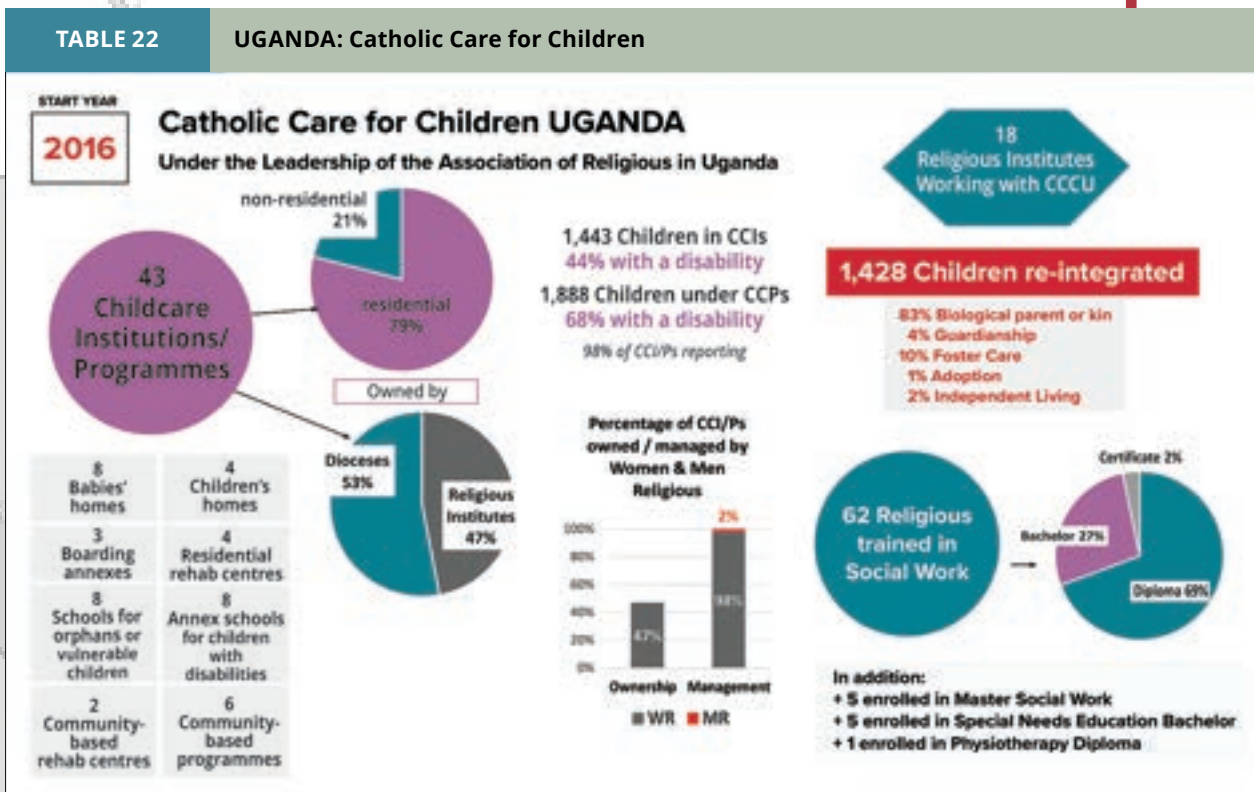
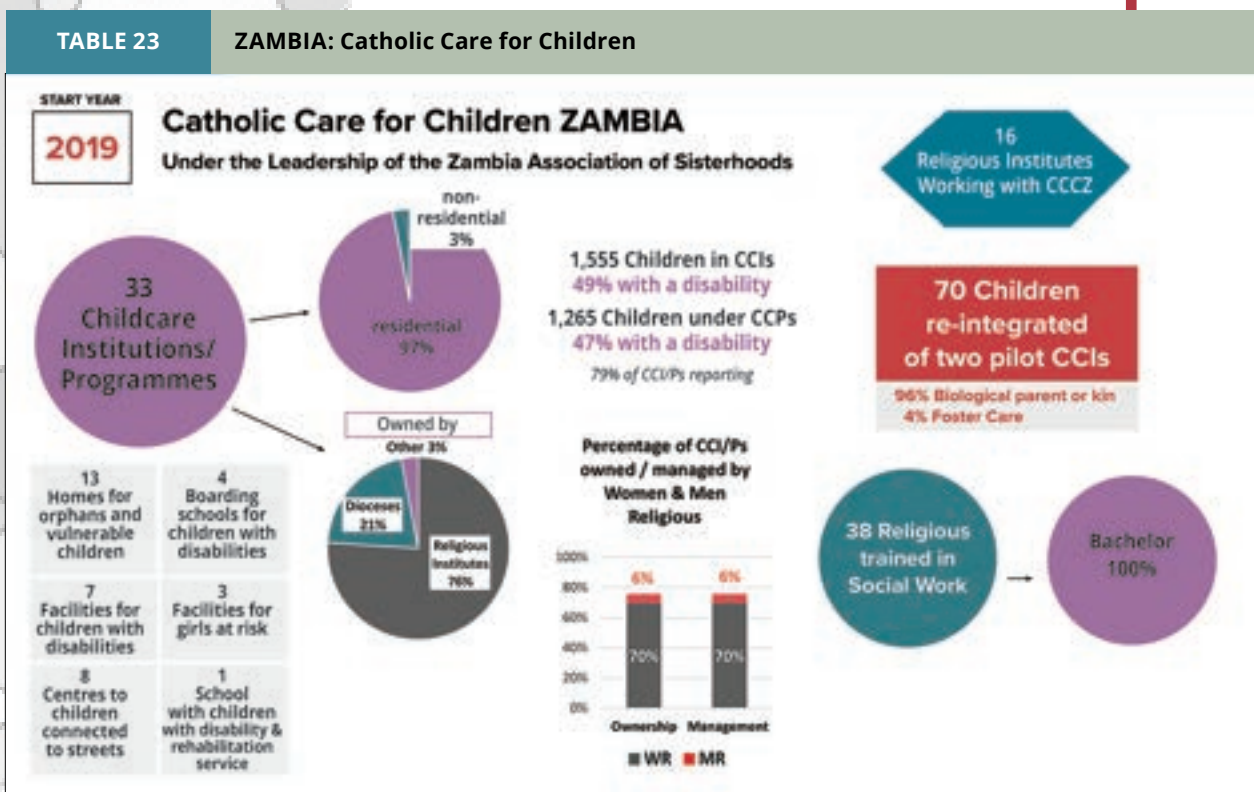


