



NECDP NATIONAL STRATEGIC PLAN 2018-2024

**Rwanda Integrated Early Childhood Development
Investment Case**

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Acronyms and abbreviations

ANC	antenatal care
BCC	Behavior Change Communication
BMI	Body Mass Index
CBNP	Community-based Nutrition Program
CBP	Community-Based Provision
CCM	Community Case Management
CCT	Conditional cash transfer
CFSVA	Comprehensive Food Security and Vulnerability Analysis
CHMIS	Community Health Management Information System
CHWs	Community Health Workers
CMC	Community Mobilization Campaigns
CMEP	Comprehensive Monitoring & Evaluation Plan
CAN	core nutrition action
C-PBF	Community Performance Based Funding
CSO	Civil Society Organization
CSR	corporate social responsibility
DAP	Data Analysis Plan
DFID	United Kingdom Department for International Development
DHS	Demographic Health Survey
DP	Development Partners
DPEM	District Plans to Eliminate Malnutrition
DQA	Data Quality Assessment
DRF	Data Reporting Form
EBF	Exclusive Breast Feeding
ECD	Early childhood Development
EDPRS	Economic Development and Poverty Reduction Strategy
EH	Environmental Health
EICV	Integrated Household Living Conditions Survey
ENAs	Essential Nutrition Actions
FBO	Faith Based Organizations
FFS	Farmer Field Schools
FNG	Fill the Nutrient Gap
GDP	Gross domestic product
GOR	Government of Rwanda
GPM	Growth Monitoring and promotion
HDI	Health Development Initiative
HH	Household
HMIS	Health Management Information System
HR	Human Resources
ICCM	Integrated community case management
IECD	Integrated Early childhood Development
IMF	International Monetary Fund
IZU	Friends of Family (Inshuti z’Umuryango)

JADF	Joint Action Development Forum
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitudes, and Practices
LODA	The Local Administrative Entities Development Agency
M&E	Monitoring and Evaluation
MAM	moderate acute malnutrition
MDGs	Millennium Development Goals
MIGEPROF	Ministry of Gender and Family Promotion
MINAGRI	Ministry of Agriculture and Animal Resources
MINALOC	Ministry of Local government
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINEMA	Ministry of Emergency Management
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NECDP	the National Early Child hood Development Program
NGO	Non-governmental organization
NISR	National Institute of Statistics of Rwanda
NSP	National Strategic Plan
NST	National Strategy for Transformation
PDA	personal digital assistant
PHC	Primary Health care
PMP	Performance Management Plan
RAB	Rwanda Agriculture Board
RBC	Rwanda Biomedical Center
RCHMIS	Rwanda Community Health Information System
RMNCHN	Reproductive, Maternal, Neonatal, and Child Health and Nutrition
ROI	Return On Investment
SAM	Severe acute malnutrition
SAP	Single Action Plan
SBCC	Social and behavior change communication
SD	Strategic Directions
SGA	Small for Gestational Age
SGD	SGD Sustainable Development Goal
SUN	Scaling Up Nutrition
ToC	Theory of Change
TOR	Terms of Reference
TQR	Technical Quarterly Reports
TTC	Teacher Training Colleges
TV	Television
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children’s Fund

USAID	United States Aid for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	United Nations World Food Programme
WfWI	Women for Women International
WHO	United Nations World Health Organization
WSS	water supply and sanitation
NIDA	National Identification Cards Authority
MINIFRA	Ministry of Infrastructure
MINICOM	Ministry of Commerce
MINIMAR	Ministry of Emergency management
NWC	National Women Council
REB	Rwanda Examination Board
MIYCN	Maternal Infant and Young Child Nutrition
IMCI	Integrated Management of Childhood Illnesses

Foreword

In December 2017, Cabinet approved the established of the National Early Childhood Development Program (NECDP). This followed the adoption of a new ECD Policy in 2016 that prioritized an integrated approach to early childhood development and this paradigm shift generated increased demand for strengthened coordination across all sectors that contribute to ECD, including integrated planning, budgeting and prioritization of ECD interventions, as well as capacity building to decentralized levels. The NECDP was created to support this strengthened coordination.

The Government of Rwanda recognizes the critical importance of an Integrated Early Childhood Development (IECD) framework in ensuring children's rights to survival, protection, development and participation. ECD targets children from conception to 6 years and has been proven through various research to contribute to social, economic and human capital development, increase of workforce productivity, and poverty reduction. Rwanda is very committed to human capital development and investing in early years significantly contributes to the critical pathway of attaining a middle income status embedded in a vibrant knowledge-based economy.

As a signatory to the global and regional frameworks such as the United Nations Convention on the Rights of Children (UNCRC), Education for All (EFA), Sustainable Development Goals (SDGs) and standards on the rights of the child, Rwanda is committed to using ECD as a platform for ensuring the fulfillment of the rights of children. The Government of Rwanda is cognizant of the fact that effective ECD programming requires effective integration and harmonization of policies and programs across sectors and has therefore developed the National Integrated ECD Strategic Plan 2018-2025 targeting children from conception to 6 years. This strategic plan is operationalized through a multisectoral annual Single Action Plan (SAP), thus requiring strong coordination across social cluster agencies and partners. In order to reduce stunting of Rwandan children to 19% by 2024, partnerships and engagement of Government sectors, civil society organizations, private sector, communities and families is critical. All these actors need to work together in a more effective and coordinated way to support the holistic development of young children. I therefore call upon all sectors to embrace this six-year National ECD Strategic Plan with renewed commitment to enable the Rwandan children grow and develop to their full potential.

Hon. Amb. NYIRAHABIMANA SOLINA

Minister of Gender and Family promotion

Preface and acknowledgement

The NECDP Strategic Plan 2018-2024 (NSP) is the first integrated ECD Plan and constitutes an important step forward towards a holistic approach to child development and ensuring that every child, irrespective of their family circumstances, is given a better start in life through investment in their early years, as clearly envisioned in the National ECDP Policy 2016.

This Strategic Plan is child-centered and emphasizes the important role of parents and primary caregivers in providing care, support and upbringing of their children. In this context, it recognizes the importance of combining a range of services that contribute to ensuring that infants and young children thrive, including: promoting early child health through good nutrition and food security; ensuring children have access to safe water and sanitation; providing access to social protection; providing opportunities for early learning and development; ensuring prevention of and protection from violence and abuse; enabling children to play and have fun amongst others.

Importantly, and in line with our commitment to inclusion, the Strategic Plan is based on the principle that no child shall be left behind and, in particular, that the needs of children with disabilities and/or developmental delays are considered and addressed through early childhood development services. I believe that the implementation of this Strategic Plan will significantly contribute to the attainment of the goals of the NST and the global Sustainable Development Goals, and in the process significantly improve the lives of many of our children.

I am grateful to all who have contributed to this exciting and challenging development, especially those who gave freely of their time, experience and expertise in the process of developing this first ever integrated strategy to Champion ECD. This NSP is a result of concerted efforts between government and its partners and we will continue to work together to ensure it is implemented as part of our commitment to provide each child with an early start for a better future.

I am exceptionally grateful to the World Bank and the Global Financing Facility (GFF) for their financial and technical support to realize this vital milestone. The complimentary technical assistance from UNICEF is very much appreciated.

Dr.Anita ASIIMWE

COORDINATOR NECDP

Executive summary

Background and context

Every child deserves the best start in life and the opportunity to thrive. A child's brain develops rapidly during the early years and lost opportunities might never be redeemed. Research has shown that first three years of life are crucial for optimal development; it is during this period that 80 per cent of a child's brain grows. It is therefore imperative that deliberate efforts are made to give children the chance to grow up in an environment conducive to the development process. A comprehensive approach to providing this environment is the Early Childhood Development (ECD) Program. This is concerned with the child's holistic development and therefore covers not only early learning and stimulation, but also other areas including health, nutrition, and hygiene and sanitation.

Rwanda has around 5 million children and an estimated 1.6 million are potential beneficiaries of Integrated Early childhood Development interventions and only 13 per cent have access to ECD Facilities. To regulate ECD interventions, the Government of Rwanda launched the National Policy on Early Childhood Development in 2016. The goal of the policy is to promote a comprehensive approach to ECD programs for children aged <6 years to fully develop their physical, socio-emotional, cognitive, spiritual and moral potential.

This National Strategic Plan for Early Childhood Development (2018-2024) has been developed to speed up the implementation of the National Policy on ECD, and ensure it is in line with the national development objectives outlined in the National Strategy for Transformation (NST 2017-2024). It is a statement of intent underlining what should be done to ensure that Rwandan children are given a fair chance to survive, grow, develop and participate.

While the pivotal role of ECD services in supporting child development is well recognized, such services are accessed by less than one-fifth of eligible children in Rwanda. This Strategic Plan is designed therefore to increase access to ECD services, as well as to ensure that services are holistic and of adequate quality.

Methodology

The process of developing the Strategic Plan was participatory. Broad consultations with key stakeholders and national and district levels were carried out, including visiting selected health facilities, ECD centers and discussions with frontline workers at community level. Stakeholders consulted included Government Ministries and Departments, international organizations, NGOs, and Civil Society organizations. The process also included an intensive literature review of best practices globally and current evidence of what is working and not in Rwanda. Presentations in various forums were made including meetings and feedbacks with NECDP, the National Steering Committee, senior management meeting, and social cluster meetings of permanent secretaries and ministers, and technical working groups, as well.

A hierarchical approval process was observed before the final report was signed and submitted to prime ministers office that monitors the implementation of this strategy.

Highlights of the Strategic Plan

The NSP articulates the status and gaps in several areas of ECD, including school readiness, parenting and early stimulation, child protection and inclusion, food security, water, sanitation and hygiene, social protection and systems related to cross-cutting areas. The NSP also defines the vision, mission, responsibilities and guiding principles, theory of change and the conceptual framework. It includes a comprehensive strategic framework with nine strategic directions and corresponding outcomes, with well prioritized interventions and strategies and a results framework.

The following strategic directions constitute the backbone of the national strategic plan:

Strategic direction 1: Improved equitable and inclusive access to early childhood development services for children under six years resulting in improved learning outcomes and adequate skills development

Strategic Direction 2: Improved and sustained quality health and nutrition status of infants and young children with a focus on the first 1,000 days of life

Strategic Direction 3: Enhanced national capacity to support vulnerable households with safe drinking water, basic sanitation and hygiene services

Strategic Direction 4: Improved and sustained equitable food security for family health in vulnerable households with children under five years and pregnant and/ lactating women

Strategic Direction 5: Improved social protection systems for the poor and the most vulnerable households

Strategic Direction 6: Strengthened coordination, implementation capacity and governance to enhance quality delivery of Integrated ECD interventions at all levels

Strategic Direction 7: Strengthened Community based platforms to enhance demand for and use of effective frontline service delivery systems of integrated quality high impact Integrated ECD services.

Strategic Direction 8: Increased efficiency, equitability and sustainability of financing National ECD program

The NSP also prescribes the financing, coordination, governance, monitoring and evaluation arrangements that will guide and inform its operationalization.

CHAPTER I: COUNTRY CONTEXT AND SITUATION ANALYSIS

1.1. Country Context

Small and landlocked, Rwanda is a dynamic country with a densely packed population of about 12.2 million people. In the last two decades since the genocide against the Tutsi in 1994, the country has made remarkable progress in reducing poverty and improving living standards. The Government of Rwanda (GoR) has put in place implementation mechanisms to rapidly achieve its long-term development goals, including through the implementation of the five-year Economic Development and Poverty Reduction Strategies—EDPRS (2008-12) and EDPRS-2 (2013-18). At the same time, nested sector-specific strategies and district development plans reflecting Rwanda’s well-advanced decentralization drive helped guide EDPRS implementation. The National Strategy for Transformation (NST) succeeded EDPRS-2 covering the period of 2018–2024, and focuses on economic, social, and governance transformation toward the aspiration of Vision 2050 – which sets an ambitious agenda for further improvements in the standard of living.

Strong and sustained economic growth has been accompanied by substantial improvements in human development, evidenced by a two-thirds drop in child mortality and the attainment of near-universal primary school enrolment. Rwanda also met most of the Millennium Development Goals (MDGs) by the end of 2015 – including on infant, child and maternal mortality. A strong focus on homegrown policies and initiatives contributed to improvements in access to services and in human development indicators. With the country’s economy growing at more than eight percent per year, the share of the population below the national poverty line dropped from 44% in 2011 to 38.2% in 2017 and inequality measured by the Gini coefficient reduced from 0.49 in 2011 to 0.43 in 2017.¹ Furthermore, life expectancy at birth was 65.7 years in 2017, which is above both the sub-Saharan average of 60.7 and the low-HD group countries of 60.8.

The Government of Rwanda’s investments in human capital development have been at the forefront of critical health reforms, such as its flagship community-based health insurance schemes, an innovative performance-based financing (PBF) program in the health sector, and a distinguished community health worker (CHW) program, which all serve as models for other countries. In recent years, early childhood development (ECD) has emerged as a national priority and the government has strengthened the policy and institutional framework for investing in the under-6 years old children including establishing the National Early Childhood Development Program (NECDP) in 2018. NECDP is now responsible for coordinating all interventions (government and donor) that support adequate development and growth for children from conception to six years of age, coordinating work with relevant ministries at central level and the implementation of activities at district, sector, cell and village levels.²

In recognition of the fact that effective ECD programming requires the integration and harmonization of policies and programs across sectors, the GoR developed and approved a national ECD policy in 2016, an ECD Single Action Plan (ECD SAP), and an annual action plan for the six-year National ECD Program Strategic Plan (NECDP SP 2018-2024); the latter which calls for the development of an integrated approach that addresses cross-cutting issues of childcare, education, growth and development, safety, health and nutrition, and food security. This high-level commitment to ECD will not only give young children the best possible start in life but is also one of the best

¹ National Institute of Statistics of Rwanda. 2017. [Integrated Household Living Conditions Survey 5 \(EICV 5\)](#).

² At national level, the key Ministries directly involved with NECDP in implementation of the program are: MINALOC, MINISANTE, MIGEPROF, MINAGRI, MINEDUC, MININFRA, MINICOM, MIDIMAR, MINECOFIN and as well as the Ministries’ affiliated agencies namely LODA, NWC, RAB, REB, and RBC.

investments Rwanda can make to achieve its national development goals including to eliminate extreme poverty, boost shared prosperity, and build the human capital needed for sustained economic growth.

In Rwanda, increasing access to and utilization of ECD services is now a national priority, as demonstrated by a substantial increase in number of public pre-primary schools from two in 2011 to 2,087 in 2018; and net enrolment increased from 6.1% (2010) to 20.8% (2018). The gross enrollment reported was 24.4% for 2018. Among the 96 pre-nursery centers reported, 73 (76.0%) were privately owned and 23 (24.0%) were public; while 14.3% of preschools are government-owned and the remaining 51.4% were religious owned and 26.1% were owned by parents and 8.3% owned by NGOs. At present, the total number of preschools is 3,210 for children age 3-6 years old and 96 for children under three years. The increase was mainly due to private sector investment in ECD, especially religious that focus on the 3-6 year age group.³

Despite global and national importance of ECD, the accessibility of services in Rwanda is still low. The reported preschool net enrollment for 3-6 years is 20.8% in 2018 (MINEDUC, 2018, and the 2016 NECDP mapping report shows that only 1% of children under three years received any form of ECD services. The DHS (2015) reported that the percentage of enrolled children varied from 9% for those aged 36-47 months to 19% for those aged 48-59 months. The MINEDUC (2018) statistics report on distribution of children enrolled showed a big proportion for 4-6 year-old children and a small proportion for 3 year-old children as well as above 6 years, the representation for the under threes is minute. This implies that the accessibility to ECD services for 3-year old children is limited and fewer children under three years of age are registered in ECD centers. This is related to physical environment factors whereby very young children find it difficult to reach the centers due to distance and parents decide to enroll them when they at least 4 years old. The GoR recognizes the substantial need to catch children while they are young (before age 3) and through the national ECD programs and other platforms are increasing investments in the under six years old children.

There are also inequalities between enrollment in the rural and urban areas. The DHS (2015) reported that a higher proportion of children living in urban areas (37%) attended an ECD program than children living in rural areas (9%). These figures make it clear that access to ECD services is still a challenge in Rwanda. Poverty in families is another hindrance to accessibility to ECD services whereby parents hold their children at home because they cannot afford to pay the caregiver's salary. The situation becomes worse when it comes to children with disability and special needs whereby parents do not enroll them at all, and ECD Facilities are not ready to receive children with disabilities both due to infrastructure and curriculum issues. The 2018 mapping study that 2,038 children aged under six years with disabilities (0.8% of the total population of 256,677 children with disabilities) were reached by ECD program⁴. This number kept decreasing where the MINEDUC (2018) Education Statistics reported 1,253 (0.48%) children enrolled in ECD facilities.

As far as the content of ECD services is concerned, the small percentage of children 0-6 years enrolled in ECD programs in Rwanda do not necessarily receive the full package of ECD interventions. For example, only 9% of all ECD facilities offer integrated ECD services (health, nutrition, education, sanitation, child protection, parenting, disability services), the rest offer less components which vary from one center to another, including 4.9% of centers offering only one component. When tracking children's development, the DHS (2015) reported that 60% of children aged 36-59 months were developmentally on track in four domains such as literacy, socio-emotional, physical and learning.

³ Ministry of Education (2018). 2018 Education Statistics. Kigali

⁴ NECDP (2018) ECD Mapping Report

The quality of ECD in Rwanda is also an ongoing challenge. The Ministry of Education developed pre-primary competence-based curriculum in 2015, which helped ECD service providers to improve education as one of the ECD components. In 2016, the Ministry of Gender and Family Promotion elaborated the ECD minimum standards to help ECD service providers improve the quality of their services; and community-based ECD facilities were also established in targeted communities, providing play-based learning and care for children aged 3-6 years. The package of services provided in these centers include school readiness: early literacy and numeracy skills, socialization and socio-emotional development, physical/motor development, communication and language skills, hygiene habits and cultural values. A growing trend in the country has also been home-based ECD services were organized to provide proper care for young children, with more than 300 parents (mostly mothers) selected by the community to provide care for neighboring children. These home-based ECDs were equipped with play materials and children's books, but still reach very few children with essential services. As such, not only is there a need to extend all ECD services to children under three years, but also to ensure that all children are receiving a full package of comprehensive, integrated and quality care services that allow for their full survival, growth and development.

1.2. Rationale for Investing in Early Childhood Development

Early childhood is a period of rapid development in a human life (see Figure 1). The period from pregnancy to six years of age is critical for a child's cognitive, social, emotional and physical development. ECD is defined as an orderly, predictable and continuous development process in which a child learns to handle more complicated levels of moving, thinking, speaking, feeling and relating to others. Physical growth, literacy and numeracy skills, socio-emotional development and readiness to learn are vital domains of a child's overall development. The Rwanda's approach to ECD is an integrated framework that links five pillars namely education; health; nutrition; WASH; and child/social protection⁵. Such a framework will be operationalized through multisectoral single action plan that integrates all the seven services.

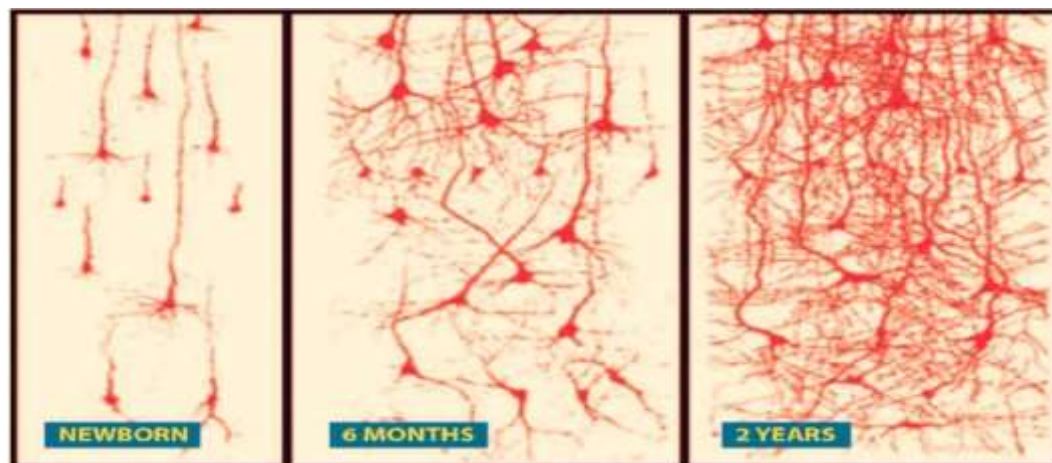
ECD typically refers to early childhood with a strong focus on the first 2–3 years of life and describes the gradual unfolding of children's sensory-motor, cognitive-language, and social-emotional capacities shaped by interactions between the environment, experience, and genetics.⁶ Early childhood experiences have a profound impact on brain and human development—affecting learning, health, behavior and ultimately, income. Early experiences shape the brain's architecture and set the stage for a child's lifelong success. By the time a child is 3 years old, the brain develops as much as 80%, and 90% of the brain development occurs by age 5.⁷ During this time, adult-child interactions literally “wire” a baby's brain and determine that child's ultimate cognitive, social and emotional capacities.

⁵ MIGEPROF (2016). Early Childhood Development Policy. Kigali

⁶ Yousafzai AK, Bhutta ZA. Integrating early child development interventions in child health services: opportunities and challenges in developing countries In: Kamat D, editor. , editor. American Academy of Pediatrics textbook of global child health. 1st edition Washington (DC): American Academy of Pediatrics; 2012.

⁷ Harvard's Center on the Developing Child. 2017.

Figure 1. Neural Connection Formation, Birth through Age Two (Harvard, 2017)



Getting it right the first time is important. It is also more cost-effective. Investment in early education must be aligned with what we know from neuroscience. Early childhood is the critical period for investment in lifelong success.

Multiple factors influence early child development, including health, nutrition, security and safety, responsive caregiving, and early learning. Nutrition and early childhood development are inextricably linked, and nutrition a major factor that impact a child's development. The 2016 Lancet series "Advancing Early Childhood Development: from Science to Scale" makes the case for why nutrition and health of mothers and babies is critical, including for preventing poor birth outcomes and life-long developmental delays or disabilities. Early childhood development programs and interventions such as breastfeeding, play and stimulation, support health and nutrition, protect children against stress, increase learning at home, and lay the foundation for learning in school. Action in other sectors is also needed for children to reach their full developmental potential, including in child protection, WASH, food security, and social protection, among other; and collaboration across all sectors is vital to the long-term sustainability and success of high-quality early childhood development services. Previously, children enrolled in ECD Facilities were provided with only education component with no emphasis laid on integration of all the services for holistic development.

Early childhood development is economic development. Programs implemented for children under six years have significant benefits for health and wellbeing, schooling and earnings, personal relationships and social life. Longitudinal studies show investment in early childhood generates multiple benefits - better learning outcomes, decreased crime and incarceration rates, reduced healthcare and social welfare expenditures, increased productivity and tax revenue, and even enhanced citizen security. For example, the annual earnings of adults who received early intervention in Jamaica and Guatemala were between 25% and 44% higher than control group children who did not receive the intervention.⁸ Economists also estimate a 7–16% return on investment (ROI) in early education for children from low-income households; and investing in early childhood leads to increased earnings for individuals and reduced public costs such as crime costs, special education, and welfare savings.⁹

⁸ Hoddinott, J., Maluccio, J.A., Behrman, J.R., Flores, R., & Martorell, R. (2008). Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults. *Lancet*, 371, 411-416; Gertler, P., Heckman, J., Pinto, R., Zanolini, A., Vermeersch, C., Walker, S., et al. (2014). Labor market returns to an early childhood stimulation intervention in Jamaica. *Science*, 344, 998-1001.

⁹ www.heckmanequation.org

For the first time in the history of global development, ECD has been included as part of Agenda 2030 which recognizes young children’s development as critical to advancing the Sustainable Development Goals (SDGs); and the SDGs on hunger, health, education and justice include targets on malnutrition, child mortality, early learning and violence. Specifically, SDGs global target 4.2 is dedicated to improving the quality of ECD, care and pre-primary education.

1.3. Situational Assessment of Integrated ECD in Rwanda

1.3.1. Maternal Infant and Young Child Health and Nutrition

Over the past fifteen years, Rwanda has made dramatic progress in improving infant and child survival and women’s health (see Table 1). With the rapid scale-up of basic health services and improvements in socioeconomic conditions both under five and infant mortality rates declined sharply during 2000-2015 (i.e. from 196 to 50 deaths per 1,000 live births, and from 107 to 32 deaths per 1,000 live births, respectively). The maternal mortality ratio also dropped steeply from 1,071 (2000) to 210 (2014) deaths per 100,000 live births. The expansion in family planning services, combined with delayed childbearing, has resulted in a steep drop in fertility during the past ten years (i.e., from a total fertility rate of about 6.0 to slightly above 4.0). Malaria control has also been strong, but there has been a recent spike in the number of cases (i.e., 1 million additional cases). Neonatal illness, malaria and acute respiratory infections are among the ten leading causes of morbidity in children under-five years old.¹⁰ Child mortality is associated with undernutrition has reduced Rwanda’s workforce by 9%, and the costs associated with child undernutrition are equivalent to 11.5% of gross domestic product lost every year.¹¹

The nutrition situation among young children remains an outlier with Rwanda needing to redouble its efforts. The prevalence of wasting among children under five years has declined over the last decades, from 5% in 2005 to 2% in 2014–2015.¹² Nevertheless, being a strong predictor of mortality, this health issue requires close attention. The prevalence of cases with bilateral pitting edema is unknown, however cases are found at community and treatment ward level. In addition, even though the inpatient and outpatient management of severe acute malnutrition (including the community-based management) has contributed to the significant decline in mortality in children under five years, disparities in access between the lowest and the highest wealth quantiles persist, as well as bottlenecks in the supply of services.

Table 1. Baseline and targets for Reproductive Maternal Newborn Child and Adolescent Health¹³

OUTCOME/OUTPUT INDICATORS HSSP 4	BASELINE 2016 (%)	TARGETS 2020 (%)	TARGETS 2024 (%)
Outcome indicators			
Prevalence of Stunting in children 0 to 59 months	38	29.9	19
ANC coverage (4 standards visits)	44	47	51
% newborns with at least one PNC visit within the first two days of birth	19	25	35

¹⁰ Ministry of Health. 2016. Annual Statistics Handbook 2016 report.

¹¹ African Union Commission, NEPAD Planning and Coordinating Agency, UN Economic Commission for Africa, and UN World Food Programme. 2013. *The Cost of Hunger in Rwanda: Social and Economic Impact of Child Undernutrition in Rwanda*. Addis Ababa, UNECA.

¹² National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF International. 2015. 2014-15 Rwanda Demographic and Health Survey. Rockville, Maryland, USA: NISR, MOH, and ICF International.

¹³ Health Sector Strategic Plan 4

OUTCOME/OUTPUT INDICATORS HSSP 4	BASELINE 2016 (%)	TARGETS 2020 (%)	TARGETS 2024 (%)
Modern contraceptive prevalence rate (mCPR)	48	54.6	60
% Children 12-23 months fully immunized	93	>93	>93
% Exclusive Breastfeeding < 6 months	87	>90	>90
Anemia in women of reproductive age	22		
Low BMI (<18.5) in women of reproductive age	7		
High BMI (>25) in women of reproductive age	19		
Teenage pregnancy rate (15-19 years)	7.3	<7	<7

Source: HSSP-IV, DHS 2015

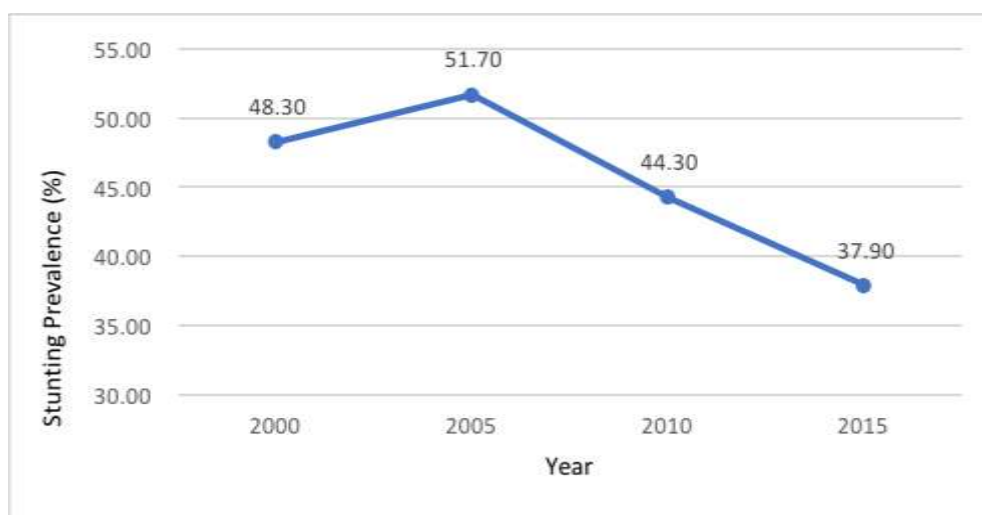
The DHS (2015) estimated that 8% of children under five years and 21% of women were overweight or obese compared to 2010, when these levels were 7% and 16%, respectively. The proportion of children who are overweight rises with the increase in mothers' body mass index. Large differences among overweight and obese women were observed between rural (17%) and urban (37%) areas. Overweight increases the risk of complications during pregnancy, such as gestational diabetes, as well as non-communicable diseases, including cardiovascular diseases and threatens child survival.

