**Concept paper**

1. **Situation in the country/project region**

Despite many positive steps towards reconstruction, Rwanda is still grappling to come to terms with its past. 13 years after the genocide during which an estimated 1000,000 people were killed, Rwanda has come a long way towards achieving internal peace and political stability but is still confronted with the debilitating legacy of years of civil war and the genocide. With a total population of 8,8 million, 52% of whom are children, on only 26,338 sq kms, Rwanda is one of most densely populated countries in the world and its population continues to grow at an alarming rate (Rwandan women bear an average of 6.1 children; DHS 2005). Though the whole population has been affected by the genocide, women have been much more affected than men. Today, 32% of Rwandan households are headed by women and 80% of these household leaders are widows, often taking care of the high number of orphans and vulnerable children (OVC), estimated at 1,264,000 OVC[[1]](#footnote-1), one of the largest populations of vulnerable children in the world.

While women’s and children rights are increasingly recognized in Rwandan laws, socio-cultural norms and traditions are so pervasive that the reality is all too often one of physical abuse, exploitation, voicelessness and second class citizenship. With a maternal mortality rate as high as 750/100.000, respectively 152 and 86 for 1000 live births infant and child mortality rates, a life expectancy of 49 years old[[2]](#endnote-1) and 56.6% of the population living with less than $1 a day, the Millennium Development Goals remain very distant.

Unlike many other African countries, Rwanda does not possess natural resources and depends on its already weakened human resources, due in large part to the 1994 genocide that took the lives of many teachers, doctors and educated people, for its social and economic development. The health and education of Rwanda’s population, particularly its children, is therefore critical for the country’s development and constitute pillars of Rwanda’s Economic Development and Poverty Reduction Strategy (EDPRS). Rwanda’s education sector is caracterized by a strong political will to achieve universal education goals combined with limited resources to make it a reality. Secondary schools are very limited compared to the number of children who successfully pass the national entry exam and are very expensive. One year of secondary school costs an average of $300. The full secondary school cycle lasts 6 years. Since primary education became free following last presidential elections in 2003, class rooms are overloaded with sometimes as many as 100 children per class or more. While tuition fees for primary school are subsidied by the Government, parents have to buy a uniform and basic school supplies for children, which is often more than what they can afford. Children are enrolled in primary school at the age of seven and finish at the age of twelve if they did not repeat a class. There is a lack of teachers who are often demotivated because of the extremely difficult conditions in which they work: low salaries, no didactic materials, too many children per class, etc. Till recently, pre-school and Early Childhood Development (ECD) were unknown concepts to parents and communities in Rwanda. However, low performance of children in the first years of primary school due to the absence of intellectual stimulation in the early years of development combined with high incidence of violence against young children prompted the Ministry of Education to develop an Early Childhood Development and Pre-school policy. In 2005, the Ministry declared that each sector[[3]](#footnote-2) should open nursery schools and that enrollment of children in nursery schools from the age of four is compulsory. However, the Government does not have the necessary resources to support this policy. Therefore, to date, very few Early Childhood Development Initiatives exist and young children not yet in primary school going age stay at home the whole day without friends their age to play with, and infortunately often without the support and protection of a caring adult. This results in many Rwandan children frequently suffering mistreatment, abuse, and exploitation, including sexual and physical violence. Young children are particularly at risk because of the lack of adult supervision. Rwandan National Police records from year 2003 show an annual increase of physical and sexual violence against very young children. There are also many unreported cases which are „resolved“ in the community. Since most cases of rape occur during the day when children are left alone while carers work, it is expected that ECD centers will provide a secure environment and that incidence of sexual and physical abuse will reduce. Young children living with their older siblings in Child Headed Households (CHH) are often left alone at home while their brothers and sisters go to school, attend professional training, or work to support the household. Young children not yet attending school who live with their parents or other adults are also often neglected. Rwandan culture does not allow for children to show their emotions. Crying is for example considered as a sign of weakness, even among very small children. Existing curricula in nursery schools are not sufficiently addressing children’s needs to play and are therefore not allowing their full cognitive development. Traditionally in Rwanda, cultivating the land, managing the care of the children, and household chores are all the responsibility of women. Balancing these various obligations is a challenge for the average Rwandan woman. It is particularly difficult for female heads of households, elderly grandmothers caring for their orphaned grandchildren, women caring for sick family members, children heading households, and the very poor.

This Early Childhood Development (ECD) project proposes to establish a nursery school/ECD centre for young children ages three to six. The project will be establish in an area that is not covered by any Nursery school or ECD center.

1. **What is “Centre Itetero” Initiative and what does it plan to do?**

Centre Itetero is a family that had ideas and Initiative is a group of four people who put together their ideas and looked for some resources in order to respond to the key issue of caring for children under six years old and children with mental impairment. That is the family of Mrs. Jeanne MUKANKUSI and Mr. Eugene RUSANGANWA. Centre Itetero started in 2010. The idea of creating it came when the couple of Eugene and Jeanne discovered that their son Herve had problems similar to autism. Herve could not be hosted in any nursery school around the family. That because there was no proper care, not only for children who have problems like Herve, but also because the equipment, materials and methoidology used are not adequate to stimulate the development of children under six years old.

