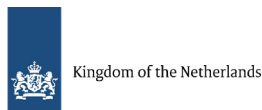




NATIONAL SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR INTEGRATED EARLY CHILDHOOD DEVELOPMENT, NUTRITION AND WASH (2018-2024)



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LIST OF ACRONYMS

ANC	:Antenatal Care
CHW	:Community Health Workers
CRS	:Catholic Relief Services
DHS	:Demographic and Health Survey
DPEM	:District Plan to Eliminate Malnutrition
ECD	:Early Childhood Development
EICV 4	:Integrated Household Living Condition Survey
FAO	:Food and Agriculture Organisation
HMIS	:Health Management and Information System
HSSP	:Health Sector Strategic Plan
HSWG	:Health Sector Working Groups
ICT	:Information and Communication Technology
IEC	:Information, Education and Communication
INWA	:Integrated Nutrition and WASH Activity
IYCF	:Infant Young Children Feeding
JDAF	:Joint Action Development Forum
KAP	: Knowledge, Attitudes and Practices
MCH	:Maternal and Child Health
MIGEPROF	:Ministry of Gender and Family Promotion
MINAGRI	:Ministry of Agriculture and Animal Resources
MINALOC	:Ministry of Local Government
MINEDUC	:Ministry of Education
MININFRA	:Ministry of Infrastructure
MIYCN	:Maternal, Infant and Young Child Nutrition
MOH	: Ministry of Health
NCC	: National Commission for Children
NECDP	:National Early Childhood Development Program
NST1	:National Strategy for Transformation
NTWG	:Nutrition Technical Working Group
NWC	: National Women’s Council
PNC	:Post Natal Care
PSF	:Private Sector Federation
RBC	:Rwanda Biomedical Center
RHCC	:Rwanda Health Communication Center
SBCC	:Social and Behavior Change Communication
UNICEF	:United Nations Children’s Fund
USAID	:United States Agency for International Development
WASH	: Water, Sanitation and Hygiene
WFP	:World Food Programme
WHO	:World Health Organisation

Foreword

The National SBCC Strategy will build on the integration of Early Children Development, Nutrition and WASH sectors which provides opportunities of benefiting from integrated ECD, nutrition and WASH social behavior and communication services aiming at improving knowledge, attitude and practices at community and household levels.

Early Childhood Development (ECD) refers to a comprehensive approach to policies and programmes for children from 0 to 6 years of age, their parents and caregivers. Lifetime behavior patterns are formed during this period when brain development is most active. As such, what happens or does not happen during these early years of a child's life, influences their growth and development outcomes as well as opportunities in adulthood. As children acquire the ability to speak, learn and reason in early years, cornerstones are laid and later affect their orientation to development and thriving in life. Investment in the early years of a child is therefore critical for both survival, growth and development of the child, community and national due to the predictable gains and productivity in adulthood.

Considering the value of ECD, the Government of Rwanda developed a comprehensive ECD Policy (2016), Food and Nutrition Policy (2013-2018) and other child development related policies, offering government orientation on interventions to support children's full physical, cognitive, language, social, emotional and psychological development. The policy is aligned with renewed government commitments under the EPRS II (2013-18), the National Strategy for Transformation (NST) 2017-2023, and the revised Vision 2020 targets.

The Government of Rwanda is also committed to improving the health of all Rwandans and has shown these commitments through several policies and strategies, which have greatly improved the overall health sector and the health and well-being of the population. The Rwandan government has invested in the health and well-being of its people through the Third and fourth Health Sector Strategic Plan (2012 – 2018; 2018-2024). This strategy seeks to address key determinants related to early children development, malnutrition and water, sanitation and hygiene (WASH) mostly related to knowledge, attitude and practices at community and individual levels.

There are many impediments within the health systems that prevent people from having productive and healthy lives. Social and Behavior Change Communication (SBCC) addresses key barriers preventing people from adopting improved health practices. The Early Children Development, nutrition and WASH sectors within the health system can benefit positively from an SBCC strategy. ECD, Nutrition and WASH have multi-sectoral dimensions that require contributions from different disciplines including but not limited to agriculture, economic strengthening, public health, gender, medicine, and social science. The theories and models from these different domains can be extracted to develop and deliver effective behavior change communications particularly in the context of promoting positive ECD, nutritional and WASH

related practices at household and community level in Rwanda. By addressing key barriers related to ECD, Nutrition and WASH by promoting Community and Household integrated best practices, this will ensure optimum health status of the population of Rwanda.

These changes in behavior and health outcomes are vital for the well-being of children (0- 6 years of age) and pregnant and lactating women. Integrating ECD, nutrition and WASH SBCC has the potential to dramatically improve the health sector through better ECD nutrition and WASH-related outcomes. This SBCC strategy typifies the Government of Rwanda’s commitment to promote positive health and ECD, nutrition and WASH outcomes as stipulated in many national frameworks including the Third and Fourth Health Sector Strategic Plan (2012-2018, 2018-2014). This strategy is deemed highly relevant to promote Early Children Development practices, in fighting malnutrition in Rwanda with special attention being given to reducing stunting among children under 5 years of age.



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The Integrated ECD, Nutrition and WASH strategy was supported by two major programs. The Integrated Nutrition and WASH Activity (INWA) program locally named “Gikuriro” is funded by the United States Agency for International Development (USAID) in Rwanda and being implemented by Catholic Relief Services (CRS) in consortium with Netherlands Development Organization (SNV). The ECD programme led by UNICEF is funded by the Embassy of the Netherlands. CRS and UNICEF facilitated the process of drafting and finalizing this National SBCC Strategy technical approach.

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1. INTRODUCTION

1.1 The overview of integrated ECD, nutrition and WASH in the fight against stunting

Scientific evidence affirms that the first three years of a child's life are the most important in the child's development and growth (Lancet). Eighty percent of brain development occurs within the first three years, making it a period of greatest sensitivity to environmental influences. Any deficiencies during this time affect subsequent child development, so investing in a child's life during this critical phase ensures a better life for the child and the nation. It is currently estimated that, worldwide, 250 million children under the age of five are failing to meet their development potential. A range of risk factors lead to this loss of human potential. Delayed care-seeking for illness, malnutrition, lack of access to clean water and sanitation, child abuse and neglect, a lack of stimulation and learning opportunities and many other challenges result in compromised child development. The levers for change rest in local and community efforts to provide a minimum package of social services to young children and their families, coupled with national and global action. Recognizing the interconnectedness of poverty reduction, health, nutrition, education, agriculture, protection, WASH, gender equality, social inclusion and development should place children and families at the heart of the government vision for development and the work on Sustainable Development Goals.

Early Childhood Development (ECD) interventions are a means of providing holistic care and stimulation to children during their formative years. In Rwanda, ECD is defined as a range of changes through which a child undergoes during their early years of life from conception to six years, as well as support that caregivers need to provide childcare. ECD interventions develop sensory-motor, social-emotional and cognitive-language skills for young children, while building the capacity of parents and other caregivers to fulfil their parenting obligations. According to Rwanda Demographic and Health Survey (DHS) 2014-15, 63 percent of children aged 36-59 months are developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains. This indicates that about one third of children need more care and support for development. In terms of stunting, 38 percent of children under five years old are stunted contributing to the developmental delays among children.

The 2014 *Knowledge, Attitude, Practice assessment on early nurturing of children report* illustrated the many social and behaviour change determinants that contribute to these issues. While the primary point of care and support occur at the household, it is recognized

that parents alone cannot provide an optimal environment for children. In line with the African belief that “it takes a village to raise a child”, communities, social services and local leaders all play important roles in a child’s life. This is where communication plays an important role in achieving a concerted effort from multi-sectoral stakeholders.

This national SBCC strategy set out in this document is intended to guide ECD, Nutrition and WASH stakeholders by analyzing the current situation and making concrete recommendations on the target audience, key messages and communication channels. The Annex of the key interventions, which will be updated annually, includes a summary of key interventions in relevant fields (health, nutrition, WASH, early learning, parenting, child protection). The document will guide the concerted efforts of the government, policy makers, UN, civil society organizations (CSOs) and the private sector to join hands for the promotion of Integrated ECD, Nutrition and WASH services in Rwanda, and foster supportive social and behavior change to give every child the best start in life.

2. NATIONAL INTEGRATED SBCC STRATEGY

2.1. Definition

Social Behavior Change Communication (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. It is a multi-level tool operating through three key strategic dimensions: a planning continuum including advocacy, social mobilization and behavior change communication for promoting and sustaining healthy, risk-reducing behaviors among individuals and communities. It achieves this objective by disseminating tailored health messages to specific audiences through a variety of communication channels, based on evidence driven communication objectives.

2.2. National Integrated SBCC Goal

The goal of this National Integrated SBCC Strategy will contribute to strengthen leadership, accountability, partnership and coordination in the delivery of communication interventions related to ECD, Nutrition and WASH at all levels. Such interventions will effectively build capacity among parents and families, raise awareness among communities, form supportive social norms, guide the local authorities and strengthen the provision of all social services that support Early Childhood Development and improving nutrition and WASH best practices.

Towards the goal of optimal child development, the interventions will ensure:

- Parents have parenting skills and engage with children with love and care;
- Parents and communities are equipped with knowledge and skills on maternal and child health, ECD, nutrition and WASH;
- Parents are supported by enabling social norms to practice positive behaviors, including emphasis on male engagement in child care practices;
- Central government and local authorities understand their roles and responsibilities in promoting ECD, Nutrition and WASH interventions
- Parents use positive parenting to guide children and the community to participate in child protection from any physical, moral or psychological harm;
- Families with young children increase demand for social services including health,

nutrition, WASH, ECD, child protection and social protection;

- Children with disabilities and special needs will have equal access to these social services and special care;
- Key integrated ECD, nutrition and WASH messages, appropriate communication channels and tools to disseminate messages are harmonized, coordinated and implemented effectively;
- Children have access to early stimulation and age-appropriate communication channels, tools and messages for school readiness;
- Monitoring framework is in place for a better follow up of the implementation of the Strategy.

3. OVERVIEW OF RELEVANT POLICIES AND KEY LITERATURES

This National SBCC Strategy will be based on the Rwanda National Policies to guide the implementers at all levels with general mission to coordinate and implement all interventions that support adequate development for children and eliminate stunting. The following policies and strategies are of particular importance.

3.1. National ECD Policy:

The government elaborated the first ECD policy in September 2011 under the Ministry of Education (MINEDUC). In 2014, the Ministry of Gender and Family Promotion (MIGEPROF) was assigned to revise the ECD policy and coordinate policy implementation, given its mandate of family promotion and child protection. The mission, goals and objectives of the revised ECD policy establish the country's vision for its youngest citizens. The mission emphasizes the delivery of credible interventions that can effectively support children's development from conception to six years of age in Rwanda. The mission is aligned with the overall vision of providing children with integrated interventions that enable their holistic development and increase their learning opportunities while also engaging the community.

The general objective of the policy emphasizes principles of equity, access and quality of ECD services, and requires systems that are coordinated and provide sustainable services. The specific objectives are: (1) to increase children's preparedness to cope with primary school; (2) to enhance positive parenting and community participation in child protection; (3) to reduce malnutrition and stunted growth among young children; (4) to reduce under-five and maternal mortality rates; (5) to develop children's self-awareness, self-esteem and self-confidence; (6) to eliminate physical, moral and psychological abuse of young children; and (7) to enhance equal access by children with special needs to ECD services. The ECD policy is supported by a strategic implementation plan, which comprises five key areas of program investment and focus: (1) parenting education and support; (2) school readiness and transitions; (3) child protection and family promotion; (4) health, nutrition and WASH; and (5) coordination, governance, resourcing, monitoring and evaluation. The ECD policy was officially adopted by the Government of Rwanda in May 2016.

3.2. Food and Nutrition Policy (2013-2018)

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. The vision of the National Food and Nutrition policy is to ensure services and practices that bring optimal household security and nutrition for all Rwandan. 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. Substantial reduction of acute malnutrition has occurred in recent years, however, problems with high levels of chronic malnutrition and micronutrient deficiency still exist. The policy recognizes that, when pregnant women do not have appropriate nutritional intake during pregnancy, and children do not receive the foods, feeding and care required for normal growth during their first two years' chronic malnutrition occurs. The policy also outlines key events and information sources that influenced the dramatic rise of nutrition and household food security on the national agenda, notably Joint Action Plan to Eliminate Malnutrition (JAPEM) at central level and District Plans to Eliminate Malnutrition (DPEM) at local level.

3.3. National Health Promotion Policy

The National Health Promotion Policy (NHPP) was developed to promote disease prevention, empower communities to translate health information into desired action, and encourage community participation and ownership of health promotion related activities. The National Health Promotion policy plays a very important role in influencing behavior change of our population thereby enhancing the adoption of positive lifestyles by individuals, families and communities to promote their health. However, behavior change is a complex process that could take a long time to be realized effectively. Therefore, it requires the provision of adequate resources on a sustained basis and for an extended period of time in order to achieve the desired impact countrywide. The Health Promotion Policy has been developed taking into consideration the HSSP III, vision 2020, EDPRS II and the WHO recommendations to member countries on the need for formal policies on health promotion. The NHPP provides an overall framework for health promotion development and practices in Rwanda, it highlights the fact that determinants of health of the population go beyond health services and calls for multi-sector partnership approaches as the way forward to attaining effective health promotion.

3.4. Rwanda Health Sector Strategic Plan IV (2018-2024)

This National SBCC Strategy is guided by HSSP IV priorities for health program which are community education and awareness on dietary and complementary feeding practices; establishment and using ECD as an entry point in provision of health interventions (specifically early childhood development, nutrition and WASH services); prevention and management of malnutrition (acute and chronic) and improvement of multi-sectoral collaboration.

3.5. National Strategy for Transformation (2017-2024)

National Strategy for Transformation (NST1) is built on three pillars: Economic Transformation, Social Transformation, and Transformative Governance. The Economic Transformation pillar aims to accelerate inclusive economic growth and development founded on the private sector, knowledge and Rwanda's natural resources. The Social Transformation pillar aims to develop Rwandans into a capable and skilled people with quality standards of living and a stable and secure society. The aim of Transformation Governance pillar is to consolidate good governance and justice as building blocks for equitable and sustainable national development. The NST1 also embraces the SDGs, and Africa Union Agenda 2063.

3.6. Sanitation Policy (2016)

Sanitation plays a vital role in preventive health care and quality of life. For that reason, the Government of Rwanda has made provision of sustainable sanitation services one of the priorities of the National Development Agenda and is establishing supportive policies and legislation. The Ministry of Infrastructure has developed the National Sanitation Policy to ensure proper implementation of activities in the sanitation sub-sector. The Policy outlines initiatives to overcome challenges and exploit existing opportunities in an integrated manner and will effectively contribute towards achieving the goals of the National Development Agenda. The Government of Rwanda will ensure expanded access to safe and sustainable sanitation services through a number of means including: establishing District sanitation centers providing a wide range of sanitation technologies; improving operation and maintenance of sanitation facilities; and assisting Districts and the City of Kigali to plan and design projects to mitigate urban storm water issues. The Government of Rwanda is also encouraging active participation of local private service providers and operators in the sanitation sub-sector and will ensure the principles advocated by this policy are adhered to in the whole process of sanitation services provision. The Government further strongly recognizes the initiatives of the international and regional communities and will continue to cooperate to achieve the 2030 Sustainable Development Goals.

