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Prepared by
Minister in the Prime Minister’s Office in Charge of Gender and Family Promotion, with financial support from UNICEF/Rwanda, and technical support from Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd. (SIAPAC), in association with MASDEC/Rwanda

ISBN: 978-92-806-4353-4
A Situation Analysis of Orphans and Other Vulnerable Children in Rwanda

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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>AIM</td>
<td>AIDS Impact Model</td>
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<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<td>AVEGA</td>
<td>Association of the Widows of Genocide - Agahozo</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>Community HIV/AIDS Mobilization Program</td>
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<td>Child-Headed Households</td>
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<td>CNF</td>
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<td>National AIDS Commission</td>
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<td>COMESA</td>
<td>Common Market for East and Southern Africa</td>
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<td>Provincial AIDS Commission</td>
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<td>United Nations Convention on the Rights of the Child</td>
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<td>Catholic Research Services</td>
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<td>Department for International Development (United Kingdom)</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>District Level Key Informant Interview</td>
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<td>Early Childhood Development</td>
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<td>Gross Domestic Product</td>
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<td>Great Lakes Initiative on AIDS</td>
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<td>GOR</td>
<td>Government of Rwanda</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPI</td>
<td>Human Poverty Index</td>
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<td>IEC</td>
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<td>LE</td>
<td>Life Expectancy</td>
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<td>MAP</td>
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<td>Millennium Development Goals</td>
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<td>M&amp;E</td>
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<td>Multiple Indicators Cluster Survey</td>
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<td>Ministry of Public Service, Skills Development, and Labour</td>
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<td>PACFA</td>
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<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>People Living with HIV/AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PPA</td>
<td>Participatory Poverty Assessment</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<tr>
<td>RPR</td>
<td>Réseau Rwandais des Personnes Vivant avec le VIH</td>
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<tr>
<td>SIAPAC</td>
<td>Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd.</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TRAC</td>
<td>AIDS Treatment and Research Centre</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
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<td>World Food Programme</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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*All photos in this report are by Mr. Robin Weeks, Project Manager for SIAPAC.*
**Definitions**

**Orphan**

An orphan is a child who has lost one or both parents. A maternal orphan is a child who has lost her/his mother, a paternal orphan is a child who has lost her/his father, and a double orphan is one who has lost both parents. Paternal orphans include those who do not know the status of their fathers, but presume they are dead.

**Vulnerable Child**

A vulnerable child is a person under the age of 18 years who is exposed to conditions which do not permit her/him to fulfil their fundamental rights for harmonious development.

In Rwanda, vulnerable children are defined as those who are:
- Children living in households headed by children.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, or HIV positive.
- Infants with their mothers in prison.
- Children in very poor households.
- Refugee and displaced children.
- Children of single mothers.
- Children who are married before they legally become adults.

**Vulnerable Child due to HIV/AIDS**

A child is defined by the Global Fund as vulnerable due to HIV/AIDS under the following circumstances:
1. Is HIV positive.
2. Has lost one or both parents.
3. Has a chronically ill parent/caregiver (living in the same or a different household).
4. Lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before s/he died.
5. Lives in a household where at least one adult was seriously ill for at least 3 months in the past 12.

**AIDS**

Acquired Immune Deficiency Syndrome (AIDS), a collection of symptomatic conditions caused by the Human Immunodeficiency Virus. AIDS develops once HIV has weakened the immune system to such an extent that illnesses easily and regularly attack the body. Although there are a number of other symptoms, when three ‘symptoms’ present themselves, it is generally acknowledged that AIDS has set in: 1) weight loss of 10% or more (for infants, could also included abnormally slow growth); 2) chronic diarrhoea lasting one month or more; and 3) prolonged fever lasting longer than one month (Whitehead, 1998).

More specifically, ‘A’ means acquired, meaning that the virus is not spread through casual or inadvertent contact, such as flu. In order to be infected, they have to be directly exposed to the virus. ‘I’ is for immune deficiency; ‘D’ for the immune system deficient. ‘S’ is for syndrome, because AIDS is not just one disease, rather it presents itself as a number of diseases that set in as the immune system fails (Whitehead, 1998).

**Anti-Retroviral**

A treatment regime for HIV with anti-retroviral drugs.

**Anti-Retroviral Therapy**

A treatment regime for HIV with anti-retroviral drugs.

**Asymptomatic HIV Infection**

The stage of HIV infection prior to the development of illness or clinical signs and symptoms.

**Base Year**

Year upon which projections are based (Spectrum Model).

**Caregiver**

An adult or child who is considered to be the person primarily responsible for the care and protection of an OVC.

**Child**

For the OVC situation analysis, a child is defined as someone aged 0-17. This is consistent with the Rwandan Constitution of 2003.

**Child-Headed Household**

Household headed by someone under the age of 18 years acting as a guardian for siblings, relatives, and other children, or living alone.

**Chronically Ill**

Someone who was ill on a continuous basis for at least three months over the past twelve.

**Counselling**

A dialogue between the client and a service provider aimed at helping the client to face the stress and to take personal decisions about their condition.

**Epidemic**

A situation where a disease is prevalent over an entire area or an entire country.

**Epidemiology**

The study of the incidence, distribution and determinants of an infection, disease or other health-related event in a population. Epidemiology can be thought of in terms of who, where, when, what and why. That is, who has the infection/disease, where are they located geographically, and in relation to each other, when is the infection/disease occurring, what is the cause, and why did it occur (Whitehead, 1998).

**Focus Group Discussion**

A discussion held among a small group of people (usually 5-9) on a specific set of issues. Usually comprised of people who are in a similar situation, or are alike in another way.

**Gender**

Gender refers to the socially defined roles and responsibilities of men and women and boys and girls. Male and female gender roles are learned from families and communities.

**IntroductIon and overvIew**

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and vary by culture and generation. Gender equality means the absence of discrimination, on the basis of a person’s sex, in opportunities, in the allocation of resources or benefits, or in access to services. Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men, and often requires women-specific projects and programmes to end existing inequalities.

**Head of Household**

Adult or, in the case of a child-headed household, child who is identified by household members as the most senior member who is responsible for key household decision-making. If the identified household head is absent at least six months out of the past twelve, the ‘de facto’ head of the household is the person who takes on this role in the absence of the household head.