The family established the Early Childhood Development (ECD) Project in Rwanda, in the Eastern Province, District of Rwamagana, Kigabiro sector that was called “Centre Itetero”.

1. **What could we achieve with the Project?**

GOAL: Contribute to the Country priority of establishing at least one ECD model center in each administrative sector in the country for the full physical, emotional and cognitive potential of children under six years old.

STRATEGIC OBJECTIVE: Increased community and government (at both central and decentralized levels) capacity to care for OVC ages 3-6 through a minimum package of interventions.

TARGET GROUP:

The project will take place in Rwamagana district, in the Eastern region of Rwanda. The ECD center will host one hundred children daily. Every year, the center will send 35 children to primary school and it will enrol an equivalent number of new ones. Direct beneficiaries will therefore include 105 children. Indirectly, the project will benefit all household members of selected children thanks to the Information, Education and Communication component of the program, estimated to be 2400. The project will also benefit more chilren and communities because it will also work at national and policy level with the Ministry of Education and the district. The center will reserve some sits for most vulnerable children even if they can not afford to pay fees for attendance.

PROPOSED PROJECT ACTIVITIES

* Sensitization of administrative and community leaders in benefits and importance of Early Childhood Development;
* Provision of basic didactic materials, furniture, equipment and toys
* Training and ongoing technical support to teachers and parents:
  + Training in the curriculum to be „taught“ in the sites (with a strong accent on learning through play);
  + Training in the development of didactic materials and toys using low cost and locally available materials (e.g. toys from garbage);
  + Training in Early Childhood Development in the three key domains (emotional, cognitive, physical); including care and support for children with mental disabilities
  + Training in nutrition and child health (how to recognise signs of common child illnesses, signs of abuse and violence);
  + Training in first aid;
  + Training in hygiene in such a setting (importance of hand washing, keeping toilets clean, ensuring children have access to safe drinking water, safe and clean food preparation, etc);
  + On-the-job training through direct coaching and supervision by Turere Initative team and experts.
* Development of income generating activities (small vegetable and fruit gardens , as well as possibly goat or poultry husbandry) for the center as a way to help feed the children and to ensure longer term sustainability (incentives for volunteers, renewing didactic materials, etc);
* Ongoing adaptation of tools developed by Ministry of Education and to monitor progress of individual children, as well as behavior changes in parents/carers, volunteer ECD center staff, communities, and local government;
* Exchange and learning visits to other ECD good models in the country;

Center-based activities (activities carried out in the nursery school) will include:

* Developmental and educational activities adapted to the children’s ages: ;
* Basic health and hygiene education of children, parents and caregivers );
* Monitoring of basic health indicators and facilitation of access to basic health care services through partnerships with health facilities (growth monitoring, verification of immunization, testing for HIV, referral to health facilities in case of illness, etc) and community workers;
* Creative play;
* The provision of one nutritional meal or porridge per day;
* Home visits to children registered at the centers when they do not show up during more than three days without explanation from the care taker;
* Organization of Information, Education and Communication sessions for all parents and care takers and the larger community on topics related to children’s healthy development: HIV, benefits on mothers and children of birth spacing, child care and nurturing principles, links between nutrition and cognitive development, child protection, etc.

PROJECT STRATEGIES

5X5 model

The project’s main strategy is 5x5 developped for Early Childhood Initiatives. The model is currently being piloted in Rwanda as mentioned above as well as in other countries in the region, Kenya, Uganda, and Zambia. The 5X5 model combines fives domains of interventions (nutrition, cognitive-emotional, economic strengthening, health, child rights-protection) with five levels of interventions (child, care giver-household, ECD-center, community, national level). Through this model, Turere Initiative is seeking to bring a holistic approach to the care of youngest children.

**The Five Levels of Intervention**

**Level 1. The Individual Child**

The primary beneficiary of all early childhood interventions is the individual child.

**Level 2. Caregiver/Family**

The health and well being of each child is highly dependent upon the health and well being of his/her primary caregiver and the level of household income. With poverty and domestic violence most often sited as major obstacles to child wellbeing within the home, caregivers and families can be supported in the care of their children through outreach, education, support groups, nutrition, and child rights trainings.

**Level 3. Child-Care Settings**

With the increased awareness of the importance of ECD , many communities have initiated child-care settings to care for children in groups, both formally through centers and informally through a wide variety of arrangements. Using a child-care setting as the point of intervention allows for increased access to caregivers, households, and individual children. At the same time, grounding the intervention in pre-existing community initiatives such as daycares, crèches, or pre-schools, facilitates wider community action and provides a forum for discussion of local and regional policy.