3.7. Environmental Health Policy (2008)

According to the Environmental Health Policy, the main contributing factors to environmental health related diseases in Rwanda are inadequate and unsanitary facilities for excreta disposal, poor management of liquid and solid wastes, and inadequate practices of handwashing with soap that leads to contamination of food and water in both rural and urban areas. This is mainly due to a population, which lacks awareness, inadequate participatory hygiene education and environmental health promotion approaches in school and communities as well as uncoordinated delivery of effective environmental health services. The negative state of environmental health conditions influences the disease burden which, in turn, contributes to poverty. The children, the elderly and the immuno-compromised individuals get sick more frequently and more resources are spent on curative services to restore their state of health, thus increasing poverty at household and community levels.

3.8. Maternal, Neonatal and Child Health National Strategy (2013-2018)

The 2013- 2018 Maternal, Neonatal and Child Health National Strategy (MNCH) outlines the role of nutrition, particularly during pregnancy, lactating, and early childhood to eliminate all forms of malnutrition in every Rwandan family through implementation of the joint action plan initiated for 2012 and strengthening of the multi-sectoral approach. It also highlights that maternal under nutrition is often reflected in the proportion of children with low birth weight (below 2.5 kilograms) and pregnant women are particularly vulnerable to anemia due to increased requirements for iron and folic acid. According to RDHS (2010), 17 percent of women aged 15-49 years were found to be anemic, but the overall prevalence of anemia has decreased by 8 percent since RDHS 2005. Maternal underweight status contributes to poor maternal health and birth outcomes.

3.9. Disability Mainstreaming Guidelines (2014)

Rwanda has endorsed many legal instruments, 13 ministerial orders, Sector policy and strategic plans to consider that all types of disabilities, including physical, intellectual, visual and hearing impairments are considered in every area of life. In terms of international legal and policy frameworks, UNCRPD was ratified and Eastern African Disability policy endorsed. Domestication of these and political intent framed with: Rwandan constitution, law on disability, Ministerial orders, EDPRS I, II, policy frameworks and Ministry sector strategic plans. In the EDPRS II document, disability is considered as a crosscutting issue to take into account in all pragmatic areas, and it is mentioned that “Rwanda does not intend to leave any of its citizens behind in the development. As such, specific steps will be taken to ensure that people with disabilities (PWDs) and other disadvantaged groups are able to contribute actively to the county’s development and to benefit from it.” The guidelines constitute as a step forward for various actors, as it proposes practical steps of mainstreaming disability in various areas of life mainly in education and health with emphasis on early childhood development. (National Council of Persons with Disabilities, Kigali, May 2014).

4. SITUATIONAL ANALYSIS AND PROBLEM STATEMENT

4.1. Stunting

Stunting is a complex form of malnutrition. Although there was a remarkable progress in reducing stunting (from 44 percent in 2010 to 38 percent in 2015 according to DHS), Rwanda aims to reduce it to 15% by 2024. Stunting is known to compromise optimal brain development and has a direct impact on a child's development.

Stunting can be caused first by nutritional factors, including mother's nutrition status (often resulting in children being born with a low-birth weight), lack of appropriate breastfeeding and poor young-child feeding practices. The breastfeeding rate is high in Rwanda (99 percent among children during their first year of life), but only 56 percent of children aged 6-8 months receive complementary foods. This partly explains the high rate of stunting and of anemia (37 percent) among children aged 6-59 months. Alongside nutrition, hygiene is critical in preventing infectious diseases that exacerbate stunting. Stunting is linked to frequent episodes of diarrhea among children under five years, whose prevalence in Rwanda is 12 percent. Children in rural areas are more affected by diarrhea (13 percent in rural areas, compared to 10 percent in urban areas). Once the child gets infectious disease, it is important to seek health care before the child health is further undermined. However, the DHS shows that out of the 19 percent of children who had fever, only 62 percent of parents/caregivers sought advice or treatment from community health workers or health providers.

In the following section, further details of the data related to ECD, health, nutrition and WASH will be presented to unpack the determinants of stunting.

4.2. Rwanda - Early Children Development (ECD) figures

4.2.1 Child development

Overall, 63 percent of children aged 36-59 months are developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains. Urban children are more likely than rural children to be developmentally on track (67 percent versus 62 percent). Being developmentally on track is positively associated with mothers' education (59 percent among children whose mothers have no education compared to 69 percent among those whose mothers have reached secondary education or higher). There is also a disparity according to family income-level with 67-68 percent of children found developmentally on track among the upper two wealth quintiles and only 59-63 percent among the lowest three quintiles. Key factors hindering the child development are described below.

4.2.2. Early childhood education and organized care

Although Rwanda has a high rate of primary school attendance, very few children below the age of six years have an opportunity for early learning. Only 13 percent of children aged 36-59 months attend an organized ECD program; children living in urban areas are much more likely to attend than children living in rural areas (37 percent and 9 percent, respectively).

Significant correlations are observed by mothers' education and household wealth quintile. Only 4 percent of children whose mothers have no education attend an ECD program, compared with 49 percent of children whose mothers have a secondary education or higher. The Knowledge, Attitude and Practices (KAP) survey looked into the reasons for not bringing children to organized care facilities. For the majority who do not take their children to organized child care centers, the main reasons provided are protection for the children, because parents feel they are too young to be out of the family setting (16%), a preference for having the children at home (12%) or fear that children might get sick (5%). Some parents also felt that the child care centers are expensive (14%), while others did not know where the centers were located (14%).

The main problem hindering access to organized care is the supply issue - availability of safe and nurturing space for children. With the aim of increasing the quantity and quality of services, MIGEPROF is mapping all ECD interventions across the country. The information generated will provide an insight on the scope and reach of Rwanda's ECD services and the actors/stakeholders involved. It will also give information on the quality of services currently provided and highlight any gaps in service-provision. The mapping will help to improve equitable scale-up of ECD services, starting from areas with the highest need. Young children spend the majority of their time at home so the home environment matters. Access to books and other learning-play materials is very low: only 1 percent of children had one or more child-friendly book, and 30 percent of children had access to play materials.

4.2.3. Children with disabilities

According to Rwanda's 2012 Census, there were 15,831 children aged 3-6 with disabilities. However, according to the 2014 Education Statistical Yearbook, only 1,387 children with disabilities were attending pre-primary school. This means only 9 percent of these children are attending pre-primary school, which is significantly lower than the national average of 13 percent. This gap indicates that many children with disabilities are staying at home without access to organized care. Efforts are therefore needed to support children with disabilities and their families by removing physical and social barriers while increasing innovative and inclusive care knowledge amongst parents and caregivers.

4.2.4. Adult involvement in early learning and stimulation

Age-appropriate, responsive care and stimulation supports the rapid brain development that occurs in the first three years of life. However, the Rwanda DHS reported that only 49 percent of young children engaged with an adult household member in four or more activities that promote learning and school readiness during the three days before the survey. Among those

children, only 3 percent engaged in four or more learning activities with their biological fathers, and 12 percent with their mothers, indicating very low parental engagement, especially with fathers. Parent-child interaction increases with increasing wealth quintile and the education-level of parents, especially mothers. The KAP Survey indicated that parents do not have accurate knowledge of when children start hearing, seeing and learning. Also, parents do not fully understand what specific forms of interaction help in the development of their children at different stages of early childhood.

4.2.5. Role of Father

The KAP survey looked into attitudes towards fatherhood. The opinions of caregivers, in relation to the importance of the father's role in the development of their child, were investigated in depth. The findings show that the most important role of the father with regard to children aged 0-2 years is seen as 'showing love and affection to the child and playing with him/her' (92 percent). This is closely followed by 'providing for day-to-day necessities' (91 percent). For children aged 2-6 years, however, the most important role of the father is found to be 'disciplining the child' (91 percent), closely followed by 'providing the things the *child needs*' (89 percent). The breadwinning role is seen as being of central importance, and the role of fathers is also particularly highlighted in relation to discipline. Key informant interviews with fathers indicated that social norms in gender roles have a negative impact on fathers' participation in parenting.

4.2.6. Adequate care for young children to protect from harm

The Rwanda DHS measured the incidence of children under five left alone or with other children. Children left alone are exposed to many risks including accidents, abuse and neglect. Thirty-five percent of children under five years were left alone or left in the care of other children below 10 years during the week preceding the interview. With regards to discipline, nearly half of those interviewed for the KAP survey expressed a belief that children need to be physically punished to grow up well. On the other hand, 50 percent agreed with the statement that '*beating children may negatively affect self-confidence, including encouraging them to beat others*'. To understand these seemingly contradicting views, attitudes towards discipline were explored in focus group discussions. Parents and caregivers are not in favor of physical punishment and the majority showed preference for talking to children and advising them on the right thing to do. This opinion is shared by male and female caregivers, as well as by community health workers. At the same time the KAP assessment finds the practice of physical methods of disciplining children to be common. Sixty-three percent of caregivers slap their children aged 4-6, for example. It is also evident from the findings that punishment becomes more abusive as children grow.

4.3. Adult Health and Nutrition

4.3.1. Antenatal, Postnatal, and Delivery Care Services

Antenatal (ANC), postnatal (PNC), and delivery care (DC) services in Rwanda are closely linked to maternal, child, and reproductive health outcomes, which make these relevant to this current strategy. According to the 2015 RDHS, 99% of women with a live birth since 2010 received at least one antenatal care service from a skilled health provider, and 44% of women attended the recommended four ANC visits during their pregnancy (RDHS 2015). The percentage of women attending four ANC visits has increased 9% since 2010 (35%). Other key findings from RDHS 2014-2015 include: 91% of live births since 2009-2010 were delivered in a health facility; 91% of live births were assisted by a skilled health provider; and 43% of women who gave birth in 2012 or 2013 received a postnatal care checkup in the first two days after delivery. The study also revealed some challenges in ANC and PNC, notably that only 19% of newborns in 2012 and 2013 received a postnatal checkup within the first two days after birth. Among these newborns who received postnatal checkups, nearly all received care from skilled personnel. Additionally, access to health care continues to be a barrier for most Rwandan women: 59% reported at least one problem in accessing health care (RDHS 2015). The main barrier to access was found to be financial, although distance to a healthcare facility, and safety issues were frequently cited by women as serious factors in them accessing health care. Generally, these barriers are heightened among women living in rural areas.

4.3.2. Maternal Micronutrient Intake:

Adequate micronutrient intake by pregnant women has important health implications for both women and their children. Breastfeeding provides children with critical micronutrients, especially vitamin A. Iron supplementation of women during pregnancy protects the mother and infant from anemia, which is known to increase the risks of premature delivery and low-birth weight (Allen, 2000). Anemia prevalence among Rwandan women is relatively low (19%) and includes almost no cases of severe anemia (DHS 2015). Nevertheless, it is important to ensure pregnant women are receiving micronutrients, so the mothers and their children do not become anemic. A common approach to improving micronutrient intake among mothers in Rwanda is to provide them with iron and folic acid supplements during pregnancy and vitamin A in the postpartum period. RDHS 2014-2015 found that 49% of women who gave birth between 2009-2010 received vitamin A supplements (RDHS 2015). Approximately 80% of women reported taking iron supplements during pregnancy, although most of these cases (68%) took supplements for 60 days or less.

4.3.3. Overweight and underweight:

According to DHS 2015, the proportion of overweight women stands at 17% and 4% of women are considered to be obese. The proportion of overweight or obese women is positively correlated to women's age, increasing from 14% among women age 15-19 to 26% among

women age 30-39 before declining to 23% among women age 40-49. Urban women are twice as likely to be overweight or obese (37%) as rural women (17%). 6% of men are overweight and less than 1% are obese. Generally, obesity in women is more than nine times higher than men. Overall 13% of men age 15-49 are underweight and about twice the percentage of underweight women (7%).

4.4. Child Health and Nutrition

While overall nutrition outcomes in Rwanda have improved in the past decade, chronic malnutrition among children continues to be a public health concern that warrants further intervention. According to RDHS 2015, the prevalence of chronic malnutrition (stunting) among children under 5 has steadily improved – falling from a prevalence of 51% in 2005 to 44% in 2010, and to 38% in 2015 (RDHS 2015). Stunting is also higher among rural households and in the Western Province (45%) (RDHS 2015). Acute malnutrition (wasting) has declined from 5% to 2% over the same period, and the proportion of children under 5 who are underweight has decreased from 18% in 2005 to 9% in 2014-15 (RDHS 2015).

These improvements may be partly attributable to Rwanda's *National Plan to Eliminate Malnutrition* which, since 2009, has included active nutrition screening of children by community health workers (CHWs). Children who are determined to be at risk of acute malnutrition are referred to a health facility for appropriate treatment using therapeutic milks, ready-to-use therapeutic food, and a corn-soy blend. Other approaches have been initiated, including a national infant and young child feeding program, community-based nutrition programs, behavior change communication efforts including mass media, and home food fortification using micronutrient powders.

Although much less significant than wasting or stunting in Rwanda, the numbers of overweight and obese children is increasing among children under 5 years of age. Overall, 8% of children under 5 are overweight or obese (weight-for-height more than +2 SD) (RDHS 2015). There is a significant difference in prevalence of being overweight/obese by area of residence: 11% in urban areas and 7% in rural areas (RDHS 2015). Thus, there remains a need for more intensive and comprehensive interventions across many sectors.

4.4.1. Initiation of Breastfeeding

The World Health Organization (WHO) recommends the provision of the mother's breast milk to infants within one hour of birth (WHO, 2016). The first breast milk produced by the mother contains colostrum, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also fosters bonding between the mother and child. In Rwanda, 81% of children are breastfed within one hour of birth, a 10% increase from 2010 figures (RDHS 2015). Ninety-six percent of children are breastfed within one day of birth, and approximately 5% of children receive a prelacteal feed, which is something other than breast milk during the first three days of life.

4.4.2. Exclusive Breastfeeding and Complementary Feeding

Exclusive breastfeeding during the first six months is widely practiced in Rwanda – 87% of children are exclusively breastfed for their first 6 months of life (RDHS 2015). However, there is still a need to convey the importance of exclusive breastfeeding for the *entire* first 6 months: 94% of infants aged 0-1 month were exclusively breastfed, but this figure drops to 90% among those aged 2-3 months and 81% among those aged 4-5 months (RDHS 2015). After 6 months, breast milk alone is no longer sufficient to maintain a child's optimal growth. For this reason, UNICEF and WHO recommend the introduction of solid food to infants at approximately 6 months of age (PAHO/WHO, 2003). After 6 months, adding complementary foods, including protein and vegetables, to a child's diet ensures the child is receiving all he or she needs to grow properly.

According to RDFS, the stunting rate increases around 6 months, after the weaning period, and Rwanda needs to significantly improve in this area. RDHS 2015 shows that only 17% of breastfeeding children aged 6-23 months consume meat or fish; 4% of children aged 6-23 months consume eggs in addition to breastfeeding; and only 1% of children in this age group consumed cheese, yogurt, or other dairy products in the 24 hours preceding the survey. Overall, it was found that 89% of children aged 6-23 months consumed solid or semisolid food during the day or night preceding the survey. Most "solid or semisolid food" refers to fruit, vegetables, and legumes. Furthermore, CFSVA 2015 indicated that for children aged 6 to 23 months, the most common food items consumed by children in this age group come from the following food groups: grains, roots and tubers; vitamin A rich fruits and vegetables; and legumes and nuts. About 32 percent of children are reaching the minimum meal frequency (*For breastfed children, twice for 6–8-months old and three times for 9–23 months. For non-breastfed children, four times for 6–23-months old*) while 29 percent are obtaining minimum dietary diversity (*four or more food items out of seven food groups*).

