



# A MODEL BEGINNING:

**CARE's Early Childhood Development  
for Rwanda's Most Vulnerable Children**





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## CARE’s ECD Donors

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CARE wishes to express our particular gratitude to **Covance Charitable Foundation**. Its two generous grants launched our ECD work, and gave us the flexibility to learn and experiment over time. They allowed our staff to become well versed ECD professionals, ready and able to guide the replication of the high-quality ECD model, whose evolution is described in this document, throughout Rwanda on behalf of the nation’s vulnerable children.

## Introduction

The United Nations’ *Convention on the Rights of the Child*<sup>1</sup> advocates for programs and services that promote early health, development and well-being of children and their caregivers. This is particularly important given that “a quarter of the world’s youngest children suffer one or more forms of severe deprivation and risk, such as poverty, disease, disability and exposure to violence.”<sup>2</sup> Strong evidence points to the importance of integrated early childhood programs that address both the biological and psychosocial risk factors that keep children from developing to their full potential. For instance,

investing in early childhood development (ECD) is critical to breaking the cycle of poverty and inequality, particularly among the most vulnerable populations.<sup>3,4</sup> The evidence also shows that return on investment with regards to human capital is higher in the early years than at any another age.

Not addressing the needs of vulnerable children during the early years can lead to lifelong deficiencies, not only in brain development but in areas such as nutrition, health and well-being. A recent report from the American Academy of Pediatrics notes, “a vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—beginning with the future mother’s well-being before she becomes pregnant—lays the groundwork for a lifetime of the physical and mental vitality that is necessary for a strong workforce and responsible participation in community life. When developing biological systems are strengthened by positive early experiences, children are more likely to thrive and grow up to be healthy, contributing adults. Sound health in early childhood provides the foundation for the construction of sturdy brain architecture and the achievement of a broad range of skills and learning capacities.”<sup>5</sup>

ECD programs are most effective when they use a holistic approach, combining improved nutrition and health with social, physical and cognitive stimulation, and addressing issues of child protection. Integrated programming has been shown to enhance health, development, school performance, and ultimately, employment and earning potential. For all children, a rich and stimulating environment with safe, stable and nurturing relationships in childhood is known to contribute to improved developmental outcomes, thus increasing the likelihood that an individual will break the cycle of poverty. These benefits, which begin at home, are enhanced and consolidated with integrated multi-sectoral support for child and family.<sup>6,7</sup>

In Rwanda, where nearly a third of all children are orphaned or otherwise vulnerable,<sup>8</sup> integrated ECD services are essential to prevent or reverse the effects of early deprivation.

CARE entered the then-empty ECD field in Rwanda in 2007. From that year to the present, we have worked with parents, community leaders and the Ministry of Education (MINEDUC) to create and test a set of high-quality ECD services for children from prenatal through age 6. Together, we have launched more than 100 ECD sites that now reach over 2,500 children a year—numbers that will climb to at least 750 and 12,000, respectively, by 2014. We find quantitative and qualitative evidence that children, their parents and their communities are reaping benefits from the ECD services, in line with those described above. Finally, we are nearing completion of an ECD model—high quality, contextually appropriate and cost-effective—that we, other organizations and especially the Government of Rwanda can scale up to meet the developmental needs of vulnerable children throughout the country.

This document tells the story of how CARE and communities created this comprehensive ECD model. It describes the model’s three major components: the ECD Center, Home-Based ECD, and Home Visits. It discusses how CARE developed these components sequentially, and how each builds on its predecessor. It presents quantitative and qualitative information about the results of our ECD work to date, and points out next steps towards a replicable ECD model. But first, this document looks back to the roots of our ECD work in Rwanda: the *nkundabana* intervention for vulnerable children in the aftermath of the Rwanda genocide.

Component	For Children Aged...
ECD Center	→ 3 through 6 years
Home-Based ECD	→ 18 months through 6 years
Home Visits	→ Prenatal through 18 months

## Nkundabana Model

Rwanda in the mid-1990s was home to the highest proportion of orphans and vulnerable children (OVC) in the world. Hundreds of thousands lived in child-headed households without adult support: these were among the most disadvantaged of all. CARE developed the *nkundabana* model as a culturally relevant, cost-effective way to meet such children's critical needs, and to help troubled communities re-establish their tradition—strained by genocide, AIDS and poverty—of caring for the children in their midst. At a time when most aid to OVCs targeted children's physical needs, the *nkundabana* model was unique in its focus on their emotional and psychological well-being. Originally working solely with child-headed households, over time we adapted the model to serve children with other types of vulnerability.

In the model, participating children choose adults they trust to serve as their *nkundabana* or volunteer mentor. With training and guidance from CARE and our partners, ARCT-RUHUKA and HAGURUKA<sup>9</sup>, each mentor helps several child-headed or extremely vulnerable households. Via regular home visits, the *nkundabana* supports the children's emotional well-being, assesses their physical needs, and acts as advocate, teacher, counselor, protector, friend and bridge to the community and to service providers.