**Heterosexual Sex**

Sex between a man and a woman.

**HIV**

Human immunodeficiency virus (HIV) is a virus which attacks the body’s immune system. HIV slowly destroys the immune system reducing the body’s ability to fight off illness. When the immune system weakens, a person becomes vulnerable to illnesses which normally would not have affected her/him (Whiteides, 1998).

There are two basic types of HIV, with HIV 1 being most common in Southern Africa and HIV 2 which is most common in West Africa. HIV 1 is more easily transmitted than HIV 2 and the period between initial infection and illness is shorter for HIV 1; these two factors may account for the difference in the spread of HIV between Southern and West Africa. There are some nine subtypes of HIV-1 (Whiteides, 1998).

**HIV Infection**

HIV is primarily a sexually transmitted infection, passed on through unprotected penetrative sex. The virus can also be transmitted through blood transfusions, the use of unsterilised injection equipment or cutting instruments and from an infected woman to her foetus or nursing infant. While some individuals experience mild HIV-related diseases soon after initial infection, nearly all then remain well for years (see Asymptomatic HIV Infection). Then, as the virus gradually damages their immune system, they begin to develop illnesses of increasing severity, characterised by various combinations of symptoms and diseases, such as diarrhoea, fever, wasting, fungal infections, tuberculosis, pneumonia, lymphoma, failure to thrive and Kaposi’s sarcoma (Whiteides, 1998).

**HIV Sentinel Survey**

The systematic collection and testing of blood from selected populations at specific sites for the purpose of identifying trends in HIV prevalence over time and location (Whiteides, 1998).

**HIV to AIDS**

Loewenson and Whitesides in Whiteside (1998: 13-14) explain what happens during the ‘transition’ period between HIV and AIDS as follows: “As the body’s defence system weakens symptoms appear, alone or severally. They include: chronic fatigue and weakness, diarrhoea, fever, wasting, fungal infections, tuberculosis, pneumonia, lymphoma, failure to thrive and Kaposi’s sarcoma (Whiteides, 1998).

**Infectiousness**

The relative ease with which a disease is transmitted. According to Whiteside (1998), each HIV-positive person is likely to infect five others during his or her lifetime. If it drops to 1:1 or lower, infection rates will fall.

The degree of infectiousness of HIV varies over the course of the incubation period, and is probably highest when people are first infected (prior to development of antibodies) and when they are asymptomatic. Whiteside (1998) describes the process as follows: During the early stages of infection, the antibodies to the virus (which we usually test for) may not be identifiable. This is called the ‘window period’. An infected person will be very infectious during this phase. Equally, at this time a person may experience a short bout of illness. The cause is a rapid multiplication of the virus and a correspondingly rapid response from the body. A battle commences between the virus and the immune system, described as the incubation period. During this stage, the viruses and the cells which they attack are reproducing rapidly and being destroyed as quickly by each other. Eventually, the virus is able to destroy the immune cells more quickly than they can be replaced and slowly the number of CD4 cells falls. In a healthy person, there are 1,200 CD4 cells per micro litre of blood. As the infection progresses, the number will fall to about 200 or less. At this point, new opportunistic infections begin to occur and a person is said to have AIDS. The infections will increase in frequency, severity and duration until the person dies. It is therefore the opportunistic infections that cause the syndrome referred to as AIDS.”

**Incubation Period**

The time interval between HIV infection and the onset of AIDS. In Rwanda, the estimated incubation period is estimated at six years.

**Intervention**

A set of activities through which a strategy is implemented. For example, promoting safer sexual behaviours is one intervention to reduce sexual transmission of HIV.

**Key Informant Interview**

One-on-one interviews with those who, by their position or through their influence, are considered to be knowledgeable or influential with regard to an issue or set of issues.

**Malnutrition**

An abnormal physiological state caused by deficiencies, excess or imbalance of energy, proteins and/or other nutrients.

**Model**

A model is a construct that is developed in an attempt to represent the real world. Models are usually expressed in the form of a mathematical equation or set of equations that represent an object or a system.

**Mortality Rates**

The percentage who die during a particular span of time.

**Mother-to-Child Transmission**

Mother-to-Child Transmission (MTCT), or vertical transmission, refers to infection during pregnancy, childbirth, or during breastfeeding from a mother to her child. In Africa, it is estimated that one-in-three children of HIV positive mothers contract HIV in this manner. The risk of transmission depends on the viral load of the mother at birth (the higher the load the higher the risk), a low CD4 count (the lower the count, the higher the risk), and breastfeeding practices. The relationship between breastfeeding and HIV transmission is uncertain, but it appears that the best practice is exclusive breastfeeding, followed by exclusive bottle feeding. The most problematic practice is a mix of breastfeeding and bottle feeding.

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Probability of Infection per 100 Exposures</th>
<th>Global Percentage of Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Transmission</td>
<td>0.033-0.2</td>
<td>70-80%</td>
</tr>
<tr>
<td>Mother to Child</td>
<td>13-48</td>
<td>5-10%</td>
</tr>
<tr>
<td>Sharing of Injection Equipment</td>
<td>na</td>
<td>5-10%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>90-100</td>
<td>5-10%</td>
</tr>
<tr>
<td>Accidental Needle Stick Injuries</td>
<td>0.3</td>
<td>less than 0.01%</td>
</tr>
</tbody>
</table>

**Morbidity Rates**

The percentage ill over a particular span of time.

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**Morbidity Rates**

The percentage ill over a particular span of time.

**Mortality Rates**

The percentage who die during a particular span of time.

**Mother-to-Child Transmission**

Mother-to-Child Transmission (MTCT), or vertical transmission, refers to infection during pregnancy, childbirth, or during breastfeeding from a mother to her child. In Africa, it is estimated that one-in-three children of HIV positive mothers contract HIV in this manner. The risk of transmission depends on the viral load of the mother at birth (the higher the load the higher the risk), a low CD4 count (the lower the count, the higher the risk), and breastfeeding practices. The relationship between breastfeeding and HIV transmission is uncertain, but it appears that the best practice is exclusive breastfeeding, followed by exclusive bottle feeding. The most problematic practice is a mix of breastfeeding and bottle feeding.
Anti-retroviral drugs may decrease the viral load and therefore decrease the risk of MTCT.