TABLE 23

ZAMBIA: Catholic Care for Children





PART THREE

Retooling Catholic Care for Children in the 21st Century

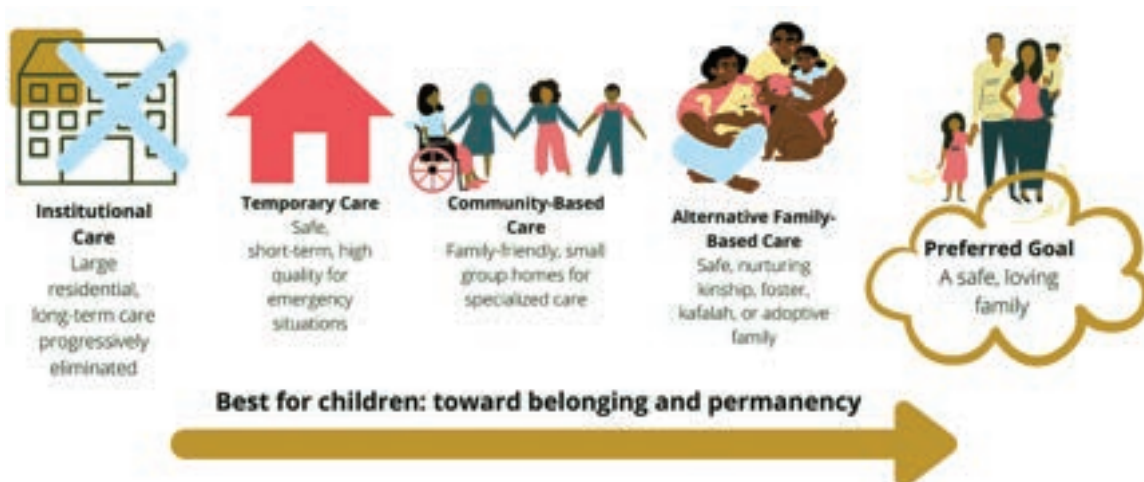
INFORMATION GLEANED from Catholic Care for Children programmes in Kenya, Malawi, Uganda and Zambia and other sources provides the basis for a rich, complex regional portrait of Catholic-sponsored care for children in Eastern Africa. In this portrait we see a deep, sustained, faith-filled commitment to care for children, especially those at risk of separation or those already separated from their families. It highlights the leadership and extensive service of women and men religious, especially those who are members of religious institutes with a charism of care. It documents the wide scope and significant footprint of Catholic care within four countries in terms of the numbers of CCIs, CCPs and children served. It reveals the diverse ways in which the Catholic community cares for children—in institutions, rehabilitation centres, community-based programmes, and others. It details growing collaborative efforts to reduce recourse to institutions and ensure children can grow up in safe, nurturing families or family-like environments.