Though OVC numbers have dropped (due largely to genocide orphans aging out of childhood), the *nkundabana* model has retained its relevance: the Government of Rwanda incorporated it into its national OVC strategy in 2007. By 2009, some 800 *nkundabana* were caring for almost 10,000 children—some in relationships that had endured for more than a decade. Now, from 2010-12, CARE is building a technical support function into the Ministry of Gender and Family Promotion (MIGEPROF), and training four Rwandan nonprofits to implement the model. Together, the government and these organizations will increase its reach at least five-fold.

It was a mid-2000 evaluation of one of our *nkundabana* projects—combined with our strategic decision to prioritize OVC as one of two groups on whom we focus all our work in Rwanda—that led CARE to undertake ECD. The evaluation underscored that, because *nkundabana* work directly with older children and only indirectly with infants and toddlers in any given family, the youngest members of the most vulnerable households were missing opportunities for support in their most crucial developmental phase. CARE thus turned to our organization's global 5 x 5 Model to guide our steps into ECD programming.



### Who are OVC?

An orphan is a child who has lost one or both parents, and a vulnerable child is one exposed to conditions that do not permit the fulfillment of his/her fundamental rights for his/her harmonious development.

#### Rwanda National Policy on OVC, 2003

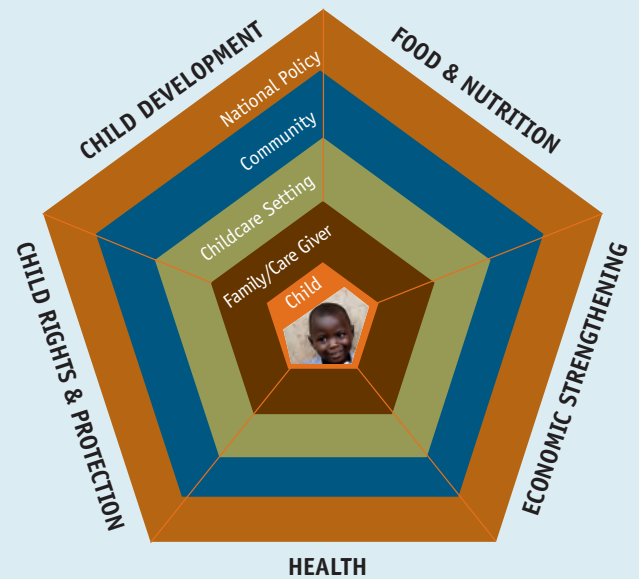
To operationalize the monolithic group 'orphans and vulnerable children,' CARE has identified 14 sub-groupings, each representing children with a specific type of vulnerability. The sub-group delineations help CARE, partners and communities identify who, specifically, our projects will serve.

#### CARE Rwanda OVC Program Strategy, 2012-2025

## 5 x 5 Model

CARE's *5 x 5 Model for Early Childhood Development*<sup>10</sup> identifies **five intervention areas** that a holistic ECD program should address to help children survive and thrive. Child development is one area, of course, but of equal importance are health; food and nutrition; economic strengthening; and child rights and protection. The 5 x 5 Model also clarifies that, while the child is at the center of any ECD intervention, activities directed solely at children will not lead to an effective, sustainable ECD program. Rather, the model spurs action at **five levels**: the individual child; the child's family or caregiver; the childcare setting; the community; and the national policy environment.

CARE originally developed the 5 x 5 to guide our work with AIDS-affected children in Uganda; we have since used it in Zambia, Angola, Kenya, Rwanda and India. As a next step, CARE, in collaboration with Save the Children and the Consultative Group on Early Childhood Care and Development recently developed the Essential Package (EP). The EP is a set of frameworks and tools that delineate age specific key messages, suggested actions and reflection questions to address the holistic needs of vulnerable children birth to age 8 and their caregivers. The tools are adaptable so that programs can modify them to develop ECD components appropriate for the local context. The EP materials can be found at [http://ecdgroupp.com/HIV\\_AIDS.asp](http://ecdgroupp.com/HIV_AIDS.asp).



## ECD Centers

In 2007, when CARE gained funds to pilot three ECD Centers for children aged 3-6 in Kamonyi district, MINEDUC had just completed an ECD curriculum<sup>11</sup> and oversaw a program of village daycares in much of the country. But, CARE ECD Professional Jacqueline Nzaramba recalls, "We had no real roadmap for how to do community-based ECD. This was the first of its kind in Rwanda. We'd come to the office every morning and ask ourselves, 'how are we going to make this work today?' Then we'd return from the field every evening and dissect the day: what went well and what did not? We worked around the clock to create the materials we had to use from one day to the next. We were truly creating ECD from scratch."

Below, we briefly highlight the major elements of the ECD Center as they relate to communities, to childcare settings, to participating children and to their parents/caretakers.

### Communities

CARE works with community members and local government to introduce the topic of ECD, to gain buy-in, and to determine eligibility for participation (using OVC subgroups, as described on previous page). We thoroughly discuss the roles and responsibilities of all involved, from CARE staff to parents, from local government authorities to volunteer teachers.