Opportunistic Infections
Infections that are caused by microorganisms which the body’s immune system is normally able to fight off. When the immune system is weakened or destroyed, as in HIV infection, opportunistic infections can then take hold.

Person Living with HIV
An individual infected with HIV, also called a person who is HIV positive or a person who is HIV seropositive. As soon as an individual becomes infected, s/he is capable of infecting others through sex, blood and perinatally. HIV infection is lifelong (Whiteside, 1998).

Prevalence
The proportion of a defined population with the infection, disease, or other health-related event of interest at a given point or period of time (Whiteside, 1998).

Preventive Measures
Measured aimed at stopping the sexual, blood borne and perinatal transmission of HIV.

Primary Data Collection
The collection of data which did not previously exist, usually carried out using structured data collection instruments. Collected via one-on-one or group interviews.

Projection
Estimate of future characteristic based on past trends, information known, and experience.

Qualitative Data
Data which are not statistically generalisable to a larger population. Tends to provide more depth than quantitative data.

Quantitative Data
Data generalisable to a larger population based on following careful sampling procedures, detailed question and questionnaire construction, and consistent implementation.

Reproductive Health
Reproductive health is complete physical, mental and social well-being in all matters related to the reproductive system. This implies that people are able to have a satisfying and safe sex life and that they have the capacity to have children and the freedom to decide if, when and how often to do so. Reproductive health care includes, at a minimum:
- family planning services, counselling and information
- prenatal, postnatal and delivery care
- health care for infants
- treatment for reproductive tract infections and sexually transmitted diseases
- safe abortion services, where legal, and management of abortion-related complications
- prevention of and appropriate treatment for infertility
- information, education and counselling on human sexuality, reproductive health and responsible parenthood, and discouragement of harmful practices like female genital mutilation.

Risk Factors
Conditions or behaviours which make it more likely that a person will become infected with HIV. These factors might include: involvement in any sexual relationship other than one which has been mutually exclusive and HIV negative for a sustained period of time; presence of an STD; injecting drug use; history of blood transfusions, skin-piercing, invasive, surgical or dental procedures that were done under possibly unsterile conditions or with contaminated blood or blood products; and sexual intercourse with a partner who has any of these risks listed.

Secondary Data Collection
Data obtained from existing published materials or available from existing databases and sources.

Seroprevalence (HIV, STI)
The percentage of a population from whom blood has been collected that is found, on the basis of serology, to be positive for HIV or other STIs at any given time.

UNGASS
In June, 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), leaders from 189 countries (Rwanda included) endorsed the Declaration of Commitment on HIV/AIDS. The signatory countries undertook to develop and implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment and orphans and other children affected by HIV/AIDS, or HIV positive.
Map 2: Map of Rwanda Showing Its Position in Africa

Map 3: Map of Rwanda Showing Regions and Demarcating Districts


Map 4: Population Density (2002 census data)

Map 5: Food Insecurity (2006)

% of Food Insecure Household in Food Economy Zone

- 10 - 15%
- 16 - 20%
- 21 - 25%
- 26 - 30%
- 31 - 35%
- 36 - 40%


The National Strategic Plan (NSP) of Action for Orphans and Other Vulnerable Children (OVC) was adopted by Government in late 2007. One priority in the NSP was the conduct of a Situation Analysis of OVC in Rwanda.

The 1994 genocide left Rwanda with the dubious distinction of having the highest proportion of orphans to the total population of 0-17 year olds in the world. In the years that followed, considerable progress was made in reaching these orphans, as well as other children made vulnerable by the genocide. This was later expanded to cover all OVC, and categories of children in particular need identified and prioritised. In the years that followed, a coherent response to OVC emerged, culminating in the 2003 National Policy on OVC, the 2006-2011 NSP (adopted in 2007), and the integration of OVC issues into a variety of policies, as well as the Economic Development and Poverty Reduction Strategy (EDPRS). Through integration of OVC issues into the EDPRS in particular, Government has signalled the importance of OVC for the future of the country, and the achievement of national development objectives.

There are, of course, severe constraints facing the response, notably human and financial resource limitations at the national, district, and sector levels, coupled with high ‘demand’ for services due to widespread poverty, especially in rural areas. In an environment of severe resource constraints, the nature of OVC requires a multisectoral, integrated response, but this is also proving difficult.

As part of efforts to overcome these constraints, secure additional resources and garner support for an enhanced OVC response, the NSP called for the conduct of a Situation Analysis of Orphans and Other Vulnerable Children. The benefits to be derived from the Situation Analysis included:

- **Effective Planning** - Rwanda is in a position to consider, in a well informed manner, how to improve the efficiency and scope of service delivery in the OVC arena.
- **Advocacy** - The Situation Analysis will help strengthen Rwanda’s OVC response.
- **Comprehensiveness** - The investigation included an assessment of the care and protection of orphans and other vulnerable children.
- **Evidence-Based Planning** - The Situation Analysis means that the situations facing OVC have an empirical basis. This will support access to finance for intended activities, significantly strengthening plan implementation.
- **Participation** - One key aim of the investigation is to consider how to directly involve OVC and caregivers in desired interventions not just as beneficiaries but also as involved parties.

The vision of the OVC response, as elaborated by Government and noted in the NSP, is that “OVC will be assisted to reach their full potential and have the same opportunities as all other children to active and valued participation in home and community life”.

The main objective of the National Strategic Plan is to “protect the rights of the child and to ensure the physical and psychosocial long term development orphans and other vulnerable children”. The main objective reflected the multiple focus on OVC as rights holders, and therefore as decision-makers worthy of influence and respect, as vulnerable children in need of assistance, and as children who need to grow up to be productive adults able to contribute to society, and who will have the skills relevant for Rwanda’s vision as a country leading in the region in communications technology.

Six strategic objectives were agreed:

1. To create a supportive environment for OVC through increased awareness on all matters concerning OVC addressing children, parents, caretakers, service providers, decision makers and the general population.
2. To ensure a protective environment for OVC through enhanced policy, legislation, procedures and regulations.
3. To provide protection, care and support to OVC by establishing and strengthening family and community based support structures.
4. To ensure access to essential services for OVC including shelter, education, health and nutrition, social protection, water and sanitation and birth registration.
5. To build and strengthen the capacity of government, civil society and service providers to respond to the situation of OVC.
6. To establish co-ordination, implementation and monitoring and evaluation mechanisms.