4.4.3. Infant and Young Child Feeding Practices

WHO and UNICEF recommend the following infant and young child feeding practices (IYCF): early initiation of breastfeeding within 1 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 2 years of age or beyond. Introducing solid and semisolid foods at 6 months is known as complementary feeding and is a time when a sharp increase in stunting and underweight is seen (RDHS 2015). Children who continue exclusive breastfeeding longer than 6 months and those who are fed inadequate amounts of food or a lack of variety of foods are at the highest risk for developing malnutrition. Challenges regarding IYCF practices in Rwanda show that only 18% of children aged 6-23 months are currently fed in accordance to all 3 recommended practices (RDHS 2015). The Minimal Acceptable Diet (MAD), a composite of both Minimum Meal Frequency

and Minimal Dietary Diversity shows that overall, in children 6-23 months, a gain of only 1% improvement in this indicator was seen over a 5-year period of time from 2010-2015 (Rwanda Stakeholder & Action Mapping 2015). 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. IYCF has made many positive contributions toward decreasing malnutrition, and it needs to continue to improve, particularly at times of complementary feeding, when the increase in rates of malnutrition can be seen.

4.4.4. Diarrheal Disease and Treatment of Diarrhea

Diarrheal diseases constitute one of the main causes of death among young children in developing countries as they are associated with dehydration and malnutrition. To combat the effects of dehydration, WHO recommends the use of oral rehydration therapy (ORT), which includes a prepared solution of oral rehydration salts (ORS) made from packets or a solution prepared at home using clean water, sugar, and salt (recommended home fluids, or RHF). According to RDHS 2015, the prevalence of diarrhea is especially high among children age 12-23 months and 6-11 months (22% and 18%, respectively). Diarrhea prevalence varies by province, from a low of 8 percent in City of Kigali to a high of 15 percent in West. Regarding treatment of Diarrhea, RDHS 2015 showed that 44 percent of children with diarrhea seek the advice or treatment from a health facility or provider.

4.4.5. Feeding Practices during Diarrhea

To minimize the adverse consequences of diarrhea for the child's nutritional status, mothers and caregivers are encouraged to continue feeding children normally when they suffer from diarrheal illnesses and to increase the fluids that children receive. These practices help also to reduce the risk of dehydration among diarrheic children. According to (RDHS 2015), only 20 percent of children with diarrhea were given ORT or increased fluids and also given the same, more, or slightly less to eat than usual.

4.4.6. Vaccinations and Micronutrient Intake

According to the 2014/15 DHS 93% of children received all 8 basic vaccinations, up from 75% in 2005. This includes vaccine against Rotavirus, which is the most common cause of diarrheal disease among infants and young children. In addition, 86% received a vitamin A supplement, 80% received deworming medication in the 6 months prior to the survey and almost 100% percent (99.7%) lived in a household with iodized salts. In a KAP survey done by UNICEF in 2012 it was found that 78% had knowledge about vaccinating a child against a preventable disease and 38% had knowledge about Vitamin A supplements. From this it was inferred that although people may not know the full importance of vaccinations and Vitamin A supplements they vaccinated their children and gave them Vitamin A supplements, an example of a positive healthy social norm.

4.5. Water, Sanitation and Hygiene (WASH)

4.5.1. Household Drinking Water

Currently, 73% of Rwandan households have access to an “improved” source of drinking water (RDHS, 2015), with protected springs (32%) and public taps (27%) are the most common sources of improved drinking water. The remaining (27%) households reported using unimproved sources of water, and only 10% of households in Rwanda have running water in their home (RDH 2015). Fourteen percent of households reported using an unprotected spring as their primary water source. By not having access to or using improved water sources, households are at a higher risk of contracting diarrhea and other waterborne diseases compared to people using an improved source or treating their water before consumption. Further, those using an improved source may still be drinking contaminated water, although data on fecal contamination in water is unknown for rural areas in Rwanda. Diarrheal diseases are linked to malnutrition, especially in children under 5 years old. If a household is unable to secure water from an improved source, then treatment prior to consumption is recommended. Further, RDHS 2015 highlighted that children in households with shared and non-improved toilet facilities are more likely to have had diarrhea than those who live in households with improved, not shared toilets.

There is an apparent association between diarrhea prevalence and household wealth. The prevalence varies from a high of 15 percent among children in the lowest quintile to a low of 8 percent among children in the highest quintile. In Rwanda, 44 percent of households use an appropriate treatment method prior to drinking, while the remaining 56% do not take any measure to treat their water prior to drinking (RDHS, 2015 p. 21). The most common method to treat water prior to drinking is boiling (38%), followed by adding bleach/chlorine to untreated water (5%). Using ceramic/sand or another filter to distill untreated water was also reported as a treatment method by 4% of the RDHS study population. The issue of securing safe drinking water also appears to be influenced by geography. Most urban households (91%) were found to have access to safe drinking water, while access to safe drinking water is considerably less among rural households (69%). It is not surprising then that Rwandans living in rural areas are more likely to drink untreated water (60%) than their urban counterparts (33%). Securing access to safe drinking water is critical to improving the health and well-being of all Rwandans.

4.5.2. Household Sanitation Facilities and Practices

A secure sanitation facility (e.g. a covered toilet) in the household is vital to reduce the risk of exposure to dangerous pathogens and diseases. Diarrheal diseases are the deadliest and most common types of illness which are caused by a lack of adequate sanitation facilities (Duncan et. al.,2010). Approximately 10% of the global disease burden has been attributed to a lack of adequate sanitation facilities, resulting in over 2 million deaths per year globally (Prüss-Üstün A et. al., 2008). Household access to adequate sanitation facilities continues to be an area in need of improvement in Rwanda. RDHS 2015 found that 54 percent of households nationally

have access to an improved, unshared toilet facility. Fifty-seven percent of households in rural areas reported access, compared to 42% accessibility in urban areas (RDHS 2015, p.21).

Almost all households in Rwanda (99%) lack toilets that flush to a piped sewer system. Twenty-seven percent of rural households and 11% of urban households reported using a pit latrine without a slab or an “open pit” (RDHS 2015, p. 22). Improving access to adequate sanitation facilities is important in the effort to reduce the impact of diarrheal disease in the country. Promotion of routine handwashing in the home is recommended widely by the global health community, as proper and routine hand washing helps deter deadly bacteria. Indeed, practicing recommended handwashing reduces the risk of contracting diarrheal diseases (UNICEF, 2016). According to RDHS 2015, this is another area in need of considerable improvement: only 12% of households nationally had a place for hand washing. Among those, less than half (37%) had water and soap in the house. Survey findings again reveal an urban/rural disparity in access to sanitation facilities – 20% of urban households dedicated a space for hand washing, compared to 10% of households in rural areas. Pregnant women and children under 5 years old are especially vulnerable to suffer from diarrheal diseases.

5. PRIORITY BEHAVIOR TO ADDRESS

Based on the data and findings above, the following measures should be given priority in communication activities.

5.1. Key negative behaviors and behaviors to promote

Key negative behaviors /Barriers	Behavior to promote
Early childhood education and organized care	
Limited access to adequate programs and facilities that benefit early stimulation and learning	<ul style="list-style-type: none"> - Increase awareness of the government officials and local leaders on the importance of budgeting to increase the number of ECD centers and community based ECD that meets the minimum standard. - Involve religious leaders, civil society organizations, community-based organizations, and private sector in scaling up the number of community-based ECD facilities. - Engage media to promote educational programs for young children and parents.¹
Adult involvement in early learning and stimulation	
<ul style="list-style-type: none"> - Insufficient awareness around ECD, particularly among parents and caregivers. - Parent and caregivers lacks knowledge on child development and age-appropriate methods of stimulation to help child development. - Misunderstanding that children's growth between 0-6 years is mainly about the physical development. There is limited understanding of "brain development" in Rwandan context that makes children smarter.² - Limited male engagement. Conventional gender role is translated into the social norm against fathers' involvement in child care practices. - Poor couple communication in household decision-making, which involves cultural and social, gender norms and misconceptions 	<ul style="list-style-type: none"> - Increase awareness among parents and community about the benefit of ECD, including importance of early stimulation and brain development. - Educate parents on age-appropriate stimulation according to the stages of child development. This includes promoting low-cost home activities such as storytelling, singing and playing with household objects. - Encourage private sector, local cooperatives and community members to produce affordable toys for children. - Promote communication between the couples in the household decision-making. Promote gender equality in the child care practices. Knowledge and practice should be shared by both fathers and mothers. - Promote the nurturing role of fathers, which would require social change for the community to embrace equal participation of both mothers and fathers in childcare.

1. A first attempt has been spearheaded by MIGEPROF and the Rwanda Broadcasting Agency with UNICEF support in the form of a weekly show called Itetero, which brings age-appropriate stimulation to children and educates parents on parenting skills.

2. Qualitative findings from a field survey confirmed during the ECD technical working group.

Adequate care for young children to protect from harm	
<ul style="list-style-type: none"> - Insufficient awareness about the risk of leaving child home alone or in the care of another child. - Lack of alternative service/care when parents need to go to work and leave the child. - Corporal punishment is common. 	<ul style="list-style-type: none"> - Raise awareness among parents on the importance of child safety and protection from harm. - Promote services such as mobile crèche and community-based solutions such as community-based ECD and home-based ECD to provide alternative child care. - Promote positive parenting skills and address the social norms around corporal punishment.
<ul style="list-style-type: none"> - Children with disabilities and children with special needs (including those with HIV) face stigma and discrimination and experience social exclusion. 	<ul style="list-style-type: none"> - Raise awareness in the community about disabilities and social inclusion (psychological and social barrier). - Promote removal of physical barriers to increase access to social services and social activities. - Promote disability mainstreaming in every activity. - Advocate for the inclusion of early detection of disabilities as part of pediatric check-up.
Stunting	
Adult nutrition	
<ul style="list-style-type: none"> - Women of reproductive age, including pregnant and lactating women and adolescent girls, are not getting minimum meal frequency and dietary diversity. - There is misconception about food taboos (e.g. girls and pregnant women should not eat eggs, vegetables are for poor people). - Increased consumption of energy-dense foods high in saturated fats and sugars, and reduced physical activity which cause overweight and obesity. 	<ul style="list-style-type: none"> - Increase awareness that women of reproductive age, particularly pregnant and lactating women should eat meals four times each day that contain foods from at least four food groups out of seven food groups (demand). - Address taboos related to food and promote correct knowledge. - Address food insecurity and rising price of nutritious food (access and resilience). - Promote reduced consumption of energy-dense food high in saturated fats and sugars, and increase physical activities among those who are obese.

Infant and Young Child Nutrition

<ul style="list-style-type: none"> - Poor infant and young child feeding practices. Minimum dietary diversity and frequency is not met, adequate amount of food and consistency are not met, and responsive feeding is not practiced; - Non-exclusive breastfeeding (giving water with sugar to the newly born baby and water or other liquids/foods to infants under six months.) - Delayed initiation and diluted complementary feeding to young children starting from 6 months. - Poor hygiene and sanitation practices such as poor handwashing practices at critical times; feeding the child without washing hands with soap; drinking unsafe water and storage; not using an improved latrine and poor disposal of children's feces; unclean household environment. - Poor food safety practices, such as not washing food before eating, which causes infection from a foodborne illness. - Not continuing feeding during diarrheal disease among young children. - Limited capacity of getting food among poor families - Issue of pregnancy and birth spacing which as one of the causes of children malnutrition 	<ul style="list-style-type: none"> - Promote good infant and young child feeding practices with a focus on quality of food as opposed to only the quantity of food; address resource allocation and prioritize nutritious food for children. - Promote optimal breastfeeding and early initiation of breastfeeding (within 30 min after delivery) and emphasis on colostrum. - Encourage adequate and timely complementary feeding to young children between 6 and 23 months. - Educate about minimum meal frequency³; Minimum dietary diversity⁴; adequate amount of food and consistency, active/responsive feeding, exclusive breastfeeding (not giving any other foods or liquids to infants besides breastmilk in the first 6 months of life). - Promote hand-washing with soap and water at four critical times⁵; always treating water prior to drinking, use an improved latrine and properly dispose children's feces. - Promote continued feeding and Oral Rehydration Treatment (ORT) during diarrheal disease among young children. - Advocate for construction and maintenance of latrines which can be cleaned. - Advocate for poor families to have income generated activities - Promote family planning among Rwandan families
<ul style="list-style-type: none"> - Lack of appropriate knowledge on responsive child feeding - Not feeding children who are sick 	<ul style="list-style-type: none"> - Raise awareness to parents and caregivers to responsive child feeding practices - Education on feeding children even when they are sick

3. Minimum meal frequency for breastfed children: twice for 6–8 months old and three times for 9–23 months; For non-breastfed children: four times for 6–23 months old.

4. Minimum dietary diversity means consumption of four or more food items out of seven food groups.

5. Critical times of handwashing are: after defecating; after cleaning a child who has defecated; before preparing meals/touching food; before eating; before feeding a child.

Health Seeking behavior	
<ul style="list-style-type: none"> - Poor attendance of growth monitoring and promotion sessions. - Mothers and caregivers of children under 5 are not properly giving micronutrient powders to their children. - Poor completion of full ANC/PNC visits. - Delayed health seeking behaviors when the child is ill. 	<ul style="list-style-type: none"> - Promote regular attendance to the monthly growth monitoring and promotion sessions to assess the growth of the child. - Educate mothers and caregivers of children under 5 about the importance of complying with the instruction on how to give micronutrient powders to eligible children. - Promote full attendance at ANC/PNC. - Promote early care seeking in case of diarrhea, fever and respiratory infection from a health facility.

5.2. Priority areas for communication

- Infant and young child feeding (IYCF): Minimum meal frequency (i.e. for breastfed children: twice for 6–8 months old and three times for 9–23 months; For non-breastfed children: four times for 6– 23 months old); Minimum dietary diversity (consumption of four or more food items out of seven food groups); adequate amount of food and consistency, active/responsive feeding. Emphasis should be put on *timely* introduction of nutritious and frequent complementary feeding at six months of age without delay.
- Efforts are needed to prevent sickness by promoting hand washing with soap (after defecating; after cleaning a child who has defecated; before preparing meals/touching food; before eating; before feeding a child), clean home environment (construct and maintain latrines which can be cleaned and cover the hole to reduce the incidence of diarrheal diseases transmitted via flies), safe handling and storage of food and water, and immunization.
- Early care-seeking behaviors when a child is sick (diarrhea, fever, acute respiratory infection) and continued feeding with ORT during diarrhea.
- Adolescent girls, women of reproductive age, particularly pregnant and lactating women, eat meals four times each day that contain foods from at least four food items out of seven food groups. When pregnant, attend ANC and PNC and take iron + folic acid supplementation.
- Family care practices: monthly growth monitoring to check whether the child is growing well; Ongera/shisha kibondo micronutrient powder.
- To ensure equity, communication efforts should ensure reaching parents with low socio-economic status and low levels of education, and children with disabilities/special needs.