With training and ongoing guidance from CARE, parents of participating children form a Parent-Teacher Committee (PTC) for each ECD center. Governed by an elected president, vice-president, secretary, treasurer, two advisors and two supervisors, the PTC's job, ultimately, is the daily operations of the center: they manage financial, human and material resources and oversee quality. The advisors, most of whom are *nkundabana*, provide guidance to teachers and parents, and supervisors are in charge of Center maintenance. Each PTC is overseen by the General Assembly, whose membership is all parents of participating children.



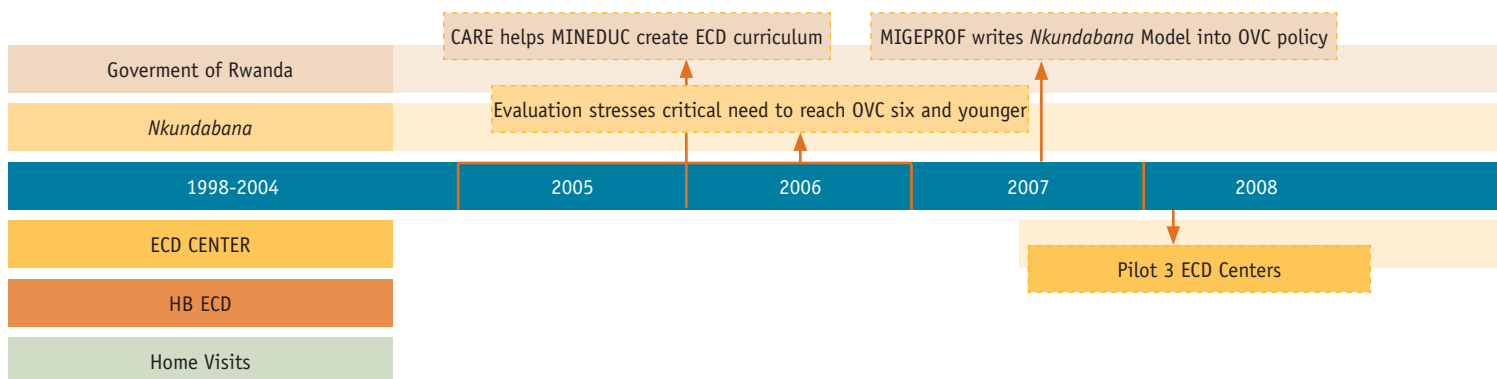
## Childcare settings

The district Social Affairs office is responsible for securing a safe and appropriate facility for the ECD Center. In reality, CARE has had to invest significant resources to build or refurbish facilities.<sup>12</sup> Each Center has spacious, cement-floored classrooms; a safe water supply; latrines and hand washing stations; child-sized furniture and playground equipment, locally made and brightly painted; and an array of toys and didactic materials.<sup>13</sup>

PTCs and local authorities select trusted community members to become teachers. Using MINEDUC’s ECD teacher curriculum, CARE provides a five-day training on emotional, psycho-motor and cognitive/language development of children under 6; on appropriate interaction and communication with children; on lesson planning; and on the use of didactic materials, games and toys. Teachers learn the basics of health and hygiene, and how to work effectively with children whose backgrounds may include extreme poverty, marginalization, abuse or developmental delays. After this formal training, CARE and sector-level authorities offer ongoing coaching, often with PTC members who, with time, gain full responsibility for teacher oversight.

The PTCs set the fees that parents pay for their children to attend the ECD Center. Fees cover recurring costs and teachers’ remuneration. Importantly, as the ECD Centers have increased in number and capacity, they have been able to enroll children who are *less* vulnerable than the original student body. PTCs have created sliding scales: extremely poor families pay, on average, 500 francs per month, while poor families pay 1,000 francs (about \$1 and \$2, respectively). Families who are unable to pay may provide labor instead. PTCs and teachers also learn to launch and manage one or more income-generating activities (IGA), revenue from which joins parents’ fees to cover the Centers’ costs.

## ECD TIMELINE IN RWANDA



## Children

In addition to age-appropriate lessons, play and other forms of developmental stimulation, children at each center benefit from:

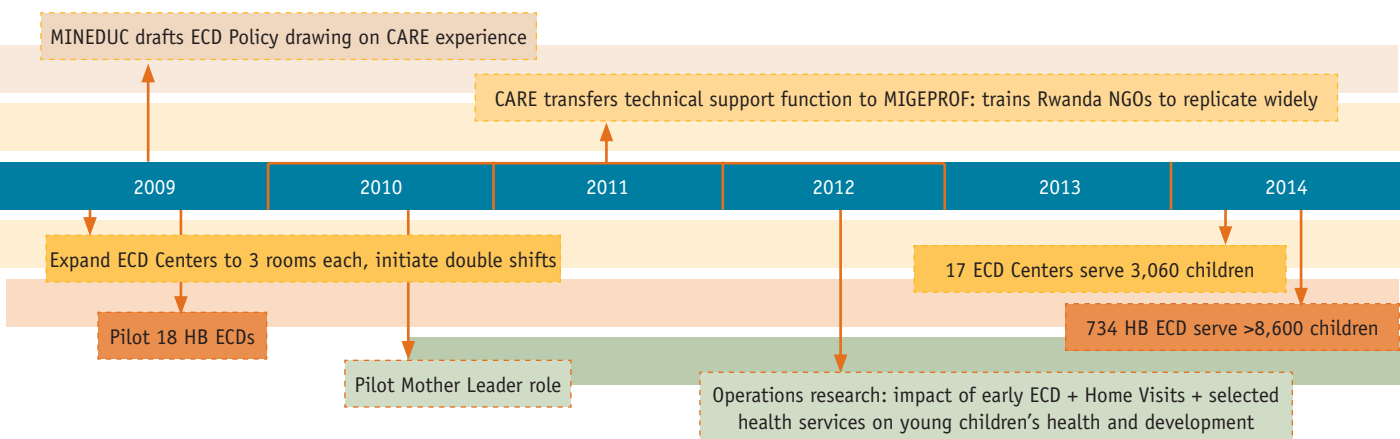
- **A daily cup of porridge:** In Rwanda, we use a nutritious blend of soy, sorghum and maize (SOSOMA), with a dash of sugar for taste. All grains are grown locally. SOSOMA is prepared on-site by the center's cook.
- **Health services:** The PTC at each Center maintains links with the nearest health center and with community health workers (CHW).<sup>14</sup> Certain health services are brought to Centers, including check-ups for incoming children, HIV tests (with parental permission, for children and parents), and periodic deworming. CHWs' and service providers' task is made exponentially easier by having children gathered in a single site.
- **Growth and Developmental monitoring:** CHWs and teachers monitor each child's growth and development.<sup>15</sup> They refer for health care if needed, and closely follow children who are missing milestones.

## Parents

CARE offers substantial training<sup>16</sup> to the fathers and mothers of participating children, commensurate with their central role in their children's well-being. Topics, each covered in a two-day session, are:

- **child development:** specific cognitive, language, socio-emotional and motor (gross and fine) milestones; stimulation activities; non-violent, positive discipline.
- **child rights and protection:** Rwandan family and child law (including inheritance), how to protect children from abuse, and procedures to follow should abuse occur.
- **nutrition and health:** adults' reproductive health/family planning, hygiene and sanitation, prevention and management of common maladies, and optimal nutrition for infants and young children (breastfeeding, complementary feeding, production and use of nutritious crops).

Parents and caretakers increase their economic security by forming and managing village savings and loan (VSL) groups.<sup>17</sup> Participation in a VSL means that parents can increase their household income and thus the money available for food, health



care and monthly ECD fees. CARE also provides parents the same training in basic business skills and IGAs that it offers to PTCs.

The three pilot ECD Centers quickly gained the approval of MINEDUC, local authorities and especially parents. Within months, demand for enrolment outstripped space available. In early 2009, CARE took three important steps to further our ECD model:

- a) We sought additional funding and launched *six new ECD Centers* in Kamonyi and Musanze districts.
- b) We increased *capacity and quality*. New and existing Centers now have three classrooms, and most host two shifts a day in each room. Children are separated by age in accordance with the Ministry of Education's aspirational standards, and the number in each class is capped at 30-35 for a better student-to-teacher ratio. These steps increased Centers' cost-effectiveness and financial sustainability: operating double-shift costs slightly more, but a greater number of parents pay fees.
- c) We piloted a second component—*Home-Based ECD for children aged 18 months to 3 years*—after positive consultations with parents in Kamonyi district.

## Home-Based ECD

In 2010, CARE tested 18 HB-ECD groups in Kamonyi with such success that the number of sites tripled by year's end.

Unlike ECD Centers, HB ECDs are managed solely by the parents of attending children. Each group is self-selecting; one family volunteers to provide an indoor room, outdoor play space and an area to store and cook SOSOMA.<sup>18</sup> Each site is fitted with hand-washing and latrine facilities. Parents—in practice, almost exclusively mothers—develop a rotating schedule in which each woman oversees the HB ECD for one morning a week.

When planning the HB ECD component, CARE looked back to our *nkundabana* model to inspire the new role that we call *Mother Leader*. Rather than mentor older children as an *nkundabana* does, the Mother Leader's focus is on the health, nutrition and developmental needs of children at the younger end of the ECD spectrum.



### Three Generations

Violette Mukakarisa stops by Gitaré ECD Center on her way to market. She is checking on her son, but also greeting Vestine Niyoyita. Vestine is a CHW in Gitaré, and in this role she attends to children at the ECD Center. But long before the center existed, Vestine was contributing to children's well-being in another way: she was *nkundabana* to six child-headed households in her village. Among her charges? Violette.

"My sister was the head of our household," says Violette, "and Vestine was like a mother to us. She visited and encouraged us to work hard. If she had anything to spare, she would share with us." Violette and her sister struggled to survive by laboring on other people's farms, and tending their own small plot of cassava and beans.

"When I was a child, I was depressed most of the time because I had no parents," Violette continues. "But slowly I understood that I could turn to Vestine and get her advice. With her help, I built my confidence and self-esteem." And as years passed and Violette had children of her own, "Vestine helped me so much. I really looked to her to show me how to care for them."

Violette's youngest son, now enjoying his time at the ECD Center, will not have to endure the same sorrows as his mother. Not only does Violette provide loving care to raise him, he can also rely on his grand-*nkundabana*, Vestine.



