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# Situation Analysis of Children in Rwanda:
## Summary report

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# Acronyms and abbreviations

| | |
|---|---|
| DHS | Demographic Health Survey |
| ECD | Early Childhood Development |
| EDPRS | Economic Development and Poverty Reduction Strategy |
| EICV | Integrated Household and Living Conditions Survey |
| FARG | Genocide Survivors Support and Assistance Fund |
| HSSP | Health Sector Strategic Plan |
| MDG | Millennium Development Goal |
| MIDIMAR | Ministry of Disaster Management and Refugees |
| MIFOTRA | Ministry of Public Service and Labour |
| MIGEPROF | Ministry of Gender and Family Promotion |
| MINAGRI | Ministry of Agriculture |
| MINALOC | Ministry of Local Government |
| MINEDUC | Ministry of Education |
| MININFRA | Ministry of Infrastructure |
| MNCH | Maternal, Newborn And Child Health |
| MoH | Ministry of Health |
| NECDP | National Early Childhood Development Programme |
| P1, P2 | Primary 1, Primary 2 (first, second years of primary school) |
| PMTCT | Prevention of Mother-to-Child Transmission (of HIV) |
| Q1 | Quintile 1 – the lowest 20 percentage in terms of consumption |
| Q5 | Quintile 5 – the highest 20 percentage in terms of consumption |
| RDHS | Rwanda Demographic Health Survey |
| RWF | Rwandan Franc |
| SDG | Sustainable Development Goal |
| TVET | Technical and Vocational Education and Training |
| VUP | Vision 2020 *Umurenge* Programme |
| WASH | Water, Sanitation and Hygiene |


# Foreword

Over the course of the last decade, Rwanda has witnessed significant improvements in child survival and the widening of access to basic social services. This Situation Analysis of Children in Rwanda provides a comprehensive picture of the status of children in Rwanda, highlights the achievements made and provides a roadmap for the future advancement of their well-being.

The analysis touches upon a wide spectrum of issues relating to children in Rwanda, including health, nutrition, water and sanitation, education, child protection, social protection and early childhood development. It highlights progress linked to key indicators, policies and strategies guiding each sector. The analysis also proposes measures to support them in their development and the achievement of their full potential as children and later on as productive citizens.

The Government of Rwanda is fully committed to further build on its success in improving child well-being. Investing in our children means we are directly contributing to our future and long-term vision for Rwanda.

NYIRASAFARI Espérance
Minister of Gender and Family Promotion


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# Introduction

In the lead-up to Rwanda's Vision 2050 and its National Strategy for Transformation (2019–2024), and in the context of Sustainable Development Goals (SDG) domestication, the purpose of this Situation Analysis is to put children first in Rwanda's national development planning. It aspires to become an important advocacy tool for the government, UNICEF and all partners with an interest in promoting children's well-being, and recognizes their importance to sustainable economic and social development. It assesses progress and achievements for children and, bearing in mind the critical importance of investing in children, notes the challenges and barriers to the advancement of child well-being in Rwanda.

A government-led technical committee guided the creation of the Situation Analysis. The process included data analysis, a review of government policies and consultations with key government and development partners. Quantitative data were derived from many sources, including the 2010 and 2014/2015 Rwanda Demographic Health Surveys (RDHS), the 2012 Fourth Population and Housing Census, the 2010/11 and 2013/14 Integrated Household and Living Conditions Surveys (EICV 3 and 4), and EICV Thematic Reports. Other data sources include the 2015 Comprehensive Food Security and Vulnerability Analysis, the Health and Education Management Information Systems and the 2015 and 2016 Education Statistics Yearbooks. A range of qualitative analysis, small-scale surveys, sector reviews and programme and policy documents were also reviewed.

Given the sheer diversity of issues relevant to children and sustainable development in Rwanda, a selective approach was taken to keep the document manageable and to focus the narrative on the most pressing issues. Considerable consensus emerged on the challenges faced by children in Rwanda, in relation to both underlying causes and the key actions to be prioritized.

## An enabling environment for sustainable development and children's rights

Since 1994, Rwanda has progressed rapidly towards ensuring peace, security, economic growth and human development. Economic growth is significant, poverty has declined, economic opportunities are expanding and social sector outcomes for children and women have steadily improved.

Key achievements include:[1]

- Improved access to services, increased educational enrolment, falling child and maternal mortality, and increased access to safe water and adequate sanitation.
- A fall in the proportion of the population living below the national poverty line (from 57 per cent in 2005/06 to 39 per cent in 2013/14). The proportion of the population living in extreme poverty decreased over the same period from 36 per cent to 16 per cent.
- Steady economic growth, averaging around 8 per cent per annum, with gross domestic product per capita more than tripling from US$211 in 2001 to US$718 in 2014.
- A fall in income inequality, as measured by the Gini coefficient, from 0.52 in 2005/06 to 0.45 in 2013/14.

1 EICV data.

- The Global Gender Gap Index (2017) highlights that Rwanda is one of only five countries that have closed 80 per cent or more of the gender gap.

## Governance and policy for children

Rwanda is a member of the United Nations and has ratified many international human rights conventions, including the United Nations Convention on the Rights of the Child. Children's rights are clearly enshrined within the Constitution of the Republic of Rwanda of 2003 (revised in 2015), and are protected in legislation. Yet, as is the case in many countries, gaps and inequities in relation to the implementation and enforcement of child-related laws and policies require further attention.

The Ministry of Gender and Family Promotion (MIGEPROF) is the government ministry responsible for strategic coordination of policy implementation in the areas of gender, families, women's empowerment and children's issues. A National Commission for Children (NCC) was established under MIGEPROF in 2011, mandated to undertake child-rights monitoring and oversight, and to implement child-protection interventions. A Child Rights Observatory Office within the National Commission for Human Rights is responsible for child-rights advocacy.

A national Integrated Child Rights Policy was adopted in 2011 to create an environment in which children's development, survival, protection and participation are ensured through a well-coordinated, multi-sectoral approach. Most ministries in Rwanda (including the Ministry of Health (MoH), Ministry of Local Government (MINALOC), Ministry of Education (MINEDUC), Ministry of Agriculture (MINAGRI), Ministry of Justice (MINIJUST), Ministry of Disaster Management and Refugees (MIDIMAR), Ministry of Public Service and Labour (MIFOTRA), Ministry of Infrastructure (MININFRA)) as well as various institutions and agencies have responsibilities for the well-being of children, women and families. These ministries and agencies provide significant financial and human-resources-related investments in the main child sectors.

## Children and sustainable development – investing where it matters

Under the 2030 Agenda for Sustainable Development (which builds on MDG progress and addresses sub-national inequities and emerging global issues), 17 Sustainable Development Goals (SDGs) have been developed. The SDGs address issues critical to children's well-being – including multidimensional poverty (SDG 1), zero hunger (SDG 2) and health (SDG 3); early childhood development and quality education (SDG 4); gender equality (SDG 5); water, sanitation and hygiene (SDG 6); and violence against children (SDG 16) – and the pursuit of the SDGs presents opportunities for the government and development partners to advance child well-being at the same time as enhancing sustainable social and economic prosperity. Investing in children, including adolescents and young people, is essential for achieving the broader SDG objectives of inclusive sustainable development: children must be understood as active agents and drivers of future growth and development.

In Rwanda, where children represent around 50 per cent of the population, ongoing investment in children is a key strategy to achieve the SDGs and sustain achievements beyond 2030. Given the inevitable financial constraints, priorities must be set when allocating resources. For Rwanda (as for all other countries), the SDGs provide a key rationale and justification for prioritizing investments in children.

## Understanding poverty in Rwanda

Rwanda has a young population. In 2012, almost half of the roughly 10.4 million population was under the age of 18 (the projected population for 2017 is 11.8 million). Most children are under 10 years, with 30 per cent aged 0 to 4 years and 29 per cent aged 5 to 9 years.[2] The number of children as a percentage of the total population declined by 6 per cent between 1991 and 2012, even though the actual number of all children almost doubled between 1978 and 2012.

2 2012 *Fourth Population and Housing Census.*

In 2013/14, 39 per cent of Rwanda's population lived below the poverty line and extreme poverty affected 16 per cent of the population.[3] Poverty declined consistently between 2010/11 and 2013/14 throughout Rwanda, except for Western Province where a minimal increase was recorded. The biggest falls in poverty (including for children) occurred in Southern Province (declined by 11 per cent) and Northern Province (declined by 9 per cent).

Children remain over-represented among the poor but the situation has improved since 2010/11: between 2010/11 and 2013/14, the percentage of children living in poverty declined from 49 per cent to 44 per cent, and children in extreme poverty from 27 per cent to 19 per cent.[4] Child poverty remains concentrated in rural areas of Rwanda, but the needs of the urban poor will require further attention in the near future. In Kigali City cells, for example, the poverty rates range from 2 per cent to 65 per cent.[5]

Members of poor households have generally benefited less from education, are employed largely in the agricultural sector, are at risk of food insecurity and have less access to infrastructure and services. Poorer households have more dependents, particularly children, and these children face multiple and overlapping deprivations. Poor children do not always have adequate access to nutritious food, safe water and sanitation, or basic services, and often live in households where caregivers do not always have adequate financial resources to support their development.

3 EICV 4.
4 UNICEF equity analysis of EICV data.
5 2013/14 NISR *Poverty Mapping Report*.

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# Maternal, newborn and child health, including HIV

Good maternal health is critical to child development in utero, in infancy and throughout a child's growth. Key interventions for young children (immunization, prevention of childhood illnesses, and proper and timely treatment of sick children) are vital to ensure they develop optimally in their early years. The majority of the health data presented below is from the 2014/15 RDHS, and data related to the socio-economic situation is from the 2103/14 EICV 4.

## How the maternal, newborn and child health (MNCH) sector is organized – policies and financing

Government commitment to the health sector is evident in the substantial expansion of health sector resources, which has improved health access across the country. Between 2013 and 2015 there was a significant increase in the number of national referral hospitals (from 5 to 8); provincial hospitals (0 to 4); health centres (465 to 499); and health posts (252 to 471).[6] In 2015 there were 36 district hospitals (more than the number of districts in Rwanda); 125 private dispensaries; 123 private clinics and polyclinics; and five private hospitals. There are currently 1,392 medical doctors (one doctor per 8,848 people – better than the World Health Organization target of one per 10,000) and 10,975 nurses (one nurse per 1,094 people – the World Health Organization target is one per 1,000).[7]

Key priorities primarily relate to achieving improvements in maternal and child health; HIV/AIDS care and prevention; malaria control; infrastructure and human resource development; increasing access throughout the country and reducing financial barriers; and ensuring effective health system financing and performance management.