The first 1,000 days, from a woman's pregnancy to a child's second birthday, is a critical window of growth and development. Stunting (chronic malnutrition) during this period is largely irreversible. Beyond height deficits, stunting is associated with diminished cognitive and physical development, reduced productive capacity, and an increased risk of chronic diseases later in life. This leaves children unable to reach their full genetic potential to grow and thrive, and keeps families, communities and countries locked in a cycle of hunger and poverty. In Africa, child undernutrition is associated with up to 0.2 to 3.6 years less of schooling, and as much as 22% loss of yearly income in adulthood.¹⁴ Nutrition is critical to building human capital, and the high costs associated with poor nutrition early in life pose an important threat to reducing poverty and achieving economic stability of individuals, communities and countries.

Despite recent declines in childhood stunting in Rwanda, it remains a pervasive and invisible public health issue and one of the country's most fundamental challenges for improved human development. Although there have been substantial declines in stunting between 2010 and 2015, the national stunting rate has remained stubbornly high with 38% of children under five years stunted (Figure 2); the prevalence of stunting in children under five years is above the WHO threshold of a severe situation (30%) in 25 out of 30 districts and there are significant socioeconomic and geographic disparities in the distribution of stunting outcomes. Stunting rates are highest among the poorest households and those in living in rural areas (nearly 50%). Even among children from the top wealth quintiles, roughly 25% of suffer from stunting, suggesting that poverty rates are not the only predictor of stunting.

¹⁴ Grantham-McGregor, S; Cheung, YB; Cueto, S; Glewwe, P; Richter, L; Strupp, B. 2007. Developmental potential in the first 5 years for children in developing countries. *Lancet* 369 (9555): 60-70

Figure 2. Rwanda: Historical (2000-2015) Trends in Childhood Stunting



Source:

Using UNICEF's conceptual framework of child undernutrition¹⁵, the key determinants of stunting in Rwanda include poor dietary intake and food adequacy, frequent and repeated episodes of illness and disease, poor maternal and child care practices, and unhealthy environments. Achieving sustainable reductions in stunting, therefore, is dependent on multiple factors and requires action from a range of sectors. Beyond multiple sectors, it is also recognized that multiple stakeholders must also contribute, including development partners, the civil society and the private sector, preferably in a coordinated fashion for maximum effect. Countries globally have promoted coordination of key prioritized nutrition-specific and nutrition-sensitive interventions to simultaneously address multiple factors behind child stunting.

Maternal health and nutrition, including infant and young child feeding practices (IYCF), are areas that require significant investment and attention in Rwanda as they are critical to the reduction of all forms of malnutrition including stunting WHO and UNICEF recommend the following IYCF practices: early initiation of breastfeeding within one hour of birth; exclusive breastfeeding for the first 6 months of life; and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to two years of age or beyond. While the proportion of infants under six months who are exclusively breastfed has remained consistently above 80%, data available on other IYCF practices in Rwanda show that only 18% of children aged 6-23 months are currently fed in accordance to all 3 recommended practices.¹⁶

Furthermore, the Minimal Acceptable Diet (MAD), a composite of both Minimum Meal Frequency and Minimal Dietary Diversity, shows that overall there has been little improvement in food intake during the 2010-2015 period with only 18% considered to have a minimum acceptable diet; less than 50% benefiting from minimum meal frequency; and 29% receiving the minimum dietary diversity. Adherence to appropriate feeding practices are linked to indicators of geography—children in urban households are more likely to be fed in accordance with the recommended IYCF practices—and household income and education level are factors associated with practicing the IYCF recommendations. The pattern of decreased food adequacy after the first six months, with inadequate feeding

¹⁵ UNICEF. 1991. Conceptual Framework on the Causes of Malnutrition.

¹⁶ National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF International. 2015. 2014-15 Rwanda Demographic and Health Survey. Rockville, Maryland, USA: NISR, MOH, and ICF International.

practices increases the risk of micronutrient deficiencies and exposure to infections and coincides with higher prevalence of stunting among infants 6- 24 months old.

Micronutrient deficiencies among children and women have significant negative effects on child survival, growth and development, as well as on women's health and well-being. New evidence shows that a woman with severe anemia is twice as likely to die during or shortly after pregnancy compared to women with anemia.¹⁷ Anemia among women and children under five years is a moderate to severe public health problem. Anemia affects 37% of Rwandan children under five years and 19% of women of reproductive age (15-49 years). Dietary intake remains a major concern, but other underlying causes of persistently poor nutrition status include low access to safe water, sanitation and hygiene and health services, and inadequate care practices.

Identified gaps

- 38% of children under five years are stunted.
- 2% of children under five years are wasted.
- Significant socioeconomic and geographic disparities in the distribution of stunting outcomes - stunting rates are highest among the poorest households and those in living in rural areas (nearly 50%).
- Even among children from the top wealth quintiles, roughly 25% of suffer from stunting, suggesting that poverty rates are not the only predictor of stunting.
- Neonatal health outcomes are still lagging behind .
- 8% of children below age 5 are overweight or obese.
- Only 18% of children aged 6-23 months are currently fed in accordance to all 3 recommended IYCF practices.
- 37% of children 6 to 59 months and 19% of women of reproductive age are anemic.
- 7% of women of reproductive age are thin, 17% overweight and 4% obese.
- Lack of data on micronutrient deficiencies.

1.3.2. School readiness

UNICEF (2012) defines school readiness as having the basic minimum skills and knowledge in a variety of domains that will enable the child to be successful in school. It also includes three dimensions of readiness: readiness of the child, focusing on learning and development; readiness of schools, focusing on the school environment along with practices that foster and support a smooth transition for children into primary school and advance and promote the learning of all children; and readiness of families, focusing on parental and caregiver attitudes and involvement in their children's early learning and development and transition to school.¹⁸ In addition to learning, school readiness includes the skills and capabilities of a child in key developmental domains such as health, physical development, social emotional development and approaches to learning. In line with Agenda 2030, the first objective Rwanda's ECD policy is a child's preparedness to cope with the primary school environment. To date, progress has been made and the most recent DHS (2015) reported that 63% of children aged 3-5 years were developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains¹⁹. Formal Preschool net enrollment also increased to 20.8% in different ECD facilities for school readiness preparation (MINEDUC, 2018).

The current statistics show an increase in number of preschool centers from 1,369 (2014) to 3,210 (2018). These centers provide comprehensive ECD services including care for young children, home visiting, parenting and growth

¹⁷ The Lancet Global Health. 2018. Risk of maternal mortality in women with severe anemia during pregnancy and post partum: a multilevel analysis.

¹⁸ UNICEF. 2012. School Readiness: a conceptual framework. UNICEF: New York.

¹⁹ National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF International. 2015. 2014-15 Rwanda Demographic and Health Survey. Rockville, Maryland, USA: NISR, MOH, and ICF International.

monitoring. In addition, home-based ECD centers (205, equal to 5% of 3,306 total ECD facilities) also prepare children for schooling. The pre-primary curriculum and accompanying documents were developed and distributed in preschools. Caregivers and teachers were trained specifically in competency based pre-primary curriculum. In collaboration with different development partners, caregivers were trained in ECD with focus on nutrition, health, hygiene and sanitation, and child protection through in-service program.

Despite some success, further improvements are needed as only 20.8% of children are prepared for primary school which is significant when compared to the percentage of children who enroll in primary one; and almost 80% of children do not have a preschool background, which serves as head start for successful life. This is reflected in the high repetition rate in Primary one (20.5%) reported in 2018 Education Statistics by the Ministry of Education.

Identified gaps

- Only 20.8% of children have attended pre school program
- Almost 80% of children do not attend preschool.
- Primary repetition rate is high in P1 (20.5%).
- Number of qualified teachers remains low.
- Availability (price, location, number) of ECD community or home-based centers.
- No formal incentives system for ECD facilities' caregivers

1.3.3. Parenting and Early Stimulation

Parenting and early stimulation are crucial for a child's healthy growth and development. This includes opportunities for stimulation, responsive parent-child interactions, child-directed/focused enrichment, early learning, and positive parenting.

The great part of care is given to the children by parents through nurturing care before the age of three. WHO (2018)²⁰ states that nurturing care starts before birth, when mothers and other caregivers start talking and singing to the fetus. By age two, massive numbers of neuronal connections have been made in response to interactions with the environment and especially interactions with caregivers. This is the critical period in the child's development where the baby needs maximum care. Research has shown that nurturing care comprises all essential elements for a child to grow physically, mentally, and psycho-socially. It has five components namely good health, adequate nutrition, responsive care giving, security and safety, and opportunities for early learning. These components are responsible for children's optimal development for life-long health, productivity and social cohesion (ISSOP, 2018).

As for who is responsible for nurturing care, Britto (2016)²¹ stipulates that "The single most powerful context for *Nurturing Care* is the immediate home and care settings of young children often provided by mothers, but also by fathers and other family members, as well as by child care services". In Rwanda, only 3% of children were reported to be engaged in four or more learning activities with their biological fathers and 12% with their mothers (MIGEPROF, 2018).

The good optimal development of a child is supported by a parenting style that Landry (2014) called responsive parenting. The DHS (2015) reported 49% of children who are engaged with adult household in four or more activities that promote learning and school readiness. As for early stimulation activities, a report by UNICEF (2018) highlighted that 9% of caregivers engaged in activities to promote learning, while 22% of caregivers did so in ECD sites. In the

²⁰ World Health Organisation (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential.

²¹ Britto, P. (2016). Nurturing Care: Science and Effective Interventions to Promote Early Childhood Development. Unicef: USA

same vein, other initiatives include the USAID-funded *Mureke Dusome* project which provides home literacy supported to child.

Communication materials were developed to promote key messages for ECD topics- including nutrition, hygiene, social and child protection; the role of fathers in parenting; and the role of religious leaders in supporting early childhood development. Among these initiatives, the radio program 'Itetero' (Nurturing space for children) was launched in 2016 and its aim is to reach young children and their families with critical ECD messages. The development of parenting curriculum is also in progress and it will address parenting related challenges. As for creating home literacy, 53% of households in the ECD sites had two or more playthings available while they were 46% in control households. Finally, as poverty has been a key factor in preventing children from realising their optimal development, a social protection program Vision 2020 Umurenge Programme (VUP) provides several services to households in the lowest Ubudehe categories. The two core safety net components of the VUP are direct support (DS) that provides unconditional cash transfers to eligible households with no labor capacity and classic public works (cPW) that offers short-term work opportunities on labor-intensive projects to households with labor capacity. A 2014 impact evaluation found that while VUP has had positive impacts in participating households, stronger impacts could be expected if payments were more predictable, eligibility criteria expanded and different job types or offered, among other things.

Identified gaps

- The number of parents who play with children is still low (51%)
- 1% of children under five years have three or more children's books
- DHS found only 7% of children age 3-5 were developmentally on track in the literacy-numeracy domain.
- Children's scores on the ECD Index are highly correlated to socioeconomic status and parents' education levels.
- Only 1% have access to at least 3 books at home.
- Parents' participation in children's learning activities is very low especially fathers
- Few households are equipped with playthings for effective stimulation and nurturing care
- Parenting curriculum not yet disseminated
- Baby sitters/house helps are not trained
- VUP is not enough to support families living in poverty

1.3.4. Child Protection and Inclusion

Birth registration and subsequent issuance of a birth certificate soon after birth is a first step towards protecting children from birth; establishing their legal identity; proof of date and place of birth; and ensuring that the GoR plans for their development appropriately and monitor their welfare during the critical years of their lives. According to the DHS (2015), 56% of children aged below five years in Rwanda were registered with the civil registration agency and only 5% of those registered had birth certificates. Registration was lowest in the South province and among children from the poorest households. The current civil registration system is not linked to other related systems, including the CRVS Web-based application and the HMIS, which capture largely the same information for births.

Child protection is an important dimension of adequate care for children. In Rwanda, while not pervasive, violence against children in the form of physical punishment and neglect remains. Violent disciplinary measures including physical punishment and psychological aggression are forms of child abuse which are barriers to healthy child development. About half of all girls and six out of ten boys experience violence during their childhoods in Rwanda, and children are usually abused by those they know – parents, neighbors, teachers, boyfriends and friends.²² A 2018

²² Rwanda Ministry of Health (MOH). 2017. Violence Against Children and Youth: findings from National Survey, 2015-16. Kigali, Rwanda.

UNICEF report found that the exposure of children to inadequate care in Rwanda was 57%. The reported types of inadequate care include being left with another child below 10 years, which represents 35% of children involved in the study (MIGEPROF, 2018); and 22% of children are left home alone (DHS, 2015). The report also found that 81% of children age 48-59 months were physical punished; and in the KAP survey by MIGEPROF (2018), nearly half of the respondents believed that children need to be physically punished to grow up well.

Among the ECD services in Rwanda, child protection from any form of abuse has received increased attention by several institutions. A national capacity development program was established, a training curriculum elaborated, and child protection volunteers identified and trained to provide services at the community or family level, known as *Inshuti Z'Umuryango* (IZU, Friends of the family). These provide psychosocial support and referrals to relevant services, as needed (UNICEF, 2018)²³ Services which respond to violence cases for children and women are available in all 30 districts through One Stop Centers²⁴. Interventions in child protection also include legislations that were established in favor of the child.

As for inclusion, inclusive ECD should not be limited at making infrastructure inclusive but should also consider the availability of high-quality early childhood activities, curricula, and services. One of the ECD policy's objectives is to enhance equal access by children with disability and special needs to ECD services. Some interventions were done to support young children with disabilities and those who are at risk of developmental delay due to stunting. According to Rwanda's 2012 Census, there were 15,831 children aged 3–6 years with disabilities²⁵. The interventions were done in sensitizing and encouraging parents to enroll these children in ECD centers. In 2018, the number of children with disabilities enrolled in ECD facilities was 1,253²⁶, down from 1,362 reported in 2017 which is also down from 1,545 children reported in 2016. Trainings are given to caregivers on how to handle children with disability and special needs by different development partners.

Identified gaps

- Child abuse is still registered in some areas. There is still a number of child labor cases, corporal punishment, home-based violence, early pregnancies and child-headed families.
- Only 1,362 children with disabilities are registered in ECD services. Many children with disabilities stay at home and do not register to any ECD setting.
- There is a considerable decrease in the number of children with disability enrolled in ECD facilities from 1,545 in 2016 to 1,362 in 2017 and to 1,253 in 2018.
- Thirty-five percent of children below age 5 were left alone or left in the care of other children under 10 years.
- Only 49% of children who are engaged with adult household in four or more activities that promote learning and school readiness
- The current total number of children under five years with disabilities is not yet known.
- Lack of vision, hearing and developmental screenings.
- Lack of suitable materials, such as books with large print or braille.
- Low birth registration and certification and parallel registration systems
- Critical need of harmonizing the package of services provided by ECD facilities

²³ Unicef (2018). Transforming the lives of children in Rwanda: Investing in family and community-centered services. Endline evaluation summary report on the ECD and Family Programme, 2015-2017

²⁴ UNICEF-Rwanda (2017). Country Profile.

²⁵ MIGEPROF (2018). National Social and Behaviour Communication Strategy for Integrated Early Childhood Development, Nutrition and WASH (2018-2024).

²⁶ MINEDUC (2018). 2018 Education Statistics.

1.3.5. Food Security

Food security exists when all people at all times have physical and economic access to sufficient, safe and nutritious food that meet their dietary needs and food preferences for an active and healthy life. The four pillars of food security include: Availability, Accessibility, Utilization and Stability. In Rwanda, food security remains a concern despite substantial growth in agricultural production over the past 10 years, especially when looking at the vulnerability to shocks at the household level. Food insecure households are dependent on low-income agriculture, reinforcing the centrality of agricultural productivity for household food security. These households have less livestock, less agricultural land, grow fewer crops, are less likely to have a vegetable garden, have lower food stocks and consume more of their own production at home.

The most recent Comprehensive Food Security and Vulnerability Assessment (CFSVA) 2018 shows that 18.7% of households in Rwanda are food insecure and 1.7% severely food insecure. The Western Province was identified as the most food insecure area with 29.9% of all households are food insecure followed by the Southern Province (20.5%), Northern Province (17.8%) and Eastern Province (16.2%).²⁷ Moreover, around 85% of households in Rwanda cultivate land and rely on agriculture or livestock as the main livelihood activity, and low income agriculturalists have a lower-than-average food consumption compared to households that are relying on livelihoods such as employment and business.

The GoR's 4th Strategic Plan for Transformation of Agriculture (PSTA 4) adopts a food systems approach for enhanced nutrition and household food security that stipulates interventions which ensures that nutrient quality of commodities is preserved or enhanced throughout the entire value chain. In addition, resilience and risk mitigation strategies will continue to be developed particularly at the household level.

Access to food is determined mainly by seasonal patterns, commodity prices and people's purchasing power, as well as by socio-economic norms and structural inequalities. Another critical dimension of food insecurity in Rwanda is the low consumption of animal-sourced foods including, but not limited to, dairy (and related processing), meat and milk from small livestock, poultry (meat and eggs), fisheries and aquaculture. The stability of food throughout the year and at all times also remains an important constraint in Rwanda. Shocks and disaster-induced food insecurity disproportionately impact poor households in Rwanda, rendering relevant the need for a shock-responsive/sensitive social protection system that strengthens risk mitigation and rapid response capacities in the most vulnerable households.

Identified gaps

- 18.7% of households in Rwanda are food insecure and 1.7% severely food insecure.
- 85% of households in Rwanda cultivate land and rely on agriculture or livestock as the main livelihood activity, and low-income agriculturalists have a lower-than-average food consumption.
- Low consumption of animal-sourced foods.
- Stability of food throughout the year and at all times.
- Shocks and disaster-induced food insecurity disproportionately impact poor households in Rwanda.

1.3.6. Water, Sanitation and Hygiene

Access to clean water and sanitation, good hygiene practices, clean air and a safe environment are all essential to protect children's health and support their development. Creating sustainable, healthy environments and reducing

²⁷ Rwanda: Comprehensive Food Security Analysis 2018.

children's exposure to modifiable environmental hazards is a critical part of the nurturing care. The lack of access to safe drinking water, sanitation and hygiene (WASH) and poor practice around leads to repeated bouts of diarrhea, intestinal worms, chronic gut infections, malaria and other preventable diseases which hinder child development.

In recent years, there have also been important improvements in environmental health in Rwanda, but important gaps and geographic variations persist. Since 2005, access to improved water and sanitation facilities has more than doubled. Nevertheless, infants and children from vulnerable and poor households in rural areas have significant deficits in environmental health that places them at a greater risk of stunting. According to the Integrated Household Living Conditions Survey (EICV 5), while 85% of the population accessed an "improved" drinking water source, only 57% of the population collected water within 30 minutes²⁸ roundtrip. Traveling long distances can reduce the amount of water collected and therefore used by the household, often negatively impacting hygiene. For sanitation, 71% of households in rural areas and 45% in urban areas have access to an improved sanitation facility which is not shared. Hand washing with soap, which is a critical lifesaving hygiene practice is still practiced at a very low rate: only 12% of households in Rwanda have a place where to wash hands²⁹

Inadequate and poor WASH contributes to diarrheal diseases, which constitute one of the main causes of death among young children in developing countries and a leading cause of malnutrition. In Rwanda, the prevalence of diarrhea is especially high among children aged 12–23 months and 6-11 months (22% and 18%, respectively). Diarrhea prevalence varies by province, from a low of 8% in City of Kigali to a high of 15% in Western Province.³⁰ To combat the effects of dehydration associated with diarrhea, WHO recommends the use of oral rehydration therapy (ORT), but less than half (44%) of children with diarrhea in Rwanda seek the advice or treatment from a health facility or provider; as well as an appropriate diet aiming at reducing the risk of malnutrition.

Identified gaps

- 34% of the Rwandan population still rely on no latrine, unimproved or shared improved sanitation facilities.
- Less than 15% of households have a designated place to wash hands after visiting the toilet or before handling food, those with soap and water at the designated place are even less.
- Young children from 6-24 months are the most affected by the poor WASH conditions.
- Only 57% of households access an improved water source within 500m or 200m in rural and urban areas respectively, and an additional 30% of households travel long distances to an improved water source.
- Need to harmonize data on connectivity and effective water supply
- 60% of the rural households do not treat water prior to drinking.
- Some primary caregivers lack knowledge and skills to nurture good hygiene and sanitation practices to young children at home, in ECD services and at schools.
- Over 87% of households do not have a handwashing station

1.3.7. Social Protection

Over the decades and worldwide, social protection has provided support to vulnerable and disadvantaged population groups. In effect, social protection has cushioned and, in many instances, prevented vulnerable people from falling into states of abject poverty and malnutrition, while at the same time improving nutrition, productivity and food self-sufficiency. Despite various definitions, 'income security' and the principle of a 'minimum standard of living' remain

²⁸ To calculate an improved water source "within 30 minutes roundtrip" (SDG definition of 'basic water services'), the proxy of 'within 500 m' in rural areas and 'within /200 m' in urban areas is used because it is in line with the National Water Policy (2016).
²⁹ (RDHS 2014-2015).

³⁰ Rwanda Ministry of Health (MOH). 2017. Violence Against Children and Youth: findings from National Survey, 2015-16. Kigali, Rwanda.

central to all definitions and conceptualizations of social protection. In Rwanda, a social protection 2009 policy was first defined in the 2009 policy and then revised and further elaborated in the Social Protection Strategy (2018-2024), as well as included in the updated National Social Protection Policy (2017).

Social protection can help address the multiple dimensions of malnutrition. If well-targeted, it can provide an effective means of reaching marginalized, resource-poor and nutritionally vulnerable populations. By reducing poverty and improving food security, social protection can address the root causes of malnutrition. By stimulating economic activity, enhancing social inclusion and increasing access to sanitation, health and education it further promotes better nutritional outcomes. Social protection will be most effective when embedded in such a multi-sector approach.

In November 2014, FAO and WHO Member States adopted the Rome Declaration on Nutrition and its Framework for Action, during the Second International Conference on Nutrition (ICN2). The ICN2 Framework for Action strongly emphasizes the importance of social protection. Recommendations 22 and 23 encourage Member States to “Incorporate nutrition objectives into social protection programs and into humanitarian assistance safety net programs” and “Use cash and food transfers, including school feeding programs and other forms of social protection for vulnerable populations to improve diets through better access to food.

The National Early Childhood Development Policy (2016) clearly articulates the role of social protection in supporting Early Childhood Development (ECD) and specifically calls for the government to:

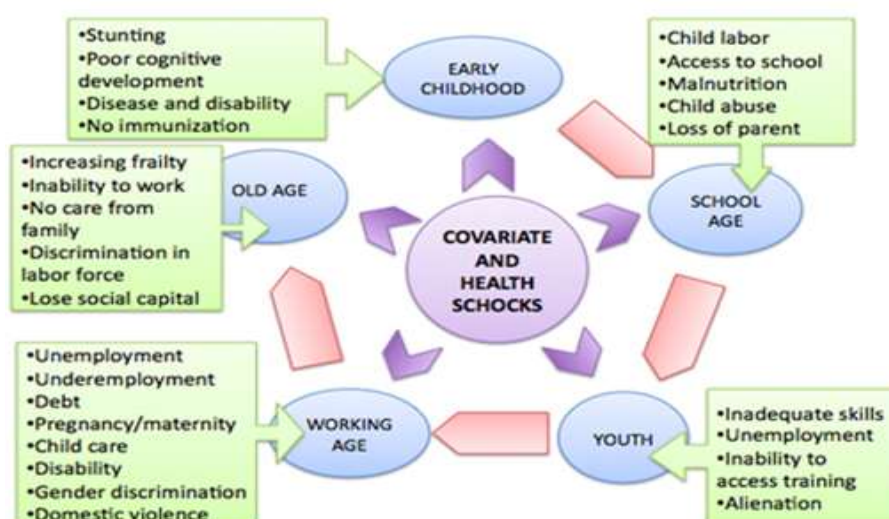
- Ensure ECD interventions are mainstreamed into social protection programs to support poor and vulnerable families and children. This includes ECD related cash incentives to vulnerable families”
- Identify families struggling to maintain their children and provide support for their care. Specific attention will be given to single parents (adoptive or biological)/ guardians. Various social protection measures in cash/kind are to be explored.
- Prioritize children in the design and implementation of programs for poverty reduction, such that child poverty is eliminated within a stipulated period of time.
- Explore provision of direct support to families in difficult circumstances, child headed households, orphans and other vulnerable children.

The National Social Protection Strategy (2018-2024) Pillar 2 on Short-term Social Assistance supports the most vulnerable to cover critical health care costs, while Pillar 3 on Social Care Services addresses protection, psycho-social support, referrals and promotes social inclusion for the most vulnerable. Notable SP programs and services include the Nutrition Sensitive Direct Support (NSDS), a new the conditional cash transfer (CCT) program aimed at increasing the human capital by investing in young children during their first 1,000 days. The NSDS payments are targeted to vulnerable households with pregnant women and children under two years of age selected from Ubudehe 1 category of poor households in Rwanda. The NSDS provides income support through cash transfers to vulnerable families to incentivize the use of health and nutrition services besides strengthening their knowledge on better parenting and child care. To receive these cash transfers, eligible families are expected to adhere to the co-responsibilities of ante-natal and post-natal protocols for pregnant women as well as to attend growth promotion/height measurement for young children in the age group of 0-6 and 7-24 months. This new initiative is consistent with the Government of Rwanda and development partners’ efforts to address poverty and boost human development in the country. Figure 3 below illustrates how the nutrition sensitive social protection can help accelerate progress in improving maternal and child nutrition, through increased income security. Additionally, SP programs support the strengthening of Rwanda’s civil registration and vital statistics (CRVS) system by supporting an action plan derived from the national CRVS strategic plan (2017/18- 2021/22) through development of a clear roadmap for

operationalizing initial elements of the reform especially those which support effective implementation of the NSDS. Social Protection interventions and CRVS provide thus a gate to timely identify those children most in need.

Targeting the right individuals and groups is central to any intervention that aims to address malnutrition. Adequate nutrition in 1,000-day period represents a critical window of opportunity to establish a lasting foundation for health. In socio-economic terms, those individuals and households most affected by malnutrition tend to be those with the lowest incomes, who are most economically and socially marginalized and whose livelihoods are most eroded. It is important to consider both types of vulnerability and the interactions between them. Comprehensive, sustainable life-cycle-based social protection system that delivers a minimum level of income security to all Rwandans at critical points in their lives and protects them against a wide range of socio-economic risks.

Figure 3. Life-cycle vulnerabilities and social protection responses



Social protection thus remains one of the main priorities of the Government of Rwanda for meeting poverty reduction and human capital development goals. To further this agenda, Rwanda has started building an integrated social protection system to ensure a minimum standard of living and access to core public services, boost resilience to shocks, promote equitable growth, and strengthen opportunity through increased human capital development. This is a part of the wider Government of Rwanda efforts to combat chronic malnutrition and invest in the early years. This Social Protection program has introduced a gender and child sensitive expanded public works model to provide more accessible jobs to those ineligible for Direct Support but still with labor constraints, including caring for young children. This specific support benefits vulnerable households primarily in Ubudehe Category 1 which dominate households with stunted children.

Identified gaps

- The design of programs and budget inadequately target deprived children and their families.
- Weak data systems to inform right targeting

- Non-reliable data on multidimensional poverty including child poverty.
- Coverage is still low and package of social protection services are inadequate.
- Some HH with stunted and malnourished children that require social protection support are not targeted.

1.3.8. Cross-cutting Areas (CCA)

The following undermentioned NSP cross cutting areas will be integrated into implementation with an aim to improve efficient and equitable service delivery.

Social and Behavior Change Communication: While biology and physiology are important contributors to an individual's health and well-being, the social determinants that shape human interaction also play an important role at the individual, family, and community levels. Improving health and development outcomes therefore requires changing the behaviors of individuals and communities, as well as the norms that underpin those behaviors. International research emphasizes the importance of Social and Behavior Change Communication (SBCC) in reducing childhood illness and malnutrition such as stunting through the promotion of key messages, interpersonal counseling (IPC) with parents and caretakers, community mobilization and visualization, and electronic/SMS messaging, among other. SBCC can also increase the demand for essential health and nutrition services.³¹ The NSP will focus on implementing a variety of SBCC activities by enhancing existing BCC tools and create new tools as deemed appropriate and by integrating communication tools and approaches across different sectors; as well as build capacity of different ministries and partners to implement and manage SBCC interventions.

Quality of services: Access to and utilization of essential health and nutrition services in Rwanda are impeded by both supply and demand side barriers. On the supply-side, health care workers (HCW) and community health care workers (CHW) often have limited training, incentives and mentorship to be able to adequately identify health risks/developmental delays early on; the supply chain for timely distribution of medicines and commodities is often strained; and information systems need upgrading. On the demand side, socio-cultural beliefs and practices, geographic and financial impediments, and high levels of poverty among impede uptake of health and nutrition services. To maximize the impact of our sectoral interventions, an integrated programming approach focus on improving the quality of service delivery will be used. This will include improving the supply chain to ensures availability and local delivery of essential supplies for children and women, integrated planning, strengthening the capacity of health personnel to deliver quality services at scale, and increasing service coverage through frontline health workers and other community agents. At the same time, support to the establishment of monitoring systems that review quality, timeliness and effective reach and use of goods and services by the most vulnerable will be provided.