- Parents should be taught about the importance of early learning and early stimulation that child growth is not only physical, but also brain development “to grow smarter”. Parental education should emphasize responsive caregiving, including adequate care of children, method of stimulation per development stage, protection and adequate nutrition.
- Access to activities and programs that benefit early stimulation and learning should be promoted. This includes i) promoting low-cost home activities such as storytelling, singing and playing with household objects. The private sector, local cooperatives and community members should be encouraged to produce affordable toys for children; ii) promoting media programs for young children and parents. A first attempt has been spearheaded by MIGEPROF and the Rwanda Broadcasting Agency in a weekly show called *Itetero*, which brings age-appropriate stimulation to children and educates parents on parenting skills. Such efforts should be amplified, and more efforts should be made to increase listenership; iii) promoting community-based ECD care, which includes expanded partnership with the religious network so that ECD services can be offered at churches and mosques.
- Male engagement and household decision making: There is a need to promote the nurturing role of fathers and couple communication for joint decision making, which would require social change for the community to embrace equal participation of both mothers and fathers in childcare. This issue of gender equality is linked to the wider gender agenda that affects children – that shared responsibility between parents will lead to mutual respect and understanding, and more cohesion in the family. When parents demonstrate gender equality at home, children will be liberated from the narrow definition of traditional gender views and feel more empowered to participate in society and explore their full potential.
- The promotion of positive disciplining needs to be approached from social norm perspective. Where the individual preference of “I do not really enjoy hitting my child” is over-ridden by the perceived social norm that it is parental responsibility to use physical discipline to maintain the social order, communication efforts should take a two-track approach. It is necessary to foster social change in the community while at the same time informing parents about the harmful effects of corporal punishment and teaching non-violent discipline skills to promote individual change.
- Improve access to nutritious food and mitigate the impact of climate change on food insecurity in terms of social protection measures while building resilience in the communities.

When creating messages to promote behaviors like those cited above, attention should be given to the specific barriers (for example: gender dynamics such as limited access to or control over household resources; cultural norms and social beliefs, limited skills and knowledge on health, etc.) that are holding people back from adopting the promoted behavior. It is also important to consider the needs of children with disabilities and children with special needs.

6. NATIONAL SBCC STRATEGY COMMUNICATION FRAMEWORK

6.1. Vision

All children in Rwanda grow to their full potential and contribute to the development of the country as a result of appropriate childcare practices in the family, equal access to social services and supportive community.

Guiding principles

- Social change should be nurtured to make ECD, Nutrition and WASH services a part of national culture. Progress on children’s holistic development will require collaboration among multi-sectoral stakeholders (gender and family promotion, WASH, health, social protection, child protection and education) for equal access to quality social services, and leveraging partnerships (government, CSOs, academia, the private sector, and community and religious leaders) to create an enabling environment. Collaboration between ministries will be coordinated as stipulated in the ECD policy.
- Special focus should be placed on building the self-confidence of parents or caregivers and children, especially for disadvantaged persons, such as persons with a disability, parents with low educational background, the poorest households and people in remote areas. The approach will be guided by the identification of what works in Rwanda, based on scientific evidence and documented good practice.
- It is necessary to invest in capacity-building of various actors at different levels – household, community, service providers and government.
- The communication mix will be carefully designed to engage communities and individuals through media, social mobilization and interpersonal communication.
- While communication often targets parents, efforts will be made to communicate directly to young children to form positive attitudes and behavior by using age-appropriate messages through child-friendly methods.

6.2. Theoretical framework

Individual childcare practice is deeply connected to social norms, including gender roles, and the availability of social services for young children and their families. This section describes and recommends three theoretical models to all stakeholders to improve the ECD, nutrition and WASH best practices.

The socio-ecological model: Developed by Bronfenbrenner, socio-ecological model looks at an individual’s development within the context of the system of relationships that form his or her environment. The theory defines complex ‘layers’ of environment, each having an effect on an individual’s development. This theory emphasizes that, to affect an individual’s attitudes and behavior, it is necessary to address the community and social systems that influence their choices. Behavior-change messaging to individuals needs to be coupled with communication interventions to address enabling social norms on care practices.

Ecologic Model: Levels of Influence on Human Behavior

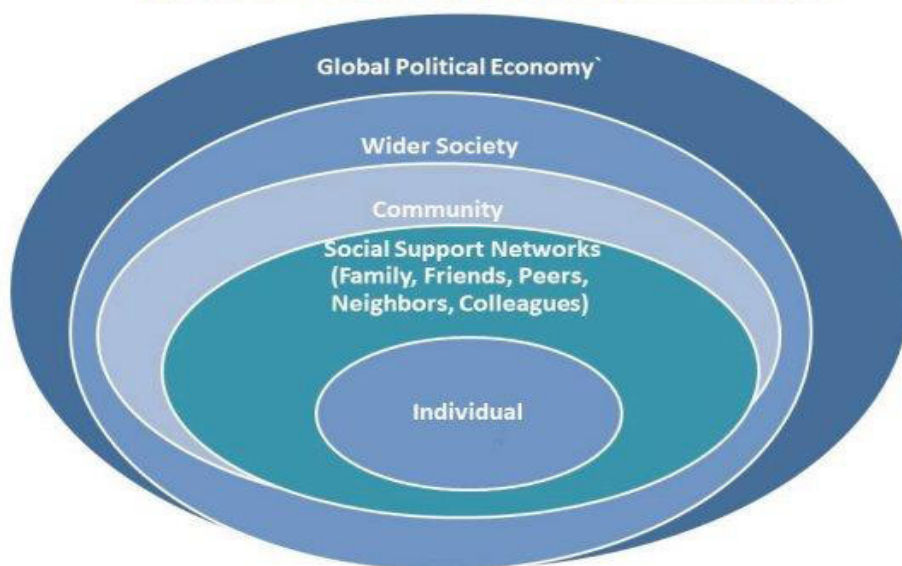


Figure: Visual Depiction of Ecologic Model. Source – U.S. Center for Disease Control and Prevention

SBCC strategy Theory of Change based on the socio-ecological model

Children of ECD age spend the majority of time at home so their family’s ability to care for children is the most important factor. The ability of family can be enhanced by supportive social norms and forums in the community, as well as access to quality social services, which in turn, needs to be supported by the national and local authority allocating adequate resources. The Theory of Change can therefore be summarized as follows:

- If the policy makers make ECD, Nutrition and WASH related family-friendly policies, and national and local authorities allocate adequate resources to support social services, community initiative and families with young children; and
- If the social services (ECD, health, nutrition, WASH, child protection and social protection) to families with young children provide equal access and quality; and
- If the communities and other partners understand the importance of ECD, Nutrition and WASH Services and hold supported social values and norms; and

- If the families understand their roles and skills for parenting and adopt ECD, Nutrition and WASH good practices; and
- If the children receive age-appropriate communication and interaction with family members;
- Then children will achieve optimal development.



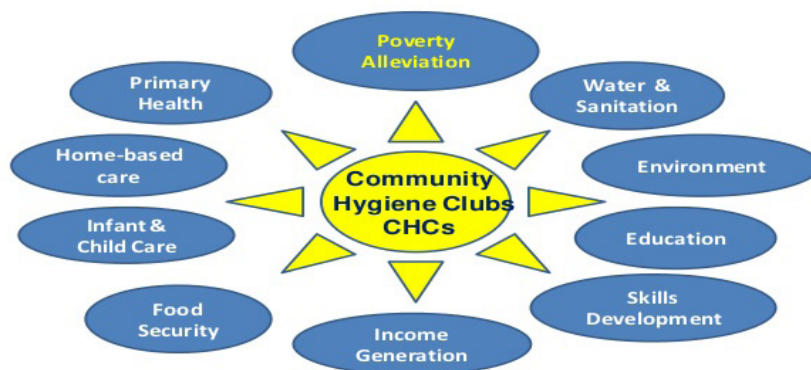
Community Health Club (CHC) Approach

The CHC approach is based on the familiar PHAST methodology and appeals to an innate need for health knowledge, which is then reinforced by peer pressure to conform to communally accepted standards of health and hygiene, and thereby creating a “Culture of Health.” The CHC Approach addresses a wide range of preventable diseases within a holistic framework of development that understands health promotion as an entry point into a long-term process of transformation of social norms and values that ultimately leads to poverty reduction outcomes.

The strength of the CHC approach is not only its ability to engender health and hygiene behavior change but it is also able to quantify behavior change using community monitoring tools as an integral part of the process of change. Each CHC is charged with monitoring the changes within in its own village membership (usually consisting of between 50 and 150 households).

These observations, known as a “household inventory” are conducted on a regular basis and the information is then entered into an exercise book, thus enabling each CHC to identify exactly when the agreed behavior and lifestyle changes have been made and house to house visits among CHC members is reinforced to strengthen the selected target practice.

Placing CHC at centre of development



WASH conference 2011

7. NATIONAL SBCC AUDIENCE ANALYSIS

Although the audience is all Rwandan, there are a number of key priority audiences. This section highlights key characteristics of the key audiences.

7.1. Primary Audience:

Adolescent girls, pregnant women, lactating mothers / caregivers of children from zero to 6 years with emphasis on children under 2 years:

Mothers are not only beneficiaries, but also have primary responsibility for day-to-day childcare. Many mothers of small children, whether urban or rural, have low levels of formal education and income, and limited access to health information and services. At times mothers may believe that they have little ability to change practices or do not have the community support to negotiate improved practices with their husbands and/or mothers-in-law. Mothers often access health and nutrition information through their religious communities, their husbands, peers, mothers-in-law, professional health workers as well as the CHWs.

Fathers:

They were also identified among the primary audience, together with mothers of children from 0 to 6 years with emphasis on children under 2, as they exercise influence on the mothers' practices. Women often ask men for advice, permission, or money for health-related matters as men have extensive financial powers and are often the key decision makers on health issues.

Girls and Boys aged 12-18:

They are found in primary school as well as at the lower secondary education level. They are important members of society as they get ready to fulfill their role as good citizens and as future parents. It is important to equip them with information on reproductive, maternal and child health and nutrition as well as their responsibility as future parents. If targeted with empowering interventions, adolescent girls and boys can change their behavior and protect their own health and that of their eventual children, as well as serve as models to improved healthy behaviors among the other members of their households.

7.2. Secondary Audience

Health care providers:

Health care providers including district hospital and health centers staff who are trained in charge of ECD, Nutrition and WASH activities. This National Integrated SBCC Strategy will enable them to coordinate and implement ECD, Nutrition and WASH behavior communication activities effectively at community and household levels aiming at improving the individual behaviors. The SBCC implementation plan will be elaborated and integrated in each district hospital and health center activities plan and be monitored in collaboration with District SBCC Taskforce under DPEM.

Community Volunteers:

Community volunteers including Community Health Workers (CHWs), ECD Caregivers, Inshuti z'Umuryango (Friends of the Family), Mamans *Lumières*/Parents *Lumières* (Model Parents), Farmer Promoters (FP) and Field Agents (FA) are trained community facilitators and recognized by the Government of Rwanda through different line ministries to sensitize the community on ECD, Nutrition, WASH, agriculture and economic-related activities. Living within communities, those facilitators will act as behavior change champions to educate and channel integrated ECD, nutrition and WASH message within the community.

Grandparents and parents-in-law:

These are older family members, usually living within the extended family. They are influential and a source of information on maternal and child care practices, often based on their own experience. Young parents usually refer to their grandparents and parents-in-law for advice, which they trust and follow.

7.3. Tertiary audience:

Community leaders, religious leaders, youth leaders, youth club members, women's group leaders and leaders of civil society organizations, opinions leaders and decision makers:

These groups are highly influential, respected and trusted entities in the community. They represent an extremely important channel for providing information and motivating adolescents and parents within their community. This National Integrated ECD, Nutrition and WASH SBCC Strategy will bring together these different entities, working at the community-level in a strategic communication planning process to identify issues, raise awareness of primary and secondary audience and support other community behavior change activities aimed at improving household ECD, nutrition and WASH behaviors.

8. COMMUNICATION OBJECTIVES

The main focus of interventions can be summarized as follows according to the target audience:

Audience 1: Children

Output 1: Children have increased exposure to early stimulation by their families, including access to age-appropriate media programs, books, and play and learning materials.

Communication objective 1.1: Children receive age-appropriate communication (e.g. media programs, books, play and learning materials).

Communication objective 1.2: Children receive preventive and curative care in terms of health, nutrition and WASH services to avoid recurring infections.

Communication objective 1.3: Children start eating nutrition-rich and balanced complementary food from six month of age.

Audience 2: Parents with children 0-6 years old / adolescent girls and boys

Output 2: Parents provide responsive care to young children.

Communication objective 2.1: Parents understand the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)

Communication objective 2.2: Both fathers and mothers participate equally in childcare and stimulation.

Communication objective 2.3: Parents practice appropriate health, nutrition and WASH practices for themselves and for their children.

Audience 3: Community

Output 3: Communities adopt supportive social norms for ECD and take ownership of ECD initiatives.

Communication objective 3.1: Communities understand the importance of ECD and its positive impact on the community.

Communication objective 3.2: Communities demand basic social services for young children (a minimum package of health, nutrition, WASH, child protection, social protection and ECD services), including their accessibility to children with disabilities, and support community-based ECD initiatives.

Communication objective 3.3: Communities embrace fathers who participate in care of young children.

Communication objective 3.4: Communities discuss their own issues related to young children and families in local forums.

Audience 4: Social service providers

Output 4: Service providers (health professionals, Community Health Workers, Inshuti z'Umuryango, social protection) provide adequate services to young children and their families.

Communication objective 4.1: Frontline workers acquire interpersonal communication skills to ensure social inclusion and to work with parents in the best interests of the child.

Communication objective 4.2: Frontline workers feel their work is important and valued by the community.

Communication objective 4.3: Quality service providers are motivated and remain in their jobs.

Communication objective 4.4: There is an established linkage at the local level among different areas of social services children and families can benefit from referrals across sectors.

Audience 5: Local authorities

Output 5: Local authorities provide adequate leadership to scale up ECD initiatives and basic social services.

Communication objective 5.1: Local authorities know the key aspects of the ECD policy, understand the importance of ECD, and their ECD-related roles and responsibilities

Communication objective 5.2: ECD is high on the local agenda (at district, sector, cell and village levels, respectively) and is included in district plans and budgets

Communication objective 5.3: Local authorities and community leaders support scale-up of ECD and strengthen the linkages between ECD and other social services.

9. ANALYSIS OF RELEVANT COMMUNICATION CHANNELS:

Mass media

Television and other media can increase home access to ECD, Nutrition and WASH programming aimed at either children or parents. For example, local versions of the educational television program *Sesame Street* reach children in over 150 countries. A meta-analysis representing more than 10,000 children from 15 countries found significant benefits from watching *Sesame Street* in literacy and numeracy, health and safety, and social reasoning and attitudes toward others. The Rwanda DHS 2014-2015 showed that radio is the most widespread and frequently used communication channel in Rwanda – more than half the population (55 percent) own a radio. Radio programs are also listened to via mobile phones, which are owned by 60 percent of the population. On average, 79 percent of men and 62 percent of women listen to radio at least once a week. Access to television is still limited (10 percent) but 29 percent of men and 16 percent of women say they watch TV at least once a week. This indicates high level of communal TV viewing, which would be expected to rise sharply with the country's rapid electrification.

Overseen by MIGEPROF, the Rwanda Broadcasting Agency launched its first home-grown children's program called *Itetero* in October 2015. This weekly 30-minute program is aired on Radio Rwanda twice a week and aims to stimulate young children aged 0-6 years and to guide their families on issues related to parenting. *Itetero* combines different creative segments including music, drama, storytelling and expert interviews reflecting the local context and culture. The content is developed by a group of technical stakeholders from various sectors who form the Content Advisory Group (CAG) on ECD. There is a scope for further expansion of children's media programs on both radio and TV.

Community forums

Rwanda has several nationwide forums that are important at the community level.