**Level 4. Community**

A center or program is only as strong as the community that supports it. The long-term stability of these interventions depends on the buy-in from caregivers, local authorities, and community leaders. Furthermore, important resources often exist within the community in the form of health clinics, child rights organizations, HIV support groups, and feeding programs. Often these resources can be more effectively identified and utilized by early childhood programs and centers and community members once awareness is increased through outreach, resource mapping, and community meetings.

**Level 5. National Policy**

Any improvement in early childhood services at the center or community level will be short-lived without the accompanying change in nation-wide policy to give early childhood programs greater recognition and financial support. Improved early childhood policy is the best way to ensure sustained, country-wide benefits for young children, center caretakers, and caregivers of young children. Improved policy can also expand the reach of early childhood programming so that vulnerable children and families are included.

**The Five Domains of Intervention**

**Domain 1. Nutrition**

Nutrition plays a vital role in early childhood development, as the period between birth and three years is when children are most vulnerable to the permanent effects of stunting as well as a number of negative cognitive outcomes due to malnutrition. With a child’s brain undergoing tremendous growth between the ages of 0-8, caloric intake, especially of protein has a major impact on a child’s future mental abilities. Numerous studies have also shown the positive impact of good nutrition on academic performance throughout childhood, adolescence, and even adulthood.[[4]](#endnote-2)[[5]](#endnote-3).

**Domain 2. Child Development – Cognitive/Emotional/Physical**

Between birth and age eight, a young child’s brain undergoes enormous growth as neural connections are formed that provide the foundation for language, reasoning, problem solving, social, and motor skills. Children need stable bonds with the caregivers and caretakers, as well as a loving environment of trust and acceptance.

**Domain 3. Economic Strengthening**

Early childhood interventions can act as platforms for community training on a wide array of skills: Village Savings & Loans (VS&L), Income Generating Activities (IGA), Small Business Selection & Management (SBSM), first aid, nutrition, safe food handling, sanitation, and child rights. These programs can also serve as important resources for Reproductive Health education, including HIV&AIDS and SGBV, stigma reduction, testing and treatment referrals, as well as providing potential hubs for support groups.

**Domain 4. Health**

In urban areas there are numerous clinics and health centers providing free treatment to young children, however, knowledge of these centers, what services they provide as well as where they are located has often been poorly communicated. Health services can be improved simply by building linkages between early childhood programs and centers and health clinics as well as by bolstering clinics’ outreach programs. In rural areas, where access can prove more difficult, linking with existing resources as well as identifying community health workers is critical to providing caregivers and caretakers with better health care options. Additionally, trainings in first aid, safe food handling, as well as water and sanitation are important in preventing illnesses.

**Domain 5. Child Rights/Protection**

Many countries have endorsed international treaties regarding children’s rights and have formulated their own official domestic laws but awareness of these acts among most communities is low. Trainings and campaigns on national and international instruments to protect and help advance children rights are important to increase awareness of children, parents, communities and local groups. Local capacity building is essential. Police officers, judges, magistrates, and child welfare officers have proven to be important advocates and guardians of vulnerable children, once they clearly understand what they can do to help.

ANTICIPATED IMPACT ON CHILDREN, COMMUNITIES AND GOVERNMENT

1. Improved development of children ages 0-6 (level 1)
2. Improved capacity of caregivers to care for children (level 2).
3. Improved capacity of ECD centre to care for children 0-6 (level 3).
4. A rediscovery by the community and parents/guardians of children’s need to learn through play (level 4);
5. An enhanced community and government understanding of children’s developmental needs in the early years (levels 4 & 5)
6. Reduced rate of malnutrition (domain 1)
7. Healthier physical, emotional, and cognitive development of young children (domain 2);
8. Improved preparedness for primary school and increased performance once in primary school (level 1 combined with domains 1, 2, 4 & 5);
9. Increased access to educational activities and opportunities for the children’s carers. Heads of households (older children, women, etc) will have more time to attend to their daily activities, resulting in economic gains at household level as well as overall improved care for the young children at home (domain 3)
10. Reduced incidence of violence against young children (domain 5)
11. Improved care and protection of young children (domain 5)



Children at Centre Itetero

1. Rwanda General Population Census, 2002 [↑](#footnote-ref-1)
2. Demographic Health Survey, 2005 [↑](#endnote-ref-1)
3. Rwanda is divided in 4 Provinces, which are divided in 30 administrative districts, which are divided in sectors, sectors in cells, cells in villages. Villages are the lowest administration unit and count between 50 to 150 households. [↑](#footnote-ref-2)
4. Pollit E. et al., Early Supplementary feeding and cognition: effects over three decades. Monographs of the Society for Research in Child Development 1993;58:7 [↑](#endnote-ref-2)
5. {Grantham-McGreggor, S. et al., (2007), 'Development Potential in the first five years of life for children in developing countries.' The Lancet 369:(60-70) [↑](#endnote-ref-3)