As of late 2007, there were an estimated 3.4 million children aged 0-17 in Rwanda. Of these, there were 825,000 orphans and 2 million other vulnerable children. The majority of vulnerable children were vulnerable due to overwhelming poverty and the inability of caregivers to meet basic needs.

Overall, there were just over 2.8 million OVC in Rwanda. In percentage terms, 24.3% of all children in Rwanda were orphans, 59% were non-orphan vulnerable children, and 16.7% were non-OVC. One-third of all vulnerable children were non-orphans living in households caring for at least one orphan, highlighting the vulnerability across all children in orphan caregiving households.

A total of 15.4% of all orphans were maternal orphans, 58.5% were paternal orphans, and 26.1% were double orphans. Child-headed households were caring for 0.7% of all OVC, while 0.6% of all OVC were living rough. Maternal orphans were significantly more likely to be living in child-headed households or living rough than paternal or double orphans.

Projections suggest that the proportion of orphans to the overall population of 0-17 year olds will decline, due to the fact that children orphaned during the genocide will all have turned eighteen by 2012, but also due to improvements in health status and education status of adults and children. Further, Rwanda’s ability to keep its AIDS pandemic in check has meant that the number and proportion of children orphaned due to AIDS has not grown like it has in other
countries in eastern and southern Africa. Current estimates suggest that 22% of all orphans are orphaned due to AIDS, with 78% orphaned due to other factors. This is projected to decline to 15% by 2012.

**Orphan Status**

Caregiving households looking after orphans were asked a series of questions about the orphans they were caring for.

The majority of orphans were teenagers, reflecting the high number of orphans from the genocide. Two-thirds of all double orphan households had neither been adopted nor fostered, but had rather just been taken in by extended family members, neighbours, or others without any formal procedures. Of those orphans with siblings, 87.2% were moved together, and 12.8% were divided across multiple households. A total of 93.9% of all orphans were being cared for by a biological relative.

Two-thirds of all orphans had lived in the caregiving household their entire lives, with only one-third having been moved. Of the one-third that had been moved, two-thirds (64.9%) had relocated to their current residence before they became orphans.

Over 80% of those who were moved were moved to a similar environment (within the same community, from a rural area to another rural area, or from an urban area to another urban area). One-quarter of all orphans had to care for a dying parent, holding equally for girls as well as boys. Overall, most orphans were not moved in a situation that would itself result in significant additional adjustment problems.

**Caregiver Status**

Caregiving households were asked about the status of those caring for the orphans in the household, and caregiver age, health status, sex, and education.

While 0.7% of all households with orphans were child-headed, a higher 2.3% of all caregivers of OVC are under the age of eighteen. While it is commonly assumed that caregivers are generally elderly, only 13.8% were aged sixty and older. However, when including those aged fifty and older, the figure rises to 30.5%, meaning that almost one-third of all caregivers were aged over 49. Two-thirds of all caregivers are aged 18-49. Almost 80% of all caregivers are female. Almost half of all caregivers have no education, and almost all the remainder only had primary schooling. Three-quarters of caregivers were healthy, and 23.8% were either sick or bedridden. Older caregivers were specially likely to be sick or infirm.

**Demographic and Socio-Economic Status**

OVC caregiving households tend to be poorer, larger, and more likely to be female-headed than non-OVC households. Households with vulnerable children are, on average, worse off than households looking after orphans.

OVC caregiving households tend to be more likely to be female-headed, and have higher dependency ratios than non-OVC households. They also tend to be poorer than non-OVC households overall, while households with vulnerable children were, on average, poorer than households with orphans.

Of orphan households, a very high 59.6% are female-headed, compared to a much lower 16% for households looking after vulnerable children, and less than one-quarter for all households nationwide. Almost 90% of all OVC household heads have no education, or only primary education, with education levels lower for female household heads. Half of all households were classified by enumerators as ‘very poor’, 12% were living in ‘abject poverty’, and almost all the remainder were classified as poor. Just under 10% were classified as non-poor, most of them orphan caregiving households. Only 13.6% of all OVC household heads had incomes/own production valued at over US$0.33 per day, or US$10 per month.

Most OVC caregiving households owned farmland, but the majority felt that the land was insufficient to meet even basic needs. A total of 6.2% of OVC caregiving households had been dispossessed of their land.

Despite high levels of poverty, 80% of OVC caregiving households earned at least some cash income. This mostly involved the sale of agricultural produce.

Access to key social services did not vary across OVC caregiving households compared to other households. Access to improved means of human waste disposal and drinking water was quite high for OVC caregiving households, as well as other households. Over half (53.5%) of all OVC aged 0-4 had birth certificates, but this was substantially lower than for children overall (78%). The majority of school-aged OVC were attending primary school, but 81% of orphans and 70% of vulnerable children were overage for the grade they were attending. Few of those who left school accessed non-formal education, vocational education, or apprenticeship training.

Over 90% of all OVC aged 12-23 months were fully immunised, and 95.9% received vitamin A supplementation, on a par with all children. One-quarter of all OVC aged 0-4 had diarrhoea in the two weeks prior to the survey, 42.3% had had an acute respiratory infection, and 13.4% had had a skin disease. In half of all OVC caregiving households, enumerators noted that there were ‘serious hygiene challenges’.

Just over 10% of all OVC caregiving households had had at least one member with malaria in the two weeks prior to the survey, with malaria especially common for underfives. Over half of all OVC caregiving households reported that at least one member slept under a mosquito net in the year before the survey, of which 82.3% were treated nets. Mosquito net use was consistent, with almost all households having nets reporting their use the night before the survey.

**Access to Support**

With the exception of support for health care and, to a lesser extent, education access and specific support for children affected by the genocide, few resources reach OVC and OVC caregiving households.

Just over one-in-five OVC caregiving households could name an agency that could provide support to OVC, aside from higher awareness of and access to health care services due to the mutuelle de santé health insurance scheme. The mutuelle scheme reached over half of all OVC who sought health care services. Over half of those who sought health care indicated that they would not have been able to do so without the mutuelle scheme.