One woman from each HB ECD group volunteers to serve as Mother Leader, with full approval of other group members. She manages the general operations of the HB ECD site (often, her home hosts the group), but also monitors children’s developmental progress.<sup>19</sup> The Mother Leader forges a strong link with the local CHW: the latter brings certain services, including growth monitoring, into the HB ECD, and the former—who interacts daily with the children—identifies concerns and brings them to the CHW’s attention. She also extends the CHW’s informational reach: CHWs train Mother Leaders, for example, in a health or nutrition topic each month, and the Mother Leaders then share this information with other parents in their HB ECD group.

CARE’s major role is to provide training and guidance to Mother Leaders, and to the parents engaged in each HB ECD group. Those who oversee the children receive a version of the ECD teacher training that focuses on the younger child. Mothers and fathers enjoy the same training on child development, child rights and health as their ECD Center parent peers.

Each HB ECD site serves 10 to 12 children. Most are aged 18 months to 3 years, although 4- and 5-year olds participate where no ECD Center (or space within one) is available. Typically, children attend HB ECD five days a week, for four to five hours in the morning. Parents, like those at ECD Centers, pay a weekly fee to cover recurrent cost such as porridge and soap, and fixed costs such as benches and mats. The costs of an HB ECD are far lower than an ECD Center, and the startup period is far shorter. (As the table below shows, by 2014 CARE will have established 17 ECD Centers in seven years, but 43 times that number of HB ECD groups in just over half the time.)

Importantly, the HB ECDs meet:

- a) the need for more *cost-effective ECD solutions*: building and maintaining enough ECD Centers to serve all OVCs is not realistic in the near-term.
- b) the need to reach *younger children* with ECD services, given the importance of stimulation, positive interactions and opportunities for learning before the age of 3.
- c) the *very high demand* for quality ECD in participating communities, not only for younger children but for those aged 3 to 6 for whom there is not enough space in Centers.

**ECD BY THE NUMBERS: Sites and Children over Time**

	2008	2009	2010	2011	2014*
ECD Centers (cumulative)	3	3	9	9	17
ECD Children (per year)	168	214	1,167	1,350	3,060
HB ECDs (cumulative)	0	0	54	95	734
HB ECD Children (per year)	0	0	567	1,240	8,643

\*projected

## Home Visits

With successful ECD Centers and HB ECD groups serving children aged 18 months to 6 years, CARE is turning its attention to the youngest children in the ECD age range: those less than 18 months old, for whom ECD facilities are not appropriate. From 2010 through 2014, we are implementing the *Kuraneza* or ‘good growth’ project in Kamonyi district. Funded by USAID’s Child Survival program, *Kuraneza’s* contribution to CARE’s ECD model is fourfold:

- It radically scales up the number of HB ECDs to more than 700 by project’s end.

- It pilots *home visits* by Mother Leaders, to more effectively reach pregnant women, new mothers and children <18 months;
- It aims for stronger health and nutrition outcomes for children from birth to 6; and
- It produces rigorous evidence of the effects of ECD + child survival services on children from birth to 6, with an emphasis on children from birth to 2.

In *Kuraneza*, each Mother Leader—already active in her HB ECD group—regularly visits the nearby homes of children under 18 months, pregnant and lactating women. She encourages pre- and antenatal care, and provides information about preventing, detecting and seeking services for common maternal and child health problems. She monitors child development, and teaches parents why and how to interact with their child to stimulate social, physical, cognitive and language development. The cadre of Mother Leaders greatly extends the coverage of a single CHW, and brings early ECD services and health information into many households.

CARE designed *Kuraneza* with a strong operations research component: we are gathering evidence in three sectors of Kamanyi district where Mother Leaders are at work, and in one control sector where CHWs (only) are providing child survival (only) information and services. The objective of our evaluative research is to determine if (a) an integrated ECD + child survival model improves health behaviors and outcomes; (b) whether the ECD + child survival model is more effective than the child survival (only) model; and (c) whether ECD programming is associated with improvements in the physical, cognitive, language and social development of children. CARE expects to have preliminary answers to our research questions in early 2013.

## Results to Date

### Among Children

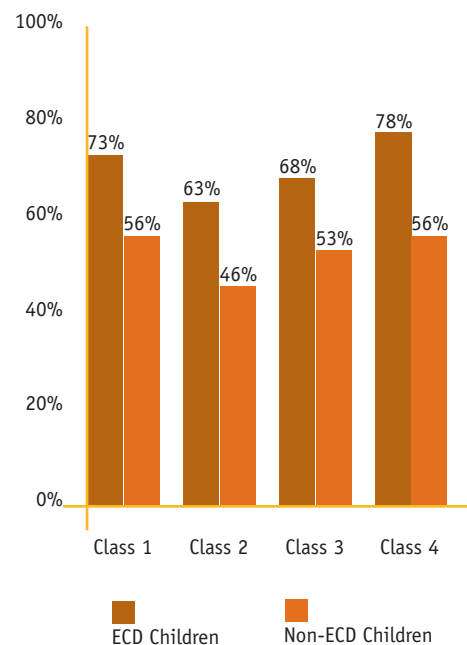
Preliminary data on ECD children’s performance once they reach primary school are encouraging. The graphic displays average year end scores of first-graders at just one school in Kamanyi sector, and shows that children who attended ECD achieved significantly higher marks than their age mates who did not. This aligns with global evidence that ECD improves children’s primary school performance, and is all the more gratifying because the ECD children represent



### Operations Research Questions:

1. Do mothers/caregivers in the intervention group identify danger signs of pregnancy complications and seek care earlier in comparison to the control group?
2. Do the improved behavior changes lead to improved health outcomes for mothers and children?
3. Do ECD interventions improve development and nutrition scores/indicators for the selected cohort?