Gender and socio-cultural factors: Gender has impact in access to and utilization of RMNCAH services. Gender related barriers to access and utilization of services include social cultural, geographical and financial barriers. For example, inequalities and gender norms that encourage early marriage and childbirth contribute to poor birth outcomes and result in less education and more economic vulnerability for women and children; and women's limited access to employment and control over family resources may impede access to and uptake of maternal health and nutrition services, as well as their ability to make decisions for their children. As such, this strategy will focus on addressing factors that impede the access and utilization of RMNCAH interventions, consider the specific needs and experiences of women and integrate that into the design of targeted interventions, consider the role of women in

³¹ Dewey, K. G., and S. Abu-Afarwuah. 2008. "Systematic Review of the Efficacy and Effectiveness of Complementary Feeding Interventions in Developing Countries."

decision-making, and ensure that women not only have equal capabilities (i.e., education and health) and access to resources and opportunities, but that they also have the agency to deploy those rights and capabilities. Moreover, through a targeted SBCC approach, this strategy will address social cultural barriers such as low male involvement which impact on access to and utilization of RMNCAH services.

Geographical disparities: There remain significant socioeconomic and geographic disparities in stunting prevalence rates with children from the lowest wealth quintiles and those living in rural areas, as well as in other core child health and development indicators (see illustrative map in Figure 4). As part of ensuring equity in service delivery, this strategy will develop innovative interventions for districts that face geographical challenges to accessing RMNCAH services.

Figure 4. Prevalence of stunted children and food insecure HHs

Systems strengthening issues (Governance, M&E, Accountability Mechanisms): Lack of accountability and inadequate monitoring and supervision systems, particularly at decentralized levels, contributes to poor access and utilization of key services that support the childhood development. There therefore exists the need to strengthen governance, M&E and accountability systems at all levels to support the implementation of this strategy. The focus will be on the strengthening of the governance and accountability capacity in the country to ensure that the priority interventions outlined in the strategy can be effectively accomplished. At the same time, improving accountability and participation of communities and citizens in addressing their health and development agendas is needed and will be a focus of the strategy roll-out. This includes developing/ strengthening feedback systems and mechanisms from communities, through facility, district, and county levels by using innovations such as the Community Scorecard, and strengthening multisectoral mechanisms at all levels.

CHAPTER II: STRATEGIC INTENT

My child, my pride /“Umwana wanjye, ishema ryanjye”

2.1. Vision

“Every child attains a healthy growth and full potential”

All young children in Rwanda have the best start in life in healthy, safe and nurturing environments, to realize their full potential for physical, social, psychological, cognitive, cultural and spiritual development. Investment in the lives of young children and their families will create a better future for themselves and for the nation – contributing to the creation of a socially and economically prosperous society that is dynamic, healthy, and equitable, with all children developmentally on track.

2.2. Mission

“Fighting stunting through Integrated ECD”

The general mission of NECDP is to coordinate all interventions that support adequate early childhood development for children from conception to six (6) years of age as outlined in the Early Childhood Development Policy. The NECDP is therefore tasked to carry out the following responsibilities:

- 1) In close collaboration and coordination with all social cluster sectors playing a role in ECD, NECDP is responsible for:
 - a. Increasing children’s preparedness for the primary school environment;
 - b. Promoting optimal child development;
 - c. Enhancing positive parenting and community participation in child protection;
 - d. Reducing malnutrition and stunted growth among young children;
 - e. Eliminating physical, moral, and psychological abuse of young children; and
 - f. Enhancing equal access to early childhood development services by children with disability and disability and special needs
- 2) Take the lead in the development of the National Early Childhood Development strategic planning process through a holistic and all stakeholder-inclusive process;
- 3) Mobilize resources for the attainment of the goals set in the early child development strategic plan;
- 4) Ensure the implementation of all interventions as set in the early child development strategic plan by closely collaborating with all involved sectors;
- 5) Ensure the alignment by all stakeholders to the National Early Childhood development strategic plan, and its monitoring and evaluation plan; and
- 6) Ensure that all stakeholders implementing early childhood development services meet quality standards as set in the National Early Childhood Development minimum standards.

2.3. NECDP specific responsibilities

1. To reduce malnutrition and stunting among young children.
2. To promote optimal child development.
3. To enhance positive parenting and community participation in child protection.
4. To increase children’s preparedness to the primary school environment and to improve children’s cognitive development and school results.

5. To eliminate physical, moral and psychological abuse of young children.
6. To enhance equal access to early childhood development services by children with disability and special needs.

2.4. Guiding Principles

▪ Principle Related to a focus on young children and family centered care

Despite the considerable evidence of how the most critical elements of child, adolescent and adult health are shaped during the first 1,000 days of life there is a common default to older children when considering investments and interventions for early learning and responsive care. Intervening from conception is formative for children and is the foundation upon which later interventions and services can build. As such, early investments that focus on the full development of a child, including in cognitive, learning, physical, social, emotional and cultural dimensions are essential. Furthermore, while all stages of the early childhood life-cycle are important, there is an emerging priority to focus on children 0–2 years of age, as it is a critical period for survival, growth, development, and protection; as well as to give special attention to those children and families most at risk for exclusion, to reduce social inequalities and promote inclusion.

The protection and support to the family as a basic unit of community, as the first and primary institution for supporting the growth and early development of children, along with constructing the foundation for life-long learning.

Gender Equity and Equality, gender-based and gender-specific interventions starting with the family are essential at the earliest stages of a child's life and have long-lasting effects on developing healthy identities and later achieving gender equity and equality.

▪ Principle Related to Integrated Services Approach

Using an integrated service delivery model is an effective and efficient strategy in the delivery of services aimed at stunting reduction and malnutrition elimination. This NSP will support and strengthen bi-directional integrated ECD services across the continuum of care using a lifecycle approach, focusing mainly on children under six years and pregnant and lactating women, and targeting the most vulnerable households.

▪ Principle Related to the Lifecycle Approach

The lifecycle approach for Integrated Early Childhood Development considers various stages of the human development to ensure optimal development of children under six years. Programs and activities focus to improve pre-pregnancy and pregnancy health and nutrition status (antenatal care to mitigate/anticipate infant and maternal mortality), early childhood care (including early stimulation, positive parenting, child protection and inclusion, reducing stunting and malnutrition) but also goes beyond to pre-pregnancy period, that include health and nutrition of adolescent girls. The NSP will provide high impact RMNCHN services package, adjusted to each category of beneficiaries: Adolescence to pregnancy, during birth, under six months, 6- 23 months, 24 - 59 months; and adopt a life course approach where investments in the under six years old children must be consolidated and expanded by complementary investments in pre-school and up to and throughout schooling and adolescence.

▪ Principle Related to Advancing a Systems Approach

Advancing a systems approach is critical to the successful implementation of ECD interventions and the NSP will focus on the development of an integrated ECD service system, covering both universal and targeted supports and services, across the key sectors and levels of government, including non-government agencies. It will also enhance multi-sectoral partnerships recognizing that the provision of ECD services is a multi- sectoral responsibility involving government, the private sector, civil society organizations, and other key stakeholders. District level management of and community-based involvement in ECD services is also considered an effective strategy for advancing sustainable, holistic child development actions, ownership and accountability.

- **Principle related to Rights-based Approach**

Protecting children’s rights is a key element of this effort, as guaranteed under the Constitution of Rwanda as well as international human rights Conventions, inter alia the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). Every child has the right to survival, growth, development, protection and participation, and to achieve his or her full potential. The Best Interest of the Child, all policies and programs for families and young children must aim to serve the child’s best interest.

No child shall be left behind, discriminated against or abused based on economic status, health status and/or disability. Children should be considered as active participants in their own development and capable of making valuable inputs. Specific attention should be given to the evolving capacities of the child, as a key component for identifying and designing opportunities for child participation. Programming and policy development for early childhood development should have child rights at its core. Core in this regard is ensuring that children with disabilities, minorities and young children in humanitarian settings are not left behind.

2.5. Child Desired Outcomes

The IECD framework is organized around three inter-related and mutually re-enforcing child-centered outcomes: (1) Children are born and remain healthy during their first 6 years of their life; (2) Young children’s environments are nurturing, responsive, safe, inclusive and culturally appropriate; and (3) Young children have the skills and opportunities for success in early learning.

2.6. Theory of Change

The overall desired impact of the NSP is to ensure that ‘Every child in Rwanda attains a healthy growth and full potential’. The NSP aims to realise this impact by increasing the coverage and quality of holistic, integrated ECD services, as well as increasing positive behaviors and practices by parents and caregivers. The NSP is structured around the sectors most important for ECD and organized under nine strategic directions (each with a related outcome) that respond to identified bottlenecks and gaps in accessing and utilizing ECD services. These strategic directions reflect the areas in which this strategy will invest.

The Theory of Change underlying the NSP outlines how incremental changes over the 6 years of the strategy cycle will combine to achieve concrete improvements in the quality and equitable coverage of an integrated package of ECD services, and empower parents and caregivers with the knowledge, skills and resources to fully adopt positive behaviours and practices. Figure 5 below provides an overarching view of how the intended

outcomes across each sector will, in combination, be necessary and sufficient to achieve the overall impact. A more extensive set of diagrams are included in Annex 8, which elaborate in detail on the expected pathways to change for each outcome. This approach has been used to allow a visual representation of each of the outcome areas. However, showing each outcome separately should not be interpreted as minimizing the fact that there are important connections between the outcomes. For example, access to improved sanitation – or the lack of it – directly influences results in health and education. It is also important to note that Outcomes 6, 7, 8 and 9 are cross-cutting outcomes that are essential in creating an enabling environment for the achievement of outcomes 1 to 5. The arrows in the diagrams show how each change (be it at output or outcome level) contributes to another change (or changes).

Outcomes: To contribute to impact-level change, the NSP identifies nine strategic directions that orient the NSP. Within each Strategic Direction, the following outcomes will be necessary to achieve overall impact:

- Outcome 1. Increased access to ECD services for all children under 6 years and provision of nurturing care and stimulation by parents
- Outcome 2. Increased, equitable access to high impact, evidence-based health, nutrition, family planning and reproductive health services at primary and community level to children under 6 years, adolescent girls, pregnant and lactating women (with a focus on the first 1,000 days), and improved positive IYCN practices
- Outcome 3. Improved and equitable access to safe drinking water, sanitation, environment and hygiene in ECD facilities, schools and targeted households, and improved WASH practices
- Outcome 4. Enhanced availability and accessibility of quality, nutrient-rich and diversified food in targeted households, and improved consumption practices
- Outcome 5. Increased access to and use of social protection services by targeted households to ensure adequate nutrition and access to IECD services
- Outcome 6. Improved coordination, planning, monitoring and reporting to deliver high priority multisectoral integrated ECD services with optimal convergence at the household level
- Outcome 7. Strengthened community-based platforms to enhance demand for and use of quality, integrated frontline ECD services
- Outcome 8. Increased and more efficient, equitable and sustainable financing of integrated ECD services
- Outcome 9. Increased demand for and use of integrated ECD services through improved knowledge, behaviours and practices of parents, carers and frontline workers

Outputs: High-level outputs have been identified that are considered essential and sufficient to achieve each of the nine outcomes. The outputs reflect the expected results from the full range of support that is covered by the NSP at national, district and community level, such as direct service provision, systems-strengthening, policy processes and normative work, and various types of support related to positive changes in social and cultural norms and beliefs.

Implementation strategies and priority interventions: A range of strategies and priority interventions have been identified that will be necessary to achieve the outputs in this Theory of Change. A more detailed, comprehensive set of activities for each of these strategies and priority interventions will be elaborated in the annual implementation plans for the NSP.

Enablers of change: There are several factors that are considered to be essential ‘enablers’ within the pathways to change. For example:

- While the Government has identified ECD as a national priority and will provide leadership across all the relevant sectors, the full momentum necessary to achieve significant change will only be enabled through the full commitment of partners and their alignment to the NSP, including government ministries, agencies and departments, civil society, the private sector, donors and other stakeholders.
- Strong, effective mechanisms for multi-sectoral coordination at national, district and community level will be essential to enable actors to work together to identify shared priorities, and to plan for, implement and monitor interventions in an integrated and systematic way.
- To enable the shift towards a fully integrated approach to service delivery, the necessary incentives should be provided to encourage and support service providers to coordinate and align their work. Strong frontline platforms will also be essential to facilitate this integration.
- Systems to enable timely and comprehensive monitoring, evaluation and learning from community level, through to district and national level, will be critical to guide implementation and strengthen ownership and accountability.

Assumptions and risks: A number of key assumptions underpin this Theory of Change. These assumptions represent the underlying beliefs and understanding about how change can be achieved, including that:

- an integrated approach will reduce duplication and increase entry-points for service delivery
- relevant sectors will be committed and have adequate human resources to provide integrated services
- strong leadership at national, district and community levels will be able to guide, motivate and hold stakeholders accountable
- if communities have adequate understanding, skills, tools and mentorship, they will demand access to and participate in delivering improved ECD services

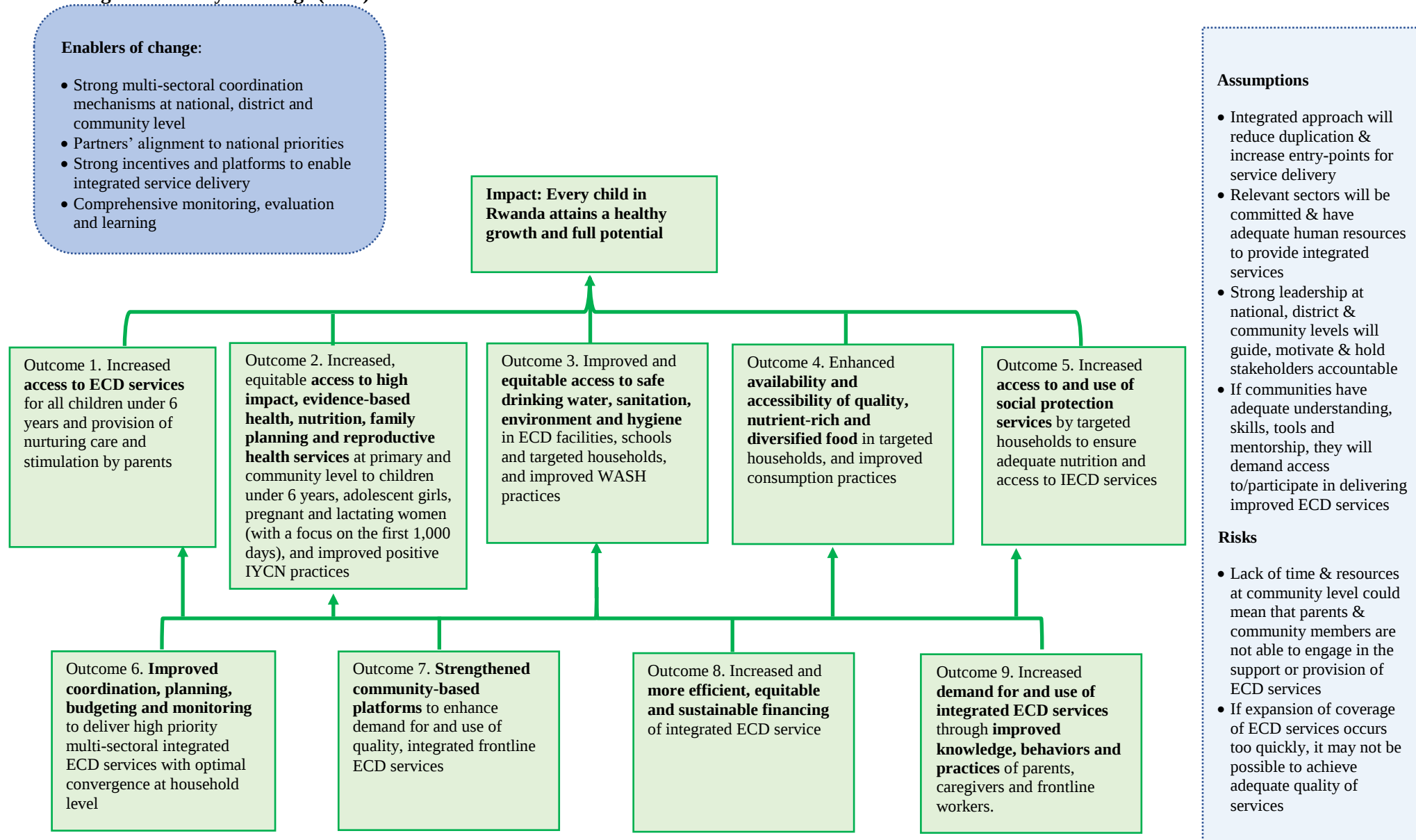
A number of risks have been identified that could restrict or block necessary changes. Such risks should be monitored and mitigating actions identified and carried out if necessary. These include:

- a lack of time and resources at community level could mean that parents and community members are not able to engage in the support or provision of ECD services
- if expansion of coverage of ECD services occurs too quickly, it may not be possible to achieve adequate quality of services

Monitoring and evaluation: The NSP Results Framework has been developed based on this Theory of Change and includes indicators with corresponding baselines and targets to measure progress in achieving the outputs, outcomes and impact. The outputs and their indicators were selected based on whether they could be attributable to the implementation of the NSP. At outcome and impact level, it is recognized that there will be other factors that are beyond the scope of the NSP that contribute to and influence their ultimate realization. Where possible, efforts were made to use existing indicators (in existing national M&E systems) that are simple to measure and in many cases are already collected.

The Theory of Change should be a ‘live’ resource that is tested to see if the theory holds true in practice, and refined over the lifecycle of the strategy based on lessons learned through monitoring, evaluation and research.

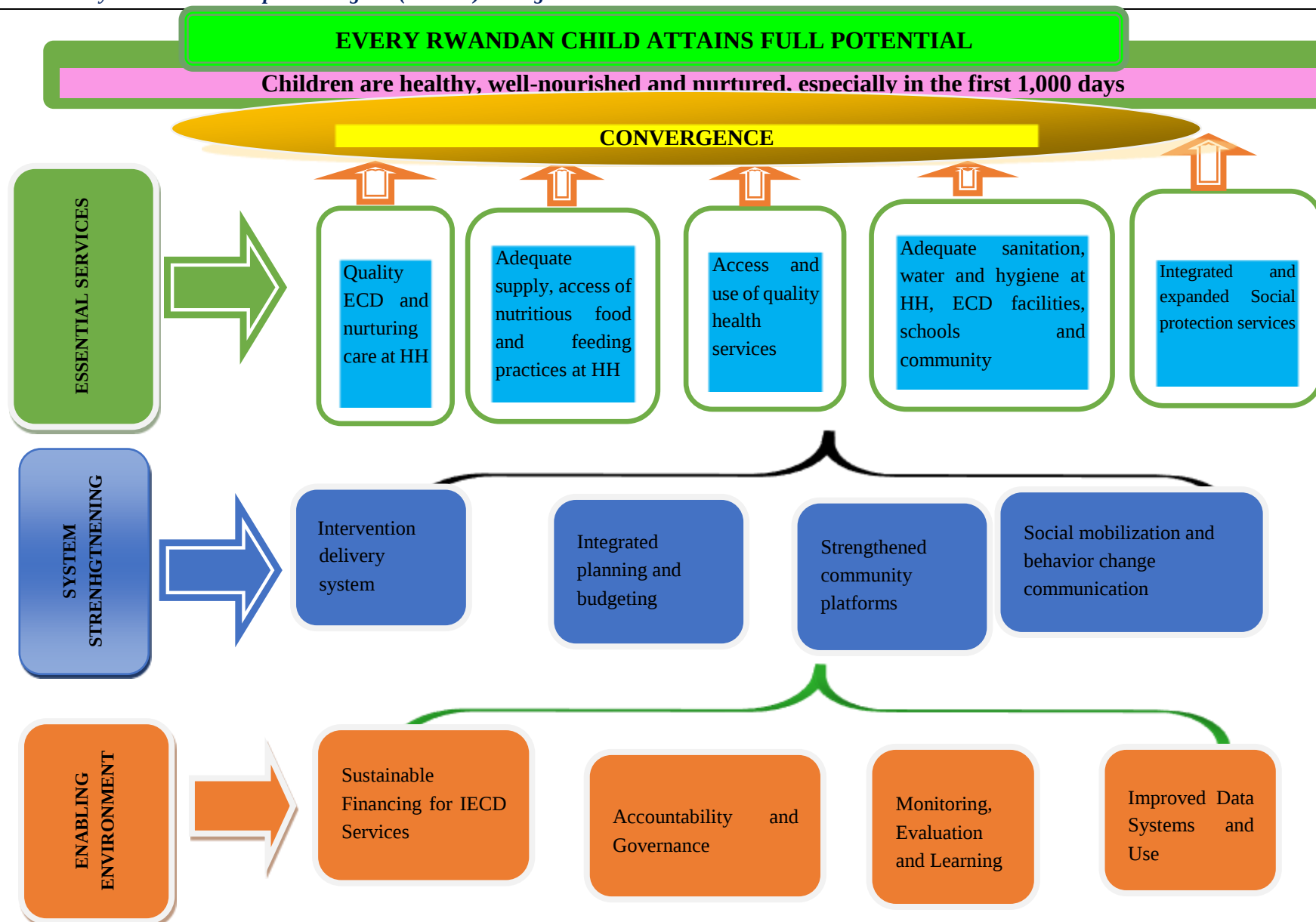
Figure 5 Theory of change (ToC)



2.7. Conceptual Framework

The figure below shows Conceptual Framework for the Strategic Planning.

Figure 6. Conceptual Framework



CHAPTER III: OVERALL OBJECTIVE, STRATEGIC DIRECTIONS AND PRIORITY AREAS FOR INTERVENTION

3.1 Overall objective

The overall objective of the NECDP strategy to ensure that **“Every child has access to comprehensive, integrated and quality care that allows for their full survival, growth and development.”**

3.2. Strategic directions

The strategy is focused on increasing the coverage and quality of high-impact, evidence-based integrated ECD interventions based on the situational analysis. To increase access to and utilization of the high impact integrated ECD interventions this strategy will implement **nine interlinked strategic directions** that respond to the bottlenecks and gaps in accessing and utilizing integrated ECD services, and are those areas that this strategy will invest in. The objectives address both supply and demand side barriers to ensure effective access to and uptake of high impact interventions by women, newborns, children and adolescents. The details of the “how” these interventions will be delivered including the health systems actions required to deliver them are described under the strategies and key actions section of this strategy. Table 2 provides more details on the specific targets, outputs and outcomes for each area.

The Government of Rwanda has prioritized nutrition and early childhood development as foundational issues to address within the Economic and Poverty Reduction Strategy (2013–2018) and in the National Strategy for Transformation and Prosperity (2017-2024). Achieving results in these areas, however, is dependent on multiple factors, and global and national evidence confirms that a combination of interventions across sectors are necessary. Furthermore, strategic planning and effective coordination combined with community-based approaches have been identified as national priorities.

To identify the priority areas for intervention a global and national evidence review was conducted. It focused on interventions that have a high impact and are cost-effective, including those in the Lancet Nutrition series of 2013³² and Lancet ECD series of 2016; areas that are most amenable to improvement; and are broadly inclusive in several respects, cutting across the entire life span, involving the continuum of care from disease prevention through the end of life, and affecting a range of demographic groups for which inequities need to be addressed. The prioritization process also relied on qualitative and quantitative data from national datasets and surveys to assess key underlying determinants and needs at the national and sub-national level. This work was supplemented by consultations with key stakeholders to collect views and concerns.

³² Black, R. E., C. G. Victora, S. P. Walker, Z. A. Bhutta, P. Christian, M. de Onis, M. Ezzati, S. Grantham-Mcgregor, J. Katz, R. Martorell, R. Uauy, and the Maternal and Child Nutrition Study Group. 2013. “Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries.” *The Lancet* 382: 427–51.

Strategic direction 1: Improved equitable and inclusive access to early childhood development services for children under six years resulting in improved learning outcomes and adequate skills development.

<i>Outcome 1. Increased access to ECD services for all children under 6 years and provision of nurturing care and stimulation by parents</i>
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Research on early childhood development confirms that effective and quality ECD interventions have a significant impact on the development and well-being of a child throughout life and is also an investment in the economic and social future of societies.³³ ECD refers to growth and development starting during a woman's pregnancy through her child's entry to primary school (0-6 years old). ECD interventions include services for pregnant and lactating mothers, young children, and their families that address the health, nutritional, socio-emotional, cognitive, and linguistic needs.

Despite global and national evidence on the importance of ECD, the accessibility and quality of ECD services in Rwanda remain as challenges. In 2018, only 24.1% of children 3-6 years old were enrolled in pre-school. There are also inequalities between enrollment in the rural and urban areas. The DHS (2015) reported that a higher proportion of children living in urban areas (37%) attended an ECD program than those living in rural areas (9%). Moreover, the quality of and accessibility to ECD services are critical areas for action in the country. Very few children (1%) under three years are enrolled in ECD services, despite the strong evidence on the importance of intervention in children under six years enrolled in ECD programs. In Rwanda, children enrolled in ECD facilities do not necessarily receive the full package of ECD interventions. For example, only 9% of all ECDs offer integrated ECD services (7 services), the rest offer less components which vary from one center to another, including 4.9% of centers offering only one component. When tracking children's development, the DHS (2015) reported that 60% of children aged 36-59 months were developmentally on track in four domains such as literacy, socio-emotional, physical and learning. As such, not only is there is a need to extend all ECD services to children under three years, but also to ensure that all children receive a full package of comprehensive, integrated and quality care services that allow for their full survival, growth and development, its Worth noting how ever that only 7% of 36-59 month olds were on track in literacy.

In Rwanda, ECD is a top national priority and an integral part of the Economic Development and Poverty Reduction Strategy II (2013–2018) and the National Strategy for Transformation (2017–2024). The GoR has committed to investing in ECD, and much has already been done to create an enabling environment for child development. In 2016, the GoR developed and approved a national ECD policy which is rooted in the premise of investment in children under six years and securing the rights of infants and young children in the country; an Early Childhood Development Single Action Plan (ECD SAP); and an annual action plan for the six-year National ECD Program Strategic Plan (NECDP SP 2018-2024); the latter which calls for the development of an integrated approach that addresses cross-cutting issues of childcare, education, growth and development, safety, health and nutrition, and security. This high-level commitment to ECD will not only give young children the best possible start in life but is also the best investment that Rwanda can make to achieve its national goals including to eliminate extreme poverty, boost shared prosperity, and create the human capital needed for sustained economic growth.

³³ Doyle, O., Harmon, C.P., Heckman, J.J. & Tremblay, R.E. 2007. *Early childhood intervention: Rationale, timing and efficacy*. UCD Geary Institute Discussion paper Series, UCD Geary Institute, Dublin & Shonkoff, J.P. & Richter, L. 2013. The powerful reach of early childhood development. In Britto, P.R., Engle P.L. & Super, C.M. (Eds). *Handbook of early childhood development research and its impact on global policy*. New York: Oxford University Press.

Priority Areas for Intervention

- 1) Increase opportunities for age-appropriate and play-based learning through quality preschool programs at home, in the community/ECD facilities and at schools
- 2) Improve nurturing care, positive parenting and early stimulation from 0 -6 years with a focus on first 1,000 days
- 3) Increase the use of a harmonized full package of integrated services in ECD and school settings
- 4) Enhance early screening and integration of children with disability and special needs in family , ECD facilities and schools
- 5) Ensure all ECD facilities and pre-primary schools meet the ECD minimum standards
- 6) Improve prevention and referral systems for protection of children from GBV and all forms of maltreatment
- 7) Establish a formal incentives system for ECD facilities' caregivers

Strategies

- a) Ensure all ECD facilities are provided with adequate play materials and other resources;
- b) Increase in-service training and ensure quality of pre-service training for caregivers and teachers for quality IECD service delivery and to guarantee adherence to ECD standards;
- c) Ensure parents are trained and empowered to improve ECD services at the household level and in home-based ECDs;
- d) Use media and other communication strategies to increase awareness of parents and local leaders on the importance of ECD for its full support;
- e) Increase and empower ECD Facilities to offer integrated services;
- f) Strengthen data collection and systems on the quality and delivery of ECD services
- g) Develop nurturing care and stimulation program
- h) Ensure that children are protected against GBV, abuse, neglect, violence, displacement and conflict
- i) Develop and operationalize a formal incentives system for ECD facilities' caregivers

Strategic Direction 2: Improved and sustained quality health and nutrition status of infants and young children with a focus on the first 1,000 days of life

Outcome 2. Increased, equitable access to high impact, evidence-based health, nutrition, family planning and reproductive health services at primary and community level to children under 6 years, adolescent girls, pregnant and lactating women (with a focus on the first 1,000 days), and improved positive IYCN practices

The first 1,000 days, from a woman's pregnancy to 2 years of age, is a critical window of growth and development. Stunting, or a manifestation of chronic malnutrition, during this period is largely irreversible and is associated with diminished cognitive and physical development, reduced productive capacity, and an increased risk of chronic diseases later in life, which have immediate and long-term effects at individual, community and national levels. In Africa, child undernutrition is associated with up to 0.2 to 3.6 years less of schooling, as much as 22% loss of yearly income in adulthood³⁴, and 1.9% to 16.5% of GDP.³⁵

³⁴ Grantham-McGregor, S; Cheung, YB; Cueto, S; Glewwe, P; Richter, L; Strupp, B. 2007. Developmental potential in the first 5 years for children in developing countries. *Lancet* 369 (9555): 60-70

³⁵ African Union Commission, NEPAD Planning and Coordinating Agency, UN Economic Commission for Africa, and UN World Food Programme. 2014. The Cost of Hunger in Africa: Social and Economic Impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda. Report. Addis Ababa: UNECA.