Although this portrait is rendered at a particular moment in time, the background is dynamic. Care reform is gaining momentum globally. Informed by the social sciences—which are clear about the risks of institutional care and benefits of family care—governments are crafting new legal frameworks and policies favouring family care over institutional. Under the aegis of their respective national associations of religious, women and men religious are reading and responding to these signs of the times. In so doing, they have recognized that family-based care aligns with the Catholic Church's emphases on the importance of family and principles of Catholic social teaching. Working together, members of religious institutes are giving expression to their charisms of care in ways that respond to emerging, contemporary needs. With the advent of Catholic Care for Children programmes, there is now a ***sustained, organised platform for substantive Catholic participation in and contribution to care reform.***

The changes are multifaceted, the results noteworthy. Mindsets have changed. Capacities have been developed. Practices have evolved. Partnerships have been forged. As these changes unfolded and new approaches were adopted, thousands of children and their families benefitted. Some efforts have prevented separation of children from their families. Many families have been able to welcome children back home with support from newly trained and resourced CCI and CCP staffs. As a result, there are far fewer children in long-term residential care. Many Catholic-sponsored CCIs and CCPs have been or are on their way toward being properly registered. They are meeting or exceeding

There is a deep, sustained, faith-filled commitment to care for children in Eastern Africa.

Continuum of Care for Children



minimum government standards. Some CCIs are transitioning toward family- and community-based care. For many children and their families, this bodes well.

Taken together, one thing is clear: Through the efforts of Catholic Care for Children programmes, along with those of other entities, *Catholic-sponsored care for children in Eastern Africa is moving toward fuller alignment with contemporary international and national care frameworks.*

While welcoming progress, *this is only a start. The degree to which Catholic efforts will continue to advance care reform will be determined, in large measure, by the extent to which the Catholic community writ large embraces the vision of a family for every child, supports new approaches and evolves its ministries.*

“

If you stay connected with your originating charism, it is not a problem if the ministry changes.

—REV. JOSEPH KYEYUNE,
FORMER ARU EXECUTIVE
COMMITTEE CHAIRPERSON

Based on the data and multi-year experiences of Catholic Care for Children in Eastern Africa, considerations for advancing care reform follow. They are

offered with hopes that they may further enliven efforts, especially within the Catholic community, to ensure all children grow up in safe, nurturing families or family-like environments.

Making the case for care reform

Care reform begins by “winning hearts and minds,” that is, making a compelling case to relevant stakeholders for adopting new approaches to care. Some will be persuaded by social science research, while others will recognise the need to align practice with new legal frameworks and comply with regulatory statutes. Others will simply appreciate the importance of familial bonds for children’s well-being and society itself.

Significant headway has been made in winning the hearts and minds of many religious, as well as local leaders and communities. But resistance to care reform does surface. Some resistance arises from a propensity for the familiar: “We’ve always done it this way.” Some flows from a perception, real or imagined, that alternatives to institutional care are inadequate or nonexistent: “Given the situation, it’s the best we can do for this child.” Some resistance reflects concerns about job security: “If they send the children home and close this institution, what will I do?”