One-quarter of all OVC reported support from Government, mostly from FARDC (the fund for genocide survivors) and mutuelle support. Only 5% reported support from an NGO, 2.1% support from a faith-based organisation, and 4% from local institutions and agencies, and a number of these reported being linked to mutuelle through these agencies. One-third of all OVC caregiving households were registered at the umutwaganda as households caring for OVC, with figures especially high for households caring for orphans.

Only 1.1% of all OVC caregiving households reported that at least one OVC received psychosocial support services in the year before the survey. This compares to a calculated 12% of OVC in severe need of psychosocial support. A total of 6.3% received social or material support, while 9.8% of orphans and 6.6% of other vulnerable children received support for schooling. While secondary school attendance is low, at under 10%, one-third of orphan children in secondary school are able to attend because of support offered from outside, with much of this going to genocide orphans. Education support tended to cover two or more types of support within the education sector. Support was more common for orphan caregiving households than for households with other vulnerable children. Only 9.1% of OVC caregiving households had received two or more types of external assistance (e.g., psychosocial support, education support, food aid, etc).

Perhaps of greatest concern, only 6.5% of all OVC caregiving households reported that they had received cash or in-kind assistance from external sources.
support from extended family members in the year before the survey. And, when asked whether they could rely on family members for support in the case of serious problems, only 12% reported that they could ‘always rely on these family members’. While most households had extended family members nearby, this was less common for orphaned caregiving households than for households looking after other vulnerable children. Overall, findings suggest that social capital networks are quite weak, and do not provide significant support to OVC caregiving households.

Child Discipline, Labour and Rights

Finding suggest that a number of OVC are subject to violence within the home, a few children are working and, of these, some are working in areas dangerous to their health. More commonly, OVC are providing so much labour towards meeting needs of the household that it interferes with education, play, and social development.

Based on the World Health Organization’s international definitions, almost half of all OVC in caregiving households were disciplined in a manner defined by the organisation as violence against children. This held for both orphans and other vulnerable children.

Qualitative discussions suggest that there is less community sanction against violence against children than in the past, largely due to the collapse of community systems of social capital due to the genocide. Among key informants, sexual abuse of vulnerable girls was a particular concern, although the number of girls so abused is unknown.

Of the 80% of households with at least one member who brought cash income into the households, 14.8% had at least one member aged 15-17 who was contributing towards the household’s cash income, as did 1.2% with 5-14 year olds. Of those 15-17 year olds in employment, 1.5% (almost one-in-ten) were working in an area that posed a danger to their health; this was not an issue for 5-14 year olds. The exception was sex work, which was reported in qualitative interviews as affecting a small number of children younger than fourteen.

Of those OVC aged 15-17, 40% of orphans and 30% of other vulnerable children were providing so much labour to household activities (including production and marketing) that it interfered with their ability to attend school, do their homework, and play with their friends.

Overall Conclusions and Implications

Conclusions are divided into ‘general conclusions and implications’ and ‘specific conclusions and implications’. The former refer to the broader environment that requires a response to OVC, while the latter refers to specific factors that affect the lives and well-being of OVC and OVC caregiving households.

Based on the results of the situation analysis, the following conclusions have been drawn:

General Conclusions and Implications

• Perhaps the most important finding from the OVC situation analysis is the sheer magnitude of the problem, both in terms of the number of OVC, and in terms of their living conditions. Despite considerable efforts, the magnitude of the problem is not matched by the response, and much remains to be done. This underlines the need to focus support on households most in need, suggesting prioritisation of households for external support. Based on consideration of the situation of OVC as a group, and considering the various aspects of vulnerability found from the study, it is estimated that:
  • 60-70% are in need of food support in times of particular stress, and affects households looking after vulnerable children in particular. Number: 1.7-1.8 million OVC;
  • 60-70% are in need of support to improve shelter. Findings from the fieldwork suggest that housing conditions increase levels of morbidity. Number: 600,000-700,000 OVC caregiving households, covering 1.7-1.8 million OVC;
  • 40-50% are in need of continued or new education support for primary school attendance. Number: 1.1-1.4 million OVC;
  • 40-50% of caregivers could benefit from supportive programmes enabling them to deal with child discipline matters in a progressive fashion. Number: 1,1-1.4 million OVC.

The vast majority of OVC in need are living their lives in poor or very poor households, mostly in rural areas. The number of OVC in caregiving institutions, in prison, serving as soldiers, etc. are relatively small in number. While they still warrant attention, the fact remains that interventions that reach communities and households will reach the vast majority of OVC in need.

• Local systems of identifying vulnerable households appear to function well, but are less pro-active than can be the case. Instead, they are largely driven by external agencies and the services that these agencies can provide. A supply-driven response is considerably less effective than a demand-driven one, and reflects low levels of reach and the lack of a coherent response. Effective demand means giving OVC and OVC caregiving households a voice in decisions that affect them, and building systems of consultation and dialogue that allow this to function over time. With such an approach, many of the co-ordination problems across support agencies could be overcome. There are important initiatives underway at the local government level that offer important opportunities.
A recently-completed study to establish criteria for vulnerability has noted that support needs to be provided not just to households with OVC, but also to households who are in danger of slipping into vulnerability. However, how effective this distinction can be in terms of identifying households in need is questionable, giving the magnitude of the problem. Therefore, recommendations on how to proceed to identify most vulnerable households are noted below.

The national response, as well as the district response, is reported to be poorly co-ordinated and under-resourced. There is a particular need to move forward with the National Commission for Children, and ensuring that it is a strong institution with influential leadership.

Even with data made available through the situation analysis, as well as the conduct of the mapping study and the vulnerability criteria study, without a strengthened institutionalised response, it is difficult to see how this information can be put to proper use.

While the response to OVC is generally perceived to largely be a social protection issue, the level and depth of poverty affecting OVC caregiving households highlights the fact that responding to OVC requires equal attention to livelihoods enhancement. Households are, of course, not just social but also economic entities. Given that only 12% of the OVC caregiving households were considered to be destitute, the majority of these households have the potential to improve their economic circumstances, if they receive the needed support.