The determinants of child malnutrition in Rwanda, and stunting include poor dietary intake, frequent and repeated episodes of illness and disease, and poor birth outcomes, such as low birth weight and premature birth. These are in turn caused by complex and multisectoral determinants, including poor maternal, infant and young child care and feeding practices; poor water, sanitation, and hygiene; and household food insecurity. Global evidence has shown that scaling up nutrition-specific interventions to address the immediate determinants of child nutrition is essential, as well as complementary nutrition-sensitive interventions to address the underlying determinants of child nutrition. The Lancet Nutrition series of 2013³⁶, estimated that scaling up 10 key nutrition interventions to 90% of coverage could result in a 15% reduction of under-five mortality, a 20% reduction in stunting and a 61% reduction in severe wasting. All sectors, particularly education, social and child protection, must play a role to meet the holistic needs of young children. However, health provides a critical starting point for scaling up, given its reach to pregnant women, families, and young children.

In the last decade, the GoR has continued to ensure access to equitable and quality reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions based on comprehensive quality health care throughout the life course of the individual from conception onwards with essential RMNCAH health promotion, prevention and treatment interventions integrated across the continuum of care. The overall goal of the RMNCAH Program in Rwanda is to eliminate preventable maternal, neonatal and child deaths and promote the well-being of women, children and adolescents using a multi-sectoral approach. Immunization coverage has been consistently maintained at around 95% with the Government covering at least 30% of the full cost of vaccines. Impressive strides in reduction of stunting have also been achieved through improved inter-sectoral collaboration and uptake of long-term methods in family planning services. In the coming years, key priorities include maternal and child health, nutrition, malaria control, infrastructure and human resource development, increasing access to health and nutrition services throughout the country, reducing financial barriers, and ensuring effective health system financing and performance management. Growth monitoring and promotion (GMP) will be strengthened with several innovations in this strategy to foster learning and knowledge, including child length mats to visualize child height growth at the community level. The Length Mat is designed to raise community awareness of stunting and to facilitate easy stunting detection at the community level by providing a visual cue to determine if a child meets normal height-for-age measurements (based on current WHO growth standards). The purpose is to provide families and communities a simple, objective measure of their children's growth to motivate them and make them feel accountable to improve behaviors towards a healthy child growth. Not only does it enable community health workers and parents to address health and nutrition practices that promote child growth, but also helps identify children needing referrals for additional services and counseling. As community length mats are a new concept in Rwanda, an evaluation of their use and acceptability will need to be conducted. The assessment will look at key aspects of the roll-out and use of the length mats, including lessons learned from early implementation

Priority Areas for Intervention

- 1) Promote four to eight antenatal care visits, and integrate/strengthen surveillance and prevention of malnutrition as part of antenatal care
- 2) Improve immediate new-born care and appropriate post-natal visits as per the guidelines
- 3) Support for early initiation and exclusive breastfeeding
- 4) Support continued breastfeeding up to 24 months and appropriate complementary feeding
- 5) Sustain increased immunization package for children 0-15 months old and pregnant women
- 6) Establish and strengthen mechanisms to address anaemia among adolescent girls
- 7) Strengthen growth monitoring and promotion at health facility and community levels, including intervention and referral
- 8) Roll-out the child length mat to support visualization and early detection of stunting

³⁶ Black, R. E., C. G. Victora, S. P. Walker, Z. A. Bhutta, P. Christian, M. de Onis, M. Ezzati, S. Grantham-Mcgregor, J. Katz, R. Martorell, R. Uauy, and the Maternal and Child Nutrition Study Group. 2013. "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries." *The Lancet* 382: 427–51.

- 9) Strengthen the quality and coverage of Maternal Infant and Young Child Nutrition counselling (individual and group counselling) through existing opportunities such as ANC, PNC, immunization sessions, and IMCI, targeting all care providers (mothers, fathers and caretakers)
- 10) Build capacity of health care providers for identification, quality care/treatment, referral, and follow up after discharge of moderate and severe acute malnutrition
- 11) Advocate for family planning, reduction of unwanted pregnancies and increasing child spacing
- 12) Provide therapeutic zinc supplementation and ORS against diarrhoea
- 13) Provide deworming every 6 months for children under five years.
- 14) Improve nutrition practices and education in schools (primary & secondary) and ECD facilities

Strategies

- a) Scale up cost-effective nutrition-specific and -sensitive programming interventions;
- b) Revamp supply chain of logistics to prevent stock outs of essential nutrition supplements;
- c) Provide continuous capacity building, supervision and professional mentoring of health providers at hospitals, health centers, health posts and CHW by District Hospitals and District health management Teams;
- d) Strengthen capacities for early identification of malnutrition, IMCI and quality treatment ;
- e) Strengthen capacities for monitoring individual children's development;
- f) Strengthen integration of ECD and nutritional care into RMNCAH promotion, prevention and treatment interventions, commodities and innovative technologies;
- g) Disseminate MIYCN messages including on preconception, pregnancy, infant nutritional care, hygiene, gender and management of family budget through different channels (Umuganda, parenting groups, religious groups, patients at health facility level etc.);
- h) Ensure services provision readiness by health facilities;
- i) Ensure therapeutic zinc supplementation and ORS for diarrhea.
- j) Reinforce GMP with innovations including child length mat to support visualization and early detection of stunting
- k) Strengthen integration of nutrition care in immunization package and IMCI management;
- l) Strengthen management of premature birth (low birth weight) to attain good nutrition outcomes
- m) Institutionalize nutrition education and practices in schools (primary & secondary) and ECD facilities

Strategic Direction 3: Enhanced national capacity to support vulnerable households with safe drinking water, basic sanitation and hygiene services.

<i>Outcome 3. Improved and equitable access to safe drinking water, sanitation, environment and hygiene in ECD facilities, schools and targeted households, and improved WASH practices</i>

Access to safe water, sanitation and hygiene services is a fundamental human right, essential to the prevention of waterborne diseases (including diarrhea), which weaken children's immune systems and leave them vulnerable to illness and malnutrition. In Rwanda, there have been important improvements in environmental health but important gaps and geographic variations persist. Since 2005, access to improved water and sanitation facilities has more than doubled. Nevertheless, infants and children from vulnerable and poor households in rural areas have significant deficits in environmental health that places them at a greater risk of stunting. The 2017/2018 EICV found that: (i) 16% of the rural population still have an unimproved or no sanitation facilities and 13% share an improved facility. The DHS (2015) also found that (ii) roughly 60% of the rural households do not treat water prior to drinking; and (iii) over 87% of households do not have a handwashing station. Collectively, these deficits represent major challenges to the health and development of infants and children.

The Government of Rwanda has the ambition to improve the standard of living of its population by providing adequate water supply and sanitation (WSS) services throughout the country given the evidence that a lack of basic services such as water supply and sanitation leads to poverty and underdevelopment. Sanitation issues are now being viewed as an integrated development strategy, and water supply and sanitation are inextricably linked as part of the broader development process and linked to many sectors. The Government has endorsed SDG 6 (Ensure availability and

sustainable management of water and sanitation for all), recognizing its importance to national development. The Government has significantly increased the allocation of resources to WASH – US\$64 million was spent on WASH in 2016/17 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 to achieve universal safe clean water and sanitation services (in SDG terms).

Priority Areas for Intervention

1. Advocate for increased investment to scale up safe drinking water services by 2024
2. Increase use of household water treatment and safe storage, especially by vulnerable families
3. Increase awareness, capacity building and support to families, with special attention to vulnerable households, to invest in and adopt appropriate/adequate sanitation and hygiene practices, including hand washing with soap
4. Increase district capacities to develop water safety plans
5. Integrate “Baby WASH” messages into Nutrition and ECD trainings and materials.
6. Improve harmonization of data on connectivity and effective water supply

Strategies

- a) Establish scalable WASH in ECD (home-based and community-based) models which address facilities, services and promotion which meets the needs of young boys and girls and their caregivers;
- b) Strengthen behavior change communication on sanitation and hand-washing practices, in households, ECD facilities and schools
- c) Increase access of targeted poor families to safe clean water and sanitation services;
- d) Expand innovative approaches to basic sanitation at the community level, including build community and household capacity and demand to achieve basic sanitation, and addressing financial barriers of the poorest households;
- e) Integrate sustainable WASH financing, including public and private options;
- f) Increase the integration and cross sectoral linkages of WASH in social protection, nutrition and ECD programming;
- g) Review of data collection and reporting on connectivity and effective water supply

Strategic Direction 4: Improved and sustained equitable food security for family health in vulnerable households with children under five years and pregnant and/ lactating women

Outcome 4. Enhanced availability and accessibility of quality, nutrient-rich and diversified food in targeted households, and improved consumption practices

In Rwanda, food security remains a concern despite substantial growth in agricultural production over the past 10 years mainly due to low agricultural productivity, climate change effects, food price fluctuations and seasonal difficulties in accessing food. Most household food items are market-sourced, and although food is generally available in the markets, nearly half of households in Rwanda experience difficulties in accessing food. The National Food and Nutrition Policy developed in 2013 builds on several achievements that have improved the status of nutrition and household food security in Rwanda. This policy focuses on the national resolve to substantially reduce the prevalence of stunting in children under two years of age, and to improve household food security particularly among the most vulnerable families. In addition, the Fourth Strategic Plan for Agricultural Transformation (PSTA4),³⁷ part of the National Strategy for Transformation (NST), covering the period of 2018–2024, adopts a food systems approach for enhanced nutrition and household food security that stipulates interventions which ensure that the nutrient quality of

³⁷ PSTA is the French acronym for the Strategic Plan for Agricultural Transformation.

commodities is preserved or enhanced throughout the entire value chain. Rwanda's NST focuses on economic, social, and governance transformation toward the aspiration of Vision 2050. The new agriculture strategy's priorities include climate smart agriculture (CSA) and nutrition-sensitive agriculture (NSA), market access for farmers and feeding the cities, and support to institutions to enable them to shift from a market actor role toward a private sector-enabler role. In addition, resilience and risk mitigation strategies continue to be developed particularly at the household level.

Priority Areas for Intervention:

- 1) Increase local food production among vulnerable households of nutrient dense rich foods for own consumption (all-year productive kitchen gardens, fruit trees);
- 2) Scale-up planting of nutritious trees and processing of thier produce to mitigate the exisiting gaps in micronutirents with a focus on Spirulina and moringa among others
- 3) Increase coverage of vulnerable households supported to produce animal sourced foods for own consumption;
- 4) Sustain Effective Food Consumption practices in vulnerable HH
- 5) Increase access to fortified foods to vulnerable households;
- 6) Ensure that all 30 districts have up-to-date nutrition and food security emergency preparedness and response plan;
- 7) Scale-up food fortification and bio-fortification efforts (protein iron rich beans, orange sweet potatoes, widely consumed food stuffs).
- 8) Improve family resilience and food availability during emergencies

Strategies

- a) Scale-up new and existing innovative programs that promote access to and consumption of nutritionally diverse foods and fortification efforts—including processing of products of nutrrious plans (e.g moringa and spirulina)
- b) Increase access of vulnerable households to subsidized agricultural inputs such as non-chemical fertilizers, seeds, lime and small-scale irrigation kits to improve production of high nutrient dense food crops;
- c) Promote the production, consumption and access to animal-sourced proteins through improved access to educational tools and modern technologies supporting agricultural practices;
- d) Create and support market initiatives for fortified food, including aligning national level purchase of food with nutrition needs;
- e) Generate reliable nutrient data to inform adequate fortification and other interventions;
- f) Build family resilience to face emergency situations;
- g) Strengthen emergency preparedness and responses in areas of nutrition and food security and post harvest processing in vulnerable families and individuals;
- h) Build local capacities on nutrition sensitive agriculture programming;
- i) Conduct operational research on food needs and deficits in the country;
- j) Increase the capacity of the National Strategic Food Reserve to deal with potential sudden food shortages and emergencies;
- k) Develop and enforce food fortification standards; and
- l) Increase access of bio-fortified foods to vulnerable poor household,
- m) Build capacities for food safety and packaging of nutritious food.

Strategic Direction 5: Improved social protection systems for the poor and the most vulnerable households

<i>Outcome 5. Increased access to and use of social protection services by targeted households to ensure adequate nutrition and access to IECD services</i>

Rwanda has built an integrated social protection system to ensure a minimum standard of living and access to core public services, boost resilience to shocks, promote equitable growth, and strengthen opportunity through increased human capital development. These efforts have allowed Rwanda to establish a strong base for a social safety net reforms. Currently, the social protection Sector in Rwanda is governed by the revised Social Protection Policy (2017) and the Social Protection Sector Strategic Plan 2018-2024. The programmatic scope of the National Social Protection Sector Strategic Plan includes four pillars: social security; short-term social assistance; social care services; and

linkages to complementary livelihood support services for graduation. The strategy recognizes the linkages between social protection and ECD.

At the heart of the delivery of the social protection for the extremely poor in Rwanda is the Vision 2020 Umurenge Programme (VUP) established in 2008. This program entails 3 components targeting different strata of the poor. The safety net component includes: 1) Direct Support (DS) component provided monthly to a poor household that has no one able to work; 2) classic Public Works (PW) program that involves providing short-term employment to massive number of people to execute a public/community infrastructure project; 3) expanded public works (ePW) program that provides year around employment to labour constrained households with children; and 4) expanded direct support (EDS) program that provides monthly cash transfers to labour constrained households caring for people with severe disabilities and nutrition sensitive direct support. The VUP program coverage has expanded in scope and diversity of measures. However, the program still only covers about 50 % of eligible households categorized as extremely poor. According to the most recent SP Sector Joint Sector Review 2017/18, the VUP program covered a total of 242,849 households, including 95,004 households with Direct Support and 147,845 through a combination of the classic and expanded Public Works.³⁸

Priority Areas for Intervention:

- 1) Increase reach of innovative interventions to address multidimensional child poverty such as Expanded Public Works
- 2) Enhance demand for key IECD services through incentives systems that augment household income
- 3) Increase access to social safety net to vulnerable households with low labor capacity and caring responsibilities;
- 4) Strengthen CRVS with a focus on registration of births and assignment of unique identification numbers at birth.

Strategies

- a) Improve the coverage, adequacy and effectiveness of the VUP (Vision Umurenge 2020) Program
- b) Increase access to social security and income support programs, particularly those benefitting young children from poor and vulnerable families
- c) Increase contribution of social protection for reducing malnutrition
- d) Strengthen social care service delivery for the most vulnerable, especially for families with children under six years, pregnant and lactating women
- e) Strengthen functionality of the CRVS information system, focusing on birth registration and certification and an integrated centralized system and
- f) Speed up the rollout of contributory social security insurance scheme.

Strategic Direction 6: Strengthened coordination, implementation capacity and governance to enhance quality delivery of Integrated ECD interventions at all levels

Outcome 6. Improved coordination, planning, budgeting and monitoring to deliver high priority multi-sectoral integrated ECD services with optimal convergence at household level

Integrated ECD services are multisectoral in nature and therefore require a broad range of actors including from Health, Local Governance, Planning (human development), Agriculture (food security), Industry and Trade (food availability), Economy (purchasing power), Women and Children Development (family empowerment), Education (knowledge and skill), Local Governance, Manpower/Workforce (productivity) and Socio-culture (nutritional behavior) and other cross cutting areas including WASH and Social Protection. Currently, the implementation of Integrated ECD interventions by different sectors could be strengthened to avoid the duplication of efforts. Integrated

ECD programs therefore requires an integrated approach with multi-sectoral coordination of actions at the national and decentralized levels.

As outlined above, a lack of accountability and inadequate monitoring and supervision systems, particularly at decentralized levels, contributes to poor access and utilization of key services that support full childhood development. Therefore, there exists the need to strengthen governance and accountability systems at all levels to support the implementation of this strategy, including improving accountability and participation of communities and citizens by using innovations. In 2017, the national agenda for stunting reduction in Rwanda became closely integrated with the larger ECD program, and the National Early Childhood Development Program (NECDP) was established. NECDP is now responsible for coordinating all integrated ECD interventions that support adequate ECD for children from conception to six years of age, including accelerating stunting reduction. The Government of Rwanda (GoR) has established several multi-stakeholder platforms at central and local levels to scale integrated ECD actions under Annual Single Action Plan (SAP) that is jointly implemented by GoR agencies and Partners. The Annual SAP is evaluated at the Prime Ministers level on Quarterly basis and participating GoR institutions have an ECD focal point at the level of the Director General. Furthermore, Rwanda adopted both National and District level administrative structures to support strong coordination of ECD SAP interventions. These structures ensure that all key stakeholders including relevant government ministries, development partners, civil society and private sector are well coordinated. At the national level, the Social Cluster Ministries under the Prime Minister's Office is the highest-level government convening body.

At the local level, multi-sectoral nutrition committees are composed of mayors, district directors of health, nutritionists, agronomists and social protection, veterinary, and hygiene and sanitation officers. The Joint Action Development Forum (JADF) coordinates activities at district and sector levels. Furthermore, every district in Rwanda has their own District Plans to Eliminate Malnutrition (DPEMs) and meets at the district level to monitor the implementation of these plans and harmonize activities. To further improve accountability for early childhood nutrition and development, key innovations are being piloted such as the Community Scorecard (CSC), and strengthening multisectoral mechanisms at all levels. The CSC is a citizen-driven accountability measure for the assessment, planning, monitoring and evaluation of service delivery. It can be used to gather feedback from service users and improve communication between communities and service providers on key health and nutrition services, and will be used to track, monitor and evaluate performance and bolster accountability. More details on governance and accountability mechanisms are in Chapter 6 of this document.

Priority Areas for Intervention:

- 1) Increase capacity for multi-sectoral coordination and planning of integrated ECD interventions and delivery systems at central and decentralized levels including integration of SAP priorities in IMIHIGO performance contracts at Districts and central levels.
- 2) Increase implementation capacity of stakeholders at national and decentralized levels;
- 3) Reinforce multi levels inter- and across-sectoral coordination to enhance convergence of various interventions at vulnerable households and ECD facilities
- 4) Establish effective accountability mechanism at all levels to ensure efficiency;
- 5) Strengthen results monitoring system and capacity to track progress, results and resources at national and decentralized level;
- 6) Strengthen use of data to inform targeting, geographical prioritization and budget allocation.
- 7) Establish clear coordination and reporting mechanism of community front line volunteers operating at village level;
- 8) Improve community data collection/information system, data quality (accuracy and completeness) and easy access of NECDP M&E to other existing Government MIS;
- 9) Establish and operationalize learning agenda including evaluations and assessments planned by all stakeholders.

Strategies

- a) Prioritization of key interventions based on the collection of disaggregated data on IECD outcomes of vulnerable households and subgroups (newborns, under 2 years, under 5 years, pregnant and lactating women) to identify and address specific needs and forms of vulnerability;
- b) Develop and integrate robust planning and M&E systems for prevention of all forms of malnutrition in children under six years and women of reproductive in districts MTEF (Medium Term Expenditure Framework) and budgets;
- c) Develop accountability tools such as the community scorecard to support the convergence, assessment, planning, monitoring and evaluation of service delivery.
- d) Capacity building at national and decentralized levels and strengthening of district level plans (including decentralized budgeting), integrated planning at district level that reflects IECD services in MTEF priorities'
- e) Ensure the alignment by all stakeholders to the National ECD SP and annual SAP implementation, evaluation and reporting systems;
- f) Set up of clear mandates and responsibilities for IECD stakeholders at different levels (from national to village levels) in the implementation of the ECD SP;
- g) Advocate and mobilize financial and human resources for IECD coordination and partnership activities at all levels.

Strategic Direction 7: Strengthened Community based platforms to enhance demand for and use of effective frontline service delivery systems of integrated quality high impact Integrated ECD services.

<i>Outcome 7. Strengthened community-based platforms to enhance demand for and use of quality, integrated frontline ECD services</i>
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Community engagement is critical to achieving results and building lasting involvement with communities in service delivery and management. The GoR recognizes that the problem of access to primary health care is not only a health sector issue, but rather a multi-sectoral challenge that requires all sectors to work together in a synergistic manner to deliver a comprehensive community health package - ranging from preventive to curative interventions - with full community participation. Specifically, the community health package consists of the Community Case Management (CCM), Mother and Newborn Health Program (MNH), Reproductive Health (RH), Family Planning (FP), Community-Based Nutrition Program (CBNP), Community-Based Provision (CBP) for Family Planning, Environmental Health (EH) and Hygiene, Behavior Change Communication (BCC) and Community Health Management Information System (CHMIS). Additionally, the package includes the Community Performance Based Funding (C-PBF). In Rwanda, community health workers are a formal part of the national health strategy and are coordinated by the Community Health Desk in Rwanda Biomedical Center (RBC).

The Integrated community case management (ICCM) involves the assessment, classification and treatment or referral of diarrhea, pneumonia, malaria, and malnutrition in children less than five years of age and includes malnutrition screening, community-based provision of contraceptives, prevention and behavior change activities and household visits. The CBNP has ensured national coverage in preventing and managing malnutrition in children under five years, with a focus on those aged less than two years, and in pregnant and lactating mothers. The main objective of the National Nutrition Program is to eliminate all forms of malnutrition through implementation of the joint action plan to strengthen the multi-sector approach and community-lead interventions.

Community health workers in Rwanda constitute one of the most cost-effective system in provision of community-based health and nutrition services. In addition, there are many community platforms/frontline workers engaged in ECD in the national strategy include: Friends of Families (IZU), Farmer Promoters, Farmer Field Schools (FFS), caseworkers, and community hygiene clubs, all of which will be strengthened, trained, and provided with systems-based incentives to enhance the convergence of interventions an community and household levels.

Priority Areas of Intervention

- 1) Increase demand of community-based quality Integrated ECD services;

- 2) Increase capacities of frontline workers (CHW, friends of family, hygiene clubs, ECD caregivers and Agriculture promoters) to effectively deliver and coordinate high impact quality Integrated ECD services;
- 3) Strengthen community referral and follow-up mechanisms of children to primary health, nutrition and social protection services;
- 4) Improve quality of measurements and reporting systems for child growth monitoring and promotion at community level;
- 5) Strengthen community based nutrition programs, including nutrition education and counselling;
- 6) Strengthen interoperability of CHMIS and use for decision making at early stages;
- 7) Build innovative cost effective approaches to enhance community participation in access and delivery of IECD services;

Strategies

- a) Review and operationalize community-based screening and early identification systems of children at risk, including adoption of new methods, including innovative Growth Monitoring and promotion (GMP) at community level;
- b) Build Capacity of the frontline workers to ensure quality of services;
- c) Scale-up a package of prioritized community-based nutrition interventions to prevent and manage malnutrition in children less than 5 years, with a focus on (i) those aged less than two years for stunting, and (ii) pregnant and lactating mothers;
- d) Scale-up nutritional direct support and management of vulnerable groups;
- e) Invest in robust M&E for nutrition innovations tracking and providing real-time disaggregated to the household level;
- f) Invest in e-health technologies including phone application.

Strategic Direction 8: Increased efficiency, equitability and sustainability of financing National ECD program

<i>Outcome 8. Increased and more efficient, equitable and sustainable financing of integrated ECD services</i>
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IECD planning and programming requires sustainable multisectoral financing to ensure continuity and meaningful results. To ensure program sustainability, integrated interventions must be supported by sustainable financing modalities beyond the current fragmented finance approaches. Multi-sectoral funding of integrated ECD interventions under the umbrella of NECDP is an opportunity that heralds with challenges that are largely attributed to lack of reliable data on planning, budgeting, allocation, Expenditure Analysis and Reporting with various streams of funding in health, nutrition, ECD, WASH and Social Protection domains.

Singling out IECD: Transparent, routine and timely nutrition financing data are needed at the country level to support domestic resource mobilization for nutrition and to help coordinate donor resources. GoR has commissioned Nutrition Expenditure Analysis that is on-going and will provide to National Platforms to make decisions to help overcome gaps in nutrition funds and inefficiencies in spending; make plans for expanding nutrition programming; and develop country-specific advocacy campaigns and investment Targets.

The 2016 Global Nutrition Report clearly states the importance of collecting these data, noting that doing so leads to a far greater focus on results and helps make the case for additional investment. Country-level nutrition financing data are needed to support domestic resource mobilization for nutrition and to help coordinate donor resources. Nutrition financial tracking includes cost, budget and expenditure data. All three can be compared to strengthen the advocacy case for investing in nutrition and provide technical support in analyzing financial data to ensure nutrition is not overlooked in the domestic budget cycle. Country-level nutrition financing data are needed to support domestic resource mobilization for nutrition and to help coordinate donor resources.

Nutrition financial tracking includes cost, budget and expenditure data. All three can be compared to strengthen the advocacy case for investing in nutrition provide country governments with technical support in analyzing financial data to ensure nutrition is not overlooked in the domestic budget cycle.

Priority Areas of Intervention

- 1) Effectively leverage existing systems and emerging opportunities in reducing the ECD financing gap;
- 2) Develop and operationalize Integrated ECD Financing strategy;
- 3) Develop and operationalize Resource Tracking System;
- 4) Develop integrated Planning and Budgeting Tools for Integrated ECD services;
- 5) Enhance Prioritization, Equitable Financing and support systems with a Focus on “High Impact” Intervention Multisector stakeholders' Accountability Framework
- 6) Develop and position DRM (Domestic resource mobilization) options that leverage other sources of funding including private sector (example of Singapore model that prescribes 1% levy on big companies to finance IECD services)

Strategies

- a) Develop long term ECD financing strategy;
- b) Prioritize and significantly increase funding for integrated ECD services;
- c) Ensure public financing for ECD services and utilize innovative finance to jump start investments;
- d) Focus financing systems on improving quality and assuring equity;
- e) Strengthen the capacity of the public sector to effectively allocate and use financing;
- f) Support the generation of contextually relevant evidence that can influence advocacy efforts to increase domestic financing and quality improvements;
- g) Develop resources tracking system of all ECD investments from national to end beneficiary;
- h) Develop scaling up scenarios for prioritized and targeted interventions;
- i) Ensure Effectiveness of External assistance and GoR investments through Prioritization, Equity, and Efficiency;
- j) Align Domestic resource mobilization strategies, including the private sector involvement, Public Community Private Partnership frameworks.

Strategic direction 9. Strengthened leadership, partnership and coordination at levels in the delivery of Social and Behaviour Change Communication (SBCC) strategies tailored to all audiences.

<i>Outcome 9. Increased demand for and use of integrated ECD services through improved knowledge, behaviors and practices of parents, caregivers and frontline workers.</i>

Stunting remains largely an invisible problem in Rwanda, and lack of awareness around appropriate practices and prevention strategies persist. To sustainably reduce stunting, the behaviors and beliefs of individuals and communities, as well as the norms that underpin them, must be changed. As such, Social and Behavior Change Communication (SBCC) is needed to change the way that individuals, communities and households understand the issue and modify health seeking behaviors as well as education, nutrition and hygiene practices.

SBCC is a behavior-centered approach to facilitating individuals, households, groups, and communities in adopting and sustaining improved health and nutrition related practices. It provides a “roadmap” for changing behaviors and social norms and identifies all the behaviors that need to be changed to attain positive health and social impacts. SBCC can increase individual knowledge and skills, strengthen community action, stimulate demand for services, and foster positive social norms. Recognizing this potential, the Government of Rwanda (GOR) has called upon partners to integrate SBCC into health planning, programming and implementation. GOR has also provided policy and strategic guidance in the form of a national SBCC policy for the Health Sector in 2012 and a National Health Promotion Strategy in 2013. Furthermore, an integrated nutrition and WASH SBCC strategy was approved in 2019, with the goal to improve overall health and well-being throughout Rwanda.

The NSP focuses on implementing a variety of SBCC activities by enhancing existing BCC tools, creating new tools and integrating communication tools and approaches across different sectors; as well as building capacity of different ministries and partners to implement and manage SBCC interventions. Targeted SBCC activities will address social cultural barriers preventing people from adopting improved health and nutrition practices vital for the

ensuring the well-being of children of all ages. Examples of SBCC interventions include: messages delivered by CHWs, targeted child growth promotion and stunting prevention via interpersonal counseling (IPC) with parents and caretakers; community mobilization and visualization of child growth; rural radio and talk shows; umuganda (monthly community work day) campaigns; electronic/SMS messaging; and mass media campaigns.

SBCC is a cross-cutting theme in the NSP and many of the activities noted above are included under Strategic Directions 1-8. As such, Strategic Direction 9 is focused on ensuring the successful implementation of the National Social Behavior Change Communication Strategy for Integrated ECD, Nutrition and WASH 2018-2024. Given the integrated nature of these activities, strong coordination mechanisms and delivery platforms will need to be established to enable a more comprehensive approach to SBCC for ECD.

Priority Areas of Intervention

1. Ensure the implementation of the National Social Behavior Change Communication Strategy for Integrated ECD, Nutrition and WASH 2018-2024, and monitoring on a quarterly basis.