Resistance also comes from care providers, including some women and men religious. Many religious have been caring for children in institutional settings for many years. Some associate the expression of

their charism with institutional care. The message that institutional care is falling out of favour may be understandably difficult to embrace. Bidding farewell to children in care may be emotionally difficult. Once persuaded, retooling for new ways of caring may require significant investments of time and energy on the part of individuals and religious institutes.

The Catholic Church has tremendous potential to “win hearts and minds” for care reform. By championing new approaches to care, the hierarchy and clergy could provide legitimacy and mitigate resistance. Messaging about the importance of family care (versus institutional care) could be disseminated in a variety of settings—parishes, small Christian communities and other associations with help from Catholic media.

Supporting women and men religious in expressing a charism of care

Within the Catholic Church, women and men religious are essential for care and care reform. They are primary carriers of the charism of care. In the Global South they own and/or manage most Catholic-sponsored CCIs and CCPs. As noted above, religious own more than half of the Catholic-sponsored CCI/Ps in Eastern Africa, while women religious manage at least 71% of the Catholic-sponsored CCI/Ps in each of the countries profiled in this report.

Women and men religious are particularly well-suited to undertake care and care

reform. Within local communities they have deep connections. They are culturally attuned, well-regarded and trusted. Given the complexity of care reform and the time and patience required, these are valuable assets.

National associations of religious have been especially propitious homes for Catholic-sponsored care reform. Insofar as national associations help religious institutes to express their respective charisms with vitality, CCC programmes are mission aligned. Working closely with religious institutes, especially those with a charism of care, CCC programmes have been able to contribute to care reform efficiently and effectively. Moreover, as legal frameworks are national constructs, engaging religious through national organisations makes for a good fit.

Women and men religious are also connected globally, resulting in an important outcome of CCC in Eastern Africa. The leadership of religious in Eastern Africa in responding to contemporary needs inspired the International Union of Superiors General (UISG) to launch Catholic Care for Children International (CCCI) in 2020. This global platform is reaching women religious around the world and encouraging more robust commitment to family- and community-based care for children.

More widely, despite the immense global Catholic footprint of care, until the advent

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We came to know that we are not alone but many brothers and sisters and involved in the same work. The differences are the localities.

—SUPERIOR

When we started sending the children back home, we did a lot of sensitisation. We used Radio Maria, made announcements during Mass, and during church services. We also used women’s guilds and catechists to spread the message about deinstitutionalisation. We would invite the probation officer, local council chairman, social workers, other stakeholders to participate. We also started encouraging parents and relatives of the babies and children at the home to come and visit the children so that they could bond with them. It was very encouraging to see positive results.

—SISTER ADMINISTRATOR OF A BABIES’ HOME

“

CCCU was just the way of expressing our charism—what moves us to do what we do, the way we do it, the attitude we use to do it, the energy we put in and the commitment. We built on that strength to ensure that this expression of charism is now combined with skills and professionalism.

—SR. SPECIOZA KABAUMA, DST, FORMER ASSISTANT SECRETARY GENERAL OF ARU

of Catholic Care for Children 2016, there was no organised, sustained, collaborative platform for ongoing participation in and contribution to care reform. There already were, of course, many individual examples of good practice: various efforts and projects that kept families intact and children connected with their families and communities. Their holistic, family- and community-based approaches to care exemplified the best of care and the principles of Catholic social teaching. But these efforts were dispersed. **In supporting religious institutes with a charism of care, CCC has provided religious—and by extension the wider Catholic community—with an identity, voice and platform in care reform.**

For those committed to care reform, partnering with women and men religious can increase impact and accelerate the pace of change.

Developing capacity

Catholic Care for Children has added significant capacity among care providers for care and care reform. Hundreds have learned professional case management practices. Hundreds more have been

introduced to the basics of safeguarding. More than 200 religious sisters, brothers and priests have undertaken tertiary studies in social work and allied fields. CCC team members regularly visit with CCIs and CCPs to advise and mentor staff as they transition towards new ways of caring for children and their families.