Perhaps of greatest concern, one of the most enduring effects of the genocide has been the severe weakening of social capital networks. While respondents felt that they lived in functioning communities, where people knew each other well, and while many lived proximate to extended family members and got together with them on a regular basis, very few felt that they could rely on their families or neighbours in times of need. Widespread poverty was part of the reason, but many argued that the systems that previously protected people in this regard had been destroyed by the genocide. It was usually when local authorities called for joint action that such co-operation occurred.

### Specific Conclusions and Implications

#### Framework Issues

- Even agencies involved in the national response to OVC did not have copies of the NSP, highlighting the need to not just disseminate the document, but engage with these actors in its implementation.
- The response to OVC needs to be well informed of progress in decentralisation, and in some respects may be able to take the lead. One example is co-operation between district authorities and NGOs at the sector and district levels.
- It is unclear how MIGEPROF can ensure that other stakeholders begin to play a more active role in implementation of the NSP. Of particular concern are local government, health and education.
- Qualitative findings in particular suggest that OVC themselves do not feel that they have been sufficiently involved in planning for the OVC response.
- The recently-adopted Economic Development and Poverty Reduction Strategy, and Vision 2020 include children’s issues and the particular situation of OVC, but neither document contains specific objectives in this regard that could attract resources. In the absence of such a link, MIGEPROF needs to employ the NSP as a tool for fund-raising and establishing partnerships.
- Many NGO programmes support OVC even beyond the age of 18, because they rightfully recognise that the problems these young people suffer do not just end at the age of 18. This is not, however, consistent with the NSP’s definition of OVC in need. Flexibility is warranted in this regard.
- MIGEPROF itself needs to be strengthened to handle the co-ordination of OVC issues. Round 7 Global Fund monies have been made available for this, and it is hoped that this will help to overcome the important gaps in the national response.
- While the Technical Working Group for OVC plays an important role in following through on plan and strategy development, and while it serves as a forum to discuss different ways of approaching OVC issues, there is considerably more potential for the body. Under the guidance of a National Commission for Children, the TWG could be significantly strengthened and its role formalised. A related opportunity presents itself with regard to the EDPRS Social Protection Cluster.
- Serious concerns remain about the institutionalisation of orphans, suggesting that institutionalisation “as a last resort” should remain Government policy.
- There remain important gaps in the NSP, particularly with regard to a demand driven approach, that suggest that additional financing is required. It may be possible to link with Ubudehe in this regard.

#### Services

- At this juncture, gaps at the legal, policy and strategy level are mostly in terms of strategies, focused around the operationalisation of good ideas in a decentralised framework, and in terms of effective reach through legal systems. While it may be tempting to expand the scope of legal interventions, it is uncertain how effective this will be in reaching children in need. Protecting children from violence, for example, is a far greater problem than can be dealt with by the legal prosecution of those who are guilty of severe abuses, and suggests a change in social norms and local solutions to the problem.
- There are particular challenges facing the strengthening of community-based organisations and community-level systems that would improve the response to OVC.
- The NSP for OVC has ambitious monitoring expectations, and ambiguous evaluation expectations.
- A number of challenges facing OVC caregiving households are problems of poverty, rather than problems facing OVC per se.

#### Findings and Conclusions

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- A number of challenges facing OVC caregiving households are problems of poverty, rather than problems facing OVC per se.
considerably more attention that other vulnerable households. In large part this is due to support offered to victims of genocide, and the perception remains that these households are in more need than other households.

- While psychosocial support services are needed, models that work with caregivers as well as the OVC themselves are likely to be most effective, because they deal with important tangible factors around parenting, but also intangible factors around children needing to be loved, and felt to be important.

- There are no clear standards for psychosocial support, and it is not certain how effective such support is, even for the few children reached. A few of the international NGOs (e.g., CARE and support through the Nkundabana Project) with a presence in Rwanda have, however, tested psychosocial service provision models which appear to be quite effective, and these models may be best to ‘roll out’ to other agencies.

- Findings from the situation analysis suggest that land grabbing may be a problem for a few households, but that it is difficult to establish its level and intensity.

- While violence against children is common, in many respects international definitions of violence are not seen as violence by caregivers. This mismatch between views of what is and what is not violence suggests that, even if there is increased awareness about violence, much of what occurs will continue to be perceived as acceptable standards of discipline. Perhaps more attention should be focused on those aspects of violence, such as sexual abuse, that are clearly outside of all social norms, but that occur with more frequency than would otherwise be the case because of the collapse of systems of social capital. However, there is still a need to strategically approach the reduction of violence against children, particularly given very low levels of social capital that could normally be expected to protect children.

- Having said this, there really is not any infrastructure designed to support children in danger that would meet demand, even if systems of demand creation were effective. It is also not clear how, in the absence of traditional authority systems that handle matters of justice in Rwanda, the resultant caseload could be efficiently dealt with.

- The final draft version of the National Policy on Gender-Based Violence and Violence against Children is currently awaiting MIGEPROF finalisation and submission to Cabinet. A corresponding Strategic Plan on Gender-Based Violence and Violence against children is at zero draft stage. The finalisation of the Strategic Plan will ideally be informed by a survey of gender-based violence, the importance of which is underlined by the high level of violence against OVC found in the situation analysis of OVC. A national policy on gender-based violence is needed, which includes violence against children, and focuses due attention on sexual violence. Ideally, such a policy should be informed by a study of gender based violence that gives information on the magnitude and distribution of the problem.

- While many services, including those listed in the minimum package, are focused largely on ‘tangible’ issues such as education support and evening access to counselling services, one of the greatest problems facing OVC caregiving households is weak social capital networks and the inability of these households to draw upon extended family and neighbourhood networks to an extent that would improve the lives of the caregivers and children. Rebuilding these networks is therefore of paramount importance, suggesting that it would be strategically important to link the NSP for OVC with Ubudehe and other programmes focused on re-establishing local systems of decision-making and fund-raising.

HIV/AIDS

- While the level of stigma associated with HIV/AIDS is relatively low, it is there, and it does mean that HIV positive children, and OVC living in households where someone is chronically ill, receive even less social support than other households.