Stewardship for the health sector in Rwanda is provided by the Ministry of Health and is guided by the third 2012–2018 Health Sector Strategic Plan (HSSP III) and the 2015 Health Sector Policy. There is also an active multi-partner Health Sector Working Group and a number of technical working groups. The overall aim of the Health Sector Policy and HSSP III is to achieve universal access to equitable and affordable health care services by improving coverage, demand and quality.

Service delivery is organized into two key streams: maternal, community and child health, and disease control and prevention. Antenatal care, management of childhood illnesses and immunization are delivered through hospitals, health centres and health posts. Links to the community are provided by a network of some 45,000 community health workers (three per village across the country).

Government commitment to the health sector is evident: health access has improved significantly

The Government of Rwanda budget allocated to health is 16.52 per cent, which surpassed the 15 per cent required under the 2001 Abuja Declaration, demonstrating the high commitment and support to the development of the health sector.[8] Recent declines in health sector resources are of concern, particularly in relation to the critical role of community health workers and pressures on the budget for MNCH service provision. The budget for MNCH seems particularly under pressure and has declined

6 2016 Ministry of Health, *Health Education Management Information System Statistical Yearbook*.
7 Ibid.
8 2015 Ministry of Health, Midterm Review of the third Health Sector Strategic Plan 2013–2018.

from 7.3 per cent in the 2013/14 allocation to only 5.6 per cent for 2015/16.[9] There is still important external financing in the health sector (60 per cent of the total health sector budget), with its actual and potential reductions presenting a major challenge. Population growth, variations in the incidence of malaria, the need to reduce neonatal mortality and increase antenatal coverage to at least four visits, and the need to maintain HIV services will all put further pressure on health-sector resources.

## Achievements in MNCH

Significant efforts have been made to increase health services at sector and cell level: there is at least one health centre per sector and the plan is to roll out one health post per cell. Access to health insurance has significantly improved (84 per cent),[10] particularly for the poorest households.

Rwanda was one of the few countries in Africa to achieve the maternal and child mortality Millennium Development Goal (MDG) targets, primarily due to concerted investment towards building a comprehensive health system. The coverage from the first visit to antenatal care is now almost universal and over 90 per cent of women have skilled assistance during delivery. Fertility has declined significantly from 6.1 births per woman of childbearing age in 2005 to 4.2 in 2014/15. The maternal mortality rate has declined by 72 per cent, achieving MDG targets, but it remains high at 210 deaths per 100,000 live births, compared to the 2030 SDG target of 70 per 100,000 live births (Figure 1). The main causes of maternal mortality are postpartum haemorrhage, infections, obstructed labour and eclampsia.

There has been a significant reduction in under-five mortality and Rwanda has achieved the MDG target in this area: it declined from 152 per 1,000 in 2005 to 50 per 1,000 live births in 2015, which underlines the steady progress towards establishing a comprehensive health system. Inequities in under-five mortality have significantly reduced but additional efforts are required to fully close the gap (see Figure 1).

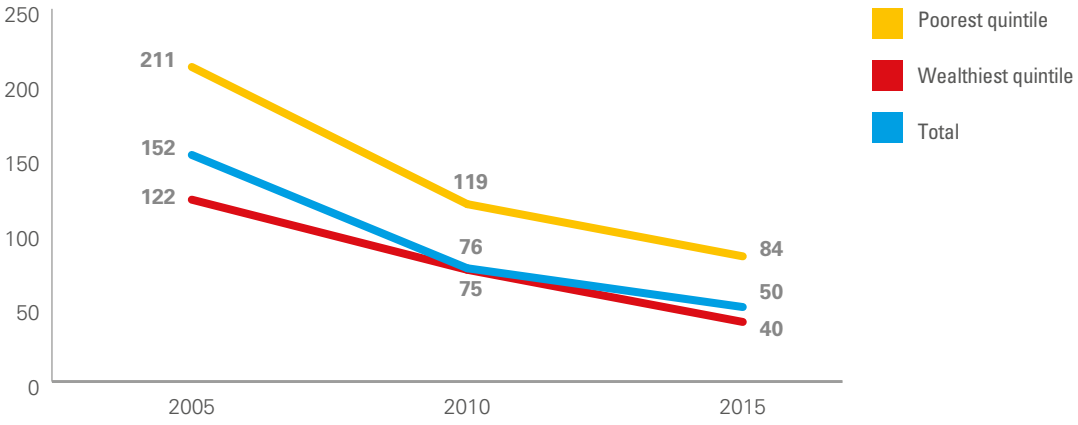


Figure 1. Under five mortality rate trends: Deaths per 1,000 live births

**Source:** RDHS

Child immunization coverage has steadily improved over the last 10 years: 93 per cent of children aged 12 to 23 months have received all basic vaccines and 94 per cent have vaccination cards, with no significant difference between boys and girls or between rural and urban locations.

9 UNICEF calculation from MINECOFIN budget law data, 2013/14 and 2015/16.
10 MoH *Annual Report 2016*.

HIV prevalence has stabilized at around 3 per cent;[11] prevention of mother-to-child transmission (PMTCT) services have reached near universal coverage and uptake of anti-retroviral therapy for PMTCT is high.[12] As a result, the rate of mother-to-child transmission has been below 2 per cent for the last three years.[13] Comprehensive knowledge on HIV among adolescents is 62 per cent for girls and 60 per cent for boys; HIV testing is 29 per cent among boys and 61 per cent among girls, and use of condoms is 52 per cent among girls and 67 per cent among boys.[14]

## Critical gaps in MNCH

- Under-five mortality remains high at 50 deaths per 1,000 live births (the SDG 2030 target for under-five mortality is 25 deaths per 1,000 live births). Declines in neonatal mortality have been only modest, indicating that further investment in neonatal and antenatal care is required. Under-five mortality is twice as high in the poorest quintile than in the richest (84 per 1,000 live births compared to 40 per 1,000 live births, respectively).[15]
- The incidence of malaria has increased (from 15 per cent in 2010 to 37 per cent in 2015).[16] Causes relate to climate change, insecticide resistance and limited effectiveness of the multi-sectoral malaria control strategy.
- Care-seeking behaviour is low, especially among the poorest families. For example, only 45 per cent of caregivers from the poorest quintile had sought help from a health facility or a provider when their child had symptoms of acute respiratory infection, compared to 65 per cent of the wealthiest quintile.[17]
- Low coverage of some essential interventions remains: postnatal care (currently at 43 per cent); four antenatal visits (at 44 per cent); and anti-retroviral therapy services for children living with HIV.[18]
- Improvements are needed in the quality of PMTCT services and retention of women and children within the continuum of care.
- There is still inadequate uptake of HIV-prevention services (knowledge, HIV testing, condom use).[19]
- Possession of health insurance remains lower in the poorest households than in the wealthiest.[20]
- Inequities in access to health services remain due to a number of factors, including poverty, place of residence and level of mother's education. For example, coverage with all basic vaccines rises from 87 per cent in the poorest quintile to 95 per cent in the wealthiest quintile; skilled assistance during delivery was provided to 89 per cent of rural women compared to 97 per cent of urban women; and 48 per cent of women with no education have used birth control methods compared to 55 per cent of women with secondary or higher education.[21]

## Recommendations for the MNCH sector

- Make concerted efforts to close remaining equity gaps and ensure equal access to MNCH services to the poorest, and families living in rural areas.
- Improve the quality of MNCH services through provision of essential equipment for mother and child health service interventions, continuous training and professional mentoring of health workers at all levels, and monitoring of service provision.
- Maintain high coverage of interventions, including in PMTCT, immunization and integrated management of childhood illnesses. Design and implement innovative strategies on how to reach the remaining few.

11 2015 RDHS.
12 2016 HIV NSP Mid-Term Review.
13 2015/2016 National HIV Annual Report.
14 2015 RDHS.
15 Ibid.
16 HSSP III Mid-Term Review 2015.
17 2015 RDHS.
18 Ibid.
19 Ibid.
20 EICV 4.
21 2015 RDHS.

- Accelerate coverage (where coverage is currently low) of high-impact interventions, including immediate newborn care, a minimum of four antenatal-care visits and postnatal care.
- Design and implement communication interventions to improve parent and caregiver knowledge and care-seeking behaviour.
- Improve the quality of PMTCT services and retention of mothers and children in care to reduce and eliminate HIV infection of children.
- Expand access to and promote utilization of HIV-prevention services among adolescents.
- Implement innovative strategies to identify (through HIV testing) children living with HIV and link them to treatment and care services.
- Increase resource mobilization for the sector, with a focus on expanding access and quality, to address the concerns about the sustainability of health financing and the capacity of the sector to adequately cover the cost of MNCH services.




Rwanda achieved the maternal and child mortality MDG targets

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# Nutrition

Adequate nutrition (especially in utero and up to 24 months) is critical to child growth and cognitive development. The effects of poor nutrition begin in the womb, continue well into adulthood, and cycle across generations. While malnutrition can trap generations of children in a cycle of poverty, good nutrition (particularly in infancy) is the building block for future health and development. Poor nutrition has high costs in terms of mortality, poor educational achievements and reduced productivity in adulthood. The causes of child undernutrition are complex (and often interconnected) but relate to a combination of poor maternal nutrition and well-being, inadequate child feeding and care practices, childhood diseases and environmental issues such as inadequate household food security and poor access to safe water and sanitation.

## How nutrition is organized – policies and financing

The government has set an ambitious target to reduce stunting in under-5-year-olds to 18 per cent by 2018 (HSSP III).[22] This commitment is in accordance with the SDG objective to end hunger (Goal 2) and all forms of malnutrition by 2030 (Goal 2.2). It also reflects the intent of the Vision 2020 and Economic Development and Poverty Reduction Strategy (EDPRS) II, and is further highlighted in the National Strategy for Transformation, which positions nutrition and food security as foundational issues for national development. The second National Food and Nutrition Policy and Strategic Plan runs until 2018 and was developed by MoH, MINAGRI and MINALOC. Its strategic objectives cut across several ministries, including MIGEPROF, MIFOTRA, MINEDUC and MIDIMAR.

Since the adoption of the 2010–2013 National Multi-Sectoral Strategy to Eliminate Malnutrition, every district has adopted District Plans to Eliminate Malnutrition. A Joint Action Plan to Eliminate Malnutrition is developed each year and a National Nutrition Secretariat was established in 2016 to improve coordination of policy and interventions.[23] The secretariat operates under MIGEPROF, as it was merged with the early childhood development (ECD) programme in 2017 into the National Early Learning Childhood Programme (NEDP). A National Food and Nutrition Technical Working Group co-chaired by MoH and the United States Agency for International Development (USAID) meets each month to coordinate the work of all agencies and development partners active in promoting improved nutrition.