Trainings and studies for religious and their lay colleagues have expanded from the “why” of care reform to the “how.” With newly gained skills and tools they are assessing what is best for each child, developing individual case management plans and supporting ever-increasing numbers of children within families or family-like settings. Others have gained technical skills, such as providing children with disabilities with a nutritious diet or transitioning donors to support new approaches to the care of children.

Training in social work has proven especially valuable for women and men religious. Social work graduates report that they are more capable in their work and confident in their increasingly robust engagement with government and local leaders and the wider church community. Combining charism with professional training and skills is powerful.

This is a strong start. Indeed, the number of sisters in Uganda trained in social work has been described as one of the largest, one-time investments in workforce development relative to care in Eastern Africa.¹² But the transition from an era when a “good heart for the children” was

A recent study by a research team based at Johns Hopkins University (USA) on national children’s care systems in Cambodia, Uganda and Zambia found none had sufficient social welfare officers to effectively implement new policies. To advance care reform, it recommended significant investments from global development actors in workforce development.

—JEREMY SHIFFMAN, ET AL., “ANALYSIS OF THE GOVERNANCE OF NATIONAL CHILDREN’S CARE SYSTEMS: CASE STUDIES OF CAMBODIA, UGANDA AND ZAMBIA”

¹² Conversation with Amy Bess, former director of the Global Social Work Workforce Alliance.

considered sufficient has just commenced. There are still significant gaps in staff qualifications. **The field of care needs more individuals trained in social work or equipped with skills to work with people with disabilities.**

To assume full responsibility for the total care of another person—a child or other vulnerable person—is a profound moral responsibility. **Training in safeguarding for all CCI and CCP staff is an immediate, critical need.**

Given its strength in the field of education, the Catholic community is well positioned to contribute to care reform. Catholic educational institutions are already preparing women and men religious and their lay colleagues to provide high quality care for children and their families. With greater focus and additional resources, Catholic institutions of higher learning could become centres of excellence driving of care reform.

Working with government and local officials

Governments in Eastern Africa are shifting toward legal frameworks and policies aligned with the United Nations Convention on the Rights of the Child, the UN's Guidelines for Alternative Care of Children and the African Charter on the Rights and Welfare of the Child. Each speaks to a child's right to a family or appropriate alternative if, and only if, it is necessary, suitable and in a child's best interest. This is a very positive development. Yet implementation is uneven and still a work-in-progress. Changing well-established systems is always challenging and especially so when resources are thinly stretched. Yet reformed care will remain elusive until governments invest more and regulatory systems catch up with family-friendly policies.

For countries transitioning toward family- and community-based care, partnerships



Religious find combining charism with professional skills to be powerful.

with faith-based organisations can accelerate policy implementation. Given the size of its footprint in care, **Catholic communities can be strong implementing partners** in raising awareness, providing training and efficiently disseminating resources (such as cash transfer programmes). They can support local officials responsible for the well-being of children and help ensure CCIs are registered and meeting minimum standards.

As an initial step, efforts should be taken to ensure all Catholic-sponsored CCI/Ps are properly registered and meeting or exceeding minimum standards for care within their respective countries.

Improving care

The overall quality of care of Catholic care is improving. With more robust gatekeeping, the number of children in CCIs is declining. The number of CCI/Ps registered and meeting or exceeding minimum standards is

increasing. Equipped with new social work skills, CCI/P staff are reuniting children with their families. Some CCIs that have moved entirely away from residential care are now launching new ministries to care for children, youth and/or families. Catholic Care for Children is moving in the right direction.

To build on this momentum and further align Catholic-sponsored care with



Persons with disabilities and their families need more support.

contemporary international and national frameworks for care, Catholic communities can strengthen families, expand options for alternative care and invest more in efforts to serve specific populations, in particular, older youth and children with disabilities.