Umugoroba w'Ababyeyi (Parents' evening) is a village gathering that brings together parents (both men and women). Young women and men who do not have children are sometimes invited to join the gathering, and children may occasionally participate if there are subjects that concern them. According to its strategy document, *Umugoroba w'Ababyeyi* aims to provide a platform where parents can discuss and address their socio-economic concerns for sustainable development. It has seen success stories in resolving family issues, improving health and nutrition, and reducing the poverty gap and violence in the family. Village Committees of the National Women's Council (NWC) in collaboration with the Village Executive Committees are responsible for overseeing *Umugoroba w'Ababyeyi's* activities. The National Women's Council highlights achievements of *Umugoroba w'Ababyeyi* in its quarterly report submitted to MIGEPROF.

National Children's Forum

This was established to provide children with a platform to express their opinions and be heard on matters concerning their life, family and country. The Forum serves as the national voice for children and a channel where children can express their views on national issues and suggest how these can be resolved by governments with children's participation. These forums are also structures where children learn leadership and socialization skills from an early age. Children's Forum committees are elected by children for three-year terms. The committees are formed at village, cell, sector and district level, and their responsibilities include leading regular Children's Forum meetings and providing views on the welfare and rights of children. Other functions include taking part in the decisions that affect children, denouncing problems affecting children in the community and disseminating the resolutions of Annual National Children Summits. Established in 2004, the annual National Children Summit brings together child delegates from all administrative sectors across the country. The Children's Summit provides children with a special opportunity to express their views and wishes about building the nation. Children also participate in understanding and proposing what is done or planned for them in terms of national policies and programs. They discuss their rights, the country's economic and social development, and their role in such concerns.

Youth-friendly Centers

Health education is provided to young people at youth resource centers, which offer young people the opportunity to participate in sports, cultural dance, and other fun activities. This channel offers an opportunity for discussion between boys, girls, and their parents about healthy behaviors based on informed choices. This national integrated strategy will collaborate with National Youth Council and use this channel to target youth at centers with appropriate messages focusing on the role of youth in improving ECD, nutrition and WASH behaviors.

Umuganda (Community work)

The word Umuganda can be translated as 'coming together in common purpose to achieve an outcome'. In traditional Rwandan culture, members of the community would call upon their family, friends and neighbors to help them complete a difficult task. As part of efforts to reconstruct Rwanda and nurture a shared national identity, the government drew on traditional practices to enrich and adapt development programs to the country's needs and context. The result is a set of home-grown solutions—culturally owned practices translated into sustainable development programs. One of these solutions is Umuganda. Modern day Umuganda can be described as a community-service day (umunsi w'umuganda). On the last Saturday of each month, Rwandans aged 18-65 come together for three hours in the morning to do a variety of public works. This often includes infrastructure development and environmental protection. Participation in Umuganda is usually supervised by a manager or Umudugudu chairperson who oversees the effectiveness and efficiency of community participation. While the main purpose is to undertake community work, it also serves as a forum for leaders at each level of government (from village up to national level) to inform citizens about important news

and announcements. Community members are also able to discuss any problems they or the community are facing and propose joint solutions. This time is also used for evaluating what they have achieved and for planning activities for the following month's Umuganda session.

Growth Monitoring and Promotion session (GMP)

Growth monitoring is the regular measurement of a child's size to monitor his growth. It refers to regularly weighing a child (from birth through the first two, three or five years of life) and recording the weight on a growth chart. Because weighing and charting alone cannot improve growth, promotional activities are also needed. These include nutrition education and SBCC actions to improve child growth and prevent all forms of malnutrition. This activity takes place monthly in all villages of Rwanda and is led by health service providers including Community volunteers in collaboration with local leaders. This national strategy will use this channel to increase awareness and educate mothers, caregivers and husband/fathers of under five children around ECD services, nutrition and WASH best practices.

Inshuti z'Umuryango (Friends of Families)

Enshrined in Rwandan society is the belief that children belong not only to the biological parents but also to the extended family and community at large. This promotes the positive value of 'treating every child as your own'. With this in mind, two persons (one man and one woman) were selected in every village to prevent and respond to violence, abuse, exploitation, neglect, abandonment and other child-protection risks in their locality. This informal cadre established in 2015 by the NCC is an integral part of the child protection system in Rwanda and works together with professional social workers and psychologists at district level. Their main responsibilities are to conduct home visits, identify any cause for concern regarding child protection, make referrals to professionals and other service-providers, and sensitize households on positive parenting and child-friendly practices. They report to local authorities and professional social workers and psychologist in districts, and work with other sectors, including community health workers and ECD caregivers, to ensure children and families receive holistic services.

Itorero (National Itorero Commission)

This is a Rwandan civic education institution which aims to teach all Rwandese to keep their culture through its different values such as national unity, social solidarity, patriotism, integrity, bravery, tolerance, the dos and don'ts of society, etc. Through this instrument, Rwandans are also informed of government policies and programs, which strengthens ownership and promotes the population's role in implementing these social-economic development programs. Civic education is organized by the 'Itorero ry'igihugu' institution under the National Itorero Commission.

Religious denominations

The majority of Rwandans are religious. According to the 2012 census, 44 percent of the resident population of the country are Catholics, followed by Protestants (38 percent) and Adventists (12 percent). Muslims represent 2 percent of resident population, and more than half of them live in urban areas. Religious leaders, although independent from government, play an important role in forming and guiding social norms and individual behavior. They also serve as an important source of information, especially for the rural population where communication channels are limited. At an advocacy meeting in December 2015, the leaders of the Catholic, Protestant and Muslim denominations expressed commitment to support stunting reduction and ECD. Under MIGEPROF's guidance, a sermon guide on ECD for Christian and Muslim is being developed. The aim is to strengthen the capacity of all religious leaders to disseminate ECD messages, and to correct misconceptions about what the religious scriptures say about gender roles.

Information Communication and Technologies (ICT)

Recent technological advances have enabled the development of new, exciting approaches to communication, especially for urban population with stable access to electricity. This strategy will build on the advantages and benefits of using appropriate technology to reach target audiences. The mobile phones are used in health communication, particularly through short message service (SMS), an inexpensive way of obtaining and sharing information and getting feedback. Similarly, ICT platforms using voice messages or call-in services can create interactive opportunities where beneficiaries can use their own simple mobile phones to proactively retrieve information across a range of topics in local language - anytime, anywhere, and free of charge. This interactive form of messaging allows individuals to make decisions regarding the choice on behavior topics and contents. The call-in services can cover a broad range of topic areas including gender, health, agriculture, and micro-finance. In a series of "listen, then choose" steps, callers can use their phones to select from among hundreds of recorded voice messages. This national strategy will encourage the use of such technology focused channels to enhance knowledge and promote optimum ECD, Nutrition and WASH related messages

Private sector

The private sector in Rwanda is growing rapidly. Domestic and foreign investments are driving the country's economy. The private sector employs many people, and the workforce is mostly young people and young parents who need to receive messages around ECD. In some instances, the busy schedules and work environment in the private sector do not allow these young parents and caregivers to attend other community gathering and events where ECD sensitization is done. Private-sector platforms can therefore serve as the channels of communication to disseminate messages to workers and stakeholders. Well-tailored communication materials such as outreach in business areas, communication materials and interpersonal communication can all be used to reach parents and caregivers working in the private sector. MIGEPROF, in partnership with UNICEF, is expanding its partnership with the

private sector to advance children rights, by observing the Child Rights and Business Principles (CRBP). Capacity-building interventions will be carried out to raise awareness of the CRBP, targeting business sectors which affect the lives of women and children, including the tea sector, the ICT sector, and leisure and tourism. Corporations will be technically supported to improve their policies and procedures and to make their working environments more child-friendly.

10. NATIONAL SBCC STRATEGY IMPLEMENTATION ARRANGEMENTS

This chapter outlines how the SBCC strategy will be rolled out. It also covers the roles and responsibilities of implementing partners and community-based organizations. Finally, the chapter spells out how the strategy should be coordinated and suggests monitoring mechanisms.

10.1. Coordination and Collaboration mechanism

The National Early Childhood Development Program (NECDP) will lead and oversee the implementation of the SBCC strategy in close collaboration with Rwanda Health Communication Center (RHCC) at all levels. The SBCC activities will be inserted into the annual action plans of line ministries and partners as well as relevant national technical working groups. Every line ministry and implementing partner will refer to this SBCC strategy when developing activities.

All communication materials related to the implementation of ECD, nutrition and WASH activities will be reviewed and validated by the National Health Promotion Technical Working Group.

10.2. Roles and responsibilities

10.2.1 Social Cluster Ministries and Rwandan Parliamentarians Network on Population and Development (RPRPD)

To strengthen the consistency and efficiency of SBCC actions undertaken by many sectors and partners, the National SBCC Strategy will be coordinated from, at minimum, at central, district level and sector levels. The Social Cluster Ministries will contribute to strength existing related policies and strategies, advocacy for SBCC implementation, mobilize resources, and support local governments in implementing this SBCC Strategy.

The Rwandan Parliamentarians Network on Population and Development (RPRPD) will contribute in advocacy and community engagement related activities for better implementation of SBCC activities.

10.2.2. National Early Childhood Development Program (NECDP)

The National Early Childhood Development Program (NECDP) was established in December 2017 as per the Prime Ministerial Instruction published in the National Gazette *no.03/003 24/12/2017*. The NECDP is an autonomous agency both administratively and financially reporting to the Ministry of Gender and Family Promotion. With the decree that instituted NECDP, the program received the general mission to coordinate and implement all interventions

that support adequate early childhood development for children from their conception to six years of age as outlined in the Early Childhood Development Policy.

The Government commissioned the National ECD Program (NECDP) with the overall goal of reducing stunting through ECD. NECDP is also mandated to coordinate all programs related to ECD and nutrition to attain the desired child development outcomes on the premise that program integration is critical for holistic child growth and development. A child needs to receive comprehensive quality early stimulation and learning, health, nutrition, WASH and protection services to grow and develop to full potential. NECDP envisage to increase children (0-6 years) access to ECD services from the current 13% to 45% by 2024. Similarly, it intends to reduce stunting from 38% to 19% during the same period.

The NECDP is therefore tasked to carry out the responsibilities cited below:

In close collaboration and coordination of all sectors playing a role in Early Childhood Development, specifically NECDP is responsible for:

- Increasing children’s preparedness to the primary school environment;
- Promoting optimal child development;
- Enhancing positive parenting and community participation in child protection;
- Reducing malnutrition and stunted growth among young children;
- Eliminating physical, moral, and psychological abuse of young children;
- Enhancing equal access to early childhood development services for children with disabilities and special needs.

The NECDP will oversee the overall coordination and implementation of this National SBCC Strategy including but not limited to organizing quarterly meeting of all related technical groups including Health Promotion TWG to monitor the progress on regular basis. A strong coordination and monitoring mechanism ensures effective and complementary packaging of interventions so that ECD, Nutrition and WASH related social services and messages can be delivered seamlessly without duplicating efforts.

10.2.3. The Rwanda Health Communication Centre (RHCC)

RHCC is the communication arm of the entire health sector. It is responsible for the coordination of health promotion interventions, handles media and public relations the sector. RHCC will chair National Health Promotion Technical Working Group activities to ensure all communications tools related to the implementation of SBCC Strategy are reviewed and approved. This includes coordination, monitoring and reporting of SBCC activities to NECDP coordination on quarterly basis. The National Health Promotion TWG members include all social clusters ministries and

implementing partners and co-chaired by UNICEF.

10.2.4. Technical Working Groups (TWGs)

All technical working groups operating in areas of ECD, Nutrition and WASH will have a representative within National Health Promotion TWG to ensure that all related communication tools are submitted for review and validation by the said team. The technical working groups include ECD, Food and Nutrition, Water and Sanitation and Agriculture Sector TWGs.

11. MONITORING AND EVALUATION FRAMEWORK

This National Integrated ECD, Nutrition and WASH SBCC Strategy represents national-level guidelines for all ECD, Nutrition and WASH stakeholders and will monitor regularly their ECD & SBCC implementation plans. Different indicators will be used based on specific ECD & SBCC related program and activities.

Evaluation of this strategy will consider measuring ECD, Nutrition and WASH related indicators at various levels including inputs, outputs, and process, outcome and impact indicators. More formative research will be undertaken periodically to monitor the changes in knowledge, attitudes, beliefs, self-efficacy and perceived risks which will contribute to the process of adapting messages, communication materials and some behavior change actions. This section will define how the monitoring and evaluation will be done and at what frequencies data will be collected.

It also highlights the program level or outcome indicators that are expected to be measured at midterm and end line of a given ECD, nutrition and WASH related SBCC interventions.

Objectives of M&E plan:

The objectives of the M&E plans include:

- To outline key ECD, Nutrition and WASH indicators for implementing this communication strategy at all levels behavior change communication monitoring and evaluation
- To guide the monitoring of planned strategy activities, measure expected outcomes and impacts
- Document challenges /generate evidence on key ECD, nutrition and WASH related practices to inform subsequent behavior change planning, implementation and strategic decisions.

Monitoring the behavior change interventions or routine tracking: This is done through record keeping, periodic review of implementation reports (e.g. supervisor's report, meeting and training reports).

This will help to generate data on output indicators (e.g.: message delivered and reached to the audience, materials disseminated, and channels used) over a planned time. It will assess the extent to which the implementation of planned activities is consistent with the M&E plans and to determine which areas require more focus.

Formative or qualitative research: This is a key step to create program materials, tools and approaches that are culturally appropriate to the local context. Qualitative methods collect data to answer questions such as “why?” and “how?” Although this approach provides rich and detailed information, it is not meant to generalize to an entire population or intended audience.

The National ECD, Nutrition and WASH SBCC Strategy recommends undertaking regular formative research to identify and track emerging changes, current level of knowledge, beliefs and attitudes, impact of channels through which messages were delivered and to customize contents and approaches accordingly.

Indicators for evaluating Integrated EDC nutrition and WASH impacts:

By improving the ECD, Nutrition and WASH behaviors, this National Integrated strategy will assist Rwandan Government effort to promote optimal Early Childhood Development and decline the stunting among children under 5 and creating positive outcomes which are reflected in the Fourth Health Sector Strategic Plan (2018 – 2024) and through strategy implementation plans, this strategy will monitor these indicators reflected in Rwanda DHS 2015 and HSSP IV (2018 -2024).

Additional to the key indicators defined in M&E plan, any government or civil society organizations conducting communication, advocacy and social mobilization activities for ECD, Nutrition and WASH in Rwanda are encouraged to use the above output and outcome indicators to measure progress and results. Using the same indicators will allow harmonized cumulative reporting across a wide range of ECD, Nutrition and WASH partners and stakeholders. The results should be shared with National NECD Program as a platform for knowledge management. These indicators include:

Outcome indicators

- Prevalence of stunting among children (0–59 months)
- Prevalence of underweight children (0–59 months)
- Prevalence of wasting (Ht/Wt)

Indicators to measure implementation progress, communication and advocacy activities:

- # of districts with ECD incorporated into their plans and budgets
- # of families/parents reached with communication messages on responsive caregiving / positive parenting.
- # of children reached with child-friendly mass media programs (radio, TV).
- # of local authorities reached with awareness-raising messages on ECD
- # of communication / advocacy events organized at different levels (national, district,

sector, community)

- # of frontline workers trained on inter-personal communication skills.
- # of children reached with growth monitoring
- # of ECD service providers / caregivers trained.
- # of parents reached with parenting education.
- # of parents reached with integrated messages.
- # of Integrated ECD, Nutrition and WASH messages developed, communication materials produced and distributed
- # of sensitization meeting organized with local leaders
- # of ECD & Nutrition and WASH radio materials produced.