**NYAKABUYE PRIMARY SCHOOL  
FIRST GRADE YEAR-END MARKS**



the most vulnerable members of their communities: they would typically be expected to perform more poorly than the general first-grade population.

“Children [who come] from the ECD Centers clearly behave differently from those with no experience in a structured setting,” says Godfrey Uwiringiyimana, Head Teacher at Butaté Village Primary School. “The ECD child knows, for example, how to handle materials like pencil and paper. He can understand abstract symbols such as a drawing that represents a fish or a rabbit. ECD children speak well. They understand good classroom behavior and how to interact with the teacher. At primary school, ECD children readily show other children how to use books and pens, how to play with toys, how to use the latrines. Many of them are wonderful little leaders.”

Children carry their lessons into the home, as parents enjoy recounting. “I remember when my older children were little. They were not as advanced as my young ones today. In fact, the young ones come home from the ECD Center and try to teach their big sisters and brothers,” says Celestin Munyanziza, a PTC President. In a nearby HB ECD, Béata Mukanyandwi also has a budding instructor in the family. “When we relax at home after dinner, my little one’s favorite game is to play teacher. She’s always trying to make her siblings name the colors, count and sing songs.”

Anecdotal evidence suggests that awareness and discussion of child rights and child abuse have increased as a result of the trainings for parents, teachers and local authorities. Certainly, all parties note that children are safe at the ECD Center or HB ECD. “Before the project, parents had different ways of dealing with their children while they worked,” explains Redemptor Nambajimana of the Gitaré ECD Center. “Some took their children to the fields. But many locked them in the house, or left them outside where they could wander, be hurt or abused.”

## Among Parents

Many of the mothers and fathers who participate in ECD are, like their children, among the most vulnerable in Rwandan society. This makes their gains, presented below in three categories suggested by parents’ own observations, the more remarkable.

### 1. We are better parents.

Mothers and fathers describe new confidence—and enjoyment—in child-rearing. Many observe that men are now more likely to play with their children, and to discipline without violence. Fabien Twagirayezu of Wihogora ECD Center describes his newfound engagement. “I have changed my attitude. I was doing my own thing before and paid no attention to my children’s education. Now I follow them closely as they go through school. My wife and I are fully confident that each of our children will go to university.” Women, by contrast, value the time that they can now devote to their children. Clementine Batamuliza observes, “Before, I never had enough time for my own work and for my children. Now they come home at mid-day full [of porridge]. I have the time to prepare a good meal and to bathe them in the evenings.”

According to Vestine Dusabemaliya, CHW and *nkundabana* in Gitaré, “What really motivates parents are new skills, like how to discipline the child without beating her and responding when the child asks questions, rather than ignoring her or telling her to go away. This helps the child have a closer relationship with her parents, and helps parents build the child’s good character and caring nature.”

### 2. We can earn more.

Parents who participate in VSL associations appreciate the ease of saving, access to loans and the security of the social fund. “We’ve learned that it is quite easy to save,” says one man in Butaté village, “yet I would not have thought it possible from my meager income.” He adds, “We take time at association meetings to discuss problems [related to IGAs].

**“If I am working in the fields and bring my child with me, it takes me a week to do what I can do in three days while my child is in the ECD Center.”**



This really raises accountability. A member cannot borrow for frivolous reasons: each must present a business plan, including how they will repay the loan.”

Even outside the VSL associations, parents—and especially mothers—find economic benefits to ECD. Women bear a dual burden of earning income (farming, marketing, etc.) and providing childcare. Sending their children to the ECD Center or HB ECD frees their time and increases their earning power. A woman in Gitaré makes a powerful calculation: “If I am working in the fields and bring my child with me,” she says, “it takes me a week to do what I can do in three days while my child is in the ECD Center.”

### **3. We value ECD for our children.**

“At first, parents were definitely skeptical,” recalls Nambajimana. “They didn’t understand how such young children could spend whole hours at a school.” Perhaps the clearest indicator that initial skepticism has given way to value is, quite simply, that demand for services consistently exceeds space available. At Wihogora ECD Center, PTC Treasurer Léa Nikuze says, “We began with 47 children and today have 230. Parents ask every day to enroll their children. And our challenge is that we can’t accept anymore: our classrooms are full.”

Clementine Batumuliza, whose two youngest attend Wihogora, says, “The fees concerned me at first, but now I am sure they are not too high compared to the benefits that my children get. The money might be hard to raise, but there is no question that I plan to continue raising it.”