- **Family strengthening is essential.**

Given the importance of the family within Catholicism and the substantial Catholic presence in the social welfare sector, the Catholic Church is well poised to strengthen families and mitigate risks of child-family separation. Reasons for child-family separation vary; each child's situation needs careful, individualised

consideration. However survival and developmental needs are so often at play: families need to be able to feed their children or pay school fees. Further efforts to strengthen families' financial position would go far in preventing institutionalisation for many children and help create conditions conducive for family reunification.

- **Alternatives are needed.** It is not always possible to keep children in or reunite them with their families. In these cases, children need alternatives that foster a sense of belonging and permanency. Kinship care is often the ideal alternative as it can keep children connected with their families, communities and cultures. Beyond kin, CCC teams report *insufficient high-quality, affordable alternatives*. Foster care is scarce. And while a notable number of children have been adopted, too often the cost of adoption is prohibitive.

- **Older youth need support for independent living.** As children in care grow older, prospects for reunification with their families or adoption dim. Independent living is on the horizon. Given that transition from an institution to independent living is often challenging, there is a moral obligation to ensure that care leavers are sufficiently prepared and supported. This step, from institutional care to independent living, needs more attention and investment.

- **Persons with disabilities and their families need more support.** Information from CCC programmes reveals a significant need for and commitment to care for children (and/or adults) with disabilities. Their families also need support. Catholic social teachings underscore the dignity

If families are in distress, provide support to prevent separation of children.

If separation occurs, see that children are re-united with families or placed in permanent family-like settings.

If alternative residential care is necessary, ensure it is of the highest quality and shortest duration possible.

of every person. Guidelines for the care for persons with disabilities emphasize social integration and self-reliance. Catholic communities can certainly mitigate all-too-common stigmatisation of persons with disabilities by modelling social integration, ensuring persons with disabilities are welcome and invited to participate fully in parish life and community life. To ensure the highest quality of care, the need for staff training and adequate facilities is acute. *And as persons with disabilities have unique vulnerabilities, safeguarding must be adapted accordingly.*

Conclusion: Envisioning Catholic care anew

The gospel mandate to care for the vulnerable is perennial. But as Christians read the signs of the times, the expression of care evolves. Catholic communities are *reading the signs of the times* pertaining to the care of children. They have taken note of the social sciences which are clear about the importance of family nurture for healthy development across the life span and the risks for children associated with institutional care. They are heeding international and national legal

frameworks that have shifted toward family- and community-based care while discouraging care for children in institutions.

Catholics are *responding to the signs of the times*. In the four countries profiled in this report, there are fewer children in long-term Catholic-sponsored institutions. Many children have been reunited with their families. For some children, suitable alternatives have been found. This regional portrait documents growing alignment of Catholic care for children with contemporary international and national care frameworks and standards.

The journey has started; a movement is afoot. But the shape of Catholic care in the 21st century is still in the making. **For religious institutes with a charism of care, how might they give expression to that charism going forward? For the wider Catholic community, how might it support family life, especially for families who are struggling?** The ways in which these questions are answered will play a role in ensuring the ongoing relevance of the Catholic Church in organised care efforts.

Given the vast footprint of Catholic care in Eastern Africa—and the rest of the world—there is a tremendous opportunity for the Catholic community to contribute to care reform. With faith-filled commitment, experience and newly accrued professional training, women and men religious and their lay colleagues are emerging as champions of care reform. They have shown that care reform is possible—and what it takes to ensure children can grow up in safe, nurturing families or family-like environments.

“

Today Religious Institutes involved in child care programmes are working together by sharing ideas, challenges, and achievements, and this has brought about bonding of Institutes and a greater desire to do the mission of the Church from a common platform.

—ARU/CCCU



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The protection of the fundamental rights of children to grow up in a family environment and to receive nutrition, education and support are duties of the family and society. Such duties must be guaranteed and protected so that they are not overlooked or denied to any child in any part of the world.

—APOSTOLIC JOURNEY OF HIS HOLINESS POPE FRANCIS TO THE UNITED ARAB EMIRATES (FEBRUARY 3-5, 2019), A DOCUMENT ON THE HUMAN FRATERNITY FOR WORLD PEACE AND LIVING TOGETHER

**Regional Portrait
of Catholic Care
for Children
in Eastern Africa**