Strategies

- a. Promote integrated delivery of the SBCC through strong oversight of overall coordination and implementation of the National SBCC Strategy by the NECDP, including but not limited to organizing quarterly meetings of all related technical groups including Health Promotion TWG to monitor the progress on regular basis.
- b. Review and validation of all communication materials related to the implementation of ECD, nutrition and WASH activities by the National Health Promotion Technical Working Group.
- c. Support the coordination of Social Cluster Ministries in strengthening existing related policies and strategies, advocating for SBCC implementation, mobilizing resources, and supporting local governments in implementing the SBCC Strategy.
- d. Support the monitoring and evaluation of behavior change interventions by ensuring data availability through routine tracking or population-based surveys.

Table 2: Impact, Outcomes, Outputs, Strategies and Priority Interventions

Impact / Outcomes / Outputs	Priority interventions	Strategies
Impact: Every child in Rwanda attains a healthy growth and full potential		
Strategic Direction 1. Increased equitable access to quality and inclusive integrated ECD services		
Outcome 1. Increased access to ECD services for all children under 6 years and provision of nurturing care and stimulation by parents		
Output 1.1 Increased number of ECD facilities, equitably distributed geographically	1) Increase opportunities for age-appropriate and play-based learning through quality preschool programs at home, in the community/ECD facilities and at schools	a) Ensure all ECD facilities are provided with adequate play materials and other resources
Output 1.2 Caregivers are skilled, have the play materials, resources and standards to provide a full package of quality, integrated ECD services	2) Improve nurturing care, positive parenting and early stimulation from 0 -6 years with a focus on first 1,000 days	b) Increase in-service training and ensure quality of pre-service training for caregivers and teachers for quality IECD service delivery and to guarantee adherence to ECD standards
Output 1.3 ECD facilities are equipped with the skills and resources for early screening and to care for children with special needs or disabilities	3) Increase the use of a harmonized full package of integrated services in ECD and school settings	c) Ensure parents are trained and empowered to improve ECD services at the household level and in home-based ECDs
Output 1.4 Capacity to deliver nurturing care, stimulation, and protection from abuse in ECD facilities and at home is strengthened	4) Enhance early screening and integration of children with disability and special needs in family , ECD facilities and schools	d) Use media and other communication strategies to increase awareness of parents and local leaders on the importance of ECD for its full support
	5) Ensure all ECD facilities and pre-primary schools meet the ECD minimum standards	e) Increase and empower ECD Facilities to offer integrated services
	6) Improve prevention and referral systems for protection of children from GBV and all forms of maltreatment	f) Strengthen data collection and systems on the quality and delivery of ECD services
	7) Establish a formal incentives system for ECD facilities' caregivers	g) Develop nurturing care and stimulation program
		h) Ensure that children are protected against GBV, abuse, neglect, violence, displacement and conflict
		i) Develop and operationalize a formal incentives system for ECD facilities' caregivers
Strategic Direction 2. Improved and sustained quality health and nutrition status of infants and young children with a focus on the first 1,000 days of life		
Outcome 2. Increased, equitable access to high impact, evidence-based health, nutrition, family planning and reproductive health services at primary and community level to children under 6 years, adolescent girls, pregnant and lactating women (with a focus on the first 1,000 days), and improved positive IYCN practices		
Output 2.1 Healthcare professionals have the skills and competencies to provide an integrated package of inclusive, holistic health and nutrition services	1. Promote four to eight antenatal care visits, and integrate/strengthen surveillance and prevention of malnutrition as part of antenatal care	a) Scale up cost-effective nutrition-specific and -sensitive programming interventions
		b) Revamp supply chain of logistics to prevent stock outs of essential nutrition supplements

Impact / Outcomes / Outputs	Priority interventions	Strategies
Output 2.2 Adequate mentoring and supportive supervision are in place to ensure service quality	2. Improve immediate new-born care and appropriate post-natal visits per the guidelines	c) Provide continuous capacity building, supervision and professional mentoring of health providers at hospitals, health centers, health posts and CHW by District Hospitals and District health management Teams
Output 2.3 Protocols and guidelines developed and rolled-out to set standards for service readiness and quality	3. Support for early initiation and exclusive breastfeeding	d) Strengthen capacities for early identification of malnutrition, IMCI and quality treatment
Output 2.4 Enhanced capacity to provide micronutrient supplementation and full immunization package	4. Support continued breastfeeding up to 24 months and appropriate complementary feeding	e) Strengthen capacities for monitoring individual children's development
Output 2.5 Improved tools and integrated approaches for growth monitoring and promotion, including rolling out of the child length mat	5. Sustain increased immunization package for children 0-15 months old and pregnant women	f) Strengthen integration of ECD and nutritional care into RMNCAH promotion, prevention and treatment interventions, commodities and innovative technologies
Output 2.6 Improved quality, coverage and utilization of IYCN counselling and support, and integration into RMNCAH services	6. Establish and strengthen mechanisms to address anaemia among adolescent girls	g) Disseminate MIYCN messages including on preconception, pregnancy, infant nutritional care, hygiene, gender and management of family budget through different channels (Umuganda, parenting groups, religious groups, patients at health facility level etc.)
	7. Strengthen growth monitoring and promotion at health facility and community levels, including intervention and referral	h) Ensure services provision readiness by health facilities
	8. Roll-out the child length mat to support visualization and early detection of stunting	i) Ensure therapeutic zinc supplementation and ORS for diarrhea.
	9. Strengthen the quality and coverage of Maternal Infant and Young Child Nutrition counselling (individual and group counselling) through existing opportunities such as ANC, PNC, immunization sessions, and IMCI, targeting all care providers (mothers, fathers and caretakers)	j) Reinforce GMP with innovations including child length mat to support visualization and early detection of stunting
	10. Build capacity of health care providers for identification, quality care/treatment, referral, and follow up after discharge of moderate and severe acute malnutrition	k) Strengthen integration of nutrition care in immunization package and IMCI management
	11. Advocate for family planning, reduction of unwanted pregnancies and increasing child spacing	l) Strengthen management of premature birth (low birth weight) to attain good nutrition outcomes
	12. Provide therapeutic zinc supplementation and ORS against diarrhoea	m) Institutionalize nutrition education and practices in schools (primary & secondary) and ECD facilities
	13. Provide deworming every 6 months for children under five years.	
	14. Improve nutrition practices and education in schools (primary & secondary) and ECD facilities	
Strategic Direction 3. Enhanced national capacity to support targeted households with safe drinking water, basic sanitation, healthy environments and hygiene services		

Impact / Outcomes / Outputs	Priority interventions	Strategies
Outcome 3. Improved and equitable access to safe drinking water, sanitation, environment and hygiene in ECD facilities, schools and targeted households, and improved WASH practices		
Output 3.1 Increased supply of safe, reliable and sustainable drinking water to ECD facilities, schools and targeted households through the use of water treatment and safe water storage	1. Advocate for increased investment to scale up safe drinking water services by 2024 2. Increase use of household water treatment and safe storage, especially by vulnerable families 3. Increase awareness, capacity building and support to families, with special attention to vulnerable households, to invest in and adopt appropriate/adequate sanitation and hygiene practices, including hand washing with soap 4. Increase district capacities to develop water safety plans 5. Integrate “Baby WASH” messages into Nutrition and ECD trainings and materials. 6. Improve harmonization of data on connectivity and effective water supply	a) Establish scalable WASH in ECD (home-based and community-based) models which address facilities, services and promotion which meets the needs of young boys and girls and their caregivers b) Strengthen behavior change communication on sanitation and hand-washing practices, in households, ECD facilities and schools c) Increase access of targeted poor families to safe clean water and sanitation services d) Expand innovative approaches to basic sanitation at the community level, including build community and household capacity and demand to achieve basic sanitation, and addressing financial barriers of the poorest households e) Integrate sustainable WASH financing, including public and private options f) Increase the integration and cross sectoral linkages of WASH in social protection, nutrition and ECD programming g) Review of data collection and reporting on connectivity and effective water supply
Output 3.2 Scalable models for increasing basic sanitation and hygiene services in ECD facilities, schools, communities and targeted households are developed and rolled-out		
Output 3.3 Targeted households, ECD facilities and schools have the knowledge, skills and resources to adopt appropriate sanitation and hygiene practices		
Output 3.4 District water safety plans that prioritise safe drinking water at ECD facilities, schools and targeted household level are developed and implemented		
Output 3.5 Increased integration and cross sectoral linkages of WASH in social protection, nutrition and ECD programming, including integration of ‘Baby WASH’ messages		
Strategic Direction 4. Improved and sustained equitable food security for family health in vulnerable households with children under 5 years, pregnant and/or lactating women		
Outcome 4. Enhanced availability and accessibility of quality, nutrient-rich and diversified food in targeted households, and improved consumption practices		
Output 4.1 Increased local production of nutrient dense food crops among targeted households for own consumption through use of subsidized agricultural inputs (GOR subsidies, diverse fruit trees, biofortified crops, kitchen gardens)	1. Increase local food production among vulnerable households of nutrient dense rich foods for own consumption (all-year productive kitchen gardens, fruit trees) 2. Scale-up planting of nutritious trees and processing of thier produce to mitigate the	a. Scale-up new and existing innovative programs that promote access to and consumption of nutritionally diverse foods and fortification efforts b. Increase access of vulnerable households to subsidized agricultural inputs such as non-chemical fertilizers, seeds, lime and small-scale

Impact / Outcomes / Outputs	Priority interventions	Strategies
Output 4.2 Increased production of animal sourced proteins among targeted households for own consumption	existing gaps in micronutrients with a focus on Spirulina and moringa among others	irrigation kits to improve production of high nutrient dense food crops
Output 4.3 Necessary strategies, standards and guidelines in place, implemented and monitored (including diversification of protein sources strategy, food fortification strategy and standards, and Food Best Dietary Guidelines	3. Increase coverage of vulnerable households supported to produce animal sourced foods for own consumption	c. Promote the production, consumption and access to animal-sourced proteins through improved access to educational tools and modern technologies supporting agricultural practices
Output 4.4 Increased access to fortified food in targeted households, including complementary food for children 6-24 months	4. Sustain Effective Food Consumption practices in vulnerable HH	d. Create and support market initiatives for fortified food, including aligning national level purchase of food with nutrition needs
Output 4.5 Agriculture extension workers have improved knowledge and skills about nutrition, including on gender dimensions of nutrition, and food consumption practices	5. Increase access to fortified foods to vulnerable households	e. Generate reliable nutrient data to inform adequate fortification and other interventions
Output 4.6 Improved capacity at all levels for food security preparedness and response in the case of food shortages or emergencies	6. Ensure that all 30 districts have up-to-date nutrition and food security emergency preparedness and response plan	f. Build family resilience to face emergency situations
Output 4.7 Improved data on micronutrient availability and research on food security and nutrition	7. Scale-up food fortification and bio-fortification efforts (protein iron rich beans, orange sweet potatoes, widely consumed food stuffs).	g. Strengthen emergency preparedness and responses in areas of nutrition and food security and post-harvest processing in vulnerable families and individuals
	8. Improve family resilience and food availability during emergencies	h. Build local capacities on nutrition sensitive agriculture programming
		i. Conduct operational research on food needs and deficits in the country
		j. Increase the capacity of the National Strategic Food Reserve to deal with potential sudden food shortages and emergencies
		k. Develop and enforce food fortification standards and
		l. Increase access of bio-fortified foods to vulnerable poor household,
		m. Build capacities for food safety and packaging of nutritious food.
Strategic Direction 5. Improved social protection systems for the poor and the most vulnerable households		
Outcome 5: Increased access to and use of social protection services by targeted households to ensure adequate nutrition and access to IECD services		
Output 5.1 Improved targeting, coverage and effectiveness of social security to reach vulnerable families with low labour	1. Increase reach of innovative interventions to address multidimensional child poverty such as Expanded Public Works	a) Improve the coverage, adequacy and effectiveness of the VUP (Vision Umurenge 2020) Program

Impact / Outcomes / Outputs	Priority interventions	Strategies
capacity and to address financial barriers to accessing IECD services	2. Enhance demand for key IECD services through incentives systems that augment household income 3. Increase access to social safety net to vulnerable households with low labor capacity and caring responsibilities; 4. Strengthen CRVS with a focus on registration of births and assignment of unique identification numbers at birth.	b) Increase access to social security and income support programs, particularly those benefitting young children from poor and vulnerable families c) Increase contribution of social protection for reducing malnutrition d) Strengthen social care service delivery for the most vulnerable, especially for families with children under six years, pregnant and lactating women e) Strengthen functionality of the CRVS information system, focusing on birth registration and certification and an integrated centralized system and
Output 5.2 Improved coverage, adequacy and appropriateness of social protection for reducing malnutrition, including nutrition-sensitive direct support, alternative income opportunities, food assistance and awareness raising on health, hygiene and nutrition		
Output 5.3 Improved capacity to deliver more comprehensive, responsive and effective social care services, especially for families with children under 6 years, and pregnant and lactating women		
Output 5.4 Capacity for integrated, interoperable CRVS system strengthened and awareness of CRVS increased		
Strategic Direction 6. Strengthened coordination, implementation capacity and governance to enhance quality delivery of integrated ECD interventions at all levels		
Outcome 6: Improved coordination, planning, monitoring and reporting to deliver high priority multisectoral integrated ECD services with optimal convergence at the household level		
Output 6.1 Strengthened platforms at all levels to enable multi-sectoral coordination of integrated ECD services	1. Increase capacity for multi-sectoral coordination and planning of integrated ECD interventions and delivery systems at central and decentralized levels; 2. Increase implementation capacity of stakeholders at national and decentralized levels; 3. Reinforce multi levels inter- and across-sectoral coordination to enhance convergence of various interventions at vulnerable households and ECD facilities 4. Establish effective accountability mechanism at all levels to ensure efficiency;	a. Prioritization of key interventions based on the collection of disaggregated data on IECD outcomes of vulnerable households and subgroups (newborns, under 2 years, under 5 years, pregnant and lactating women) to identify and address specific needs and forms of vulnerability b. Develop and integrate robust planning and M&E systems for prevention of all forms of malnutrition in children under six years and women of reproductive in districts MTEF (Medium Term Expenditure Framework) and budgets c. Develop accountability tools such as the community scorecard to support the convergence,
Output 6.2 Strengthened capacity for planning, budgeting, M&E and resource tracking to scale up integrated ECD interventions to targeted households at all levels		
Output 6.3 Strengthened mechanisms and tools for governance and accountability at all levels		
Output 6.4 Strengthened use of data and analysis to inform targeting, geographical prioritization and budget allocation		

Impact / Outcomes / Outputs	Priority interventions	Strategies
Output 6.5 Strengthened learning agenda for IECD through harmonized approaches to evaluations, surveys and research, and improved management information systems	5. Strengthen results monitoring system and capacity to track progress, results and resources at national and decentralized level; 6. Strengthen use of data to inform targeting, geographical prioritization and budget allocation. 7. Establish clear coordination and reporting mechanism of community front line volunteers operating at village level; 8. Improve community data collection/information system, data quality (accuracy and completeness) and easy access of NECDP M&E to other existing Government MIS; 9. Establish and operationalize learning agenda including evaluations and assessments planned by all stakeholders.	d. assessment, planning, monitoring and evaluation of service delivery. d. Capacity building at national and decentralized levels and strengthening of district level plans (including decentralized budgeting), integrated planning at district level that reflects IECD services in MTEF priorities' e. Ensure the alignment by all stakeholders to the National ECD SP and annual SAP implementation, evaluation and reporting systems f. Set up of clear mandates and responsibilities for IECD stakeholders at different levels (from national to village levels) in the implementation of the ECD SP g. Advocate and mobilize financial and human resources for IECD coordination and partnership activities at all levels.
Strategic Direction 7. Strengthened community-based platforms to enhance demand for and use of effective frontline service delivery systems of integrated quality high impact integrated ECD services		
Outcome 7. Strengthened community-based platforms to enhance demand for and use of quality, integrated frontline ECD services		
Output 7.1 Increased capacities of frontline workers (CHW, friends of family, agriculture promoters and ECD caregivers) to effectively deliver and coordinate high impact quality health, nutrition and ECD services	1. Increase demand of community-based quality Integrated ECD services 2. Increase capacities of frontline workers (CHW, friends of family, hygiene clubs, ECD caregivers and Agriculture promoters) to effectively deliver and coordinate high impact quality Integrated ECD services	a. Review and operationalize community-based screening and early identification systems of children at risk, including adoption of new methods, including innovative Growth Monitoring and promotion (GMP) at community level b. Build Capacity of the frontline workers to ensure quality of services
Output 7.2 Increase investments in and incentives for community-based platforms to improve quality and enhance convergence, including through community performance-based financing	3. Strengthen community referral and follow-up mechanisms of children to primary health, nutrition and social protection services 4. Improve quality of measurements and reporting systems for child growth monitoring and promotion at community level	c. Scale-up a package of prioritized community-based nutrition interventions to prevent and manage malnutrition in children less than 5 years, with a focus on (i) those aged less than two years for stunting, and (ii) pregnant and lactating mothers
Output 7.3 A harmonized, community-based package of prioritized nutrition interventions to prevent and manage	5. Strengthen community based nutrition programs including nutrition education and counselling	d. Scale-up nutritional direct support and management of vulnerable groups

Impact / Outcomes / Outputs	Priority interventions	Strategies
malnutrition is scaled up, including direct nutritional support for vulnerable groups	6. Strengthen interoperability of CHMIS and use for decision making at early stages 7. Build innovative cost effective approaches to enhance community participation in access and delivery of IECD services	e. Invest in robust M&E for nutrition innovations tracking and providing real-time disaggregated to the household level f. Invest in e-health technologies including phone application.
Output 7.4 Effective tools, systems and incentives in place to strengthen early identification and management of malnutrition and delayed development at community level		
Output 7.5 Strengthened community referral and follow-up mechanisms of children to primary health, nutrition and social protection services		
Output 7.6 Improved community health information systems, data quality and interoperability, including through the use of new technologies		
Strategic Direction 8. Increased efficiency, equitability and sustainability of financing national ECD program		
Outcome 8. Increased and more efficient, equitable and sustainable financing of integrated ECD services		
Output 8.1 Integrated ECD financing strategy for resource mobilization developed and operationalized	1. Effectively leverage existing systems and emerging opportunities in reducing the ECD financing gap 2. Develop and operationalize Integrated ECD Financing strategy 3. Develop and operationalize Resource Tracking System 4. Develop integrated Planning and Budgeting Tools for Integrated ECD services 5. Enhance Prioritization, Equitable Financing and support systems with a Focus on “High Impact” Intervention Multisector stakeholders' Accountability Framework	a. Develop long term ECD financing strategy b. Prioritize and significantly increase funding for integrated ECD services c. Ensure public financing for ECD services and utilize innovative finance to jump start investments d. Focus financing systems on improving quality and assuring equity e. Strength the capacity of the public sector to effectively allocate and use financing f. Support the generation of contextually relevant evidence that can influence advocacy efforts to
Output 8.2 Strong partnerships for resource mobilization developed, including with the private sector		
Output 8.3 Improved capacity of the NECDP sector, including skills and tools for integrated planning, budgeting, allocation and resource tracking at national and subnational levels		
Output 8.4 Increased financing for IECD leveraged though evidence-based advocacy		

Impact / Outcomes / Outputs	Priority interventions	Strategies
Output 8.5 Integrated ECD resource tracking system developed and operationalized	6. Develop and position DRM (Domestic resource mobilization) options that leverage other sources of funding including private sector (example of Singapore model that prescribes 1% levy on big companies to finance IECD services)	increase domestic financing and quality improvements g. Develop resources tracking system of all ECD investments from national to end beneficiary h. Develop scaling up scenarios for prioritized and targeted interventions i. Ensure Effectiveness of External assistance and GoR investments through Prioritization, Equity, and Efficiency j. Align Domestic resource mobilization strategies, including the private sector involvement, Public Community Private Partnership frameworks
Strategic direction 9: Strengthened leadership, partnership and coordination at levels in the delivery of Social and Behaviour Change Communication (SBCC) strategies tailored to all audiences.		
Outcome 9. Increased demand for and use of integrated ECD services through improved knowledge, behaviors and practices of parents, caregivers and frontline workers.		
Output 9. The National Social Behavioural Change Communication (SBCC) Strategy for Integrated ECD, Nutrition and WASH 2018-2024 is implemented	1. Ensure the implementation of the National Social Behavior Change Communication Strategy for Integrated ECD, Nutrition and WASH 2018-2024, and monitoring on a quarterly basis.	a. Promote integrated delivery of the SBCC through strong oversight of overall coordination and implementation of the National SBCC Strategy by the NECDP, including but not limited to organizing quarterly meetings of all related technical groups including Health Promotion TWG to monitor the progress on regular basis. b. Review and validation of all communication materials related to the implementation of ECD, nutrition and WASH activities by the National Health Promotion Technical Working Group. c. Support the coordination of Social Cluster Ministries in strengthening existing related policies and strategies, advocating for SBCC implementation, mobilizing resources, and supporting local governments in implementing the SBCC Strategy. d. Support the monitoring and evaluation of behavior change interventions by ensuring data availability through routine tracking or population-based surveys.

CHAPTER IV: MONITORING, EVALUATION AND LEARNING

4.1. Purpose & Scope of the Comprehensive Monitoring and Evaluation Plan (CMEP)

General Objective

To establish a national harmonized mechanism for performance monitoring and impact evaluation with agreed upon sets of input, process, output, and outcome indicators for tracking implementation progress over the duration of the NSP.

Specific objectives

1. To develop clear M&E strategies using standardized M&E and supervisory guidelines;
2. To regularly monitor progress and achievements of NSP components as a whole and improvements pre and in service delivery, quality of care and financial performance;
3. To evaluate the impact, effectiveness and cost-effectiveness of the Integrated ECD service delivery;
4. To define the roles of stakeholders in the systematic collection, collation, analysis and use of data in order to avoid duplication of efforts;
5. To improve information sharing and dissemination of information and the use of data for planning; and
6. To generate evidence on ECD and nutrition.

The CMEP is a tool, grounded in results-based management, to integrate and guide the process of planning, monitoring, evaluating, and reporting on NECDP progress toward achieving intended outcomes in the period of its National Strategic Plan (NSP) of 2018-2024. The CMEP addresses the standardization, the measurability, accountability, transparency, accuracy, responsiveness and learning. Overall CMEP will constitute a separate document.

4.2. NECDP M&E Organizational Structure

The NECDP M&E institutional framework / structure is divided into three levels: The national, district and community levels. Although described separately, these levels are linked and form an integral part of the NECDP M&E Framework.

4.2.1. National Level

The NECDP has the mandate of coordinating, monitoring, and evaluating all services related to Integrated ECD in the country. This includes operationalizing M&E and Research Policy and the development of standards in consultation with stakeholders and partners. Different M&E tools will be used by for monthly, quarterly, annually and 6-yearly performance monitoring and evaluation purposes. For each indicator, a separate textbox will provide space to record a succinct conclusion or interpretation of the observed value.

4.2.2. Decentralized levels (Districts, Sectors, Cells, and Villages)

The NECDP focal person based at district level will collect indicators (progress, output, proxy and outcome) at district level and monitor program activities. Specifically, he/she is expected to:

- Register and submit names of all stakeholders (Private sector, NGOs and CBOs) involved in the IECD related activities in the district, develop a database to track all partners and submit reports to the NECDP;
- Coordinate Integrated Supportive Supervision of M&E at the district level;
- Facilitate and ensure the use of M&E standardized forms for partners and ECD facilities and submit monthly data forms to NCEDP.
- Disseminate information from the NECDP and sensitize partners at the district/community levels.

Other decentralized entities will coordinate with NECD district focal person to monitor stakeholders' field activities and provide report at due time.

At community level, frontline workers will report on their respective indicators using simplified templates and/or forms. Those will feed the health centers, districts and other existing MIS exploited by trained staff.

4.2.3. Role of NGOs, CSOs & Private Sector

The NGOs, CSOs, and private sector at the district level have responsibilities to collaborate in the implementation of the district Single Action Plan, submit their program activity, data and information products to the district JADF, and participate in M&E and Research related activities and coordination.

Specifically:

- They will register and submit their annual plans, reports to the district NECDP focal person at regular time.
- Facilitated the M&E activities by using M&E standardized forms for partners and ECD facilities and submit monthly data forms to NCEDP;

The table below (Table 3) summarizes roles of all stakeholders in NSP implementation and M&E

Table 3. Summarized stakeholders' nature and method of engagement

Stakeholder group	Nature and Method of engagement
NECDP Coordination and staff: <i>Coordination, management, planning, monitoring</i>	NECDP is the GOR coordination entity the center of multisectoral relations: • To ensure all stakeholders' actions, interventions and support, related to integrated ECD respond to the needs of the most vulnerable children and families, meaning households with children under six years, pregnant and/or lactating women. • Interventions supported by domestic earmarked budget, as well as the support by non-governmental partners. • Systems are put in place for proper targets with appropriate IECD package. • NECDP ensures also all interventions planned by other GOR departments (Ministries, agencies and districts), are implemented and monitored accordingly, and reports are shared at due time with appropriate feedback. • Oversight of M&E and Research; • Setting minimum requirements for NECDP M&E and mainstreaming in all stakeholders' programs • Policy-making on M&E and address policy issues
Government: Steering Committee, Social Cluster and the public sector in general: <i>political leadership, guidelines</i>	• NECDP is governed by a Steering committee appointed by the GOR and chaired by the MIGEPROF Permanent Secretary; • NECDP collaborates closely with Social Cluster Ministries. • NECDP regularly engages central and local government and other public institutions through various relationships. • NECDP occasionally consults other GOR Departments and collaborates with districts and other decentralized entities for the implementation of stunting prevention and malnutrition reduction.
Prime Minister' Office	• Overall coordination and monitoring of the NSP
MIGEPROF	• Overall support and guidance for NSP implementation
MINAGRI	• Ensure food security particularly for most vulnerable households
MINALOC	• Ensure coverage of all vulnerable households in social safety nets
MINISANTE	• Ensure health system and services accommodate needs of most vulnerable households
MINEDUC	• Expansion of ECD facilities in existing primary schools
MINEMA	• Coordination and monitoring of emergency preparedness plans including nutrition services in all districts
MININFRA	• Enhance access to safe drinking water
Service end user stakeholders – : <i>ownership and sustainability</i>	• NECDP's service end users (<i>traditionally called Beneficiaries</i>) base comprises mainly children under six years and their families. • However, some interventions focus on adolescents, pregnant and/or lactating women. • Data on children are disaggregated into some age range according to the specificity of each age's needs.
ECD/Nutrition TWG And Social Cluster Ministries and Agencies	• Advise on technical/scientific matters in M&E and Research; • Provide support for scientific and technical indicators; • Participation in monitoring activities, mechanisms and reviews;

Stakeholder group	Nature and Method of engagement
Development Partners (DP) and Donors: <i>Financial and technical support</i>	• The relationships with DP such as UN family, multilateral and bilateral agencies are managed in terms of written Memorandum of Understanding (MOU) and/or collaboration agreements. • Particular relationship are developed with a given department based on specificity of DP and donors. The NECDP partnership officer serves as point of contact. • This group of stakeholders is also engaged through various Technical Working Groups chaired by NECDP which comprise stakeholders from various horizons. • Providing technical and financial support to NSP implementation, Monitoring and Research • Provide technical /scientific support in M&E and Research related matters; • Participation in monitoring activities and mechanisms;
Implementing stakeholders (NGOs & CSOs): <i>provision of service to target beneficiaries,</i>	• Most of implementing stakeholders are financially supported by DP and donors which are also NECDP partners. • The collaboration is also formalized through MOU and/or collaboration agreements, specifying areas of intervention, as well as package, targets, duration... • They are also members of Technical Working Groups • Participation in monitoring activities and mechanisms; • Participate in aligning their M&E units using the National M&E Framework/plan provided by the NECDP;
Private Sector: <i>Financial support</i>	• Recognition of the potential role of the private sector in the delivery of integrated ECD services especially. This may include: ○ Initiate, support and funding ECD facilities at workplace such as in Tea, Rice, sugarcane cooperatives and factories; ○ Participation in bio fortification of most consumed food stuffs and their distribution. ○ Increase great involvement of private sector in Rwanda in the provision of ECD services. For instance, according to ECD mapping³⁹, overall private ECD initiatives represent 37.31 % as the biggest group. In Kigali City and Eastern Province, they even represent respectively 67.25% and 40.99 % of ECD service provision. ○ Motivate private companies to take their corporate social responsibility (CSR), to regularly support IECD. Most of such support is sporadic, not easy to forecast and needs more orientations to make it more beneficial to the community. • NECDP role would be to channel the good will of CSR into strategic and convergent input that enriches the Strategic Plan and overlap positively with existing interventions. • NECDP also engages with the business community, professional associations and research organizations across various levels on a regular basis. • It a positive rewarding habit of NECDP to regularly recognize for their contributions to prevent stunting and/or reduce malnutrition

³⁹ The national mapping of ECD programs for children in Rwanda, 2018, MIGEPROF, ESRI

Stakeholder group	Nature and Method of engagement
Public Service Providers: District, sector and cell: <i>provision of service to target beneficiaries</i>	- Engagement include ongoing equitable, convergent and inclusive service provision to eligible and vulnerable children and families. - District, sector and cell staff as well as volunteers at grass roots level have the core responsibility to ensure convergence during implementation related directly or indirectly to stunting prevention and malnutrition reduction. - Decentralized entities staff have also a huge mandate during implementation of GOR and other stakeholders' programs and projects: to provide insight on local reality and context, and targeted beneficiaries, . - Accuracy, transparency, objectivity, punctuality in reporting will maximize evidence based intervention - Coordinate data collection from community level and partners, monitoring and reporting; - Provide technical input and capacity to community frontline volunteers involved in data collection at grassroots level, - Identify gaps and lessons learnt to share with NECDP and concerned stakeholders
Members of the media: <i>advocacy, public awareness rising</i>	- NECDP engages with the public through media for community awareness and to better spread its activities, achievements and lessons learnt: this includes weekly radio magazine, popular social media (Facebook, twitter...) that allow interactions with broad audience and provide update on activities. Journalists who wish so can conduct one-on-one interviews (radio, TV, print and/or online) with officials or technicians of NECDP. - Ad hoc requests for interviews and participation in panel discussions are also very common.
Communities (Individuals, Households, CBOs)	- Participation in monitoring activities and mechanisms; - Providing views and perceptions to evaluations
Research institutions/ Consultancy companies	- Conduct high quality research and disseminate research findings to the NECDP and partners; - Advise in the development of the NECDP Research Strategy

4.3 Performance Management Plan (PMP)

The PMP is part of CMEP, and is a tool designed to help setting up and managing the process of monitoring, analyzing, evaluating and reporting progress toward achieving NECDP objectives. PMPs will enable operating units to collect comparable data over time.