### **In the Childcare Setting**

ECD Centers and HB ECDs are the physical hub of integrated services for children. As noted, the sites are well equipped and, importantly for parents, safe. Teachers, meanwhile, are confident with the training and classroom experience they have gained. “We have learned to do lesson plans that are age-specific and sequential, so children build one skill on another,” says Appoline Mwubahamana, who teaches 5-year-olds in Butaté ECD Center. Her colleague Fébronie Mutuyimana, who teaches 3-year-olds, incorporates knowledge of developmental milestones into her plans. “We know that children need time to play and socialize—that these things help the child as much as classroom time.” Both agree that teacher-child interaction is excellent. “Before, when a teacher had to correct a child, she might yell or beat with a stick. Now, we get close and talk to the child. Corporal punishment does not exist at this center,” Mwubahamana declares. “We believe that when you hit a child, all you develop is fear.”

Like teachers, PTCs have steadily gained skills and experience to manage daily operations of ECD Centers. Nikuze recalls, “When we began, we didn’t believe we could really do it. But once we started, we gained confidence and really saw the good we could accomplish.” In Butaté, PTC secretary Noël Kanyaruhengeri is optimistic. “Today the

management of the Center is tremendously changed from early days. Activities and procedures are in place. Most parents try to play some role in managing the school. It is much easier now.”

## In Communities

Working jointly on the ECD components has built the capacities of and cooperation between key players: parents, teachers, community and local authorities. CARE observes several other effects that were not directly intended, but that have great value. The first is *building trust* (see box).

The second is *channeling the talents of OVCs’ parents*, who are themselves poor and on the margins of their societies. Celestin Munyanziza embodies this effect. Today he is PTC President at the Wihogora ECD Center, yet when activities began his son—selected for participation—was malnourished, the family was near-homeless (and later did live on the streets), and Celestin had neither land nor income.

“Poor people might shy away from participating in community affairs, out of shame of being dirty and ill dressed,” he observes. “But I just got ready and joined in. I am more confident in myself as a parent, a community member and a PTC member. If I’m in any community meeting, I always ask for a few minutes to talk about child rights. Even at sector and district level, I am recognized and can have an impact, though I never went to school myself.

“The ECD has helped families and neighbors come together,” Munyanziza concludes. “This ECD is a model for the whole country, and we are very hopeful about the future. When we look back, we are amazed at how far we have come, and this gives us confidence that we can keep the ECD going.”

## At National Level

When CARE launched three pilot ECD Centers in 2007, virtually no other ECD programs existed in Rwanda, nor did the government yet have policies or plans. Our work in the ensuing years has strongly influenced MINEDUC, including its draft 2009 ECD Policy, and other actors in the child education and health sectors.

At the same time, CARE has consulted the government at each step, and uses or adapts existing government materials (MINEDUC’s ECD curriculum, for example, and Ministry of Health training guides) where they exist, knowing that the ECD model we develop must represent Rwanda’s standards if it is to be replicated and reach



## ECD Participation Builds Trust

Parents anywhere will want to be involved in selecting the ECD Center or HB ECD group in which their children participate. They need to trust other parents—especially those who will directly care for their children—and know that the care setting is safe, clean and close.

Parental trust takes on extra shades of importance in post-genocide Rwanda. Donatien Hazitayezu, CARE Capacity Building Professional, recalls instances where he feared to suggest collaboration between some households because he knew that one’s family had perpetrated violence on the other. Yet, he says, “they choose to put their children together, to keep their generation’s dissent in their generation, and not let it pass to the next.”

“After the war, people were so detached, divided and mistrustful,” says Léa Nikuze, PTC Treasurer at Wihogora ECD Center. “The ECD has allowed us to work together to get beyond the conflict. We have built mutual trust based on our common interest in the well-being of our children.”

Clarisse Mukaruhumurizu, a Mother Leader in Remera village, agrees. “Caring jointly for our children has broken down many misunderstandings.” Marie Josée Dusabeyezu, CHW, chimes in. “I see much greater trust among parents. I know that she will take care of my child,” she says, gesturing to Clarisse, “exactly as she knows that I will take care of hers.”

greater numbers of children. At the broadest level, notes Jaime Stewart, CARE's Health, OVC and Economic Development Coordinator, "CARE's 5 x 5 Model, as now operationalized in Rwanda, seamlessly brings together three essential Government of Rwanda priorities: its nutrition protocol, its ECD policy, and its Community Health policy."

## Next Steps

CARE now turns to the latest steps in creating an ECD model that is culturally appropriate, holistic, cost-effective, sustainable and—importantly—replicable by others, including the Government of Rwanda.

### Ground the ECD model in evidence

- **Tighter, more purposeful monitoring and evaluation systems.** We are now developing and using, with communities, an M and E system that gathers new data and makes more systematic use of existing information to detect changes in individual children, within age groups, and at the care setting and community levels. These data are also used in decision-making for ongoing program quality improvement.
- **Statistically rigorous evidence of effect/impact.** By 2013, our *Kuraneza* project will have the data to determine: (a) if integrated ECD + child survival services improve health behaviors and outcomes, (b) whether the ECD + child survival services are more effective than child survival services alone; and (c) if ECD interventions improve development and nutrition scores/indicators for the selected cohort.