- The level of resources allocated to HIV/AIDS for prevention, care, treatment and support is far in excess of funds made available for impact mitigation, including OVC. Nevertheless, the focus on HIV/AIDS has helped raise the profile of OVC issues as well. If this attention could be translated into increased financial, human resource and administrative support, and concerted attention is devoted to effective demand creation, significant progress can be made. (Rwanda’s Round 7 Global Fund application was successful, and includes a component specifically for OVC. This is one example of using the HIV/AIDS ‘profile’ to raise funds for OVC. Another is the Community HIV/AIDS Mobilization Program, supported by the US Government.)

Recommendations

The previous sub-section noted a series of conclusions, and implications arising from those conclusions that should be considered. In this sub-section, broad-based recommendations are provided emphasising more strategic issues.

Systems to Identify OVC Most in Need

- While Rwanda has been successful in accessing a variety of resources to support OVC as well as other vulnerable populations, the fact remains that the extent of the problem is such that prioritisation of those most in need is required for some resources. It is recommended that three key mechanisms that would best identify children most in need be considered:

  1. Reaching OVC through the provision of broad-based services.
  2. Reaching OVC through a more effective local identification and response procedure.
  3. Reaching OVC through the identification of what the most vulnerable assessment refers to as ‘clinically’ vulnerable children by various agencies and individuals that would interact with the children.

- Reaching Children through Local Systems of Identification: While broad-based identification may be the best mechanism for key services around health, education, and the shortage of food, there is still a need to link OVC with these services, as is the case for many other services. This is best done at the local level, so that those most in need can be prioritised, supported by various agencies offering services, and agencies skilled in community dialogue (Governmental and non-governmental). Such a ‘demand-led’ approach responds most effectively to resource limitations. This approach is fully consistent with how the vast majority of development agencies already operate, but it needs better co-ordination and more focus on community-led diagnosis of needs, and community-led identification of households most in need.

- Identifying Clinically Vulnerable Children: Demand-led local procedures to identify children most in need, if done correctly, with prioritise most children in need. However, it will only reach some of the children who are vulnerable due to factors that are rarely ‘public knowledge’. It is here that the vulnerability criteria established recently to MIGEPROF is of particular use, as it provides criteria of vulnerability that key local level actors, specialist agencies, and others can use to identify children in particular need. This includes health workers (e.g., HIV, children, severely malnourished children, sexually abused children), NGOs and CBOs working with especially vulnerable children (e.g., street children, abused children, sexually exploited children, child soldiers needing reintegration), children in prison charged with, or guilty of, crimes, children working in dangerous work arenas, children consuming alcohol or drugs, pregnant teenage girls, etc.), NGOs and CBOs providing broader services (e.g., children in need of education support, children who need to be linked to health services, children and caregivers in need of psychosocial support, etc.).

  - Given the strengthening of local systems of ‘demand-led’ identification of OVC most in need, attention should be focused on enhancing these systems and linking the identification of those in need with the services required.

  - Government has shown a commitment to the direct involvement of children in decisions that affect their lives. The Children’s Forum is one of the most important examples, but consultation processes put into place (for example, for the EDPRS) reflect broader commitment. These fora nevertheless remain weak, with particular challenges facing the involvement of children at the local level. In this respect, there is considerable opportunity for a demand-led approach to effectively strengthen these structures.
Ability to Respond

- It nevertheless remains the case that the ‘infrastructure’ around the response varies considerably across Rwanda. The mapping exercise has mapped service delivery, and the tables annex of this situation analysis report has mapped levels of need by the districts in the survey. Ideally, the district level mapping process should continue under the guidance of RALGA, but this needs to be specifically informed by information on the situation of OVC. For example, RALGA has noted the number of OVC in need of support by district. However, in checking the numbers across the four districts also included in the situation analysis, it was estimated that only 1 in 53 OVC were identified in Nyarugenge District, 1 in 39 in Kigali, and 1 in 10 in Musanze. These gaps highlight the need to ensure that estimates of need established through consultations with local authorities and others be complemented by survey data. The information contained in this report, including detailed district-level information as contained in Annex A, should be used by the districts to consider the population in need of various services.

- However, as only eight districts are covered to date (as well as the three Kigali Province districts grouped together), there is a need to collect data on the remaining 19 districts. It is recommended that the situation analysis be extended to collect quantitative data on the situation of OVC in the remaining 19 districts. It is also recommended that MGE PROF and MINELOC plan together on avenues for RALGA utilisation of the information on the situation of OVC contained in the situation analysis. This information could be included as part of district development planning documents.

Coping and Populations Most in Need

- Not all OVC are in the same situation in terms of material and emotional threats to their well-being. Material problems affect the vast majority of OVC, and three approaches to meeting these materials needs have been noted above. In this respect, households and children least able to cope with their material circumstances can be effectively targeted. For emotional stress, this if more difficult to identify. Key aspects of emotional stress are associated with older children who have had to care for a dying relative, children who are moved from a familiar environment to an unfamiliar one, separated siblings, children who are exploited sexually or in terms of other forms of dangerous labour, and children who are living outside a family environment. But, while these issues can be considered in discussions with local communities, the pre-identification of children and households most in need from outside agencies would undermine local decision processes. If communities are going to be able to identify with decision processes around most-affected OVC and OVC caregiving households, they must have a large measure of control over the process, and involvement in its implementation. It is recommended that community consultations include a coping diagnosis, using a variety of participatory tools. The consultations would need to include issues around social protection (e.g., education, health, counselling, testing, protection from property grabbing, etc.) as well as issues around livelihoods enhancement (e.g., training, micro-finance support, group formation, etc.).

- The situation analysis found that high levels of poverty hampered the effectiveness of positive coping strategies, and in some cases led to the use of negative coping strategies. An example in this respect is the need for children to provide so much labour to meeting households needs that it affected the ability of the children to perform effectively in school. In some cases, it also resulted in a minority of children having to engage in dangerous child labour activities. In many respects the solution to this problem revolves around effective service reach including both livelihoods enhancement and social protection mechanisms. Recommendations in this regard are noted elsewhere in this section of the Executive Summary. Nevertheless, there are specific coping issues that need direct consideration:
  - The design of vertical interventions delivered by agencies with particular expertise have their role to play in improving the lives of OVC and OVC caregiving households, but currently these households have little ability to influence the agenda in terms of who would receive these services and how. This also holds for many of the CBS initiatives requesting financing from various funding agencies, and service delivery initiatives centrally defined. The more that approaches can be demand-driven, the more effective they will be in reaching those most in need. Such an approach is entirely consistent with a variety of Government policies and programmes, with the Ubdhehe initiative an example of one initiative that can improve demand-driven development approaches for OVC.
  - Interventions that include caregivers as well as the OVC themselves appear to offer the best examples of effective reach. With community level targeting mechanisms and effective consultations, rather than simply transferring resources, these approaches can be broadened.
  - Further, at district level, district co-ordination agencies dealing with OVC issues provide an excellent forum for out scaling of these initiatives.
  - It is further recommended that these discussions include consideration of problems associated with social capital and social networks, and how these can be strengthened. Given that this is a widespread problem, and given that this is a key factor undermining livelihoods, it should receive considered attention.