12. CONCLUSION

The implementation of this National Integrated ECD, Nutrition and WASH SBCC Strategy will be led by National ECD Program with the support from line ministries, central and local government, and non-governmental agencies, including local and international organizations, U.N. agencies, development partners, private sector, and other health sector implementing partners. Collaboration among all stakeholders is key for successful implementation of the National Integrated ECD, Nutrition and WASH SBCC Strategy activities at the national, district, and community levels.

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ANNEXES

ANNEX 1: SBCC integrated Implementation plan

INTEGRATED SBCC COMBINED BUDGETED ACTIVITIES											
SN	Activities	Timeframe							Proposed Budget	Responsible	Source of Funds
		2018	2019	2020	2021	2022	2023	2024			
I.	Workshops										
	National Workshops										
1.1	Dissemination Workshop for Integrated SBCC Strategy								3,150,000	NECDP	NECDP , UNICEF, RBC and CRS
1.2	Conduct Workshop with Media Owners and Editors on programming about Integrated ECD, Nutrition and WASH behavior change related services and appropriate age or/and child friendly media								62,300,000	NECDP	NECDP , UNICEF, RBC
1.3	Conduct Workshop for target artists on Child friendly composition								45,000,000	NECDP	UNICEF
1.4	Conduct a Workshop to review and adapt IEC materials and message								80,000,000	NECDP	NECDP , UNICEF, RBC

	District Workshops																		
1.5	Cascaded Dissemination Workshops for Integrated SBCC Strategy at District level																		NECDP , UNICEF, RBC
II.	Community Mobilization																		
2.1	Awards of champions / community volunteers to promote Social behavior change communication ECD, Nutrition and WASH (ECD, Nutrition and WASH Services providers, IZU, CHW, Model Parents, Artists, Journalist etc																		NECDP , UNICEF, RBC
2.2	Conduct community mobilization through Parent forums,Community Work/Umuganda, Inteko z'Abaturage, Itorero ry'Umudugudu; Community Drama, Cine Mobile, ICT Platforms, Religious Forums, Sport events;Village cooking demonstration sessions .																		NECDP, RBC, UNICEF,

2.3	Conduct Interpersonal Communication through Home Visits through community volunteers									105,000,000	NECDP and RBC	NECDP, RBC, UNICEF, CRS
III.	Awareness Campaigns											
3.1	Day of African Child (DAC) / SBC related interventions									90,000,000	NECDP	NECDP, RBC, UNICEF, NCC and NWC
3.2	Family Campaigns/SBC related interventions									15,000,000	NECDP and MINAGRI	NECDP, MINAGRI, WFP, FAO
3.3	Hand Washing and Toilet Day / SBC related interventions									80,000,000	NECDP	NECDP, UNICEF
3.4	International Day of Persons with Disabilities									50,000,000	NECDP	
3.5	World Breastfeeding Week / SBC related interventions									105,000,000	NECDP, RBC	NECDP, UNICEF
3.6	World Food Day / SBC related interventions									50,000,000		NECDP, MINAGRI, FAO, WFP
3.7	MCH week / SBC related interventions									150,000,000	NECDP	NECDP, UNICEF, RBC, CRS
3.8	Day of African Child (DAC) / SBC related interventions									90,000,000	NECDP	NECDP, RBC, UNICEF, NCC and NWC

IV.	Production of media and IEC Materials																			
4.1	Produce and broadcast media adverts (Radio and TV spots)																			NECDP,UNICEF ,RBC,CRS
4.2	Produce and broadcast Radio and TV Programs (Radio and TV Talk shows; Pre recorded magazines , Audio Visual Documentaries, Child friendly Drama (e.g: Itetero and DJ mentions)																			NECDP,UNICEF ,RBC,CRS
4.3	Produce and publish articles and supliments in newspapers and web based media including Web Banner																			NECDP,UNICEF ,RBC
4.4	Test and distribute the existing IEC materials and messages (brochures ,flyers, banners ,booklets etc)																			NECDP ,RBC,UNICEF
V.	Trainings																			
5.1	Conduct To T for ECD, Nutrition and WASH service providers on revised, adapted and produced IEC materials and messages																			NECDP, UNICEF, Other Partners

5.2	Conduct cascaded Training for Community volunteers on on revised, adapted and produced IEC materials									120,000,000	NECDP	NECDP, UNICEF, Other Partners
5.3	Conduct trainings with Journalists on reporting about Integrated ECD, Nutrition and WASH behavior change related services									44,250,000	NECDP	NECDP, UNICEF, Other Partners
VI.	Technical and financial Support											
6.1	Create and support media networks to promote ECD ,Nutrition and WASH behavior change related activities									125,000,000	NECDP	NECDP , UNICEF,RBC
6.2	Support child friendly arts production									225,000,000	NECDP	NECDP , UNICEF,RBC
VII.	Advocacy meetings											
7.1	Advocacy meetings with stakeholders on effective service provision of integrated ECD, Nutrition and WASH									12,600,000	NECDP	NECDP, UNICEF, CRS, Other Partners according to their District of Intervention

ANNEX 2: SBCC M&E framework

Audiences/ Target	Communication Objectives	Evaluation indicators	Baseline	Targets/milestones						Data source	Frequency Data collection	Responsible
				Y1	Y2	Y3	Y4	Y5	Y6			
Outcome: Enhanced optimal Early child development, children's preparedness to the primary school environment, positive parenting and community participation in child protection and reduced malnutrition and stunted growth among young children.												
Strategic outputs 1: Children have increased exposure to early stimulation by their families, including access to age-appropriate media programmes, books, and play and learning materials.												
Children (0-6 years old)	Communication objective 1: By 2024, a 50% increase in the proportion of children listening to age-appropriate and inclusive media programmes.	% of children aged to 0-6 years listening to age-appropriate media programmes.	Need baseline information	5% of children aged to 0-6 years listening to age-appropriate media programmes	5% of children aged to 0-6 years listening to age-appropriate media programmes	10% of children aged to 0-6 years listening to age-appropriate media programmes	10% of children aged to 0-6 years listening to age-appropriate media programmes	10% of children aged to 0-6 years listening to age-appropriate media programmes	10% of children aged to 0-6 years listening to age-appropriate media programmes	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Quarterly	NECDP: Conduct Advocacy RHCC: design media programs HMC: Channelize media programs
Children (0-6 years old)	Communication objective 2: By 2024, a 50% increase in proportion of children playing with age-appropriate books, and play materials and learning materials.	% of children aged to 0-6 years children playing with age-appropriate books, and play materials and learning materials	30% of children under 5 ages have access to toys and play-things and only 1% of children under 5 ages with access to children's books (RDHS 2015)	8% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	8% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	8% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	8% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	8% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	10% of children under 5 ages have access to toys and play-things and 1% of children under 5 ages with access to children's books	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: Advocacy RSAU: Rwanda Society of Authors Facilitate the publication of age-appropriate books, RAC: Rwanda Arts Council
outputs 2: Parents' responsive care to young children provided												
Parents with children 0-6 years old / adolescent girls and boys	Communication objective 1: By 2024, a 50% increase in the proportion of Parents understanding the importance of ECD especially responsive care of young children including PWDs (talking, interacting, reading and playing)	% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	13% of children age 0-6 months attending an organized early childhood education program (RDHS 2015)	5% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	5% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	10% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	10% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	10% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	10% of parents with children 0-6 years old / adolescent girls and boys with increased knowledge of the importance of ECD, especially responsive care of young children (talking, interacting, reading and playing)	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annual	NECDP: Provide key messages NCPD: Provide key messages appropriate to PWDs. NWC, NCC, MICEPROF, MINALOC, Local Authorities, church leaders, etc. Disseminate key messages

Parents with children 0-6 years old / adolescent girls and boys	Communication objective 2: By 2024, a 50% increase in the proportion of both fathers and mothers participate equally in child care and stimulation.	% of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	Baseline Data: (RDHS 2015): 35 % of children under 5 years were left alone or in the care of other children	5 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	5 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	10 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	10 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	10 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	10 % of both fathers and mothers with children 0-6 years old / adolescent girls and boys participating equally in child care and stimulation	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: Provide key messages. NWC, NCC, MICEPROF, MINALOC, Local Authorities, church leaders, etc: Disseminate key messages GMO: Monitor gender equality
Parents with children 0-6 years old / adolescent girls and boys	Communication objective 3: By 2024, a 50% increase in the proportion of parents practicing parenting skills, including positive disciplinary measures.	% of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	Baseline Data: (RDHS 2015): 49 % of children engaged with an adult household member in four or more activities that promote learning and school readiness	5 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	5 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	10 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	10 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	10 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	10 % of parents with children 0-6 years old / adolescent girls and boys practicing positive parenting skills, including positive disciplinary measures	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: Provide key messages appropriate to PWDs. NWC, NCC, MICEPROF, MINALOC, Local Authorities, church leaders etc: Disseminate key messages
Strategic outputs 3: Parents practice appropriate health, nutrition and WASH practices												
Maternal Nutrition - Increase intake of nutrient-rich foods by pregnant and lactating women												
Pregnant women	Communication objective 1: By 2024, a 50% increase in the proportion of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	% of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	Data gaps: need baseline information	5 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	5 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	10 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	10 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	10 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	10 % of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: Provide key messages MoH: Develop guidelines RBC: participate in implementation LODA: Distribute extra meal to Ubudehe 1&2 RAB: Facilitate to produce extra-food. CHWs: conduct sensitization of extra meal to beneficiaries

Lactating Mothers	Communication objective 2: By 2024, a 50% increase in the proportion of lactating women eating daily two extra meals that contain food rich in energy, vitamin A or iron	% of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	Data gaps: need baseline information	5 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	5 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	10 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	10 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	10 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	10 % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: Provide key messages MoH: Develop guidelines RBC: participate in implementation LODA: Distribute extra meal to Ubudehe 1&2 RAB: Facilitate to produce extra-food. CHWs: conduct sensitization of extra meal to beneficiaries
Improve Infant and Young Children Nutrition (IYCN)												
Children (0-6 months)	Communication objective 1: By 2024, a 10% increase in the proportion of children under 6 exclusively breastfed for the first 6 month	% of infants under 6 months of age who are exclusively breastfed (receiving breast milk, and not receiving any other fluids or foods, with the exception of oral rehydration solution, vitamins, mineral supplements and medicines)	Baseline Data: (RDHS 2015): 87% of children under 6 months are exclusively breastfed	2 % of infants under 6 months of age who are exclusively breastfed	1% of infants under 6 months of age who are exclusively breastfed	1% of infants under 6 months of age who are exclusively breastfed	2% of infants under 6 months of age who are exclusively breastfed	2 % of infants under 6 months of age who are exclusively breastfed	2 % of infants under 6 months of age who are exclusively breastfed	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: 1.Conduct awareness campaign 2.Provide key messages MoH: Develop guidelines RBC: participate in implementation LODA: Distribute extra meal to Ubudehe 1&2 RAB: Facilitate to produce extra-food. CHWs: conduct sensitization of extra meal to beneficiaries NWC, NCC, MICEPROF, MINALOC, Local Authorities, church leaders, Disseminate key

Children (6-23 months)	Communication objective 2: By 2024, a 50% increase in the proportion of children aged 6-23 months fed in accordance to all 3 (health, nutrition and WASH) recommended practices	% of children aged 6-23 months fed in accordance to all 3 recommended practices	Baseline Data: (RDHS 2015): 18% of children aged 6-23 months are currently fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	10% of children aged 6-23 months fed in accordance to all 3 recommended practices	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	<p>NECDP: 1. Conduct awareness campaign</p> <p>2. Provide key messages</p> <p>MoH: Develop guidelines</p> <p>RBC: participate in implementation</p> <p>LODA: Distribute extra meal to Ubudehe 1&2</p> <p>RAB: Facilitate to produce extra-food.</p> <p>CHWs: conduct sensitization of extra meal to ...</p> <p>NWC, NCC, MIGEPROF, MINALOC, Local Authorities, church leaders etc</p> <p>Disseminate key messages</p>
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Improve Water, Hygiene and Sanitation practices - Hand Washing at all Critical times with a soap, disposes all feces included children's in a safe; hygienic latrine; Drink always properly treated water;												
Mother / Caregiver of children/ teachers (0 -59 months)	Communication objective 1: By 2024, a 50% increase in the proportion of mothers or caregivers of children 0-59 months wash their hands and children's hands with soap at all critical times	% of mothers/ caregivers wash their hands with soap at critical times	need baseline information	5 % of mothers/ caregivers wash their hands with soap at critical times	5 % of mothers/ caregivers wash their hands with soap at critical times	10 % of mothers/ caregivers wash their hands with soap at critical times	10 % of mothers/ caregivers wash their hands with soap at critical times	10 % of mothers/ caregivers wash their hands with soap at critical times	10 % of mothers/ caregivers wash their hands with soap at critical times	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	<p>NECDP:</p> <ol style="list-style-type: none"> Conduct awareness campaign Provide key messages <p>WASAC: Provide treated water</p> <p>MINEDUC: Monitor WASH guidelines implementation at Schools</p> <p>Districts:</p> <ol style="list-style-type: none"> Conduct advocacy to WASAC to supply safe drinking water To ensure the new and existing Schools have water harvests. <p>CHWs: conduct sensitization for appropriate hand wash.</p>

Mother / Caregiver of children/ teachers (0 -59 months)	Communication objective 2: By 2024, a 50% increase in the proportion of mothers or caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	need baseline information	5% of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	5% of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	10 % of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	10 % of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	10 % of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	10 % of mothers /caregivers of children 0-59 months dispose of feces, including children's, in latrines with cover	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	<p>NECDP:</p> <ol style="list-style-type: none"> 1. Conduct awareness campaign 2. Provide key messages <p>WASAC: Provide treated water</p> <p>MINEDUC:</p> <p>Monitor WASH guidelines implementation at Schools</p> <p>Districts:</p> <ol style="list-style-type: none"> 1. Conduct advocacy to WASC to supply safe water for latrines use. 2. To ensure the new and existing Schools have appropriate latrines <p>CHWs: conduct sensitization for appropriate hand wash.</p>
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Mother / Caregiver of children/ teachers (0 -59 months)	Communication objective 2: By 2024, a 50% increase in the proportion of mothers or caregivers of children 0-59 months	% of mothers / caregivers of children 0-59 months treating drinking-water with recommended methods	Baseline Data: (RDHS 2015) :44 % of households use an appropriate treatment method prior to drinking	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	5 % of mothers /caregivers of children 0-59 months treating drinking-water with recommended methods	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Annually	NECDP: 1. Conduct awareness campaign 2. Provide key messages WASAC: Provide treated water MINEDUC: Monitor WASH guidelines implementation at Schools Districts: 1. Conduct advocacy to WASAC to supply safe water for latrines use. 2. To ensure the new and existing Schools have appropriate latrines CHWs: conduct sensitization for appropriate hand wash.
Improve Health Seeking behavior at community level												
Pregnant women	By 2024, a 50% increase in the proportion of women attended the recommended four ANC visits during their pregnancy	% of pregnant women who attend the four- recommended ante natal care visits	Baseline Data: (RDHS 2015) : 44% of women attended the recommended four ANC visits during their pregnancy	5% of pregnant women who attend the four- recommended ante natal care visits	5% of pregnant women who attend the four- recommended ante natal care visits	5% of pregnant women who attend the four- recommended ante natal care visits	5% of pregnant women who attend the four- recommended ante natal care visits	5% of pregnant women who attend the four- recommended ante natal care visits	5% of pregnant women who attend the four- recommended ante natal care visits	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Quarterly	NECDP: 1. Conduct awareness campaign 2. Provide key messages RBC: Reinforce health facilities levels CHWs: conduct sensitization for ANC NWC, MIGEPROF, Church leaders, UMUGOROBA, W'ABABEYE: mobilization and disseminate key messages on ANC