### Sustain and scale up

- **Package materials and costs.** CARE is collating into a single package the *training and guidance materials* that we use to implement the ECD model. Likewise, we are developing a budgeting package, based on experience, that itemizes the *costs of launching and operating* ECD Centers, HB ECDs and the Mother Leader role in Rwanda. (Ideally, the package will include the per child cost of the ECD model, from prenatal to age 6.) Our goal is to make materials and cost information freely available, thereby facilitating replication and scale-up of ECD services in Rwanda and indeed in other countries.
- **Sustainability.** CARE has shifted from direct implementation to helping communities manage and sustain the components of the ECD model. However, our stance is that communities should not bear this responsibility alone. The government, nationally and/or locally, must weigh the considerable benefits of ECD services and factor at least part of their cost into their budgets. In a related vein, MINEDUC's 2009 draft ECD policy aspires, in the long term, to enroll all 3- to 6-year olds in ECD Centers; in the shorter term, it calls for at least one model ECD Center in each of the country's 416 sectors. Obviously, significant resources are needed to achieve either aim. CARE posits that our HB ECD and Mother Leader components—which operationalize MINEDUC's ECD policy, and the Ministry of Health's nutrition protocol and community health policy—can provide crucial, cost-effective services to children under 6 to help them survive and thrive. The quantitative evidence and cost package noted above may serve as powerful advocacy tools for both these issues.

## Endnotes

- <sup>1.</sup> UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, available at: <http://www.unhcr.org/refworld/docid/3ae6b38f0.html>.
- <sup>2.</sup> Early Childhood Development Programs in Global Contexts: Improving Quality Society for Research in Child Development (SRCD) Volume 25, number 2, 2011.
- <sup>3.</sup> Walker SP, et al. 2011. "Inequality in early childhood: risk and protective factors for early childhood development". *Lancet*; Published online September 23, 2011.
- <sup>4.</sup> Engle P, et al. 2011. "Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle income countries". *Lancet*; Published online September 23, 2011.
- <sup>5.</sup> Shonkoff, Jack, MD, et al. "Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress". *Pediatrics*. 2012; 129:e232-ee246. (quoted from p. e242).
- <sup>6.</sup> Grantham-McGregor et al. (2007). "Child development in developing countries 1. Developmental potential in the first 5 years for children in developing countries". *Lancet*, 369:60-70.
- <sup>7.</sup> Engle, P., Black, et al.(2007). "Child development in developing countries 3. Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world". *Lancet*, 369:229-242.
- <sup>8.</sup> Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. *Rwanda Demographic and Health Survey 2005*. Available at <http://www.measuredhs.com/publications/publication-FR183-DHS-Final-Reports.cfm>.
- <sup>9.</sup> ARCT-RUHUKA - Association Rwandaise des Conseillers en Traumatisme
- <sup>10.</sup> CARE. 2007. *Early Childhood Development for OVC in Resource Constrained Settings: The 5x5 Model*. Available at <http://pqdl.care.org/CuttingEdge/Promising%20Practices%205x5%20Model.pdf>
- <sup>11.</sup> In 2005 and 2006, a CARE education specialist worked closely with MINEDUC to develop the curriculum, which is still in use today.
- <sup>12.</sup> This fact is important when considering replicability and sustainability of ECD Centers.
- <sup>13.</sup> To date, CARE donors have been happy to purchase these items for ECD Centers. For cost-sustainability reasons, the ECD model will include local fabrication of furnishings and parent- and child-made toys using available materials.
- <sup>14.</sup> The CHW is a government-mandated position; these volunteers are responsible for offering health information, encouraging use of health services, and serving as a link between households and health center outreach services.
- <sup>15.</sup> Recently, we began using the Ages and Stages Questionnaire, which offers tools for developmental and social-emotional screening of children aged 1 month to 5.5 years, and tracks individual children against a standardized sample of 15,000 (American) children. With permission from the publisher, we are contextualizing the tools for use in Rwanda. See: Paul H. Brookes Publishing Co., Inc. 2012. *Ages and Stages Questionnaires Third Edition*. Available at <http://agesandstages.com/>
- <sup>16.</sup> CARE recently adopted a training-of-trainers approach to more efficiently reach the thousands of parents whose children are entering the ECD program. Training sessions are spaced over several months, rather than given all at once.
- <sup>17.</sup> CARE created the VSL methodology in 1991 in Niger, and now uses it in some two dozen African countries. VSL members use only their own money to save and borrow useful amounts, in sustainable groups, with a flexibility that micro-finance institutions cannot match. The 20 to 30 members of each VSL association pool modest weekly savings (amount set by the group) to disburse loans which members use to start or grow IGA. Members repay with interest (rate set by the group); the interest joins the savings to grow the pooled fund. Most groups also have a social fund to help members meet unusual expenses (medical fees, funeral, etc).
- <sup>18.</sup> Participants have developed a set of criteria for choosing an HB ECD site, with careful attention to safety, cleanliness and accessibility.
- <sup>19.</sup> Using the Ages and Stages Questionnaire screening tools noted above.





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