It serves as a reference document that contains indicators definition, unit of measurement, data disaggregation, rationale, responsible office/ person, data source, frequency and timing, data collection methods, data quality assessment procedures, data limitations and actions to address those limitations, data analysis issues, data use, baselines and targets.

All NECDP indicators will be included in the Data Reporting Form that contains targets for each indicator and will be used by programs to report results. Data quality checks shall be done at least twice per year by the central Monitoring & Evaluation Unit and more frequently at the District and ECD setting level.

4.3.1 Using M&E Results for Improving IECD Performance

Monitoring and evaluation are carried out at different intervals and with a common purpose. Table 4 below presents some of the specific purposes of using different types of M&E results.

Table 4. Using M&E Results for Improving IECD Performance

Use of different series of M&E reports	Monthly monitoring	Quarterly monitoring	Annual Monitoring	Evaluation (Mid-Term, yearly)	6
Improve the quality and coverage of services	X	X	X	X	
Solving practical problems	X	X	X		
Supervision	X	X			
Preparing the annual plan			X		
Fine tuning annual plans	X	X			
Preparing the NSP				X	
Fine tuning the NSP			X		
Budget allocation			X	X	
Human resource allocation			X	X	
Calculation of supply requirements	X	X	X		
Target revision			X	X	

4.4. Management Information System

This subsection describes the data management information system to be used by the NECDP. This may include use of DBMS, Microsoft Access, or some other participant tracking platform. For non-direct service programs, a simpler information management system may be developed to capture capacity and awareness raising efforts, including tracking of trainees, training of trainers, etc. This section describes key functionalities and features of the database, including data security. NECDP will put in place a MIS that can access to existing MIS from social Ministries. In case different systems could not talk to each other, NECDP MIS officer would be given rights to access to those systems to get accurate data related to NECDP mission.

4.4.1. Assessment of Effectiveness and Gaps of Sectoral Management information systems

The first step would to assess interoperability between existing MIS for social Ministries and agencies; those are mainly MOH/RBC, MINAGRI/RAB, MINALOC/LODA, MINEDUC/REB, MININFRA/WASAC, etc.

4.4.2. NECDP MIS and Dashboard

The aim would be to allow NECDP MIS to read data from those systems and/or to have live access to the system. This assessment would then lead to the design of NECDP MIS, taking into consideration existing data and their sources versus NECDP expected database.

NECDP M&E/planner will have access as administrator. However, all stakeholders will have access to their respective portfolios.

4.5. Learning and Knowledge Management Agenda

In this section, NECDP and partners will list and briefly describe the evaluations and any M&E-related surveys and studies to be undertaken by the program during the SP of 2018-2024. Research and Evaluation Activities that should be listed in this section include: interim and final evaluations as applicable, baseline and follow-up surveys, institutional surveys, pre-situational analysis, market assessments, capacity-building needs assessments, Knowledge, Attitudes, and Practices (KAP) surveys, and any other qualitative and/or quantitative studies that directly relate to tracking program results or to informing program strategy.

CHAPTER V: FINANCING OF INTEGRATED ECD PROGRAMS

5.1 Financing Landscape of IECD Interventions

Early Childhood Development Program requires sustainable multisectoral financing to ensure continuity and meaningful results. To ensure program sustainability, integrated interventions must be supported by sustainable financing modalities beyond the current fragmented finance approaches.

Multi-sectoral funding of Integrated ECD Interventions under the umbrella of NECDP is an opportunity that heralds with challenges that are largely attributed to the complex nature of integrated ECD framework that spans from the period from conception to six years and covers a range of sectors including early learning and education, nutrition, water, sanitation and hygiene (WASH), health, social protection, and community initiatives. This is exacerbated by lack of reliable data on Planning, Budgeting, allocation, Expenditure Analysis and Reporting within various streams of potential funding mechanisms for this strategic plan.

The multisectoral dimension of NECDP National Strategic Plan 2018-2024 presents a vital opportunity to guarantee certain levels of domestic funding of a broad range of interventions that are reflected annual single action plan (SAP) where all GoR institutions commit resources for I-ECD services within the institutions and periodic monitoring of the implementation of SAP is under the Leadership of the Prime Minister with Management and Technical coordination aspects under NECDP.

The funding for several I-ECD related sectors is unpredictable. For example- a review of food and nutrition security (FNS)⁴⁰ issues revealed that, the share of ministries engaged in FNS fell between 17% and 34.8% during 2013/2014 to 2016/2017. Financial estimates of specific activities linked to FNS measure between 5% and 8% of the annual budget increments in the agriculture and health sectors. These two sector ministries rely partly on external funding which constitutes 49% and 50% of their respective annual budgets. Furthermore, specific FNS activities receive low prioritization in terms of resource allocation during the annual Imihigo, in which they receive an estimated 5% of the total planned budget.

In respect to social protection programs, this review indicated that the overall level of annual budget increments is about 12%. Comparatively, the role of the private sector in investing toward FNS-related activities is still limited partly because FNS continues to be perceived as a social responsibility of the government.

The 2017 Global Nutrition Report⁴¹ indicates that Rwanda registered one of the largest decreases in donor investments in nutrition. Key bottlenecks to effective financing of this investment case include but are not limited to:

- Multisectorality of the investment case with fragmented sources and flows of funding.
- Prioritization of interventions for increased investments in Integrated ECD Financing.
- Inadequate reliable data and tools to inform integrated planning, budgeting and resource allocation while ensuring quality and equity.
- Little evidence of incentives/motivation for private sector engage in ECD service provision.
- Inadequate capacity of delivery systems of the public sector to effectively allocate and use financing for ECD services.
- Inadequate capacity for multi-sectoral policy planning to scale programs, and ensure efficiency, coordination, and alignment across financing streams.
- Lack of institutional capacity to generate contextually relevant evidence that can influence advocacy efforts to increase domestic financing and quality improvements.
- Lack of reliable data and institutional analytical capacity to inform ECD investment cases with financing scenarios where GOR and donors increase volumes of financing.

⁴⁰ Rwanda Strategic Review of Food and Nutrition Security June 2018 Report

⁴¹ 2017 Global Nutrition Report

- Lack of Systems and Tools to ensure Accountability for resources invested and optimal convergence of services at various levels.
- Unpredictability of both medium and long-term funding for I-ECD services (Macroeconomic projections for social services & External funding reliance)

5.2 Financing Framework for IECD financing

Financing of Integrated ECD services is largely from domestic and development partners sources. Funding portfolios of both domestic and external sources vary across the components of integrated ECD package including health, food security, nutrition, WASH, social protection and ECD domains. Further analysis to explore potential increase of resources allocated to I-ECD related services as well as un-packing their net share with-in their respective sectors and identifying with-in-sector opportunities and trade-offs to increase fiscal space of I-ECD services. Table 5 below illustrates various financing frameworks for the integrated ECD services

Table 5. Various financing frameworks for the integrated ECD services

Financing framework	Financing Mechanisms	Funding flows	Management and spending decision levels	Convergence issues at Targeted levels
Domestic Financing	• Multisectoral funding of NSP/SAP from Sectoral domestic budget • Direct Domestic Budget allocation to NECDP through MTEF	• Direct Transfers to Ministries/Affiliated agencies • Direct transfers to subnational entities for specific activities and services • Multiple flow of funding • Fragmented Action Plans and reporting systems	• Management and spending functions are both national and subnational levels based on levels of interventions • No clear-cut delineation between national and subnational level functions	• Harmonization of Activities and resources at National and district levels towards the desired Convergence remains elusive. • Multiple flows of financing present a threat to effective convergence of services
External Financing	• Direct Budget support • Sector Budget support • GoR projects support • Off Budget support	• Multiple flows of financing • Fragmented Action Plans and Levels of Implementation. • Fragmented accountability and reporting systems • Donor specific interests in Prioritization and funding levels allocation for off budget • Geographical and coverage inequities	• National with limited responsibilities to districts and below • Dialogue with several sectors presents difficulties	• Difficulties in alignment of external finding to domestic resources, fragmented planning and budgeting is a critical challenge to optimal convergence of services to the targeted levels/Households
Private Sector	• Direct investments • Partnerships • CSR	• Purely private sector Engagement • Public Private Community Partnerships (PPCP)	• GoR dialogue with potential private sector actors	• Ensure alignment of investments, Geographical coverage, and quality of services to ensure optimal convergence.
District resources	• Domestic Budget Support to district • District own generated resources • 25% of Annual district performance contracts to reflect I-ECD specific priorities	• Transfers from central government • Local administration taxes • Development Budget support to districts	• Management functions are at district level • Spending/Allocation • Functions are predetermined during Annual Planning and Budgeting process aligned to GoR MTEF.	• District specific Annual Single Action Plans to maximize convergence of services at beneficiaries' levels • District ECD SAP to be holistically integrated in Integrated Districts Annual Action Plan that informs the MTEF budget consultation Process.
Community systems	• In-Kind • Volunteering	• Direct community participation in constructing low cost and/or won ECD community centers • Leveraging Community level infrastructure for ECD Facilities • Parents Volunteers directly providing care to ECD Facilities	• Community level leadership and dialogue with other local actors and district authorities	• -Community participation in Accountability tools like Community Score cards • Community participation in all channels targeting underserved areas and Households

Financing framework	Financing Mechanisms	Funding flows	Management and spending decision levels	Convergence issues at Targeted levels
Health centers	- Internally generated resources - Direct Transfers from central Government (MoF) - Transfers from vertical funding programs	Generated own resources and Transfers	Spending done at health center/Community levels	Health Center has supervisory role of frontline workers (Community Health Workers) and providing integrated health and Nutrition Services—therefore critical in ensuring optimization of Convergence actions.
CHW Cooperatives	- Internally generated resources - Performance based financing payments	- Income Generating Activities - PBF payments	Provide Community based Health and Nutrition package of services.	Frontline workers critical in ensuring Optimal convergence of services
Strategic Purchasing of High Impact Health and Nutrition services	PBF payments to Health centers and Community Health Workers	Combination of Domestic and External Funding	Prioritization by services and districts is critical	Increase demand and supply sides of these services with enhance Convergence
Health Insurance Schemes	Community Based Health insurance Scheme (Mutuelles)	Mutualism covers all package if health services at health center	All the vulnerable households are subsidized by the Government	Increased access and utilization of essential PHC services for the poor and vulnerable will enhance convergence
Civil society and Faith based organizations	-Need to Establish CSO engagement Strategy - FBOs are very instrumental in providing ECD services	- Strategic partnership with FBOs to finance ECD services is vital - Strategic engagement with CSOs in service delivery platforms accountability is critical	FBOs and CSO make their own contributions through dialogue and engagement of actors at all levels.	FBOs and CSOs are inevitable partners in ensuring accountability in service delivery and optimal convergence of actions at targeted communities/HHs
Special programs (social protection programs, Monthly Community Service day etc.	Special programs targeting the poor directly leverage financing of I-ECD	Ensure that the design of these programs and coverage are pro-poor and I-ECD sensitive.	Management and spending /allocation functions are both and national and decentralized levels depending on sources of support	Special pro-poor programs are critical in increasing access and utilization of I-CED service and therefore imperative in enhancing optimal convergence.

5.3 Resource Mobilization

Resource increases from Various financing frameworks for integrated ECD services that include; Health, Nutrition, WASH, Social protection, and ECD remain unpredictable although all these social services constitute the social transformation pillar of Rwanda's National Strategy for Transformation 2017-2024. This poses challenges and uncertainty in realization of some social sector targets and more specifically stunting and given its long-term negative effects on human capital development and poverty eradication, stunting is high on the government of Rwanda's political and development agenda. This generates the need for unconventional strategies to mobilize resources and increase efficiencies while maximizing conventional modalities largely the public and external funding.

5.3.1. Public Financing of Integrated ECD services

These include;

- Domestic resources
- Local government (Districts) resources
- Community (Health centers and Health Posts)

The public financing of I-ECD SERVICES should be built along two main channels: (i) on the supply side, the implementation of fiscal decentralization with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance. (ii) On the demand side, established and strengthen local financing mechanisms that are subsidized by domestic resources and the private sector.

5.3.2. Domestic Funding of I-ECD services

Domestic resources at the central level for the integrated ECD services are allocated through annual planning and budgeting cycle to various budget agencies specifically 11 ministries and affiliated agencies. They include; Ministry of Health, Ministry of Agriculture and Animal Resources, Ministry of Gender and Family Promotion, Ministry of Local Government, Ministry of Education, Ministry of Youth, Ministry of Infrastructure, Rwanda Biomedical center (RBC), Rwanda Agricultural Board (RAB), Local Administrative Entities Development Agency (LODA) and the main stream National Early Childhood Development (NECDP) which is the coordination and main implementation agency.

The Multisectoral funding and allocation is aligned to Annual Single Action Plan (SAP) that is developed in aligned to the GoR annual Planning and budgeting cycle. The SAP is developed prior to sector budget consultations so that its priorities are included in the budget framework paper (BFP).

The Multisectoral domestic funding for the NSP/Investment case through Annual SAP presents a unique opportunity that locks domestic resources for Integrated ECD services and a strong and sound SAP planning and budgeting process supported with evidence and data is an imperative pre-requisite to make a compelling to the ministry for financing an economic planning for more resources.

The report dubbed 'ESA National Commitment to Nutrition' indicated that while regional countries have failed to meet their commitment of injecting 3% of budgets to nutrition, Rwanda allocated the biggest amount and the South Sudan the least. Rwanda had the highest allocation from own resources at 0.8% of the national budget, while South Sudan had the lowest at 0.09%. Rwanda allocates the most, followed by Malawi (0.58%) and Madagascar (0.57%)," read in part the report conducted on national budget frameworks between 2016/17 fiscal years.

5.3.3. Local government financing (Districts)

Districts are also budget agencies separate from sector-line ministries and prepare the annual district development plans in line with GoR planning and budgeting cycle. Districts start the planning and budget process with the performance review of the previous in consultation with partners, then with support of the Intergovernmental Fiscal Relations Unit in the ministry of finance and economic planning, districts consult line ministries for earmarked transfers. Districts from Annual budget are approved by the District Council and submitted to the ministry of finance

and economic planning and fed into the consolidated Budget Framework Paper. District sources include Block transfers, Earmarked transfers, district own generated resources (mainly from local taxes) and development budgets.

District planning process also include prioritization for Annual performance contract they sign with the president and a threshold of 25% of interventions in the annual performance contract are Integrated ECD services drawn from the Annual I-ECD Single Action Plan. The Single Action Plan (SAP) at District level presents a unique opportunity for districts to finance the priority high impact interventions and integrate into DDPs.

5.3.4. Health Centers

Health Centers mainly operate with internal revenues from insurance fees among other as well as support from central government more especially financing targeting diseases and programs (Vertical funding).

They also receive performance-based financing (PBF) for services they provide and these are also considered as additional (generated) revenues.

Additionally, Health Centers manage pay for performance (Community PBF) funds for Community health workers frontline workers and also have a supervisory role to CHWs in ensuring quality delivery of integrated health and Nutrition Services—therefore critical in optimization of Convergence actions.

There is a dire necessity to reduce the financial management burden of Health centers that includes funds from the general GoR budget, donor support, insurance schemes and co-payments as well as out-of-pocket payments from those not covered by insurance. These types of multiple flows could be streamlined in future reforms to decrease transaction costs, increase efficiency and create clearer value for money incentives for the different actors in the health financing system

5.3.5. Community Participation

Community participation is critical in leveraging financing of I-ECD services more specifically in establishment of community ECD Facilities, home-based ECDs, community partnerships in constructing low cost ECD Facilities and Parents Volunteers directly providing care to ECD center as well nutrition support. Community level leadership and dialogue with other local actors and district authorities are pivotal in success of community driven approaches and this community model presents an excellent opportunity for Accountability tools like Community Score cards.

5.3.6. Community Health Workers (CHW)

Community Health Workers (CHW) are frontline workers and have a cooperative in each catchment area of the health center. They are close to 15,000 CHW and provide among others Community based Health and Nutrition package of services at community and household levels. CHWs also provide support referrals to Health Centers. CHW cooperatives receive incentives through performance-based financing mechanisms. Funds generated through pay for performance are invested in Income Generating Activities (IGA), shared as individual dividends, and a certain percentage re-disbursed to PBF account at the health center. The model is currently being revised to address financing sustainability challenges.

Community health workers in Rwanda constitute one of the most cost-effective system in provision of community-based health and nutrition services and present an investment opportunity for sustainable financing of delivery of integrated ECD services. Other Frontline workers in the national strategy including but not limited to; Friends of Families (IZU), Farmer Promoters, Farmer Field Schools (FFS) will be strengthened, trained, and provided with systems-based incentives as well in framework of enhancing the convergence of interventions an community and household levels.

5.3.7. Faith Based Organizations (FBOs) and Civil Society Organizations (CSO)

Faith Based Organizations (FBOs) have been and remain instrumental in providing ECD services through establishment and supporting of ECD Facilities. A strategic partnership modality with FBOs and the Governments

(National and sub national levels) will be explored. This partnership will accelerate access to ECD services and effectively leveraging the financing systems of Integrated ECD services. The Access to ECD gap is wide and there a need for unconventional approach to accelerate to that NST target of 45% in 2024.

5.3.8. Civil Society Organizations (CSO)

Strategic engagement CSOs in service delivery platforms and accountability for convergence is critical. A clear pathway to empower and improve access of CSOs to funding thus enabling them to play a pivotal role in service delivery and accountability of integrated ECD services at community level will be explored. CSO in Rwanda have established and ECD platform to coordinate and inform their actions in supporting the delivery of integrated ECD services. Capacity building with CSOs with accountability tools is vital in harnessing better accountability for resources and results.

5.3.9. Private Sector Engagement

Private Sector Contribution to integrated ECD services is currently not adequately documented but can traced from specific sectors notably; Health, Nutrition, WASH, Social Protection and ECD domains. Citing Health sector as an example, As Rwanda looks to sustain and build on its hard-earned gains , it prioritizes Private sector investment , which could potentially help fill this gap from 1.7% to 5% of health sector share of GDP (or approximately \$260 million/ year) would cover almost 50% of annual total health expenditure.

The GOR, its development partners (DPs), and key stakeholders recognize the importance of increasing private sector engagement (PSE) as a means to Availability, Access and Utilization of quality equitable I-ECD services. There is a need to assess the landscape, identify potential opportunities and key obstacles, and develop a framework or roadmap toward increased and sustained PSE in Integrated – ECD services. Private health expenditure remained lower during these years, with USD 8.2 per capita in 2010 National Health Accounts (NHA). Public Private Community Partnerships (PPCP) have worked well in establishing Community Health Posts in Rwanda and this model can potential be replicated to accelerate access to ECD Facilities. Corporate Social Responsibility (CSR) is also a way forward to enhance access to ECD services and The National Agricultural and Exports Agency (NAEB) has introduced partnership with Local Tea Company and Communities in the catchment of Tea Plantations to establish and fund ECD Facilities benefiting those communities.

5.4. External Funding

External Funding vital to the sustainable financing for Integrated ECD program in the medium term and phased graduation in the long-term. Mechanisms of support include; Direct Budget Support, Sector Budget Support, Projects and off budget support. Though not aggregated by sectors, External funding remains significant in ensuring adequate and effective delivery of services. The spending on nutrition is at \$9.48 per child from the government's own resources and donors spend \$39.55 per child (ESA report 2018) Rwanda's proportion of budget to nutrition stood at 1.12% with 0.80% was supported by donors.

There is considerably more donor investment in nutrition-sensitive approaches and programmes with declining funding for nutrition-specific investments (Global Nutrition report 2018). Much alike, in Rwanda, Development partners need to prioritize investing in nutrition-specific and nutrition-sensitive programmes equally. GoR has demonstrated high level commitment to bridge the nutrition financing gap though buying-in to global initiative including the Global Financing Facility (GFF) and *The Power of Nutrition* initiative .GoR is committed further through international obligations – Sustainable Development Goals (SDGs), the UN Decade of Action on Nutrition 2016–2025 and the Milan Global Nutrition Summit in 201 and on track ahead of the Japan 2020 N4G Summit.

There is a need for improved coordination, harmonization of development partners funding in Rwanda in light of multifaceted challenges including but not limited to;

- Multiple flows of financing
- Fragmented Action Plans and Levels of Implementation.
- Fragmented accountability and reporting systems
- Donor specific interests in Prioritization and funding levels allocation for off budget

- Geographical and coverage inequities
- Difficulties in alignment of external funding to domestic resources, fragmented planning and budgeting is a critical challenge to optimal convergence of services to the targeted levels/Households

5.5. Purchasing, payments and services

5.5.1. Strategic purchasing

Improving the strategic purchasing of health, nutrition services is central to improving health system performance and achieving desired outcomes. Moving to strategic purchasing is the focus of health financing reforms with aim to address some of the underlying bottlenecks in accessing high impact Health, Nutrition and services. Careful considerations on who purchases the services? Which services are purchased? How are services purchased? From which providers are services purchased? Could potentially have a major impact on health system performance, in particular the efficiency and quality of services, and reducing inequities in access and use of the prioritized high impact health and Nutrition Services. This purchasing mechanism will be expanded to cover a range of other IECD services (ECD, WASH).

Rwanda has successfully implemented performance-based financing (PBF) at all levels of the health care delivery system. It is among the best practices in health financing innovation establishing direct linkages between finances and outputs and outcomes. The PBF system, that purchases outputs and outcomes, has been a key factor in supporting improved efficient utilization of scarce financial resources for health and progress rapidly toward the health Goals. There is a need to have improved integration of prioritized high impact Health and Nutrition services into purchased services to ensure more sustainable outputs and outcomes for quality health and nutrition services for the targeted age groups with a focus on children under two years, pregnant and lactating mothers. Innovative stronger linkages and integration all health and nutrition purchasing mechanisms is critical. Some development partners in Rwanda are starting budget support in different sectors using results-based financing (RBF) approaches.

5.5.2. Health Insurance Schemes (Community Based Health Insurance)

The costs of health and Nutrition care services increases as the burden of diseases is stressing existing health systems. Financial prevention and risk pooling for health cost sharing are an important pillar of universal health coverage (UHC) and translates into increased access and Utilization of high impact health and nutrition services for all children under six years, Women in Reproductive Age (WRA) and adolescent girls. The population coverage in 2018 was at 85% with the poor (Ubudehe Category 1&2) fully subsidized. This critical to child survival, maternal during pregnancy and at birth and adolescent health.

Health Insurance schemes (Mutuelle de Sante) continues to be strengthened and ensuring the comprehensive coverage for the low income and informal sector categories of the population with cross-subsidization (increasing contribution by private and public insurances) for the low- income categories.

With the changes in burden of disease, the benefit package of health insurances will be expanded to include some non-communicable diseases (NCDs) and other emerging health priorities while maintaining coverage for Communicable diseases.

The financial health protection will be enhanced for the reduction of out of pocket payment through the reduction of co-payments. The effective management of co-payments will ensure that there are no barriers to service utilization. More analytical work is needed to explore the feasibility of high cost co- payments subsidizing low cost co-payments.

There is ongoing analytical work to devise strategies & interventions increasing domestic resources to subsidize the co-payments that are becoming increasingly unaffordable. High impact services like reproductive health, child health, Malaria, HIV/AIDS, and other programs are heavily (more than 85% for HIV and Malaria) funded by external financing. It makes Rwanda's health financing system unsustainable and exposed to any rapid shock as external funding is declining and current increase in domestic resourcing not unable to fill the gap. Innovative options will be developed for raising domestic resources to cover a larger part of health resources.

5.5.3. Special programs for the poor

Special programs for the poor will attract non-conventional funding and appeals to different actors at Special programs targeting the poor directly leverage financing of I-ECD. Although these programs sanctioned by the national level leadership, or Districts Initiative provide an opportunity for increased investments towards those specific programs that have been prioritized. They include One-cow or small stock per family, VUP, Kitchen garden per House hold among others.

5.5.4. Integrated Planning and budgeting for I-ECD services

The Overarching goal is to strengthen coordination among GoR and all development actors working at the national and local government levels to achieve shared development objectives, align development plans. This is pivotal for mutual accountability for resources and results.

The Integrated ECD Single Action Plan (SAP) at National and District levels will reflect implementing partner budgets and work plans and integrated into the district development plans. This will enable national and district levels to successfully coordinate ECD partners and strengthen their service delivery. It's in this respect that, introduction of an Integrated Planning and Budgeting (IPB) tool for both central and district levels will substantially enhance better coordination, resource allocation and accountability for results while advancing the Paris Declaration Principles of Aid Effectiveness and the GoR Partnership with DPs. Furthermore, ECD- SAP processes at National and District levels will lead to Increased domestic resources for the Investment case through

- Aligning annual planning and budgeting of the ECD-SAP to GoR planning and budgeting process (MTEF) at National and Districts Levels. The SAP process will essentially lock resources from various sectors earmarked for I-ECD services in various GoR budget agencies. The process will inform various stages of GoR planning and Budget Cycle.
- Introduction of IPB will facilitate effective Integration of SAP priorities in district performance contracts at a threshold of 25% that's is required by the office of the prime minister (OPM).
- Effective Integrated Planning and Budgeting process will optimize District I-ECD SAP district budget allocation approved by district councils.

District Budget Cycle

Intergovernmental Fiscal Relations Unit (IGFR) in MINECOFIN acts as the coordinating unit between the district and national budget cycle.

- Districts carry out their own review of last year's performance which is discussed at the Joint Action Forum in month 2.
- During budget preparation, districts participate in consultations with line ministries on Earmarked Transfers.
- MINECOFIN (IGFR) sends out the District Budget Call Circular for Districts to prepare their budgets.
- Following the finalization of the BFP at the national level, districts can prepare their detailed budget based on final resource envelopes in discussion with the districts' Joint Action Forum.
- District budget is approved by District Councils

Specific aims of the application of IPB Tool at national and district levels include but are not limited to;

- Ensure that SAP priorities are aligned with national level sector plans and district development plans.
- Eliminate duplication and improve complementarities among ECD SAP implementing partners.
- Strengthen the district's National and District level ECD SAP joint coordination, implementation, monitoring, and evaluation of activities within the district.
- Facilitate district governments' understanding of ECD SAP portfolio and increase the resources allocated in the district Budget cycle.

5.6. Efficiency, Equity and Accountability of I-ECD Financing

Efficiency, Equity and Accountability are cardinal ingredients of any financing regime with resource limited setting and result oriented –Reducing stunting by over 2% per year in such resource constrained environment requires greater efficiency, addressing geographical disparities and having accountability mechanisms at all levels of implementation. This will require a balanced combination of both Technical efficiency and Allocative Efficiency.

Technical efficiency will focus on which inputs in I-ECD care and service are optimized and allocative efficiency', will focus on how well the outcomes of services provided are distributed among the targeted population--Revolving around what might represent the mix of services or interventions that maximizes the improvements and outcomes needed. This concept of value for money will require additional analytical work like cost-effectiveness analysis among others. The Efficiency phenomenon has to be institutionalized at both national and district level planning process in order to secure an optimal convergence on necessary interventions in targeted communities and households.

Key Efficiency gains

Increased efficiency for improved quality and service delivery of Integrated ECD services (value for money) through;

- 1) Improving Planning, Prioritization and budgeting process at national and district level
- 2) Improving Allocation and utilization processes:
- 3) Explore opportunity for improving categorizing of budget finance flows to reduce transaction costs.
- 4) Examine which elements of the budget can be used to purchase outputs instead of inputs.
- 5) By examining various systems and their delivery mechanisms, explore significant opportunities and multiple options for improving efficiencies.
- 6) Reducing administrative costs, reducing transaction costs and management costs.
- 7) Developing increased performance or result-based financing, and
- 8) Improving aid efficiency. Through better alignment of their planning and budgeting process to GoR systems and priorities
- 9) Utilization of innovations in Information & Technology (IT) platforms for service delivery

5.7. Resource mapping

NECDP will initiate and operationalize a periodic multi-sectoral IECD resource mapping exercise in routine systems and in consultation with stakeholders to provide better data for the planning cycle. Key considerations include:

- Clarity on how and when data will be used
- Embedding IECD resource mapping data needs in information systems to increase efficiency, reduce duplication and enhance sustainability
- Building capacity in the public sector, donors and other implementers
- Getting buy-in from government and development partners on what data to collect and how to collect it (this will also help to build ownership)
- Identifying and tracking IECD multisectoral programs
- Consulting with all relevant sectors to ensure the data is useful to them.