Mother of new born infant	By 2024, a 50% increase in the proportion of mother of new born infant reporting to health facilities to seek professional care	% of mother of new born infant reporting to health facilities to seek professional care	Baseline Data: (RDHS 2015): 43 % women who gave birth in the two years preceding the survey received a postnatal care checkup in the first two days after delivery.	5 % of mother of new born infant reporting to health facilities to seek professional care	5 % of mother of new born infant reporting to health facilities to seek professional care	10 % of mother of new born infant reporting to health facilities to seek professional care	10 % of mother of new born infant reporting to health facilities to seek professional care	10% of mother of new born infant reporting to health facilities to seek professional care	10% of mother of new born infant reporting to health facilities to seek professional care	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Quarterly	NECDP: 1. Conduct awareness campaign 2. Provide key messages RBC: Reinforce health facilities levels CHWs: conduct sensitization for ANC NWC, Church leaders, UMUGOROBA W'ABABEYI: conduct mobilization and disseminate key messages on ANC
Mother of new born infants	By 2024, a 1 % increase in the proportion of fully immunized children at age one year per health care providers	% of fully immunized children at age one year per health care providers	Baseline Data: (RDHS 2015) : 99% of children age 12-23 months have received all basic vaccines (5 % of mother of new born infant reporting to health facilities to seek professional care	5 % of mother of new born infant reporting to health facilities to seek professional care	10 % of mother of new born infant reporting to health facilities to seek professional care	10 % of mother of new born infant reporting to health facilities to seek professional care	100 % of fully immunized children at age one year per health care providers	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Quarterly	NECDP: 1. Conduct awareness campaign 2. Provide key messages RBC: Reinforce health facilities levels CHWs: conduct sensitization for ANC NWC, Church leaders, UMUGOROBA W'ABABEYI: conduct mobilization and disseminate key messages on ANC	

Mother of US child / Caregivers teachers/ and ECDs services providers	By 2024, a 10 % increase in the proportion of Mother / Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	% of Mother / Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	need baseline information	1% of Mother /Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	1 % of Mother /Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	2 % of Mother /Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	2 % of Mother /Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	2 % of Mother /Husband of children under five attending regular growth monitoring and promotion sessions (GMP)	RDHS Reports, KAP surveys, Program baselines, FGDs, NECDP Reports	Monthly	<p>NECDP: 1. Conduct awareness campaign</p> <p>2. Provide key messages</p> <p>RBC: Reinforce health facilities levels</p> <p>CHWs: conduct sensitization for ANC</p> <p>NWC,</p> <p>Church leaders,</p> <p>UMUGOROBA</p> <p>W'ABABEYI: conduct mobilization and disseminate key messages on ANC</p>
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ANNEX 3: Messages for SBCC

Inkingi y'imbonezamikurire:

1. Ubuzima n'Imirire

Imiterere y'ikibazo (Negative behavior)	Impamvu zibitera	Imyitwarire yifuzwa (Desired behavior)	Abo ubutumwa bugenewe	Uburyo bw'iherekanyabutumwa bushoboka	Ubutumwa bw'ingenzi
<p>1. Kutita ku kamaro k'imirire myiza y'Umwana mu minsi 1000 ya mbere y'ubuzima bwe, bituma abana badakura neza mu gihagararo no mu bwenge bikanongera impfu z'abana bato</p> <p>Bamwe mu babyeyi ntibonsa abana ku isaha ya mbere bakivuka</p> <p>Bamwe mu babyeyi bavangira abana amashereka n'ibindi mu mezi 6 ya mbere</p> <p>Nyuma y'amezi 6, bamwe mu babyeyi baha abana babo ifashabere ariko bakayibaha idahagije kandi itagizwe n'indyo yuzuye, bigatuma bagwingira cyangwa bakarwara bwaki</p>	<ul style="list-style-type: none"> • Ubumenyi buke ku mirire myiza y'umwana muto • Kutamenya akamaro k'imirire mu minsi 1000 ya mbere y'Umwana • Abagabo batitabira inyigisho zijyanye n'imbonezamikurire y'abana bato • Kuba mu igenamigambi ry'inzego zimwe na zimwe hatabamo ibikorwa bishyigikira imbonezamikurire y'abana bato nko mu mihigo • Ababyeyi ntibazi akamaro ko gushyira umwana ku ibere akivuka • Ababyeyi ntibazi akamaro konsa gusa mu mezi atandatu ya mbere • Ababyeyi ntibazi akamaro k'ifashabere • Ababyeyi bumva ko guha umwana ibere binagije • Hari ababyeyi babura ifashabere kubera ubukene • Hari abatazi gutegura neza ifashabere igizwe n'indyo yuzuye • Hari abatazi igihe n'inshuro umwana akwiriye guhabwa amafunguro 	<ul style="list-style-type: none"> • Ubufatanye bw'abagize umuryango kwita ku buzima n'imirire by'umwana mu gihe cy'iminsi 1000 ya mbere y'ubuzima • Abayobozi mu nzego zose: Kugira uruhare mu gukangurira abo bayoboze kwita ku mboneza mikurire y'abana bato, ku buzima no ku mirire myiza mu gihe cy'iminsi 1000 ya mbere y'ubuzima bw'umwana • Konsa umwana ku isaha ya mbere akimara kuvuka • Konsa umwana igihe cy'amezi 6 nta kindi avangiwe • Guha umwana imfashabere igizwe n'indyo yuzuye igizwe n'ibiryo bitandukanye byuzuzanya mu ntungamubiri kuva agize amezi atandatu 	<ul style="list-style-type: none"> • Ababyeyi bombi n'abandi barera abana. • Abayobozi mu nzego zitandukanye • Inzego za leta • Amadini • Abajyanama b'ubuzima • Inshuti z'umuryango • Abajyanama b'ubuhinzi • Abafashamyumvire 	<ul style="list-style-type: none"> • Ibiganiro n'abagize umuryango (Home Visits) • Ubujyanama bukozwe n'abajyanama b'ubuzima (Counseling Talks by CHWs) • Ubutumwa butanzwe n'Inshuti z'Umuryango • Ubutumwa bunyuzwe mu masibo, ingamba n'andi mahuriro ategurwa n'itorero ry'igihugu • Umugoroba w'ababyeyi (Evening Parents Forum) • Ishuri mbonezimirire ry'umudugudu (Village Nutrition School) • Imirima shuri (Farmer Field Learning School) • Aho bapimira abana ibiro mu mudugudu (Growth Monitoring Promotion) • Amatsinda yo kubitsa no kugurizanya/Ibimina (Saving and Internal Lending Communities) • Kalabu z'isuku n'isukura (Community Health Club sessions) • Ibiganiro bitangirwa kwa muganga (IEC sessions) • Ibitabo n'izindi nyandiko (Printed materials) 	<p>Ubutumwa bw'ingenzi</p> <p>1. Kwita ku mirire myiza y'Umwana wawe mu minsi 1000 ya mbere y'ubuzima bwe, ni ingenzi ku mikurire, haba mu gihagararo, mu bwenge no mu mbamutima. Fata indyo yuzuye kandi ihagije mu gihe utwite no mu gihe wonsa. Shyira umwana ku ibere mu isaha ya mbere akivuka, onsa umwana nta kindi umuvangiye habe n'amazi mu mezi 6 ya mbere, muhe ifashabere igizwe n'indyo yuzuye kuva ku mezi 6 avutse kugeza kuri 24, bizamurinda kugwingira akure neza afitse ubuzima bwiza, azigirire akamaro, akagirire umuryango n'igihugu muri rusange.</p> <p>2. Onsa umwana ku isaha ya mbere akimara kuvuka kuko bimufasha kugumana ubushyuhe, guhumeka neza, bikanamuha ubudahangarwa bw'umubiri</p>

			<ul style="list-style-type: none"> • Ibiyamakuru byandika (Newspapers) • Ingo mbonezamikurire/Amarerero (ECD centers) • Inama za VUP (VUP Meetings) • Ibiganiro kuri Radiyo na TV (Radio talk show TV) • Sinema zo hanze (Cine mobiles) • Ibiganiro mbwirwaruhame na za videwo bikorewe hanze (Road shows and mobile video shows). • Umuganda (Community work) • Inteko z'abatwaga (Community Meeting) • Ubutumwa butangwa n'abashinzwe irangamimerere (Civil status and notary officers) • Amatorero/insengero n'imisigiti (church and mosque) • Amashuri: Aho abanyeshuri bateraniye (Students' assemblies) • Ibiganiro mpaka (debates in ...) • Amakoraniro y'urubwiruko (Youth corners) • Ikinamico (Drama), Imivugo (poem), Ubutumwa bunyujijwe mu ndirimbo (song for community outreach), • Ubutumwa bunyujijwe ku mbuga nkoranyambaga na Interinete (BCC ICT) 	<p>3. Onsa umwana igihe cy'amezi 6 ya mbere nta kindi umuvangiyiye habe n'amazi kuko bimurinda indwara zitandukanye harimo impiswi, umusonga n'imirire mibi. Kuva ku mezi 6 kugezako myaka 2, komeza wonse kandi uhe umwana imfashabere igizwe n'indyo yuzuye igizwe n'ibyakaba umubiri, ibitera imbaraga n'ibirinda indwara.</p> <p>4. Ni inshingano z'umugabo mu kwita ku mirire n'ubuzima bw'umwana we mu minsi 1000 ya mbere y'ubuzima bwe. Fasha umugore wawe gufata indyo yuzuye kandi ihagije mu gihe atwite no mu gihe yonsa.; guhyira umwana ku ibere mu isaha ya mbere akivuka, kumwonsa nta kindi amuvangiyiye habe n'amazi mu mezi 6 ya mbere, kumuha ifashabere igizwe n'indyo yuzuye kuva ku mezi 6 avutse kugeza kuri 24, bizamurinda kugwingira akure neza afitse ubuzima bwiza, azigirire akamaro, akagirire umuryango n'igihugu muri rusange.</p>
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				<ul style="list-style-type: none"> • Ubukangurambaga bwose bugamije kwita ku buzima bw'abana bato (Icyumweru cyahariwe ubuzima bw'umubyeyi n'umwana (MCH campaign), icyumweru cy'umuryango (Family campaign)... • Ubuvugizi mu nama nabafatayabikorwa (advocacy Partnership meetings) • Ubukangurambaga n'inama kuri serivisi zikomatananyije z'imboneza kurire y'abana bato (campaign and meetings on integrated ECD services) 	<p>5. Ni inshingano z'abayobozi mu nzego zitandukanye; abanyamadini, abajyanama b'ubuzima, inshuti z'umuryango, abajyanama b'ubuhinzi, n'abafashamyumvire mu kwita ku mirire myiza n'ubuzima bw'abana. Kangurira umubyeyi utwite n'uwonsa gufata indyo yuzuye kandi ihagije; guhyira umwana ku ibere mu isaha ya mbere akivuka, kumwonsa nta kindi amuvangiyeho habere n'amazi mu mezi 6 ya mbere, kumuha ifashabere igizwe n'indyo yuzuye kuva ku mezi 6 avutse kugeza kuri 24, bizamurinda kugwingira akure neza afitse ubuzima bwiza, azigirire akamaro, akagirire umuryango n'igihugu muri rusange.</p>
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<p>2. Kutitabira gupimisha abana mu rwego rwo gukurikirana no guteza imbere imikurire yabo</p>	<ul style="list-style-type: none"> • Kutamenya no kudaha agaciro ikurikirana imikurire y'umwana • Ubumenyi bucyeye ku kamaro ko kwita ku mwana mu gihe cy'iminsi 1000 ya mbere y'ubuzima bwe • Kutamenya uko bagomba kubitaho 	<ul style="list-style-type: none"> • Cupimisha ibiro, uburebure, ... ku gihe kugira hakurikiranwe imikurire y'abana • Kwita ku mirire y'umwana muto mu gihe cy'iminsi 1000 ya mbere y'ubuzima bwe 	<ul style="list-style-type: none"> • Ababyeyi bombi n'abandi barera abana. • Abayobozi mu nzego zitandukanye; • Inzego za Leta • Amadini • Abajyanama b'ubuzima • Inshuti z'umuryango • Abajyanama b'ubuhinzi, Abafashamyumvire 	<p>1. Mubyeyi, kurikirana imikurire y'umwana wawe umupimisha ibiro n'umuzenguruko w'ikizigira cy'ukuboko ku bajyanama b'ubuzima n'uburebure .ku kigo nderabuzima kugira ngo ugirwe inama, bizatuma mu gihe agaragayeho ikibazo cy'imirire mibi, yitabwaho n'abajyanama b'ubuzima cyangwa n'ibigo nderabuzima.</p> <p>2. Mubyeyi, gana urugo mbonezamikurire rukwegereye cyangwa ikigo nderabuzima, kugira ngo uhabwe inyigisho ku mirire n'imikurire iboneye y'umwana wawe</p>
<p>3. Hari ababyeyi batitabira kwipimisha no kwisuzumisha kwa muganga igihe batwite na nyuma yo kubyara</p>	<ul style="list-style-type: none"> • Ubumenyi buke ku kamaro ko kwipimisha igihe umugore atwite 	<ul style="list-style-type: none"> • Kwitabira kwipimisha no kwisuzumisha kwa muganga igihe umugore atwite nibura inshuro enye zagenwe 	<ul style="list-style-type: none"> • Abagore batwite n'abagabo babo • Abajyanama b'ubuzima • Abayobozi b'inzego z'ibanze, abo mu miryango itari iya Leta • Abajyanama b'ubuzima, Inshuti z'umuryango ... 	<p>Mubyeyi, igihe utwite itabire kwipimisha inda inshuro enye zagenwe, bizagufasha gukurikirana imikurire myiza y'umwana uri mu nda no kwita ku buzima bwawe n'ubw'umwana utwite; igihe cyo kubyara nikigera, ubyarire kwa muganga kuko bizagufasha kubyara neza kandi ubyare mwana muzima</p>