Achieving nutritional food security requires multi-sectoral interventions, so it is a complex task to analyse nutrition-related budget expenditure. The 2013–2018 National Food and Nutrition Strategic Plan notes the responsibilities of budget agencies and the various ministries, but there is less clarity in relation to what key-funded activities are implemented by various actors. Nonetheless, the available budget analysis for nutrition shows that in recent years there was a significant increase in the budget allocated to nutrition-specific interventions. However, allocations for 2017/18 show a decline.

Achieving nutritional targets requires multisectoral interventions

22 Both the government and development partners recognize that systematically addressing stunting in children under 5 necessitates interventions that also have a positive impact on maternal undernutrition, maternal and child micronutrient deficiency, and the overall capacity of service providers to address undernutrition in its broader manifestations.

23 There are also several policy mechanisms in other sectors with direct relevance to the reduction of child undernutrition and stunting. These include the 2004 National Agriculture Policy; the 2013 Strategic Plan for the Transformation of Agriculture (phase 3); the third Health Sector Strategic Plan (HSSP III); the 2011 National Strategy for Infant and Young Child Feeding; the 2009 National Child Health Policy; the 2013–2018 National Policy on Community Health; and the 2016 Early Childhood Development Policy.

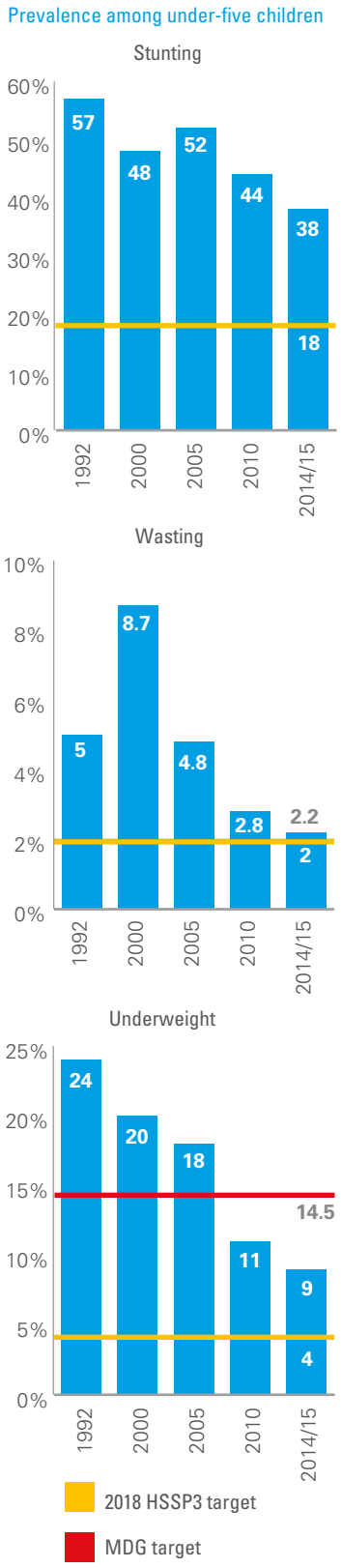


Figure 2. Stunting, wasting and underweight trends compared to national targets

**Source:** DHS

## Achievements in nutrition

There have been real improvements in the nutritional status of children in Rwanda. Wasting levels are low (2 per cent of all children under 5) and vary only slightly in relation to location and wealth quintile, and progress has been made towards reducing the level of stunting in children under 5. Most children (87 per cent nationally) are exclusively breastfed for the first 6 months and almost all (96 per cent) children aged 6 to 23 months are given breast-milk or milk products.[24]

These achievements are the results of multiple factors. Overall, there is high political commitment to reduce malnutrition and nutrition-specific interventions have been successfully scaled up and coordinated – including monthly provision of fortified blended foods to all children aged 6 months to 2 years and to lactating and pregnant women (nationwide for *Ubudehe* Category 1, and in the 11 districts most affected by malnutrition for *Ubudehe* Category 2).[25] Multiple partnerships have been leveraged, and there have been successful publicity campaigns to encourage behaviour change. For instance, the 1,000 days campaign, launched in 2013, promotes the importance of adequate nutrition.

## Critical gaps in nutrition

Key challenges in child nutrition:

- Stunting remains a major concern. In 2015, stunting in children under 5 stood at 38 per cent. Almost half (49 per cent) of children under 5 in the poorest quintile are stunted compared to 21 per cent in the wealthiest quintile. Stunting rates are higher in rural than urban areas (41 per cent and 24 per cent, respectively). They are also higher in children whose mothers have no education (47 per cent) than in children whose mothers have secondary or higher education (19 per cent).[26]
- Infant and young child feeding practices are sub-optimal. Only 30 per cent of children aged 6 to 23 months received food from at least four food groups (minimum dietary diversity); 47 per cent were fed with adequate frequency; and only 18 per cent were fed in accordance with all three minimum recommended infant and young child feeding practices. Children are less likely to be fed properly in poorer households and where the mother's education levels are lower.[27]

Key challenges in maternal nutrition:

- Maternal anaemia affects a quarter of women in the poorest quintile but only 6 per cent of women in the wealthiest quintile. About half of all women receive at least one postpartum dose of vitamin A and the same proportion of self-administered deworming tablets during their most recent pregnancy.[28]
- Despite steady reductions in income poverty and a doubling of agricultural production between 2000 and 2012, food insecurity remains a major challenge and a key cause of malnutrition. In 2015, 20 per cent of all Rwandan households were food-insecure, and of these 3 per cent were severely food-insecure.[29]

24 2015 RDHS.
25 *Ubudehe* is a community-based categorization of socio-economic status.
26 2015 RDHS.
27 Ibid.
28 Ibid.
29 2015 CSFVA.

## Recommendations for the nutrition sector

- Continue support to the recently established National Early Childhood Development Programme (NECPD) to further develop its capacity to coordinate and oversee policy, implementation and evaluation at both national and district levels. Further formalize the district-level coordination of nutrition interventions needs to ensure integrated, well-targeted interventions.
- Undertake comprehensive assessment of the Essential Nutrition Actions (ENAs) with a view to improving the relevance and efficacy of the district-level ENAs, including continued emphasis on proven nutrition interventions.
- Design and implement innovative sustainable solutions to support the poorest households which demonstrate high levels of stunting.
- Scale up nutrition-sensitive programming interventions, including saving and lending groups and farmer field learning schools, among others.
- Further explore gender disparities in under-five stunting so that stunting-reduction interventions can be designed to redress these inequities.
- With regard to budgeting, consolidate sectoral plans and data on expenditure (off-budget and within national budgets) and contributions towards nutrition-sensitive interventions. This will allow both government and partners to better assess the levels of investment needed, and more effectively evaluate and plan resource allocation.

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# Water, sanitation and hygiene

Universal access to safe water, sanitation and hygiene (WASH) services are government priorities (as per Vision 2020 and EDPRS II) as WASH underpins sustainable socio-economic development and is critically linked to efforts to improve nutritional status, overall population health, food security and environmental management. Access to safe water, sanitation and hygiene services is fundamental to the prevention of waterborne diseases (including diarrhoea), which weaken children's immune systems and leave them vulnerable to illness and malnutrition.

## How the WASH sector is organized – policies and financing

The government has endorsed SDG 6 (Ensure availability and sustainable management of water and sanitation for all), recognizing its importance to national development. MININFRA is the lead government ministry responsible for sector policies and strategies, sector oversight, budgeting and resource mobilization, and overall sector performance monitoring. While MININFRA is the lead ministry for water and sanitation, the WASH sector includes multiple ministries and agencies holding complementary responsibilities in the sector or as players in the sector. The Ministry of Environment leads in water resources management and the Ministry of Health leads in household sanitation and hygiene promotion, and household water quality. MINALOC leads district governance, which oversees service provision, MINEDUC oversees WASH in schools and the Rwanda Water and Sanitation Corporation plays a key technical role in supporting districts in rural areas and is the service provider for urban areas. In rural areas, private operators are contracted by district administrations to operate and maintain water supply services. Independent regulation is provided through the Rwanda Utilities Regulatory Agency, the Rwanda Standards Board and the Rwanda Environment Management Authority. A Sector Working Group brings key actors together, and is co-chaired by a development partner agency.

The government has significantly increased the allocation of resources to WASH – US$64 million was spent on WASH in 2016/17,[30] and for 2018–2024 the government has budgeted between US$21 and 22 million per year in the Water and Sanitation Sector Strategic Plan. However, although over 100 per cent of the planned allocation is being spent in the WASH sector, financial resources are inadequate with an estimated need of US$134 million annually.[31] Strong commitment is demonstrated through the adoption in 2016 of revised national policies and implementation strategies for drinking water supply and sanitation. These new policies include measures to strengthen the decentralization of water and sanitation services, with a focus on innovative financing mechanisms for decentralized service provision and enhancement of the performance of public-private partnerships.

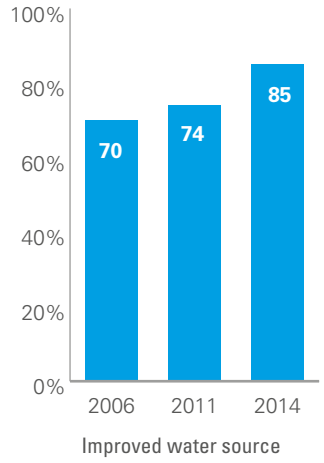
Rwanda has made progress towards increasing access to both safe water and adequate sanitation facilities

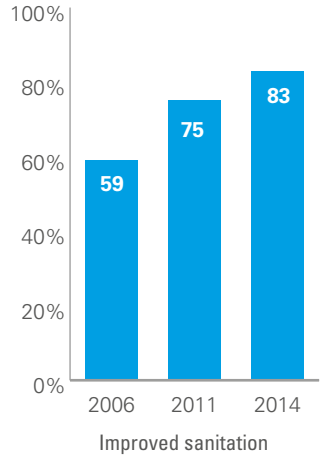
## Achievements in WASH

In line with the MDGs, Rwanda has made remarkable progress towards increasing access to both safe water and adequate sanitation facilities, with access to safe water increasing from 74 per cent to 85 per cent between 2010/11 and 2013/14, and access to improved sanitation from 75 per cent to 83 per cent over the same period (see

30 *Draft Water and Sanitation Policy 2016/2017.* Backward-looking Joint Sector Review Report, MININFRA. November 2017.

31 *Rwanda Overview: Water, sanitation and hygiene.* Draft prepared for the 2017 Sanitation and Water for All High-Level Meeting in Washington DC. April 2017.