5.8. Resource Tracking of IECD Interventions

It is a high priority for NECDP as envisaged in ECD-SAP 2018/219 to track all I-ECD services including Health Nutrition, WASH, Social protection and ECD investments at the national, district levels and below. The resource tracking attribute adds more value to accountability at decentralized levels with the view that district authorities are responsible for a sizable proportion of total spending as well as delivering key services including Nutrition, primary health, early childhood education, water and sanitation and social protection programs.

The importance of district level financing of integrated ECD services is Picking momentum given the significance of improved data on domestic spending in improve track ability and impact of this financing. Resource tracking shows which actions are being financed and which are not.

NECDP will initiate and operationalize a Resource Tracking System (IECD-RT) where all stakeholders (GoR and Patners) supporting the implementation of IECD-SAP enter their planned activities and the estimated budgets for the forthcoming fiscal year and also enter achieved activities, Targets and expended budget for the preceding fiscal year. The IECD-RT will also have district levels of reporting and approvals. The system will have feature and user guides that prevent double counting of financing and reports.

CHAPTER VI. IMPLEMENTATION AND COORDINATION ARRANGEMENTS

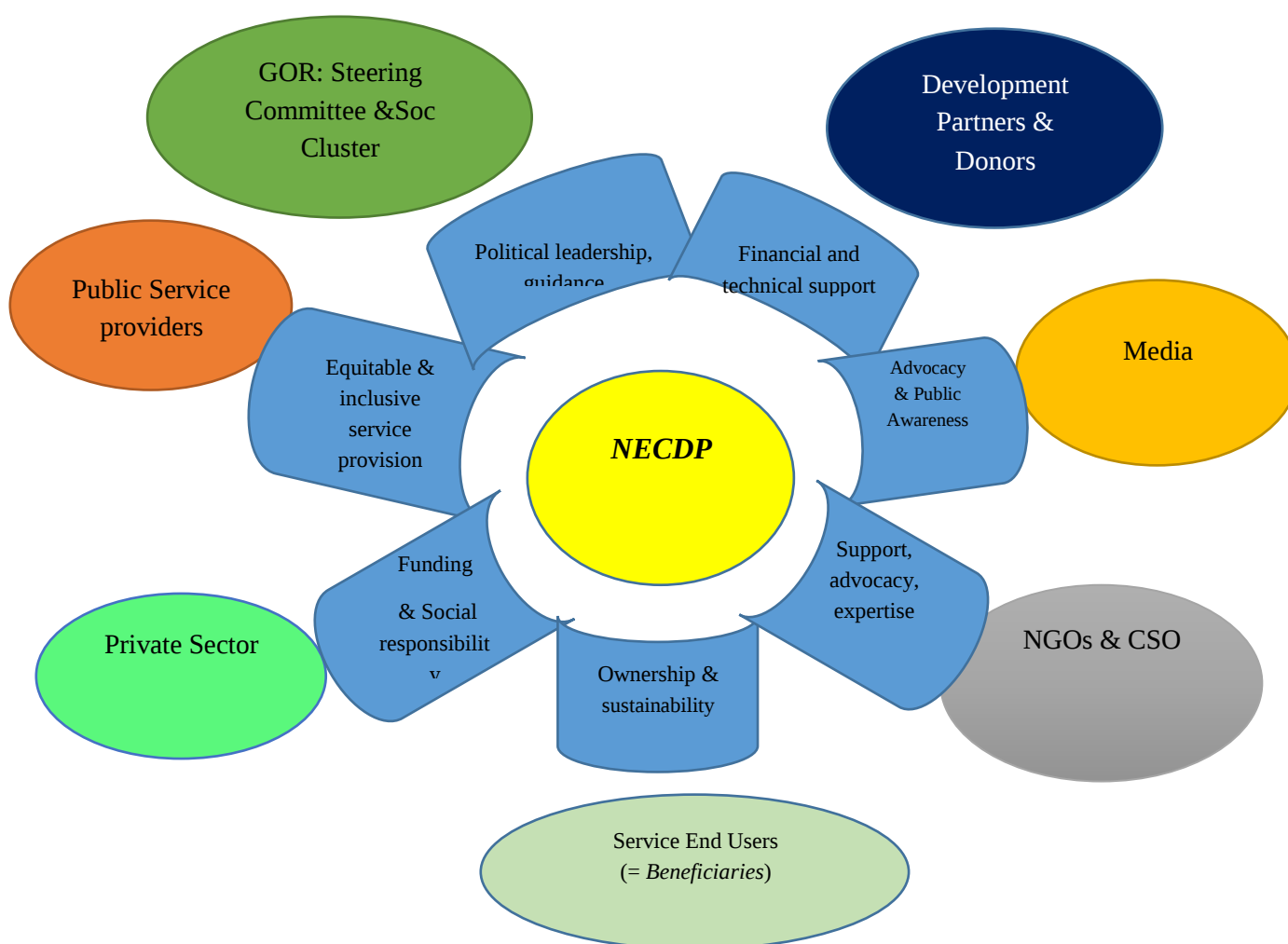
This chapter intends to describe the implementation arrangements for the National Strategic Plan (NSP) that would allow smooth achievement of target and reach efficiently real impact.

6.1. Institutional Arrangement

6.1.1. NECDP structure at national level

This section briefly describes the organizational structure of NECDP at national level. It clarifies the roles & responsibilities for the implementation of NSP at national level. According to the article 4 of the Prime Minister's Instructions N°003/03 of 23/12/2017 determining the organization and functioning of the NECPD, its mission is to coordinate all interventions that support adequate early childhood development for children from their conception to six (6) years of age as outlined in the Early Childhood Development Policy. The figure 7 illustrates well key positions for NECDP organigram at national level. Therefore, NECDP is at the center of multistakeholders' interventions, from GOR institutions and other stakeholders, as illustrated in Figure 6.

Figure 7. NECDP central role



6.1.2. Country Management Platform

The NSP framework will operate under a platform for collaboration and collective action by the NECDP and the district Teams, and a wide array of stakeholders including beneficiary communities, FBOs, CSOs, NGOs, the private sector, and development partners. These partnerships are critical to build capacity, support innovations, foster multi-sectoral collaboration across disciplines and invest in research and performance measurement and accountability (PMA) to measure results and track progress. The NECDP intends to use the IC (NSP) to enhance operationalization and management of the external support and improve the coordination in program planning and implementation, at central and decentralized levels.

The NECDP liaises with social cluster ministries, including MIGEPROF, MINALOC, MINEDUC, MOH, MININFRA, MINISPOC, MINAGRI, MINEMA and their respective agencies, as well as through existing technical working groups, to build synergies to help obtain overall Investment Case objectives leveraging. Existing funding and programming available at district level will allow for greater impact across all sectors.

6.1.2.1. Leadership at National level

A great political commitment to rank IECD among country priorities, henceforth NSP implementation comes from His Excellency the President of the Republic, concretized by the instructions from the Prime Minister to the district Mayors to ensure that at least 25% of their “imihigo” (performance contract) are IECD related. Coordination of overall NSP implementation at its highest organizational level is in the Prime Minister’s Office through the Social Cluster Ministerial Committee that meets quarterly to review progress reports on integrated ECD from NECDP. This will surely boost budgeting from domestic resources, in addition to various donors and implementing partners on the field. A quarterly evaluation of NSP takes place at the PMO convening all social cluster Ministries that help NECDP monitoring the progress of NSP/IC implementation at all levels.

In order to strengthen the consistency and efficiency of actions undertaken by many sectors and partners, integrated ECD activities will be coordinated at all levels. Each level has its specific mission: central level to conceptualize policies and strategies, mobilize resources, and coordinate all interveners, while offering technical services in support of the district level which operationalizes or implements programs and supports those managed by the community.

The overall guidance of NECDP is ensured by the Steering Committee, nominated by the Government meeting, whose responsibilities embrace: providing overall leadership of NECDP coordination and address institutional challenges that may arise on the course of implementation, providing overall guidance and orientation on key priorities of NECDP, receiving and approving the progress reports on a quarterly and annual basis, providing recommendations and feedback for policy and program adjustment towards effective implementations, considering the final NECDP implementation plans and budget. The National Steering Committee has its regular meetings monthly.

6.1.2.2. Decentralized levels (Districts, Sectors, Cells, and Villages)

District level coordination

The District Platform will have three components: oversight, management, and operationalization of the IC, meaning the NSP for NECDP. It will use existing structures already in place, such as JADF and DPEM. The latter should be revised and strengthened as needed throughout a District SAP reflecting integrated ECD and convergence approach, under the guidance of NECDP district focal person; he will ensure that all key implementers align their interventions with NECDP NSP, hence district SAP. In addition, new members should be added to the existing DPEM (Vice Mayor in charge of Social Affairs, Director of Health, Director General of Hospital, hospital nutritionist, Health centres managers’ representative, National Women Council, National Youth Council, CHWs supervisor, District Agronomist and Veterinary); those are the ones in charge of Education, Family and gender, Disaster Management Officer, in charge of Nursery, Hygiene and Sanitation Officer. Other key actors from development partners, NGOs, CSOs, private interveners involved IECD related matters should join as well. The DPEM committee primary functions are: review and planning, coordination of multisector participation in joint IECD activities, monitoring implementation of interventions; and ensuring full integration of DPEM into district development plans, performance

contract (imihigo) and budget. At district level in particular, NECDP focal person will provide guidance on implementation, monitoring and reporting of IECD related activities implemented by district and/or its partners.

Sector level coordination

Sector level administrations will also form sector IECD steering committees or any other coordination committee, with similar membership of the district one, to coordinate technical assistance to communities, mainly targeting, as they refocus on integrated ECD beyond nutrition and food security. Technical assistance and funding support will be welcomed from NGOs, CSOs, private sector at each level, including those at community level. This layer of coordination may be needed to effectively support village-level activities.

The NECDP focal person will support sector staff in capacity building to ensure that all interventions are implemented, monitored and reported accordingly.

Cell and Community level

At community level (cell and village), all frontline volunteers will contribute to NSP realizations in their respective sectors of interventions. Those include CHW in maternal and children's health and nutrition, Friends of Family (IZU) in child protection care, agriculture promoters in food security and nutrition-sensitive agriculture, including kitchen gardens, and community-based nutrition support services.

For accountability of community service delivery, NECDP and its stakeholders will initiate community score card (CSC) for frontline community volunteers. CSC on village level will focus on the convergence of essential services to reduce stunting and eliminate malnutrition through IECD: (a) Access and Utilization of Quality ECD services, (b) Child Protection and Inclusion services, (c) Positive Parenting and Early Stimulation, (d) mother and child health services; (e) Food Security services, (f) nutrition counselling services; (g) safe drinking water, Hygiene and sanitation services; (g) and Social Protection.

CSC helps to identify how services are being experienced by the users and providers, reports on quality of services to a district executive committee or council, ensures informed decision making, tracks if services and programs are progressing well. It involves the community and service providers in joint decision-making and planning processes, share responsibilities for monitoring the quality of services with users. The CSC, in addition to being useful in planning at village level, will also become input into NCEDP MIS.

6.2. Governance, Convergence and Accountability

This National Strategic Plan for NECDP aims at reducing Stunting through integrated ECD, is also a guide to promote institutional cooperation and ensure the convergence of all programs and activities associated with IECD at all levels. The optimal convergence focuses on children from 0 to 6 years of age, pregnant women and lactating mothers, especially in most vulnerable households. The first 1,000 days of a child are the most critical in addressing stunting and malnutrition, which includes the nine months of pregnancy, six months of exclusive breastfeeding and the complementary feeding period from 6 months to 2 years. Further, continued attention on children in the age group of 3-6 years would contribute to their overall development.

6.2.1. Convergent coordination

The NCEDP Strategic Plan (NSP) counts on convergence of various patterns by identifying and bringing under one framework key integrated Early Childhood Development related interventions, meaning early stimulation, child protection, positive parenting, food security, nutrition, water, sanitation, hygiene indicators and targets to be monitored and achieved by relevant line Ministries/Departments implementing the NSP.

The convergence guidelines are annexed to this document.

NECDP role will also strengthen convergence through coordination and consolidation of central, district and village programs and activities. Implementation of convergent interventions will be conducted by aligning processes of planning, budgeting, implementation, monitoring, evaluation and activity controls across sectors, as well as between different governance and public levels.

The National Steering Committee at national level and DPEM committees at district level will ensure convergence mainstreaming in planning, periodic review, coordination, monitoring and evaluation, identifying gaps and suggesting measures to fill the gaps.

At district level, DPEM committees will perform the convergence approach to design Annual DPEM aligned to NSP and SAP by end June for the subsequent year. To facilitate the bottom up approach of convergence plan adoption, decentralized entities and frontline community volunteers will participate in early stage of development of DPEM. They will also contribute in implementation and regular monitoring.

During this process of convergent action planning and review, the identified gaps will be addressed by initiating interventions by the respective Department(s). These gaps could either be a financing gap for an existing intervention, an intervention which is relevant for IECD but missing from the action plan, or an innovation that the district wants to undertake to address the nutrition challenge.

The Action Plans at different levels (SAP, DPEM, performance contracts/imihigo at village level) will incorporate 'Baseline and/or contextual Data' and specific time bound 'Targets' to be achieved, monitored and mechanisms to track progress. Committees at all levels will be expected to use this convergent framework to track these key interventions and their progress. All activities are coordinated at the national level by the NECDP, involving relevant technical ministries, GOR agencies, decentralized entities and other stakeholders, at all levels.

The NECDP coordination aimed at reducing stunting and eliminating malnutrition, adopts a convergent, life-cycle and result oriented approach. While several services aimed at improving malnutrition are delivered through the health services, the role of other programs is equally relevant. Children's brain early stimulation, child protection, positive parenting, water, sanitation, hygiene, social protection and poverty reduction, are among some of the critical factors that contribute to improved nutrition and ensuring that all these services converge on a household is essential for reducing stunting in the country.

The delivery and implementation of high priority multisectoral services with optimal convergence requires an improved coordination, planning, monitoring and reporting at all levels. The national level is driven by NECDP coordination team, the district level by District Executive Committee supported by NECDP focal person and the community level by frontline community at grassroots with direct support and supervision of respective GOR services and staff. Those are health facilities that coordinate CHW, in charge of social affairs at sector level that coordinate IZU and Agronomist who coordinate agriculture promoters.

A prioritization exercise will be conducted at different stages to select the most highly interventions from the NSP and SAP at national level. Each district will proceed to customize and adjust its SAP and DPEM, based on its respective local context and reality: stunting rate, identified gaps versus existing opportunities, etc. Surveys and studies reports such as DHS, EICV, FNG, CSFVA will be of great help.

DPEM at district levels will ensure that Community based platforms have got skills and incentives to coordinate and support demand for and use of effective frontline service delivery systems of Integrated quality high impact Integrated ECD services. Financial support will come from both domestic resources and partners' investments.

A strong governance, management and coordination structure is as critical as the proposed interventions in ensuring effective implementation and achievement of the NSP stated results. To the extent possible, the governance and management of the NSP will build on existing structures at national and district levels. The existing structures will be assessed, then strengthened to ensure effective coordination, inclusiveness, transparency, accountability and convergence. DPEM will be revised taking into consideration the convergence at all levels of IECD in reducing stunting and malnutrition.

Steering and DPEM committees respectively at national and district levels will further ensure release of funds to the relevant department for action/implementation of the NSP interventions. (i) they will follow up with the concerned

line department to ensure that funds for implementation of the outlined interventions have been released to the districts concerned, wherever required.

Customizing DPEM should be based on existing data at each district level, such as health MIS, RAB/MINAGRI database, data on existing ECD facilities and gaps.

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|---|
| <ul style="list-style-type: none">● Overall Coordination & Accountability: <i>The NECDP Steering Committee chaired by the Permanent Secretary at the Ministry of Gender and Family Promotion</i>● Operational Implementation at National Level: <i>NECDP Coordination team</i>● Operational Implementation at District Level: <i>Expanded DPEM</i>● Support Committees: <i>Relevant TWGs, various Cluster Ministries including their implementing agencies</i> |
|---|

At district level, the revised/expanded DPEM Committee will be responsible for the overall implementation of the NSP at all levels of IECD service delivery as well as coordination of all players within the district of operation. NECDP district focal person will provide technical guidance to the convergent implementation and monitoring of the NSP. Each year, he will ensure an adjusted SAP from the NSP prioritizes convergent interventions into the district plans, performance contract and budget.

Village level: sector and cell staff will provide to frontline community volunteers at village level information related to key indicators, gaps and target in IECD related matters, to help them commit to realistic, measurable and impactful “imihigo” in reducing stunting and malnutrition at their level.

6.2.2. Service Delivery Approaches

6.2.2.1. Integrated Service Delivery Approach

Integrated service delivery model is an effective and efficient strategy in the delivery of services aimed at stunting reduction and malnutrition elimination. Various mechanisms will ensure this integration, such as joint planning and coordination, joint M&E frameworks, joint reporting, pooled funding, etc. This NSP will support and strengthen bi-directional integrated ECD services across the continuum of lifecycle approach, focusing mainly on children under six years, pregnant and lactating women targeting the most vulnerable households.

The lifecycle approach for integrated Early Childhood Development considers various stages of the human development to ensure optimal development of children under six years. Programs and activities focus to improve life during pregnancy (antenatal care to mitigate/anticipate infant and maternal mortality), early childhood care (including early stimulation, positive parenting, child protection and inclusion, reducing stunting and malnutrition) but also goes beyond to pre-pregnancy period, that include health and nutrition of adolescent girls. The NSP will provide high impact RMNCHN services package, adjusted to each category of beneficiaries: Adolescence to pregnancy, during birth, under six months, 6–23 months, 24–59 months.

6.2.2.2. Multisectoral approach

The Rwanda Investment Case will prioritize and implement evidence based multisectoral interventions. The NSP recognizes that improving maternal, new born, child and adolescent indicators involves many varied sectors completing each other. To adequately and sustainably address bottlenecks to access and utilization of quality integrated ECD services, this strategy will promote a multisectoral response bringing in other sectors that impact on children under six years. It involves health, education, nutrition, food security, agriculture, social protection, economic empowerment, water, hygiene, sanitation among others.

6.3. Roles and responsibilities

6.3.1. Stakeholders’ engagement

A stakeholder engagement program considers the impact that each stakeholder group may have on NECDP business, while the frequency and form of engagement is aligned to its estimated impact. NECDP’s stakeholder engagement

program supports its efforts to be a successful, stable and ethical program contributing to the reduction of malnutrition and prevention of stunting of the vulnerable communities in Rwanda.

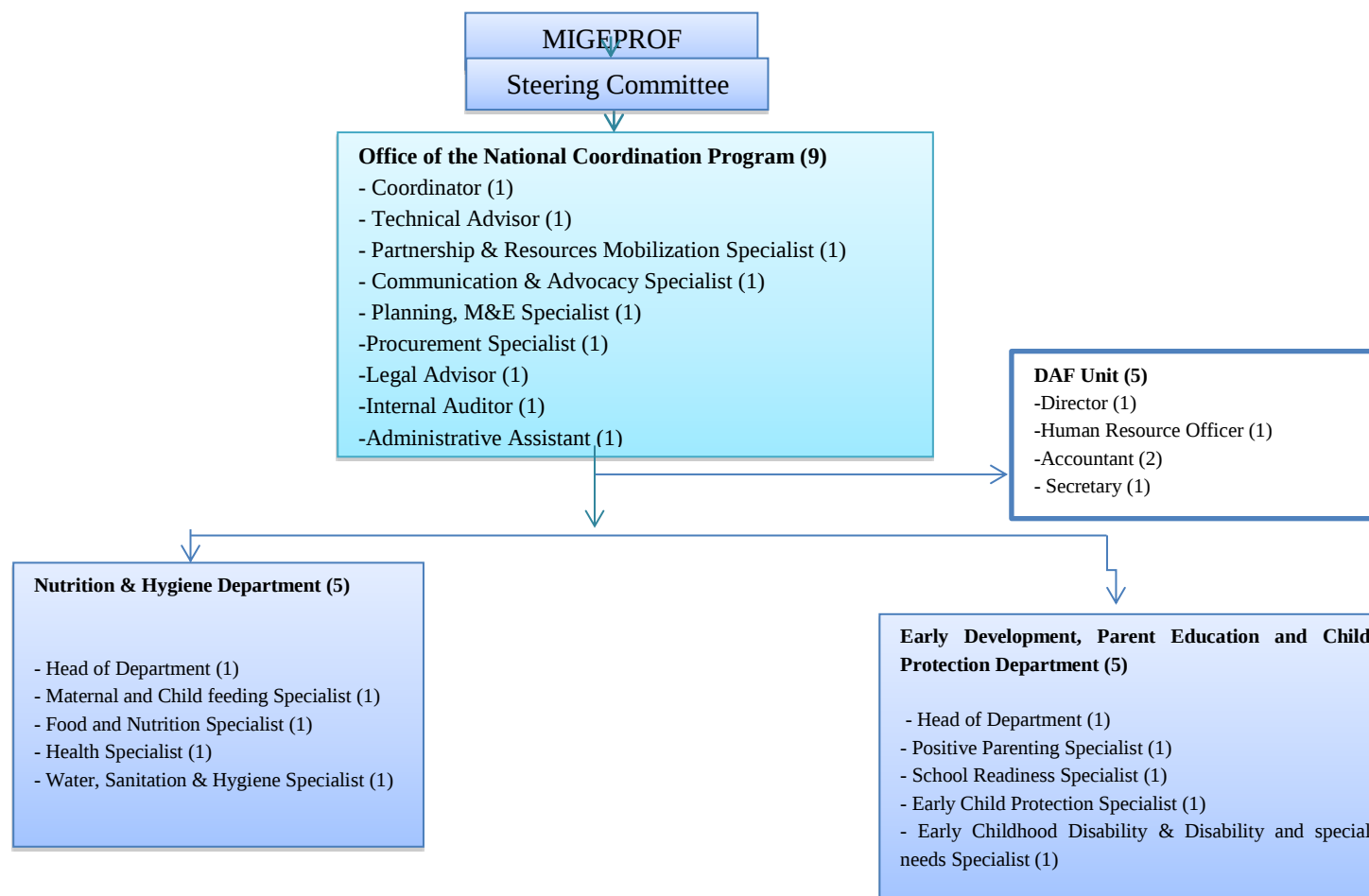
The development of the NSP as well as the SAP has been very participatory. Input and contributions were provided by all key stakeholders, in addition to NECDP technical staff, officials and its steering committee. Particular commitment involved Permanent Secretaries of all social cluster Ministries, who ensured that all SAP 2018/2019 activities had respective approved budget, while final validation was done by the social cluster Ministers on September 17, 2018 during a special meeting convened for only the SAP validation. A final approved SAP was officially submitted to the Prime Minister's Office (PMO) on September 18, 2018

NSP is the guiding tool for partnership, resource mobilization and allocation. All partners' interventions in the upcoming 6 years will align with identified NSP high impact priorities to reduce stunting and eliminate malnutrition.

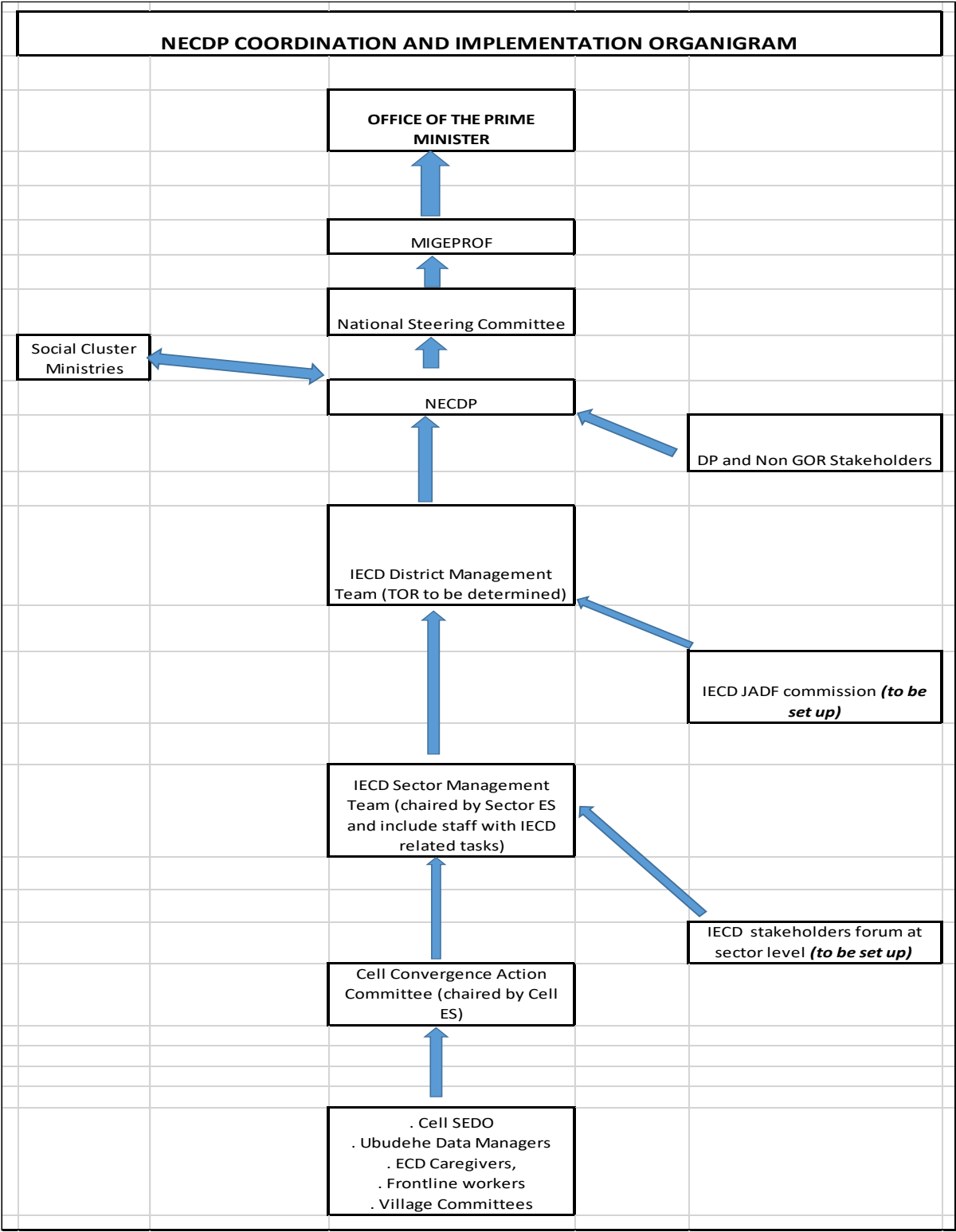
6.3.2. Multi-stakeholder Management, Monitoring and Reporting Mechanism

Stakeholders' engagement and management is pivotal to the NECDP partnership initiatives. The ultimate purpose of such engagement is the efficient use of time and resources thereby positively impact existing and/or emerging NECDP challenges. NECDP will design a digital tool (application) for the Stakeholders' Engagement and Accountability that outlines a systematic model for planning, managing, and implementing and monitor stakeholders' engagement based on NECDP Six Years Strategic Plan. This tool will be equally viable at central and decentralized levels.