<p>4. Hari ababyeyi batitabira gukingiza abana inkingo zose</p>	<ul style="list-style-type: none"> • Ubumenyi buke bw'ababyeyi ku kamaro ko gukingiza abana inkingo zose 	<ul style="list-style-type: none"> • Kwitabira gukingiza umwana uko inkingo zose zikurikirana 	<ul style="list-style-type: none"> • Abagore batwite n'abagabo babo • Abajyanama b'ubuzima • Abayobozi b'inzege z'ibanze, abo mu miryango itari iya Leta • Abajyanama b'ubuzima, Inshuti z'umuryango ... 		<p>Mubyeyi, kingiza umwana wawe inkingo zose uko ziteganyijwe, bizamurinda indwara zizahaza abana cyane cyane ko n'iyi indwara zije zitamugiraho ubukana nk'ubwo zigira k'udakingiye. Gana ikigo nderabuzima kikwegereye ahatangirwa inkingo zirimo urw'imbasa, iseru, akaniga, igituntu, agakwega, umwijima wo mu bwoko bwa B ndetse n'umusonga.</p>
<p>5. Hari ababyeyi batitabira kuboneza urubyaro</p>	<ul style="list-style-type: none"> • Ubumenyi buke bw'ababyeyi kuri gahunda yo kuboneza urubyaro • Uruhare ruto rw'abagabo bumva ari uruhare rw'abagore gusa • Imyemerere ishingiyeye ku madini • Imyumvire ishingiyeye ku muco wo kubyara abana benshi 	<p>Kwitabira kuboneza urubyaro ku buryo bubereye buri wese kandi yihitiyemo</p>	<ul style="list-style-type: none"> • Abagore batwite n'abagabo babo • Abajyanama b'ubuzima • Abayobozi b'inzege z'ibanze, abo mu miryango itari iya Leta • Abajyanama b'ubuzima, Inshuti z'umuryango ... 		<p>1. Kuboneza urubyaro birinda imfu z'ababyeyi, kugwingira kw'abana n'ubukene mu miryango. Mubyeyi, itabire gahunda yo kuboneza urubyaro kuko bituma ubona umwanya uhagije wo konsa no kwita ku mwana ukiri muto cyane cyane mu minsi 1000 ya mbere y'ubuzima bwe. Uburyo bwo kuboneza urubyaro buboneka ku bajyanama b'ubuzima mu mudugudu, ku kigo nderabuzima cyangwa ku kigo cyunganira ikigo nderabuzima (poste de sante) no ku bitaro. Abakozi babihugukiwe bazagaha ibisobanuro bihagije kugira ngo wifatire icyemezo unihitiremo uburyo bukunogeye.</p>

					<p>2. Kuboneza urubyarwo ni inshingano y'umugore n'umugabo. Mugabo, fasha umugore wawe kwitabira gahunda yo kuboneza urubyarwo kuko bituma abona umwana uhagije wo konsa no kwita ku mwana ukiri muto cyane cyane mu minsi 1000 ya mbere y'ubuzima bwe. Herekeza umugore wawe ku bajanama b'ubuzima mu mudugudu, ku kigo nderabuzima no mu bitaro ahatangirwa serivisi zo kuboneza urubyarwo. Abakozi babihugukiye bazabaha ibisobanuro bihagije kugira ngo mwifatire icyemezo mwumvikane uzaboneza urubyarwo muri mwe n'uburyo bumunogeye.</p>
<p>Inkingi y'Imbonezamikurire: 2. Amazi meza, isuku n'isukura</p>					
<p>6. Isuku nke kuri bamwe mu babyeyi n'abandi barera abana, umuco wo gukaraba intoki hakoreshejwe amazi meza n'isabune ukiri hasi, isuku nke y'ibiry, ingo zidafite ubwiherero n'ingo zifite ubwiherero butujuje ibyangombwa</p>	<p>• Hari abantu bagifite umuco mubi wo kutita ku isuku y'umubiri, ibikoresho n'ahadukikije... • Ubumenyi buke no kutita ku kamaro ko gukaraba intoki uko bikwiye • Ubumenyi buke no kutagira umuco w'isuku mu gutegura ibiribwa • Ubumenyi buke ku kamaro ko kugira no gukoresha ubwiherero bwujuje ibyangombwa</p>	<p>• Isuku igihe cyose ku mubiri, ku bikoresho, n'ahandi hakikijye abantu • Umuco wo gukaraba intoki neza mu bihe byagenwe • Gutegurana amafunguro isuku ihagije • Kugira ubwiherero bufitre isuku, bwujuje ibyangombwa kandi bukoreshwa neza ku ngo n'ahandi hahurira abantu benshi</p>	<p>Abo ubutumwa bugenewe:</p> <ul style="list-style-type: none"> • Ababyeyi bombi n'abandi barera abana • Abana • Inzego za Leta • Amadini • Abajyana b'ubuzima • Inshuti z'umuryango 		<p>1. Isuku ni isoko y'ubuzima. Umwanda ni isoko y'indwara nyinshi harimo: inzoka zo mu nda, mu bwonko n'izo mu miyoboro y'amaraso; kolera; impiswi; shishikara; amavunja; n'izindi nyinshi. Izi ndwara zose zikaba zizahaza uzirwaye, zigatera kugwingira k'umwana n'imirire mibi muri rusange; zikaba zamuhitana cyangwa zikamutera ubumuga.</p>

<p>2. Gira umuco w'isuku unywa amazi asukuye, ukaraba intoki ukoresheje amazi meza n'isabune mbere yo gutegura amafunguro, ugiye gufungura, ugiye konsa cyangwa kugaburira umwana n'igihe cyose uvuye mu bwiharerero. kandi ugire isuku ku bikoresho byose byo mu rugo.</p> <p>3. Gira ubwiharerero busukuye kugira ngo wirinde inzoka zo mu nda n'izindi ndwara zose zikomoka ku mwanda nk'inzoka zo mu nda, mu bwonko n'izo mu miyoboro y'amaraso; kolera; impiswi; shishikara; amavunja; n'izindi nyinshi.</p> <p>4. Gira isuku ku mubiri wiyuhagira umubiri wose buri muni ukoresheje amazi meza n'isabune, kandi ugire n'isuku ku myambaro no ku buriri; wite ku isuku y'aho utuye n'aho ugenze kandi wirinde kurarana n'amatungo, bizatuma wirinda kandi urinde n'abawe indwara zose zikomoka ku mwanda nk'inzoka zo mu nda, mu bwonko n'izo mu miyoboro y'amaraso; kolera; impiswi; shishikara; amavunja; n'izindi nyinshi.</p>					
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Inkingi y'Imbonezamikurire: 3. Kurengera umwana

<p>7. Hari abana bato bagikorera ihohoterwa harimo n'irishingiye ku gitsina, iribabaza umubiri, iribabaza umutima, kutitabwaho, gushakirwaho inyungu, gukoresha imirimo itajanyane n'inyaka yabo ...</p>	<ul style="list-style-type: none"> • Imyumvire ya bamwe itakijanyane n'igihe mu bijyanye no kurinda umwana, • Abana basigirwa abandi bantu babarera ariko batafaftiye urukundo cyangwa badashoboye • Imwe mu miryango ihorana amakimbirane mu ngo 	<ul style="list-style-type: none"> • Kurresha abana abantu bizewe banabifitiye ubumenyi • Kurandura umuco mubi wo guhohotera abana bato • Kubahiriza uburenganzira bw'abana bato • Kurwanya amakimbirane mu miryango hagamijwe inyungu z'abana bato 	<p>Abo ubutumwa bugenewe:</p> <ul style="list-style-type: none"> • Ababyeyi bombi • Abandi barera abana • Abayobozi mu nzego zitandukanye • Inzego za Leta • Abafashamyumvire (care givers) 	<p>1. Mubyeyi, ita ku mutekano w'abana bawe ubaherekeza igihe bagiye ku ishuri n'igihe batashye, bizabarinde kugira impanuka, guhutazwa cyangwa gukorerwa ihohoterwa iryo ari ryo ryose harimo n'ihohoterwa rishingiye ku gitsina.</p> <p>2. Mubyeyi, ihutire kwandikisha abana mu bitabo by'irangamimerere mu gihe kitarenze iminsi 30 nk'uko biteganywa n'itegeko kugira ngo bibafashe kubona uburenganzira bwabo imbere y'amategeko kandi bifashe igihugu mu igenamigambi</p> <p>3. Mubyeyi, muturanyi, muyobozi nawe murezi, ihutire gutanga amakuru ku gihe ku nzego z'umutekano n'iz'ubuyobozi igihe umenye ko umwana yahuye n'ihohoterwa iryo ari ryo ryose</p>
<p>8. Hari ababyeyi batandikisha abana babo mu gihe cyagenwe mu bitabo by'irangamimerere</p>	<ul style="list-style-type: none"> • Kutamenya amategeko n'amabwiriza agenga irangamimerere kuri bamwe mu babyeyi • Kudaha agaciro akamaro ko kwandikisha abana mu bitabo by'irangamimerere 	<ul style="list-style-type: none"> • Kwandikisha abana mu irangamimerere bakivuka mu gihe cy'iminsi 30 		
<p>9. Haracyagaragara ikibazo cy'abana bato bajya ku ishuri badafite umuntu mukuru ubaherekeje</p>	<ul style="list-style-type: none"> • Uburangare bw'ababyeyi no kutita ku mutekano w'abana babo 	<p>Ababyeyi bakwiye guherekeza abana babo igihe bagiye ku ishuri kandi bakajya kubakurayo igihe cyo gutaha</p>		

Inkingi y'Imbonezamikurire:

4. Uburere buboneye

<p>10. Ababyeyi benshi b'abagabo ntibatetsha abagore babo batwite cyangwa ngo bite ku buzima bw'abana babo bakiri mu nda</p>	<ul style="list-style-type: none"> • Umuco wa kera utuma abagabo badatetsha abagore babo • Ubumenyi budahagije ku buryo n'akamaro ko kwita ku mwana ukiri mu nda • Imyumvire y'uko umugabo utetsha umugore yitwa inganzwa 	<p>Abagabo bakwiye kwita ku bagore babo n'igihe batwite, kubyinirira no kuririmba inda no gukurikirana imikurire yayo</p>	<ul style="list-style-type: none"> • Ababyeyi bombi • Abandi barera abana • Inzego za leta, Abanyamadini • Abafashamyumvire (care givers) 	<p>1. Mugabo, Gira uruhare mu mikurire n'uburere buboneye bw'abana bawe. Irinde guhohotera, gutoteza cyangwa gufata nabi umubyeyi utwite kuko bigira ingaruka mbi ku buzima bw'umwana akiri mu nda ya nyina n'igihe cye kizaza.</p>
<p>11. Hari ababyeyi bataganiriza abana babo bakiri bato</p>	<ul style="list-style-type: none"> • Imyumvire idaha agaciro ibitekerezo by'abana • Imyumvire ituma abagabo baharira abagore babo • Uburere bw'abana bonyine • Imyumvire y'abagabo yumva ko guhahira urugo bihagije 	<ul style="list-style-type: none"> • Ababyeyi bombi bakwiye kugira umwanya wo kuganira n'abana babo bato • Ababyeyi bombi bakwiye gukinisha abana babo udukino tujyanye n'imyaka yabo kandi bakabacira imigani, indirimbo, kubasomera udukuru ... kugira ngo bakangure ubwonko bwa bo kare 		<p>2. Mugabo, ita ku buzima bw'umugore wawe igihe batwite, umwitaho, umutetsha. Tangira kuganiriza umwana wawe akiri mu nda kugira ngo utangire gukangura ubwonko bwe hakiri kare bityo azakurane urukundo.</p>
<p>12. Hari ababyeyi bagitanga ibihano bibabaza umubiri n'imbamutima by'abana bato</p>	<ul style="list-style-type: none"> • Kwibwira (imyumvire) ko igit'sure gikabije ari cyo kigorora umwana • Ubumenyi buke ku ngaruka ibihano bibi bigira ku bana bato 	<ul style="list-style-type: none"> • Kurerera no guhana hadakoreshejwe ibihano bibabaza umubiri n'umutima by'umwana (inkoni, ibitutsi,...) 		<p>3. Babyeyi, muganirize abana bakiri bato, mubakinishe udukino dutandukanye bityo bitume ubwonko bwabo bukanguka kare bizabafasha kubaka n'imibanire myiza n'abandi.</p> <p>4. Babyeyi, mwirinde kukubita umwana cyangwa kumuha ibihano bibabaza umubiri n'imbamutima ze, ahubwo mumuganirize, mumukosorane urukundo.</p> <p>5. Babyeyi namwe barezi, mujye mucira abana imigani, mubarimbire, mubasomere udukuru ... kugira ngo mukangure ubwonko bwabo hakiri kare, amarangamutima n'imibanire myiza n'abandi</p>

Inkingi y'Imbonezamikurire:

5. Gutegurira umwana kwiha amashuri abanza

<p>13. Serivisi mbonezamikurire zikiri nke ugereranyije n'umubare w'abana bazikeneye</p>	<ul style="list-style-type: none"> • Abafatanyabikorwa bake mu gutanga serivisi z'imbonezamikurire y'abana bato • Ababyeyi badafite ubumenyi ku kamaro k'ingo mbonezamikurire y'abana bato 	<ul style="list-style-type: none"> • Abafatanyabikorwa batandukanye bakwiye kwinjira muri gahunda ikomatanyije y'imbonezamikurire y'abana bato • Ababyeyi bakwiye kujyana abana babo bato mu ngo mbonezamikurire 	<ul style="list-style-type: none"> • Ababyeyi bombi • Abandi barera abana • Abayobozi mu nzego zitandukanye • Abikorera • Abanyamadini • Imiryango itari iya leta 	<p>1. Babyeyi, mwishyire hamwe mushyireho Ingo Mbonezamikurire z'Abana Bato (ECD) ku rwego rw'umudugudu bizabafasha kwita ku mikurire n'uburere bw'abana banyu no kurwanya igwingira ryabo n'ubuzererezi. Mwibumbire mu matsinda y'ingo ziri hagati ya 10 na 15, mugene urugo abana banyu bari muni y'inyaka 6 bazajya bahuriramo mu masaha mwagaye mu mirimo, maze mujye ibihe byo kurera abo bana. Mushobora kandi gukorana n'abayobozi banyu n'abandi bafatanyabikorwa mu gushaka ibyumba byose mu mudugudu; nk'ibyumba by'inama, insengero cyangwa ibindi byumba by'abanyamadini, ndetse n'amashuri atagikorehwa, byasanwa bigakorehwa muri gahunda mbonezamikurire y'abana bato.</p>
<p>14. Haracyari abana badahabwa amahirwe yo kwiha amashuri y'inshuke cyangwa mu ngo mbonezamikurire y'abana bato</p>	<ul style="list-style-type: none"> • Akamenyero gashingiyeye ku myumvire y'uko abana batangira kwiha (kuva mu rugo) bafite imyaka 7 	<ul style="list-style-type: none"> • Gutangiza abana kwiha mu mashuri y'inshuke no kubajyana mu ngo mbonezamikurire hakiri kare 		
<p>15. Inyinsi mu ngo mbonezamikurire n'amashuri y'inshuke menshi ntiyakira abana bari mu nsi y'inyaka itatu</p>	<ul style="list-style-type: none"> • Amikoro make n'Ubushobozi bw'ingo mbonezamikurire ntibutuma bashobora kwakira abo bana 	<p>Kongerera amashuri y'inshuke n'ingo mbonezamikurire y'abana bato hirya no hino mu gihugu</p>		
<p>16. Abana bafite ubumuga n'abakeneye kwitabwaho by'umwihariko ntibitabwaho uko bikwiye</p>	<p>Umuco wo guheza n'akato bikorerwa abana bafite ubumuga n'ibibazo byihariye hari aho bikiri</p>	<p>Uburezi n'uburere budaha abana bafite ubumuga n'abafite ibibazo byihariye</p>		<p>2. Bashoramari namwe bikorerera, nimushore imari mu mikurire myiza y'abana bato mushyiraho ingo mbonezamikurire n'amashuri y'inshuke cyane cyane aho bitari, bityo mugire uruhare mu gutegura abana bato gutangira neza amashuri abanza: bizatuma biga neza, muzaba mutanze umusanzu mu kubaka igihugu kitarangwamo igwingira.</p>

<p>3. Babyeyi, barezi namwe bayobozi, muri gahunda zishingiye kuri serivisi zose z'imbonezamikorire, muzirikane uburezi budaha abana bafite ubumuga n'abakeneye ubufasha bwihariye; bizabafasha gukurira mu buzima buzira akato.</p>					
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