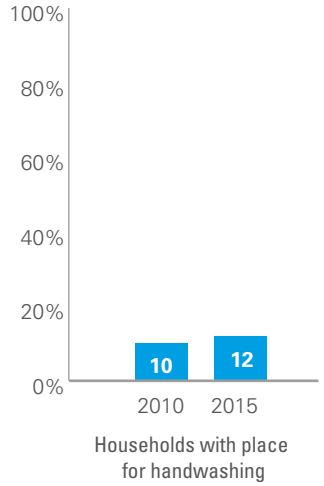




Figure 3. Trends in improved water, improved sanitation and handwashing

**Source:** RDHS and EICV

Figure 3).[32] Significant progress has also been made towards closing equity gaps with regard to rural-urban disparities and access to water and sanitation for the poorest. The new national policies recognize the need for a pro-poor approach that addresses vulnerable populations (including children and the disabled).

## Critical gaps in WASH

### Water supply

- While access to water has been improved, the gains made in terms of availability, water quality and distance from home are less tangible. Recent policy recommendations to follow a three-tiered approach for water quality control (including the role of private operators, the Rwanda Water and Sanitation Corporation and the Rwanda Utilities Regulatory Agency) need to be further strengthened (i.e. private operators self-monitoring with Rwanda Water and Sanitation Corporation oversight and the Rwanda Utilities Regulatory Agency providing external spot checks).
- Although government allocations to the sector have increased, a financing gap remains.
- While the government has established a private operator model to manage clusters of rural water-supply systems, the scheme is still new and capacity needs amongst all actors – private operators, district contract managers, users and regulator – should to be addressed to ensure accountable and reliable services are provided.
- There is a need to study and establish pro-poor tariff structures for rural water supply.
- More research is needed to understand the impact that altered rainfall patterns, due to climate change and land use changes, have on drinking water sources.

### Sanitation

- Uneven access to improved sanitation which has implications for children's health and nutritional status.[33] 94 per cent of households in the wealthiest quintile access improved sanitation and this falls progressively to 74 per cent in the poorest quintile.
- General population (user) knowledge and demand to invest in improving the hygiene conditions of latrines (to ensure faecal matter does not enter the environment) remains inadequate.
- As the poorest households face financial challenges in building improved latrines, it is likely that access to microcredit and/or targeted subsidies may be required to meet 2020 sanitation coverage targets.

### Hygiene

- Handwashing practices are sub-optimal. The 2015 DHS found that just 12 per cent of households have a place reserved for handwashing and that number drops to 5 per cent for those with soap and water.
- Community health clubs have been established in all districts (and are registered in 98 per cent of villages) to promote improved sanitation. Further efforts are required; 42.3 per cent of community health clubs are fully functional.

32 EICV 4.
33 Ibid.

### WASH in institutions

- WASH coverage in primary and secondary schools is just 36 per cent.
- Support for girls to manage menstrual hygiene in schools requires improved monitoring.

## Recommendations for the WASH sector

- Ensure increased investment to scale up access to drinking water and improve technical, financial and social sustainability through improved service-delivery models.
- Improve understanding of and responses to the barriers to hand-washing in households and institutions, and prioritize the improvement of hand-washing practices, targeting primary caregivers of under-five children (in order to further reduce stunting, and under-five mortality and morbidity). Further strengthen communication strategies as key factors leading towards hand-washing behaviour change.
- Build community and household capacity and demand to achieve basic sanitation, including addressing financial barriers of the poorest households.
- Develop and implement a comprehensive management information system to address the challenge of insufficient data in the WASH sector. This will continue to be a government priority in the coming years.
- Establish more structured interventions to meet the needs of adolescent girls in school. Girls must be given the social support, information, facilities and products they need to manage their menstrual hygiene with dignity.
- Better understand the impacts of climate change and build resilience at community level, and through all levels of government, to mitigate negative impacts on water, sanitation and hygiene.
- Further strengthen collaboration between government and partners to improve monitoring and increase the level of public financing available for WASH, especially for remote and/or vulnerable rural communities, and to leverage other sources of finance, including private finance.

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# Education

Ensuring the realization of children's rights to inclusive and quality education is a key government priority and essential for sustainable social and economic development. Education enables children's personal development through a structured and safe social environment where children can acquire the knowledge and skills to improve their lives and, in due course, contribute to society.

## How the education sector is organized – policies and funding

The government recognizes the importance of education for sustainable development. The Education Sector Strategic Plan highlights expanded access, improved quality and strengthened labour market alignment. Key priorities include increasing completion and transition rates; investing in human resource development; improving post-basic education; expanding training in science and technology; and strengthening institutional capacity to deliver quality educational services.

The overarching Education Sector Policy is supported by a variety of other policies, including the revised 2016 Early Childhood Development Policy and Strategic Plan; a nine-year Basic Education Policy; a Teacher Development Policy; a Girls' Education Strategy; a Technical and Vocational Education and Training (TVET) Policy; and a Special Needs Education Policy. The Special Needs and Inclusive Education Policy is being updated and an Inclusive Education Teachers Guide has been developed and validated, demonstrating MINEDUC's commitment to ongoing sector reform in relation to children with disabilities and other special needs. There has also been a move from a knowledge-based curriculum to a competency-based curriculum.

MINEDUC is the lead ministry in education, responsible for all levels of education. Implementation is done through a number of agencies, including the Rwanda Education Board. At national level, the sector is coordinated through the Education Sector Working Group, with UNICEF and the United Kingdom's Department for International Development co-chairing with the government.

Education is largely government-funded, with external funding representing just 13.5 per cent of total sector financing for 2015/16. The largest recipient of external financing is the TVET sector, which received 97 per cent of all external education-sector funding for 2015/16. The budget allocated to the education sector has fluctuated throughout the past five years and, overall, its share as a proportion of the total government budget has declined from 16.2 per cent in 2012/13 to 12.9 per cent in 2017/18.

The Education Sector Strategic Plan highlights expanded access, improved quality and strengthened labout market alignment

## Achievements in education

Achievements in Rwanda's education sector have been remarkable. Rwanda is one of the top performing countries in sub-Saharan Africa in education, having achieved MDG 2 (Universal primary education) with a net enrolment rate of 98 per cent, thanks to significant efforts over the last decade to expand access throughout the country.[34] Enrolment in primary education has increased steadily since universal free primary school education was introduced in 2003, and net primary enrolment now stands at 98 per cent for girls and 97 per cent for boys. Efforts are under way to increase the number of teachers and improve teacher training. Progress towards

34 MINEDUC 2016.

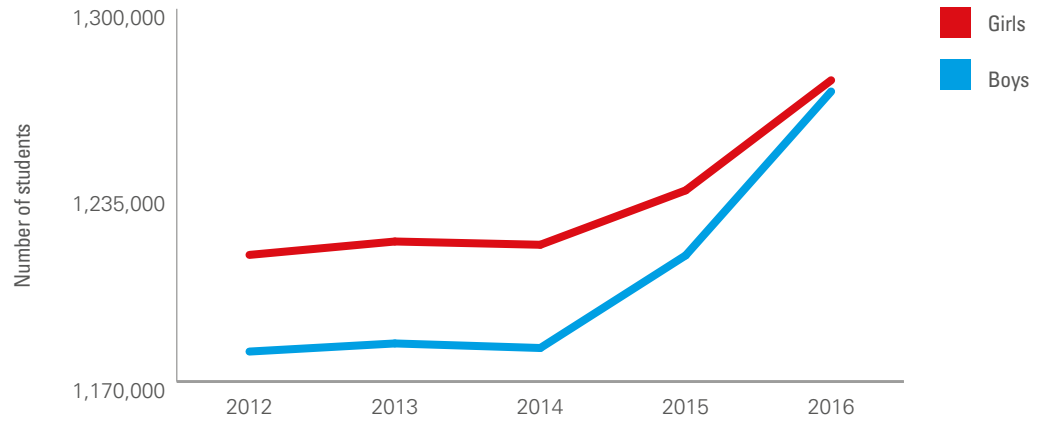


Figure 4: Trends in primary school enrolment by gender

**Source:** MINEDUC *2016 Statistical Yearbook*

MDG 3 (Gender equality) is good, with gender parity having been achieved at pre-primary, primary (see Figure 4) and secondary levels of education.

Increasing access to pre-primary schooling and early childhood education is a government priority, demonstrated by the substantial increase in the number of public pre-primary schools (from just two in 2011 to 1,474 in 2016). The net enrolment rate for pre-primary increased from 10 per cent in 2011 to 18 per cent in 2016 (17 per cent boys and 18 per cent girls).[35] Efforts are also under way to expand access to and improve the quality of pre-primary education, including development of standards. A major achievement is the move from the use of knowledge-based learning towards a competency-based curriculum.

The number of students enrolled in lower and upper secondary schools increased from 486,437 to 553,739 between 2011 and 2016.[36] Repetition levels are much lower and promotion to the next levels are higher for secondary school than primary.[37] Enrolment in secondary school stood at 33 per cent in 2016 and net secondary school enrolment continues to be higher for girls (35 per cent) than for boys (31 per cent).

TVET facilities and enrolments have both increased following significant government investment.[38] Rwanda's remarkable development has been aided by the expansion of tertiary education, which has provided skilled graduates across professions.

## Critical gaps in education

The challenges noted below should be viewed in the light of the enormous progress that has been made, particularly in relation to expanded access to primary school.

### Challenges across the education system

- Many children are not acquiring the foundational knowledge and skills required to fully benefit from secondary and further education. *Learning Achievement in Rwandan Schools* is an assessment of literacy and numeracy in primary schools, and the 2014 test results noted considerable concern in the literacy and numeracy levels of students. Mean test scores, for example, for children in Grade P2 were 45 per cent for literacy and 33 per cent for numeracy. Children in urban areas score significantly better

35 EICV 4.
36 Management Information System 2016.
37 EICV 4.
38 MINEDUC Education Management Information System.

than rural children, and mean scores were considerably higher in urban private primary schools than for any other category.