Figure 8. NECDP Organizational Structure



6.4. Coordination platforms structure

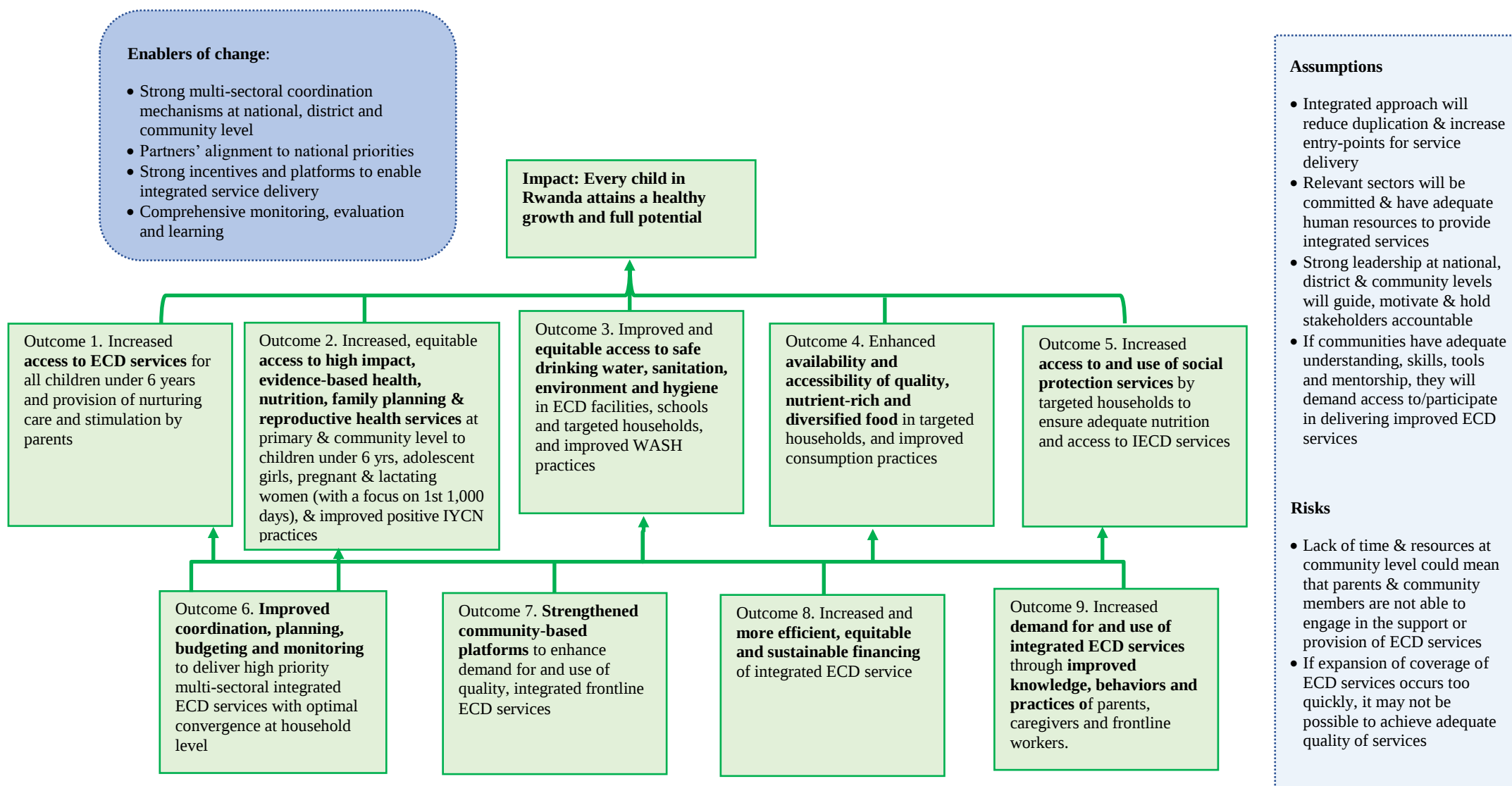


ANNEXES

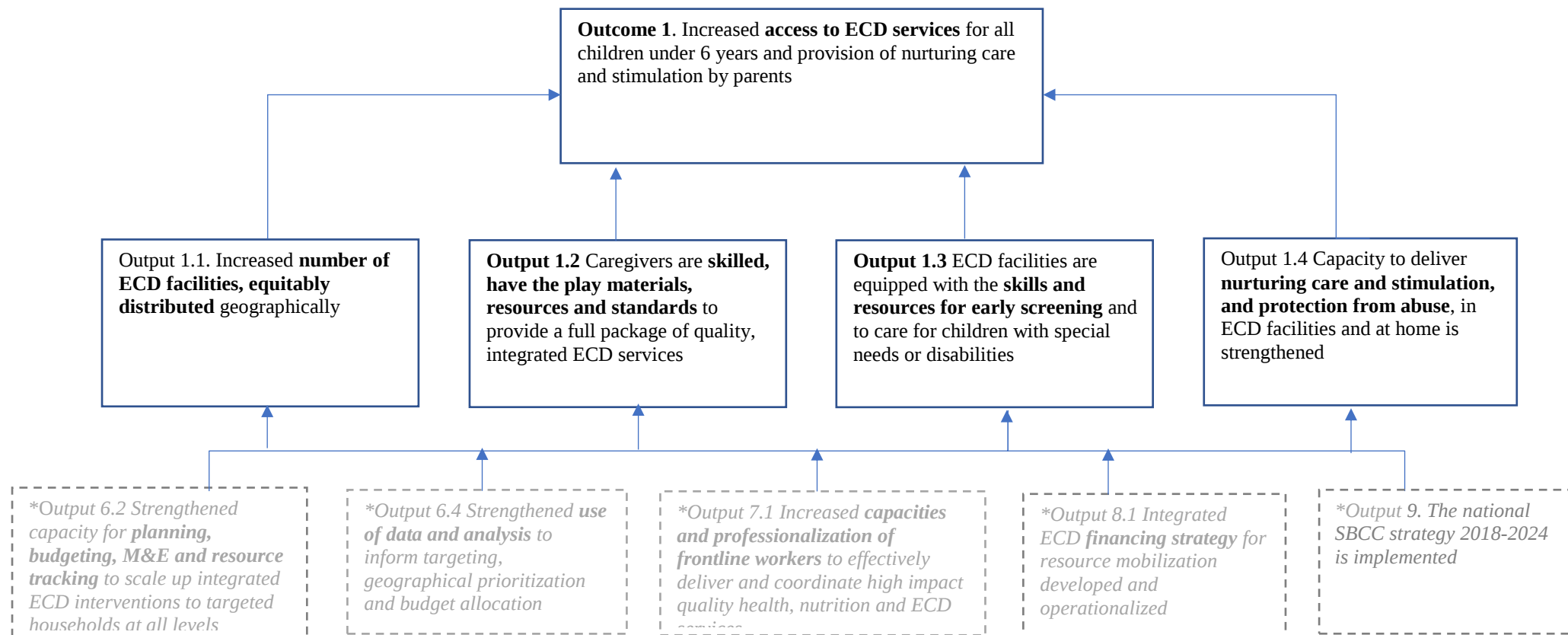
Annex 1: Results Framework

Annex 2: Comprehensive Monitoring and Evaluation Plan (CMEP)

Annex 3: Detailed Theory of change (ToC)

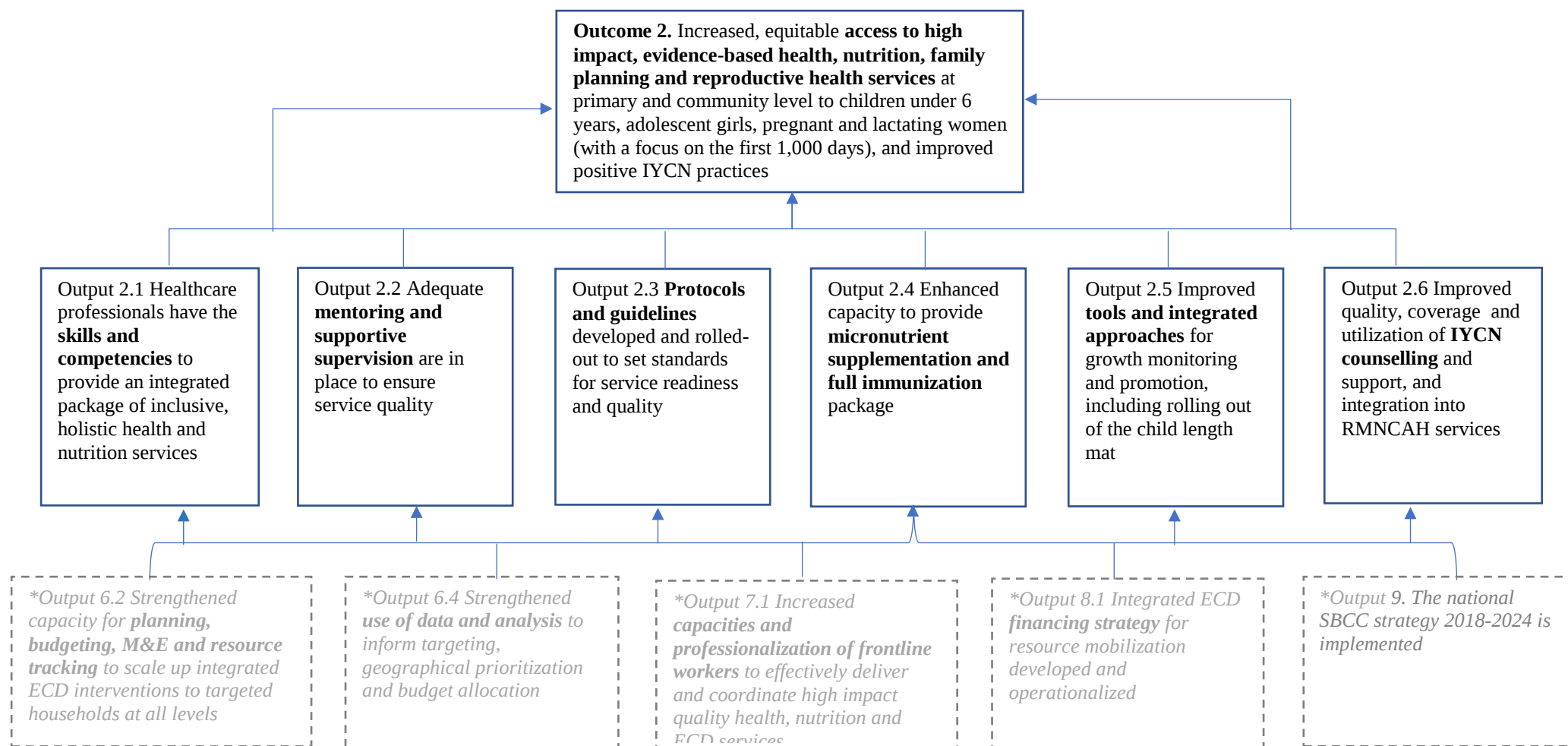


Strategic Direction 1. Increased equitable access to quality and inclusive integrated ECD services



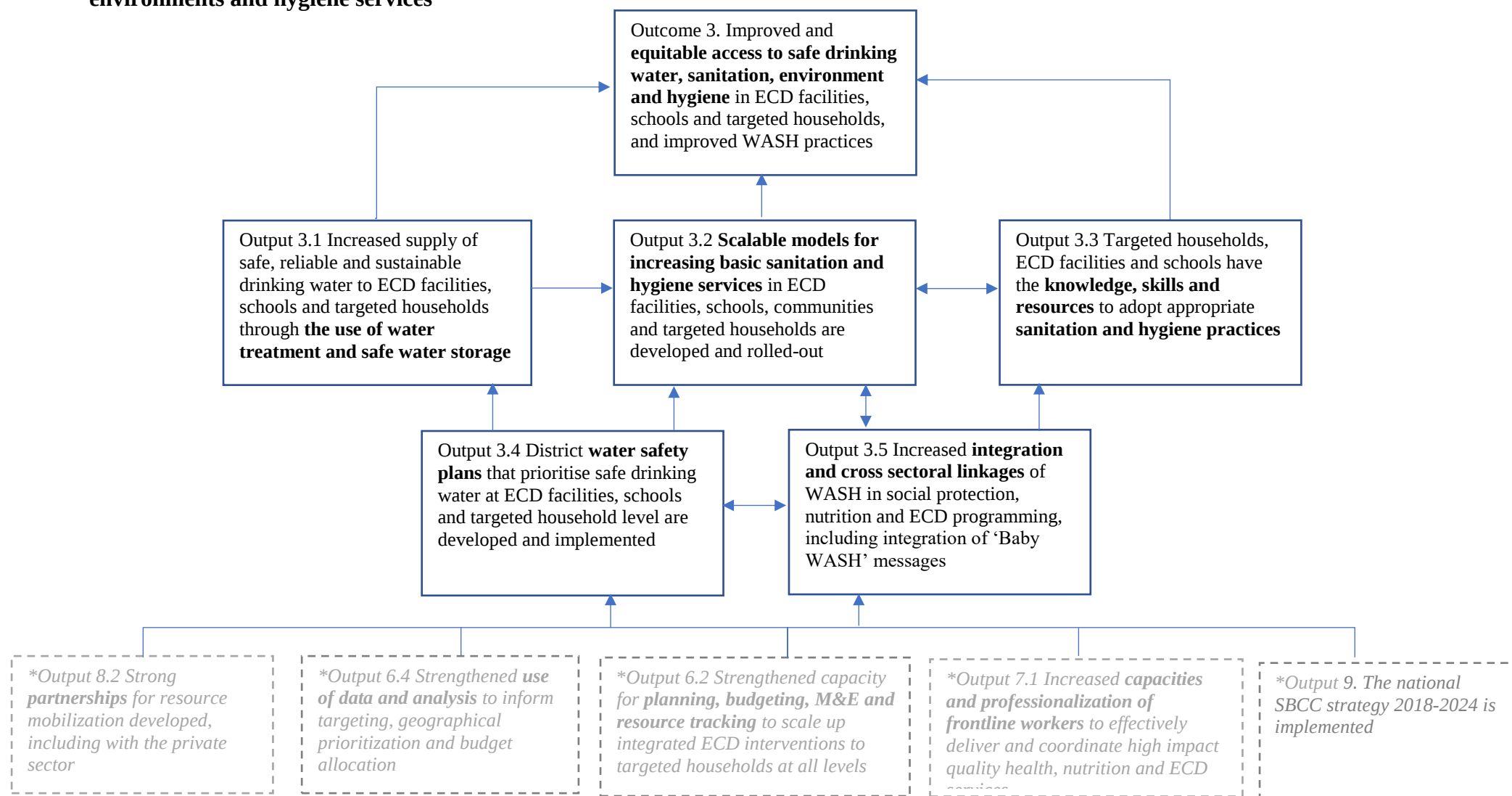
** All the changes in Strategic Directions 6, 7, 8 and 9 contribute to achieving the outputs and outcome above, but those outputs that are directly critical to this particular Strategic Direction are included here in the boxes with dotted lines*

Strategic Direction 2. Improved and sustained quality health and nutrition status of infants and young children with a focus on the first 1,000 days of life



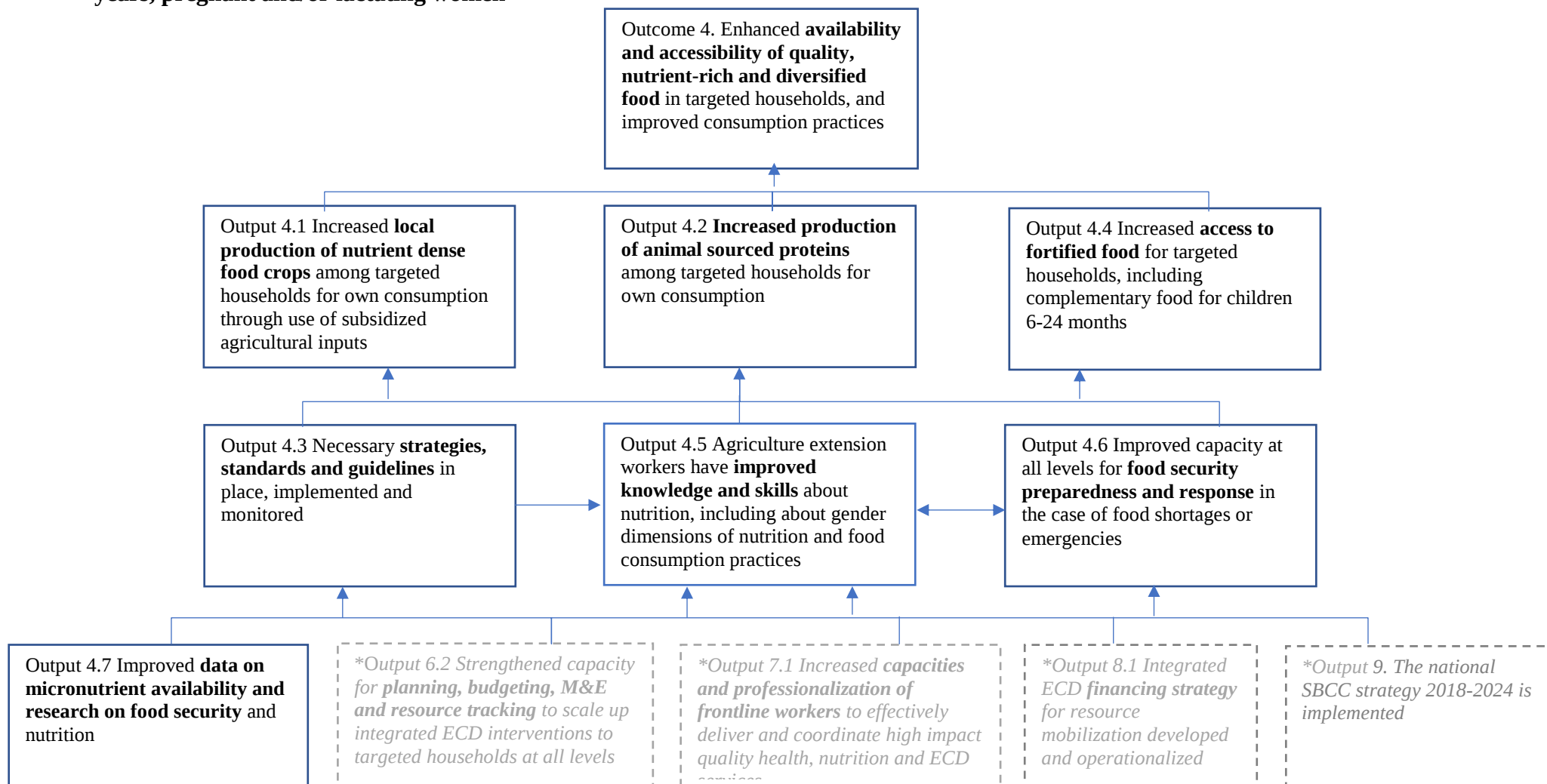
** All the changes in Strategic Directions 6, 7, 8 and 9 contribute to achieving the outputs and outcome above, but those outputs that are directly critical to this particular Strategic Direction are included here in the boxes with dotted lines*

Strategic Direction 3: Enhanced national capacity to support targeted households with safe drinking water, basic sanitation, healthy environments and hygiene services



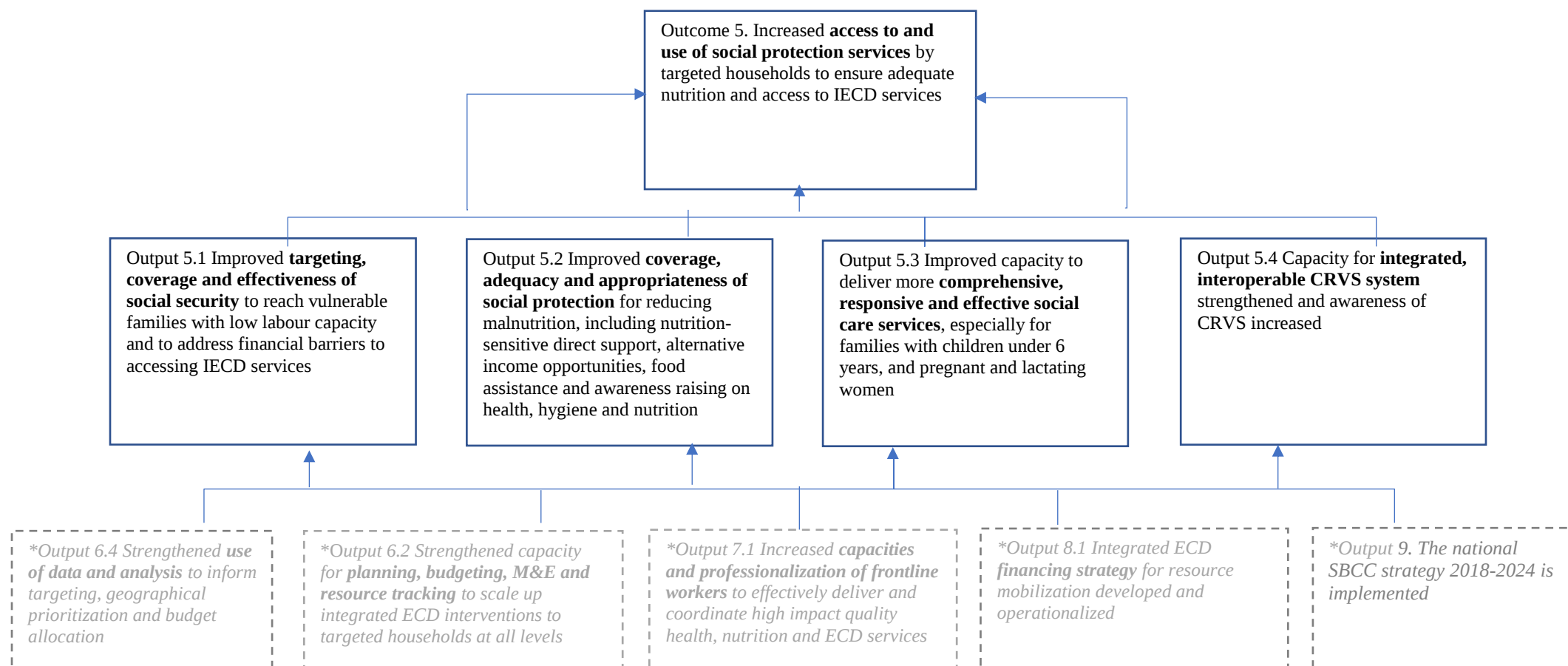
* All the changes in Strategic Directions 6, 7, 8 and 9 contribute to achieving the outputs and outcome above, but those outputs that are directly critical to this particular Strategic Direction are included here in the boxes with dotted lines

Strategic Direction 4. Improved and sustained equitable food security for family health in targeted households with children under 5 years, pregnant and/or lactating women



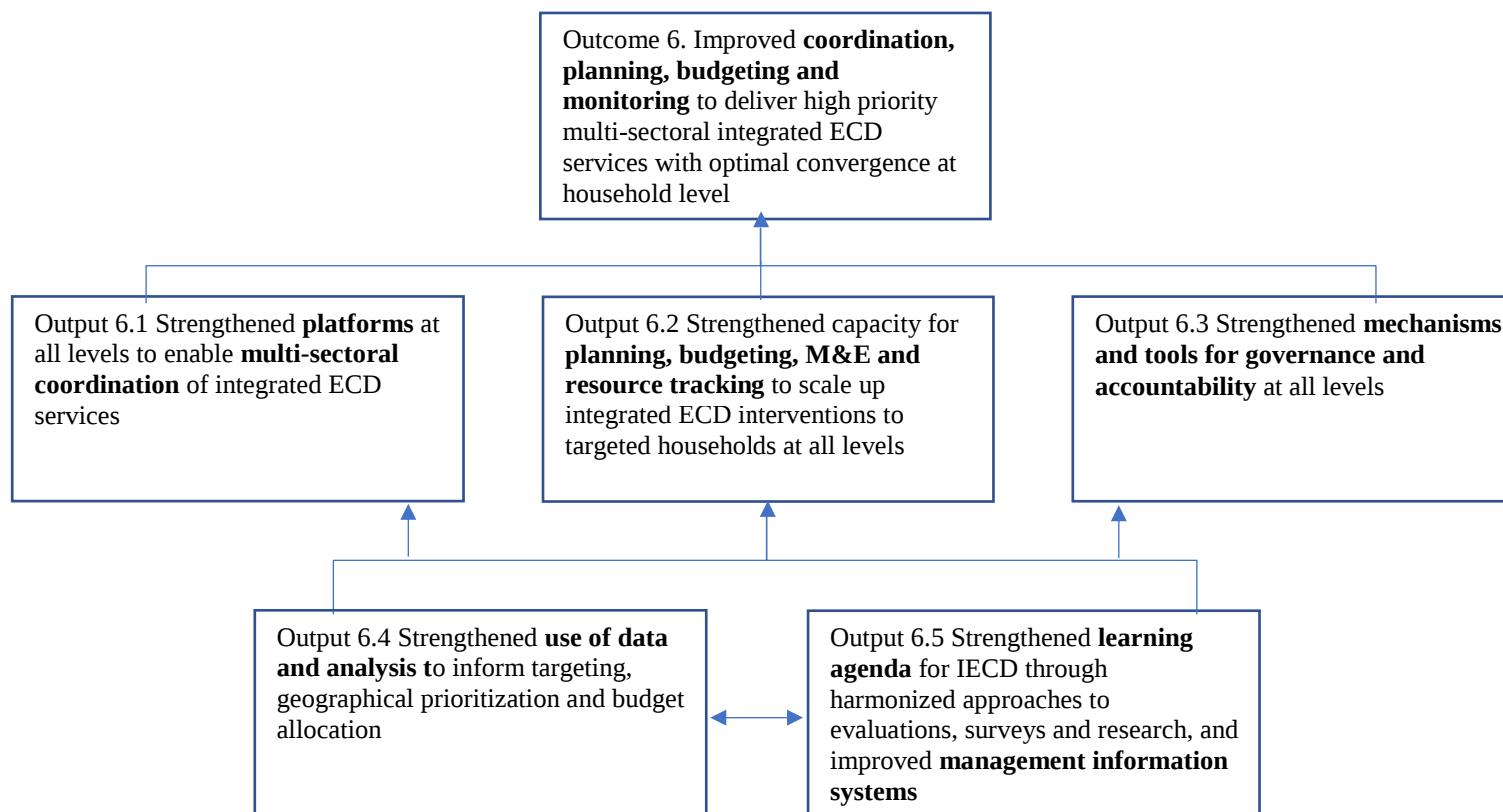
* All the changes in Strategic Directions 6, 7, 8 and 9 contribute to achieving the outputs and outcome above, but those outputs that are directly critical to this particular Strategic Direction are included here in the boxes with dotted lines

Strategic Direction 5. Improved social protection systems for enhanced opportunities and delivery of child sensitive social protection services for targeted households targeted households

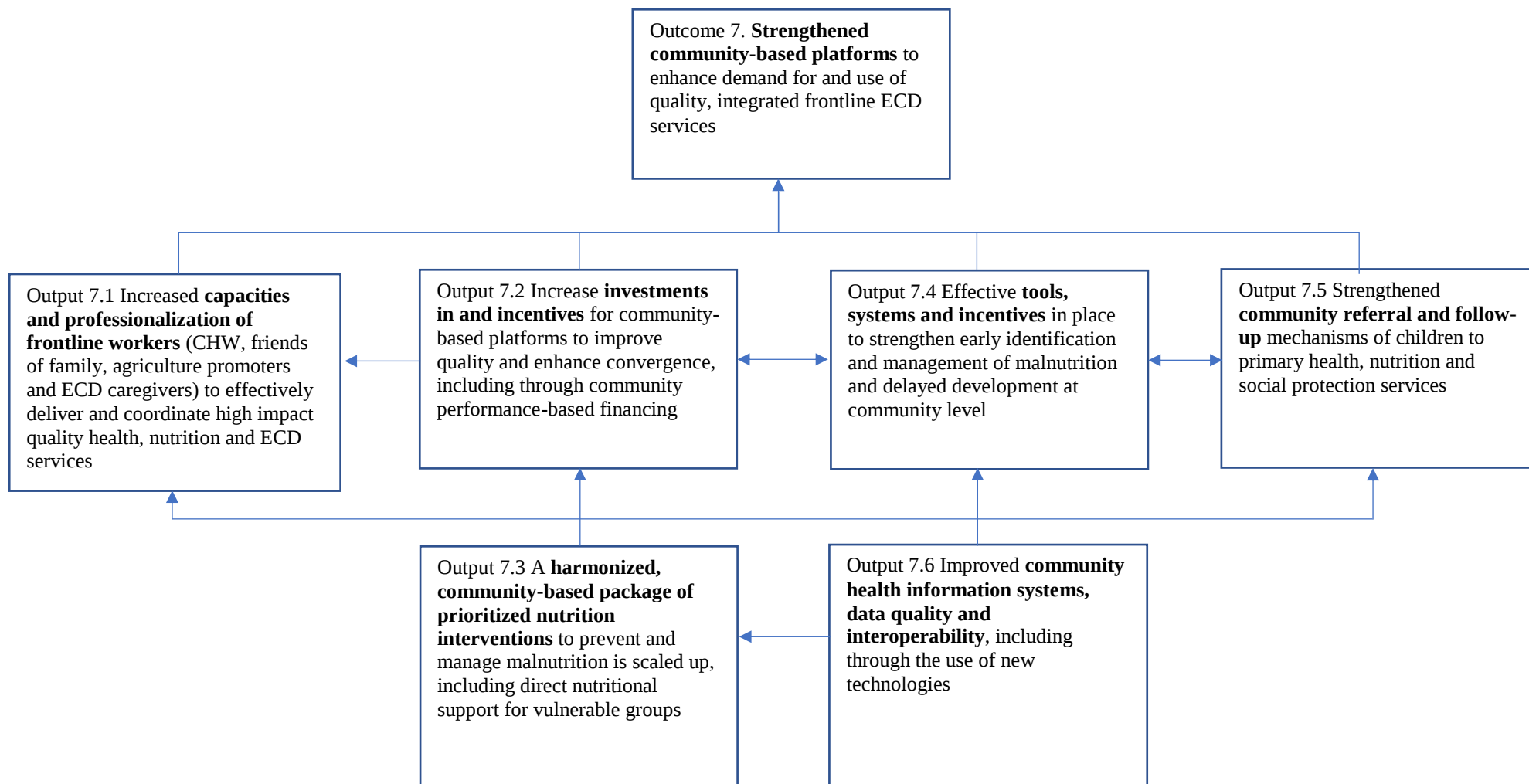


* All the changes in Strategic Directions 6, 7, 8 and 9 contribute to achieving the outputs and outcome above, but those outputs that are directly critical to this particular Strategic Direction are included here in the boxes with dotted lines

Strategic Direction 6. Strengthened coordination, implementation capacity and governance to enhance quality delivery of integrated ECD interventions at all levels



Strategic Direction 7. Strengthened community-based platforms to enhance demand for and use of effective frontline service delivery systems of integrated quality high impact integrated ECD services



Strategic Direction 8. Increased efficiency, equitability and sustainability of financing national ECD program