- Language is a challenge. Since 2008 Rwandan primary school children have been taught in Kinyarwanda for Grades P1 to P3 and in English from Grade P4. Some pupils do not achieve literacy in either their native Kinyarwanda or in English.[39]
- Human resources: 94 per cent of primary school teachers were qualified in 2016, a 5 per cent decline since 2011.[40] Just 69 per cent of secondary school teachers were qualified, representing a slight increase since 2011. In primary education, student-to-teacher ratios are high at 58 to 1, but student-to-teacher ratios for secondary schools have reduced markedly from 37 to 1 in 2011 to 28 to 1 in 2016.
- Despite significant investment in school infrastructure and the adoption of standards for child-friendly schools, some school environments are inadequate for learning, and some also lack basic equipment and electricity. Just 19 per cent of secondary schools and 10 per cent of primary schools had viable Internet connections in 2016.[41]
- The student-to-toilet ratios are high for primary schools (59 students per toilet: 58 female and 60 male).
- Primary school attendance for children with disabilities (57 per cent) is below levels for the general school-age population.[42] Children with disabilities currently face a range of challenges including socio-cultural barriers, too few special schools and facilities for mainstreaming, and a lack of assistive devices.[43]
- A number of issues affecting the education of girls require further research and investment. These include the lower performance of girls compared to boys in national examinations; higher rates of girls dropping out of upper secondary school; insufficient gender-sensitive sanitation facilities in schools; gender disparities among teaching and management staff; and lower levels of access to TVET and tertiary education.

### Early childhood education

- Many pre-primary teachers are either unqualified or under-qualified and, although decreasing, pupil-to-teacher ratios in pre-primary remain high (32 to 1 in 2016).[44]
- Not all pre-primary school facilities meet minimum standards.
- There are inequities in access to early childhood education. Rural children, children from poorer quintiles, and children whose mothers have had less education are much less likely to attend any organized programme or facility.[45]
- A recent review suggests that many parents choose not to incur the costs of pre-primary education because they know that children can enrol in Grade 1 (P1) for free at the age of 7.[46]
- The share of the overall education budget spent on pre-primary education is a concern, but there is to be a nominal increase over the course of the next Education Sector Strategic Plan.

### Primary education

- Nationwide access to primary school for children aged 7 to 12 has declined slightly to 88 per cent since EICV 3.[47] Attendance is slightly higher for girls (89 per cent) than for boys (87 per cent) and increases with children's age, from 69 per cent at age 7 to above 90 per cent for ages 9 to 12 (some children

39 The Education Sector Strategic Plan Mid-Term Review also observes that high repetition and dropout rate in Grades P5 and P6 are likely to have a direct relationship with the change in medium of instruction, including the high dropout rate at the end of Grade P5, the year before preparation for the final exam and transition to lower secondary school.
40 MINEDUC Education Management Information System.
41 For data relating to school physical infrastructure and learning resources, see: MINEDUC. 2015. *Statistical Yearbook*.
42 EICV 4.
43 MINEDUC. 2016. *A study on children with disabilities and their right to education*: Republic of Rwanda (the report makes several key recommendations).
44 Education Management Information System.
45 2015 RDHS.
46 2016 Education Sector Strategic Plan Mid-Term Review.
47 Data is calculated in relation to 2012 Fourth Population and Housing Census population estimates.

enter primary school late). Access decreases somewhat across the wealth quintiles.

- There are inequities in the numbers of children aged 7 to 8 who are not attending school: 24 per cent of children in the poorest quintile are not attending, compared to only 4 per cent of children in the wealthiest quintile. More rural than urban children in this age group are out of school (13 per cent and 8 per cent, respectively), and more children from families where the household head has no education than children where the household head has secondary education and above (18 per cent and 7 per cent, respectively).[48]
- The introduction of a capitation grant has increased the overall equitable allocation of resources. However, financial resources allocated to primary education decreased slightly between 2012/13 and

48 EICV 4.


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2014/15 (from 32 per cent to 29 per cent of the total education sector budget). There are concerns about gaps between policies (particularly the more ambitious and reform-orientated elements) and the level of resources available.

### Secondary, TVET and tertiary education challenges

- Secondary school attendance increases with children's age, indicating – as with primary school – that many children start secondary school late. Only 6 per cent of children aged 13 attend secondary school, compared to 35 per cent of children aged 18.[49] Access to secondary schooling is less equitable than for primary schooling: attendance is only 11 per cent for the poorest quintile compared to 40 per cent for the richest.
- Transition rates from primary to secondary school declined from 86 per cent to 73 per cent between 2011 and 2014, and a gender gap is emerging with transition rates being higher for boys than girls – the 2014 transition rate was 75 per cent for boys and 71 per cent for girls.[50], [51]
- Although enrolment in both TVET and tertiary has increased, women are underrepresented and participation is strongly skewed in favour of wealthy and urban populations.[52] The tendency for females to take courses that reinforce gender norms is noted (e.g. sewing, agriculture, home science).[53]

## Recommendations for the education sector

- Ensure that children are ready for primary school by scaling up access to quality pre-primary schooling and organized early childhood education. Significant efforts have been made in recent years to build capacity and improve quality, but systematic inquiry into the quality of early childhood education/pre-primary schooling needs strengthening.
- In primary schools, improve the quality of education through building the capacity of both teachers and the education system to provide child-centred learning and inclusive education. Address the educational needs of vulnerable and poorly performing children, and those with disabilities, and ensure that they are systematically supported within the school environment through remedial classes and individually tailored approaches.
- The competency-based curriculum needs to be further promoted, and increased investment is necessary in teacher training (including training to enhance English language skills); in developing teacher capacity to fulfil the needs of students of all abilities; in improving gender-sensitive teaching; and in building the capacity of education officers and head teachers to support implementation of the competency-based curriculum.
- At district level, it will be critical to further develop the capacity of the education sector to streamline data systems and utilize the data to inform planning and evaluation. Innovative approaches to gathering data and monitoring the quality of learning should also be explored.
- Building on the achievement of gender parity in primary school enrolment, systematic support structures need to be built to ensure that all children – both girls and boys – are in school and learning and are receiving the necessary support. In addition, there is a need to promote the enrolment of girls in TVET and tertiary education.

49 UNICEF equity analysis of EICV data.
50 MINEDUC.
51 Despite higher transition rates for boys, primary school completion rates for girls have been significantly higher between 2011 and 2015 with, for example, data showing that 66 per cent of girls and 55 per cent of boys completed primary school in 2015. This may suggest that parents are prioritizing secondary education for boys over girls.
52 EICV 4.
53 EICV 4, *Youth Thematic Report*.

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# Child protection

Child protection encompasses policies, legislation, programmes and interventions that prevent and respond to abandonment, neglect, violence, exploitation and abuse against children. It covers issues such as children without parental care and children at risk of separation from their families, harmful child labour, sexual abuse and exploitation, child trafficking, corporal punishment, and children affected by emergencies and/or displacement. Child protection ensures that children in contact with the law are treated in accordance with the Convention on the Rights of the Child and with reference to juvenile justice best practice. Protecting children also implies protecting women from violence, abuse and exploitation. Ensuring the protection of children and women will be essential to achieving the SDGs as a whole and particularly SDG 5 (Gender equality) and SDG 16 (Peace and justice).[54]

## How child protection is organized – policies and funding

The Government of Rwanda, with UNICEF and other partners, supports the establishment of child protection systems which address risk factors specific to child protection (such as violence neglect and exploitation) not otherwise covered by the health, education or social protection sectors. Under the leadership of MIGEPROF, Law No. 54/2011 on the Rights and Protection of the Child was passed and Child Care Reform was initiated. Also in 2011, the National Commission for Children was established and a National Integrated Child Rights Policy was adopted. The Justice for Children Policy and the National Policy on the Elimination of Child Labour, and their accompanying strategic plans, are also important for child protection guidance. Other important elements of the institutional framework to uphold children's rights in Rwanda include the National Child Rights Observatory Department within the National Human Rights Commission and the National Children's Forums (including the Annual National Children's Summit). There are also various National Technical Working Groups concerned with children's rights.

Most child-protection resources are allocated to the district level. The National Commission for Children budget has been increasing, even though it has decreased as the share of MIGEPROF's overall budget. Given the cross-sectoral nature of child protection interventions, it is difficult to accurately assess overall allocations to child protection.

A key achievement of the child care reform strategy is the establishment of the child protection system with a workforce of professional psychologists and social workers

## Achievements in child protection

Rwanda has made considerable progress towards establishing an enabling environment for the protection of children and women, ratifying the Convention on the Rights of the Child and its optional protocols and incorporated them into domestic legislation.[55] It also recognizes Conventions 138 and 182 of the International Labour

54 SDG Target 5.2 – Eliminate all forms of violence against women and girls; Target 5.3 – Eliminate all harmful practices such as child, early and forced marriage and female genital mutilation; Target 16.1 – Significantly reduce all forms of violence and related death rates everywhere; Target 16.2 – End abuse, exploitation, trafficking and all forms of violence against children.

55 These include the Organic Law No. 01/2012/OL of 02/05/2012 instituting the Penal Code; Law No. 54/2011 of 14/12/2011 relating to the Rights and Protection of the Child and related ministerial orders; Law No. 13/2009 Regulating Labour in Rwanda and related ministerial orders specific to child rights; Law No. 59/2008 of 10/09/2008 on the Prevention and Punishment of Gender Based Violence; Organic Law N°30/2008 of 25/07/2008 relating to Rwandan nationality; and Law No. 22/2011 of 28/06/2011 which establishes and regulates the National Commission for Children.

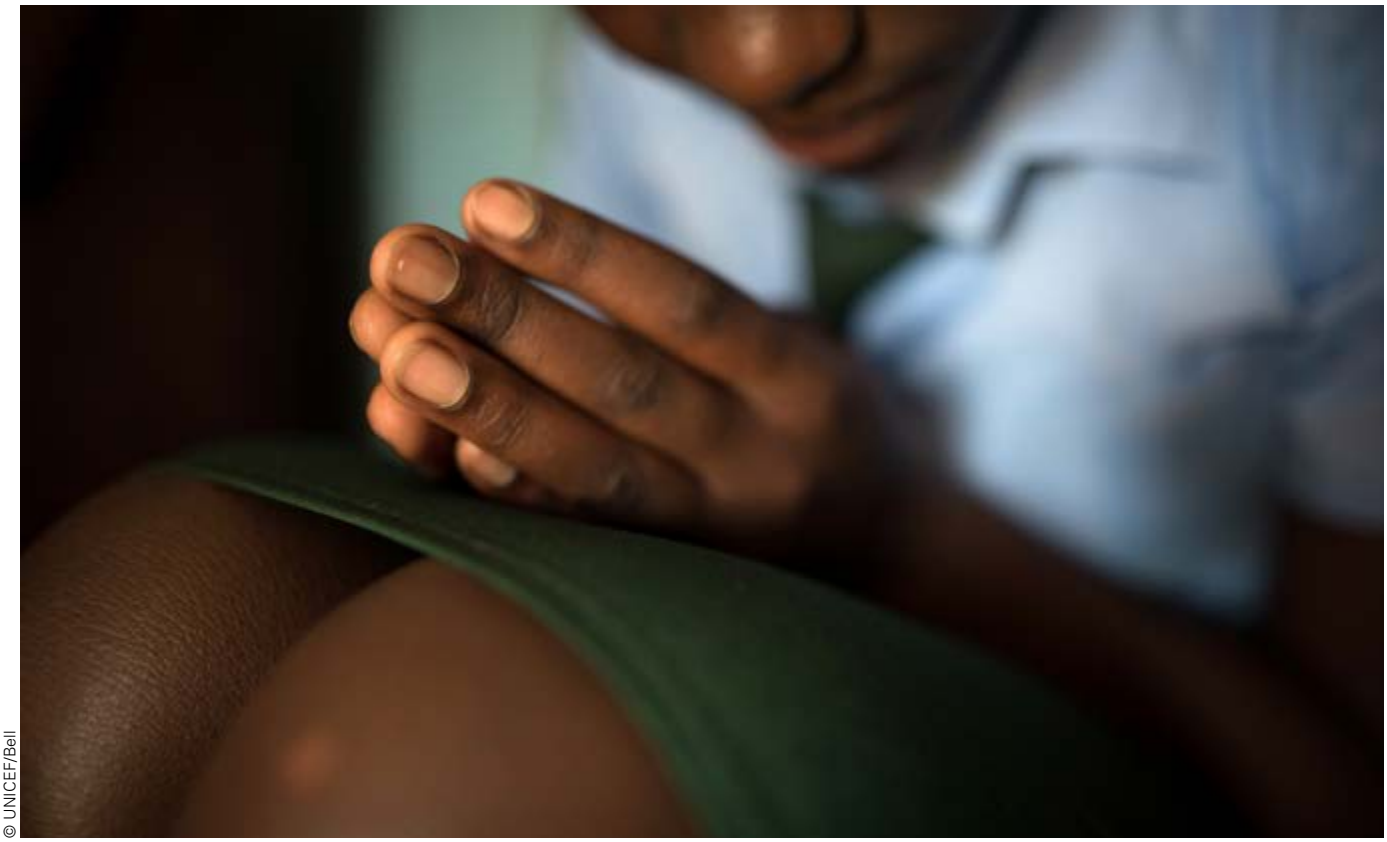
Organization (which specify the minimum age of employment and outlaw the worst forms of child labour, respectively). Child marriage is illegal under Article 194 of the penal code. Positive discipline is promoted, and the use of corporal punishment is unlawful in schools and the penal system.[56] Under Rwandan law, children under 16 years are legally prohibited from employment and are required to attend school. The government has established steering committees on eliminating child labour at both national and district levels.

The Strategy for National Child Care Reform reflects a progressive shift towards family-based care, with children living in institutions regaining their rights to live in a safe family environment. The *Tubarerere Mu Muryango* (Let's raise children in families) programme is a key part of the strategy. Between 2012 and 2017, 2,993[57] institutionalized children and young adults have been placed in family-based care. A notable achievement stemming from the Child Care Reform Strategy is the establishment of the child protection system with a workforce of 68 professional social workers and psychologists deployed in 19 districts in Rwanda with a view to having the workforce rolled out in all 30 districts. A network of almost 30,000 (two in every village) community-based child and family protection volunteers known as *Inshuti z'Umuryango* (Friends of the family) to monitor child-rights violations and family welfare has also been established and received pre-service training.

The government takes the issue of violence in society seriously and has implemented several measures, including training security personnel and police on gender-based violence, and founding district-level anti-gender-based violence clubs. With support from One UN and the World Bank, 44 One-Stop Centres have been established in district hospitals to meet the needs of child and women victims of violence and abuse. The recently validated violence against children and youth study will provide a rationale for

56 The government, through MINEDUC, has abolished caning and other corporal punishment in schools. Schools receive related instructions and a code of conduct for teachers is being developed. There is also a Ministerial Order specifying the adoption of educational measures and other forms of non-violent disciplinary punishments, care and treatment for the child.

57 The Survey on Institutional Care conducted in 2012 by MIGEPROF, in partnership with Hope and Homes for Children, revealed that there were 3323 children living in 33 institutions at that time.



strengthening child protection systems, and MIGEPROF/National Commission for Children and UNICEF are developing an action plan to prevent and reduce violence in the community.

Regarding birth registration, the recently concluded Comprehensive Assessment of the Civil Registration and Vital Statistics Systems (CRVS) in Rwanda, and the soon-to-be validated five-year National Strategic Plan to modernize the civil registration and vital statistics system must be commended.

The justice for children environment has been strengthened through the adoption of a law on the rights and protection of the child. The Maison d'Accès à la Justice Programme supports the transformation of minors' prisons into rehabilitation centres. District-level justice sector coordination committees promote and strengthen justice-related activities.

## Critical gaps in child protection

- Although great strides have been made in addressing violence against children, the 2014/15 RDHS reveals that around a quarter of young people aged 15 to 19 experienced physical violence (24 per cent of girls and 28 per cent of boys). There is gender disparity in the experience of sexual violence, 14 per cent of girls have experienced sexual violence but only 3 per cent of boys aged 15 to 19 have (see Figure 5).[58]

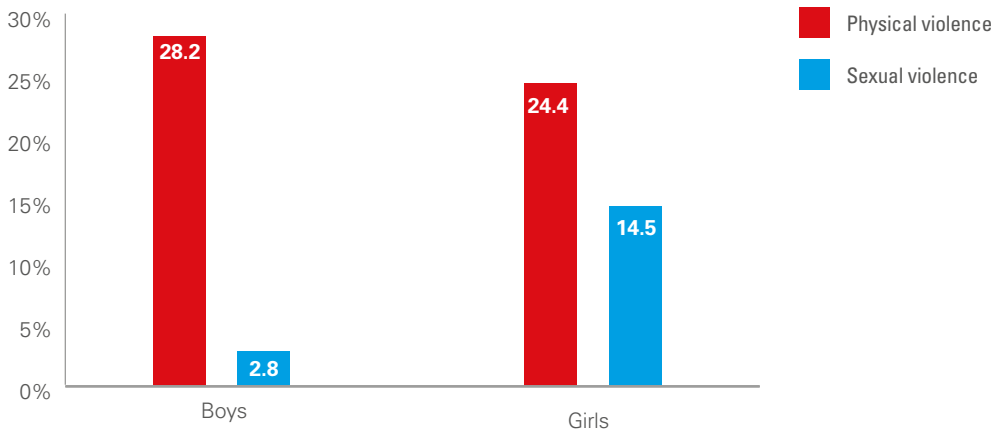



Figure 5. Percentage of boys and girls (15 to 19 years) having ever experienced physical and sexual violence
**Source:** RDHS

- Challenges relating to children with disabilities and their special needs cut across all sectors. Such children frequently face stigma and discrimination and often suffer social exclusion, violence, abuse and exploitation. Less than 1 per cent of adolescents with disabilities are employed and (as highlighted in the education chapter) net attendance at primary school is much lower for children with disabilities than for children with no disability.[59] Also of concern is the high level of institutionalization of children with disabilities.
- Although the efforts under the childcare reform programme resulted in the placement of almost 80 per cent of children who were in institutional care in 2012, there are still some 900 children living in 15 orphanages in Rwanda.
- Family-based placement of children with disabilities is a major challenge and the social workforce has limited guidance on how to address particular disability-related needs.

58 2015 RDHS.
59 EICV 4. The 2012 Fourth Population and Housing Census reports net attendance at primary school for children with disabilities is 68 per cent.

- Post-placement follow-up of children by professional social workers and psychologists in the community is not consistent and linkages of the professional social workforce with *Inshuti z'Umuryango* needs to be strengthened.
- Birth registration is not universal, parents are rarely in possession of birth certificates, and the absence of birth registration correlates with higher levels of poverty.[60] Birth registration in under-five-year-olds is lower outside Kigali and for the poorest quintiles.
- Enforcement of the legislation requires strengthening, and delays in the judicial system lead to low rates of prosecution for cases of abuse, exploitation and neglect.
- The child protection system is still evolving and needs to be further strengthened to reach its potential to prevent and respond to child protection concerns.
- The dangers of children being engaged in the labour market are not fully recognized among employers and society at large.

## Recommendations for the child protection sector

- Tackling violence will require a multi-sectoral approach and a good undersanding of existing norms that perpetuate violence.
- Put in place a comprehensive approach to sensitization of communities and service providers to reduce stigma associated with disability and increase the number of children with disabilities reintegrated into families. In addition, strengthen capacity building programmes and referral mechanisms to connect diverse stakeholders and services.
- Focus on strategic interventions to improve linkages between birth registration processes and protocols, and ongoing efforts to strengthen the CRVS system. In addition, CRVS programme implementation should be prioritized by including appropriate performance indicators within MINALOC and district *Imihigos*.
- Strengthen institutional capacity and community awareness to eliminate child labour, and enforce laws prohibiting child labour.
- Improve the capacity of the social workforce as a way to ensure quality and coverage of the child protection system. One critical aspect of the system is to further strengthen ongoing efforts to build the capacity of community volunteers to prevent violence and abuse, and to provide appropriate case-management and referral services.
- Raise community awareness of child protection issues and generate community-level demand for child protection services such as birth registration, services for children with disabilities and prevention of violence.
- Ensure the capacity of the justice system to better enforce child-related laws and prosecute violations, and develop effective linkages and referral across the sectors as a matter of priority.
- Strengthen coordination across sectors at the national, district and community levels on child protection issues.
- Strengthen the evidence-base to support planning and monitoring of interventions, including development of the management information system for child protection.
- Invest additional resources for MIGEPROF, the National Commission for Children and district child-protection focal points and staff to address the full range of child protection-related challenges within their remit.
- Allocate additional national budget to enable absorption of the social workforce into civil service structures and increase sustainability of the child protection system.

60 RDHS.

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# Social protection

Social protection has a critical role to play in reducing poverty and inequality, and is a key reflection of societal and political commitment to the promotion of inclusive development. Well-designed social transfers can alleviate income poverty, thereby helping families to ensure that children are adequately nourished, can benefit from education, are able to receive appropriate health care and ultimately enjoy an adequate minimum standard of living.

## How the social protection sector is organized – policies and funding

Alongside the provision of key social-sector services, the social protection sector in Rwanda has been developed and expanded as a key strategy for poverty reduction through measures including income support, social assistance, financial services and in-kind support to improve household food security, nutrition and livelihoods.[61] Coordinated by MINALOC as the lead ministry for the sector, the Social Protection Sector Strategy (currently being revised) outlines processes that build on, and improve, the core set of social protection programmes and better align complementary initiatives delivered by other government ministries.

Government commitment to poverty reduction was consolidated under EDPRS I when the flagship Vision 2020 *Umurenge* Programme (VUP) was established in 2008. Under the current 2013–2018 EDPRS II, social protection contributes to 'enabling graduation from extreme poverty' under the theme of rural development. Social protection has two other core programmes: the Genocide Survivors Assistance programme (managed through the FARG fund) and a demobilization programme managed by the Rwanda Demobilization and Reintegration Commission.

Targeted at extremely poor families, the VUP has three components. The first is the safety net which includes direct support (cash transfers for very poor people who are unable to work); the classic public works scheme (cash for work); the expanded public works scheme (cash for work); and nutrition support services. The second component, livelihoods enhancement, comprises asset transfers, skills development and financial services. The third component focuses on sensitization and community mobilization.

Support is based on a community-based categorization of socio-economic status (*Ubudehe*) linked to levels of household assets and the capacity to sustain livelihoods. It also takes other factors into account (including distance to health and education facilities and access to safe water). The government pays health insurance (Mutuelle de Santé) to households in *Ubudehe* Category 1 (the poorest). The social protection system also includes the *Ubudehe* Project, targeting households at village level to increase income-generating activities. Agricultural social protection measures such as the *Girinka* (One cow per poor family) initiative are aimed at households in *Ubudehe* Categories 1 and 2.

Social protection has expanded as a key strategy for poverty reduction

Budget allocations have increased from 3.3 per cent of the national budget in 2012/13 to 4.3 per cent in 2015/16 (from RWF45.3 billion to RWF75.5 billion). This positive trend is expected to continue and, considering the restrained fiscal space available to the government for social sector programming, this represents a major

61 The government's classification of social protection also includes women's empowerment and child protection.

accomplishment. It is expected that the sector will continue to be financed through a combination of national revenues, overseas development assistance and borrowing.

## Achievements in social protection

Households with children are generally well covered within all social protection programmes. Of households benefiting from VUP Direct Support and Public Works, 67 per cent and 89 per cent of households have children, respectively; 79 per cent of households benefiting from FARG have children; and of those benefiting from the Rwanda Demobilization and Reintegration Commission, 95 per cent have children.[62]

VUP coverage has expanded (see Figure 6): Direct Support covers 416 sectors, Public Works covers 240 sectors and Financial Services covers 239 sectors (out of a total of 416 sectors in Rwanda).[63] Expanded Public Works has now reached 30 sectors and is to be gradually expanded to include all VUP sectors. It offers work appropriate for households with low labour capacity and responsibility for caring children or persons with disabilities[64] and it also takes into account the needs of breastfeeding women by including them in public works projects close to home. The Direct Support component appears well targeted towards families where the community has determined that no member is able to work. Households receiving Direct Support are smaller than average, with fewer children and working-age adults. Half of these households include a member with a disability.[65]

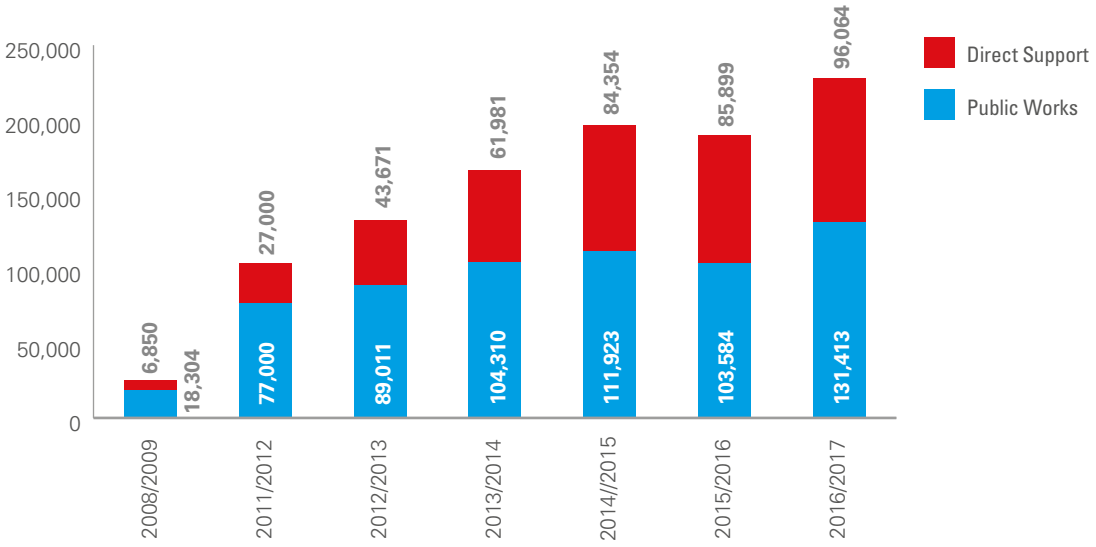


Figure 6. Trends in VUP coverage of households

**Source:** Joint Sector Review reports

National coverage of health insurance is relatively high with 79 per cent of VUP programme beneficiaries covered by Mutuelle de Santé. Children have slightly higher access to health insurance than the general population (72 per cent).[66]

62 Equity analysis of EICV 4 data.
63 Joint Sector Report for 2016/17.
64 VUP Programme Document.
65 EICV 4 data.
66 UNICEF equity analysis of EICV 4 data.

## Critical gaps in social protection

- As already highlighted, poverty has reduced in the past decade. However, the MDG poverty target was one of the few MDG targets Rwanda did not meet.
- Despite a consensus that the *Ubudehe* categorization process is relatively transparent, there are concerns about the overall quality of VUP targeting including, in particular, the inclusion errors of households from higher *Ubudehe* categories and consequently exclusion errors of poorer households.[67]
- Despite the significant scale-up of the VUP, coverage remains low compared to needs: less than 52 per cent of households in *Ubudehe* Category 1 are covered by direct income support schemes (direct support and public works).
- The Financial Services component of the VUP (microcredit) is considered (in combination with other VUP components and skills training) a key strategy to enable graduation from extreme poverty. Yet coverage is still limited, with just 5 per cent of eligible Direct Support households and 27 per cent of households participating in Public Works having taken out a loan in the last 12 months.[68]
- Where households with children are beneficiaries of Public Works or Direct Support, the benefits received are often inadequate to cover essential and basic household needs such as nutrition, health and education.
- Income support coverage (public support provided through the VUP programme, including financial assistance to support education and health needs, or food relief) is limited, with just 14 per cent of all households reporting having received any financial assistance.[69]

## Recommendations for the social protection sector

- Income poverty, particularly extreme poverty, is a key driver of child deprivation. Building on commendable efforts to expand coverage of social protection and to initiate child- and gender-sensitive approaches, harmonize and expand coverage of social protection, ECD and nutrition services to maximize impact and improve the resilience of households with children to economic and climate shocks. Consider scaling up of access to Direct Support for vulnerable households with children.
- Further embed the implications of monetary and multidimensional poverty of children, men and women (as guided by SDG 1) into social protection policies and programmes. The aim would be to ensure that all aspects of poverty are addressed through the social protection system linked to a system of pro-poor measures in other social sectors, while taking into consideration the specific needs of individual children and households. In doing this, the sector will build on significant progress made in introducing child-sensitive social protection, links to ECD and nutrition services.
- Strengthen the efficiency of the social protection system through better targeting of households with vulnerable children. The next round of *Ubudehe* categorization, plus the introduction of categorical targeting for old age pensions, disability grants and child-nutrition support grants planned for implementation within the next three years, will provide an opportunity to ensure that acutely vulnerable households are well targeted by the VUP.
- Continue strengthening the key social protection management information systems including complementarity between social programmes.
- Strengthen capacities of the community-level social protection workforce and of lower-level administrative staff for district and community-level case management, referral across sectors and monitoring to improve programme delivery.

67 EICV 4.
68 EICV 4 data.
69 Ibid.

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## BOX 1: DECENTRALIZATION – BUILDING ON SUCCESS

Rwanda's policy of decentralization has been a success, underpinning countrywide sustainable social and economic development. For the health and education sectors, decentralization has promoted accountability and local engagement, including community engagement in maintaining and establishing facilities, and through forums such as parent-teacher associations and community hygiene clubs. Substantial efforts have also been made to work with communities to accelerate the delivery of ECD interventions and to scale up the construction of sanitation facilities. For Rwanda to benefit further from decentralization, several key steps have been identified:

- In relation to **service delivery**, sectoral decentralization needs to be accelerated – and local authorities provided with the necessary leverage and authority to implement reforms and the resources to meet sector objectives. Greater devolution of responsibilities for key services will promote accountability and local decision-making, and consequently enhance human capital and institutional capacity. Efforts are required to clarify sectoral decentralization priorities, and to better define and operationalize institutional linkages across sectors.
- **Relationships** between local authorities, central government and the sectoral ministries are often complex, and programming and results-management are at times overburdened, particularly by a lack of clarity around social development objectives and responsibilities. Further ensuring the integration and budgeting of cross-sectoral priorities (such as malnutrition elimination plans and ECD interventions) within district development plans will also help strengthen coordination between government entities.
- In relation to the **use of evidence**, local government can be further supported to generate, cross-tabulate, analyse and utilize data to develop locally owned programmes that reach the most vulnerable children and families.
- **Evaluating and demonstrating results** to constituents is also critical to generating community acceptance of policy and promoting community engagement.
- In relation to **community participation in decision-making**, there is a need to further strengthen and promote community consultation processes and to ensure that children of all ages are empowered to participate in public debate about social and economic development – at both local and national levels.

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# Early childhood development

Investment in early childhood development (ECD) supports children's full cognitive, physical and emotional development, and benefits not only children's future learning and personal achievement, but also overall prospects for sustainable national development. Effective ECD requires interventions that address maternal and child nutrition and health, the quality of parental care, child protection, early childhood education, and poverty reduction through effective and child-sensitive social protection.

For the first time in the history of global development, ECD has been included as part of the transformative agenda for 2030, making it an international priority for the 21st century. The SDGs include a specific global target (4.2) to improve access to quality ECD, care and pre-primary education, complemented by additional targets in health (3.2), nutrition (2.2) and protection (16.2). In addition, investments in ECD help towards achieving several of the other goals.

## How the ECD sector is organized – policies and funding

Support to early childhood development and family has emerged over the past several years as one of the priority areas for development in Rwanda. The National ECD Policy and a five-year Strategic Plan were revised in 2016, and costed and endorsed by the Cabinet in May 2016. These two policies set out key cross-sectoral interventions covering child health and nutrition, access to safe water and sanitation, hygiene, early childhood education, child protection and social protection. These interventions aim to develop 'children's full sensory-motor, social-emotional and cognitive-language potential from conception to the age of six years'.[70]

MIGEPROF has responsibility for overall coordination and leadership, for monitoring and evaluation, and for the national regulation of ECD services. The National Early Childhood Development Programme (NECPD) has the general mission to coordinate all interventions that support adequate early childhood development for children, from their conception to 6 years of age, as outlined in the ECD policy. Other key responsibilities under the policy are delegated to the National Commission for Children (child protection and promoting children's rights in families and communities), MINEDUC (scaling up pre-primary education), the MoH (health-related issues for both mother and child) and MININFRA (access to safe water and sanitation). The budget for ECD-related spending was estimated to be around RWF15 billion for 2015/16, representing an increase since 2014/15.[71]

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## Achievements in ECD

The new ECD policy developed by MIGEPROF laid the foundation to guide other sectors on strategic priorities, roles and responsibilities. Policy implementation has led to significant achievements. National minimum standards and norms for ECD services have been developed and widely disseminated. The coordination of cross-sectoral ECD interventions has been strengthened by setting up a national ECD Technical Working Group (the name is currently under revision) chaired by MIGEPROF with UNICEF as secretariat. The ECD Technical Working Group brings together all relevant stakeholders on a quarterly basis to review achievements, share experiences and plan priorities.

70 Government of Rwanda. 2016 National Early Childhood Development Policy.
71 UNICEF calculations based on MINECOFIN data.

Community-based ECD centres have been established throughout the country, providing comprehensive ECD services (including care for young children, parenting education, home visits, and growth monitoring and promotion). The training curriculum for ECD caregivers has been developed and rolled out, and a system for mentoring and supervising caregivers has been established.

Links have been established with other social services (social and child protection, health, nutrition) and services which were missing – child protection and an expanded child-friendly public works system – have been brought to young children and their families.

Overall, there have been noticeable improvements in the physical environment for young children. Family care practices have improved and there is increased access to ECD and other social services. There are strong indications that these actions are giving desired outcomes: 63 per cent of all children aged 3 to 6 years are now developmentally on track.[72] Successful implementation of the ECD programme and the partnerships leveraged has generated interest in ECD among stakeholders, including the private sector and new donors.

## Critical gaps in ECD

The Rwandan home environment is not fully conducive to optimal early childhood development. For example, only one in five parents is engaged in activities that support early learning at home; more than half of young children are left at home alone or in the care of other siblings; and there is limited awareness among men of early nurturing and care.[73]

Young children and families have limited access to ECD services. Only 13 per cent of young children have opportunities to attend organized care/early learning facilities, and children from the poorest families and in rural areas are significantly less likely to benefit from those services.[74]

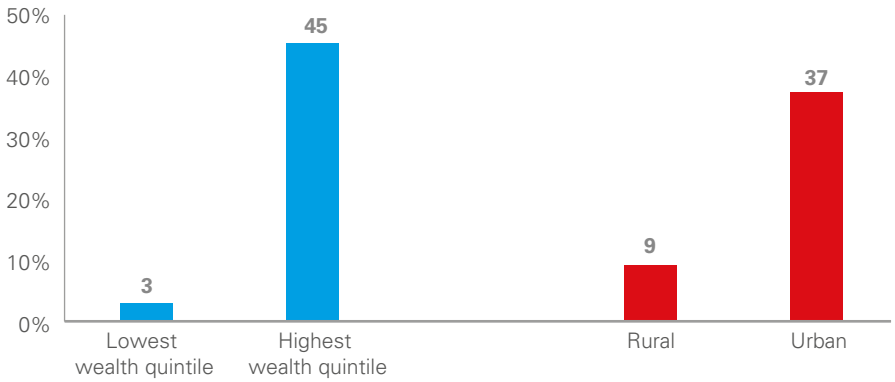


Figure 7. Percentage of children aged 36 to 59 months attending an organized early childhood education programme, by wealth quintiles and urban/rural areas

**Source:** RDHS 2014/15

There are significant bottlenecks and barriers to scaling up ECD services, such as:

- Limited capacity at decentralized levels to implement the ECD Policy and Strategic Plan.
- Financial resources insufficient to fully scale up ECD services.
- Limited availability of qualified caregivers.
- Lack of physical infrastructure.

As a result, approximately a third of young children are not reaching their full potential in Rwanda.[75]

72 2015 RDHS: scored in relation to four key domains (literacy and numeracy, physical, social-emotional and learning).
73 2015 RDHS.
74 Ibid.
75 2015 RDHS.

## Recommendations for the ECD sector

- Under MIGEPROF leadership, enforce the implementation of the ECD Policy and Strategic Plan at national and decentralized levels, ensure accountability of the sectors critical to young child development (health, nutrition, protection), and oversee investment of development partners and civil society organizations in scaling up ECD services. At district level, efforts should be made to incorporate ECD priority interventions into district plans and budgets, monitoring and evaluation.
- Further strengthen links with other social services (social and child protection, health, nutrition), and bring social services to young children and their families in a coordinated manner.
- Systematically address the shortage of qualified caregivers – this would include setting up a system for identifying ECD caregivers, and providing training, mentoring and supervision.
- To address the lack of physical infrastructure, and deliver on government committment to provide quality community and family-based ECD services for every young child and family, prioritize the establishment of low-cost community-based ECD centres (by restoring or redesigning existing community spaces) in addition to current models of ECD centres.
- Promote social norms supportive to early learning and the participation of fathers.
- Explore options to increase financial and human resource investments by government and civil society organizations, in accordance with the costed ECD Strategic Plan.

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## BOX 2: HUMANITARIAN SITUATION

Rwanda is located in the Great Lakes region, an area prone to natural disasters and to civil conflict in neighbouring countries. Natural hazards recurring in Rwanda include droughts, floods, landslides, earthquakes, volcanic eruptions and severe storms.[77] Over the last decade, the frequency and severity of natural hazards and disasters have increased, resulting in human casualties as well as economic and environmental losses.

Since 1996, Rwanda has received refugees from neighbouring countries, mainly the Democratic Republic of the Congo and the Republic of Burundi. In October 2017, the total refugee population stood at 162,532 (about 46 per cent from the Democratic Republic of the Congo and 54 per cent from Burundi), of which 50 per cent were children.[78]

The Ministry of Disaster Management and Refugees and partners coordinate and manage the protection and assistance of refugees in camps and urban areas. Refugees are provided with food and services (including health and nutrition, water, hygiene and sanitation, birth registration, child protection and gender-based violence services) to ensure their well-being.

- Refugee children follow the National Education Programme and are being integrated into national schools, with children sharing classrooms with Rwandan students and following the same curriculum. Children also benefit from the school-feeding programme and ECD centres have been built in refugee camps for younger children.
- Birth registration is done in partnership with the local authorities, which provide civil documentation and issue birth certificates to refugee children.
- Health services for refugees are provided via the national health service, with all refugee children receiving routine immunizations and pregnant women accessing pre- and antenatal care.
- WASH services meet minimum standards and bridge the humanitarian development nexus with sustainable approaches that include local communities.
- Child protection cases are managed and handled within refugee settings. Due to the influx of refugees from Burundi and the issue of separated and unaccompanied children, alternative care arrangements (in foster families) were initiated in Mahama refugee camp.
- Child forums meet on a quarterly basis to handle protection issues for refugee children and manage general cases according to national law. Refugee children participate in the National Children's Summit and are able to share concerns with their peers.

76 Ministry of Disaster Management and Refugee Affairs, 2013.
77 Ministry of Disaster Management and Refugee Affairs reports.

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# Conclusion

Rwanda has made significant progress towards economic prosperity and human development over the past two decades, and as already highlighted is among the few countries which achieved all the MDGs. Children's rights are protected within the Rwandan Constitution and in various legislation, and Rwanda is a signatory to the Convention on the Rights of the Child. The government has made significant investments in sectors relevant for children, including in increasing the capacities of the social sector workforces (in health, education, social and child protection) with a focus on decentralization and devolution, and home grown solutions. Thus, substantial progress has been made towards ensuring that children in Rwanda increasingly realize their rights to good health, education, protection and participation. With a long-term view of building the human capital of all its children while leaving no child behind, the government has systematically tackled poverty and inequities that continue to correlate with living in rural areas, lower levels of household education, higher rates of household dependency, limited access to services and sub-optimal health, nutrition and education outcomes for children and women.

Building on its successes in achieving the MDGs, Rwanda is well poised to achieve the SDGs and continue improving the well-being of children, including through a number of sector-specific recommendations identified in the Situation Analysis of Children in Rwanda and summarized below.

- *Social Protection:* Rwanda has steadily increased its social protection coverage, and efforts are under way to address the coverage gap of about 50 per cent through introduction of innovative measures and increased investment in the sector. Linkages between the social protection and other social sectors are being prioritized particularly in the areas of linking social protection with nutrition, health and early childhood development.
- *Health:* Building on significant achievements in health outcomes of children and women, the priority in the health sector is further reduction of maternal and child mortality that will require maintaining high impact interventions (e.g. immunization, skilled attendance to delivery) along with improved quality, and scaling up access to other high-impact health interventions, for example, antenatal visits (minimum four visits); post-neonatal coverage, as well as increased budget allocations to the sector.
- *Nutrition:* In order to maintain results achieved, and to reduce the still high prevalence of stunting, it is critical to further strengthen the multisectoral coordination system that will ensure sustainable universal coverage of nutrition specific interventions (e.g. growth promotion and monitoring, micronutrient supplementation) and scale-up nutrition-sensitive interventions (e.g. sanitation, early childhood development, social protection) to the poorest families in remote areas that are mostly affected by stunting.
- *WASH:* The WASH sector needs to prioritize increased investment to scale up access to drinking water and improve technical, financial and social sustainability of improved service-delivery models. In addition, sector needs to improve responses to the barriers to hand-washing in households and institutions, build community and household capacity and demand to achieve basic sanitation, and address financial barriers to access faced by the poorest households.
- *Education:* Improving the quality of education emerges as one of the key priorities for education sector, it is essential to increase allocation of resources to basic

Building on its successes in achieving the MDGs, Rwanda is well poised to achieve the SDGs and continue improving the well-being of children

education; complete roll-out of the competency-based curriculum; improve quality of teaching, and increase access to well-equipped school facilities. One of the priorities is to increase access to pre-primary education while strengthening systematic inquiry into the quality of early childhood education/ pre-primary schooling.

- *Early childhood development:* In order to ensure that young children access integrated social services for optimal development, further scale-up of diversified ECD services is needed. This will require increased investment of human and financial resources for ECD, and continuous coordination with communities, as well as with health, nutrition, education, child protection and social protection stakeholders.
- *Child protection:* In order to further strengthen child protection in Rwanda, additional resources are required to scale up the child protection system and the social workforce and to address the full range of child protection related challenges, such as prevention of violence, birth registration and full integration of children with disabilities into social services.

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