- The situation analysis highlighted the particular challenges facing non-orphan vulnerable children, including non-orphans in orphan caregiving household. Evidence collected during the situation analysis suggests that a disproportionate amount of attention has been focused on orphans instead of considering OVC more broadly. It is recommended that programmes that specifically focus on orphans reconsider their mandates to establish whether a broader focus on OVC would make sense for the types of services they deliver, and the types of activities they are involved in.
parents have prepared wills. This has knock-on impacts on access to services, as well as the ability to formalise fostering and adoption arrangements, and threats to livelihoods (e.g., land grabbing). It is recommended that MIGEPROF, MINSAUE, and MINELCO consider how to increase the proportion of births registered. Some of this could occur through locating ‘clinically vulnerable’ children at points of contact (e.g., health facilities), and could also occur through community-based consultations. It is also be linked with succession planning.

- While the survey suggests that levels of child labour are relatively low for 5-14 year olds, it nevertheless remains a problem for the affected children. It is recommended that the ILD proceed with prioritising support to eliminate the worst forms of child labour in Rwanda.

- Only anecdotal data on returning refugees was made available during the conduct of the situation analysis. It is therefore not certain how vulnerable these children are. It is recommended that emergency and social protection service needs of these children be established by Government, with the United Nations High Commission for Refugees and the World Food Programme in Rwanda. Ressetted children would thereafter need to be registered as children in need at the cell and umudugudu levels.

- There is no question that there are children in need of legal protection. Property-grabbing, while not common, is developing into a problem for those who lack access to such an important productive resource, and there is little more devastating to the life of a child than child sex work. There are a range of other legal challenges as well. It is recommended that collective approaches be linked with succession planning.

- There is compelling evidence from northern Uganda (see Annan, J., C. Blattman, K. Carlson and D. Mazuranam, 2008) that highlights the targeting children in need of reintegration back into their communities (e.g., returning refugees, former prisoners, former street children, child soldiers, etc.), rather than targeting child soldiers specifically. Given that Rwanda already has similar experiences to Uganda, it is assumed that child soldiers will be integrated back into their communities.

- Data from the situation analysis suggests that the overall number of children in need does not vary across boys and girls. However, the impact of vulnerability and different aspects of vulnerability, affect boys and girls differently. Community consultative processes must include careful consideration of gender issues in terms of OVC. This also include gender issues associated with caregivers and household heads.

### Policy Framework

- There is a strong policy framework for responding to the needs of OVC. From the EDPRS and the decentralisation policy to Vision 2020, from the OVC Policy to the National Strategic Plan for OVC, and from special policies designed to improve the situation of OVC (e.g., the National Education Policy on OVC), the framework is largely in place. The operationalisation of strategies has now emerged as an important priority, constrained by implementation capacity issues that do not yet match this broader political commitment. Nevertheless, there remains a degree of ambivalence within the broader policy framework about whether OVC issues should be focused on social protection of livelihoods enhancement. When considered in the context of strong local knowledge of the situation of OVC, demonstrated in a number of key informant interviews, the following recommendations apply:

  - It is recommended that MIGEPROF ensure that there is a proper balance between social protection and livelihoods enhancement when it proceeds with operationalisation of the National Strategic Plan for OVC. Without specific attention to livelihoods enhancement, it is likely that the approach to OVC will largely be a social protection matter. While important, it is only half the story. Therefore, while OVC are considered through the Social Protection Cluster, the EDPRS, they should also be considered through the livelihoods enhancement cluster of the EDPRS.

  - It is further recommended that livelihoods enhancement support not be treated as a social protection matter. When these two issues are muddled, as they sometimes are in responding to, for example, the livelihoods improvement needs of HIV+ persons, the fundamental business principals that need to underpin decision-making are undermined. This does not mean that you cannot target livelihoods enhancement support to the very poor, indeed the very poor have been shown, time and again, to be best able to use these schemes to improve livelihoods.

### Monitoring, Evaluation and Research

- The NSP has included a number of ambitious monitoring requirements, and it remains questionable how well agencies involved in the OVC arena will be able to collect or provide these data in a manner useful for monitoring the impact of NSP actions. While the strengthening of MIGEPROF is important, opportunities arise that may allow for more effective monitoring, but only if a Monitoring and Evaluation Framework for OVC is fully elaborated, and thereafter linked with the NSP and an annual planning process. It is recommended that such a framework be fully developed in this respect, and thereafter resourced. Ideally, it would be based on district-level monitoring processes that would collect data from umudugudu, cell and sector levels, themselves based on quantitative data collection but also qualitative ‘evaluative’ data from those involved in the OVC arena and OVC caregiving households and OVC themselves.

- For the often-neglected evaluation aspects of the Framework, it is usually more cost effective to launch a meta evaluation covering multiple aspects of OVC than it is to conduct detailed evaluations of each bundle of support. Meta evaluations organised around particular themes in the NSP, would serve an important purpose in terms of assessing system effectiveness and dysfunctions, levels of delivery, impacts, and gaps. It is recommended that, as part of NSP planning, MIGEPROF detail the timeline and resources for meta evaluations.

- For areas of particular research interest, the NSP should offer broad guidance on how such research can inform the NSP more broadly, and not just the issue under consideration.

- More generally, there is a need to roll-out the quantitative data collection under the situation analysis to the remaining 19 districts, and to increase the number of interviews conducted for the three Kigali Province locations.
1.1 Background

Rwanda is a small, densely populated country of 26,338 square kilometres located in central east Africa, bordered by the Democratic Republic of the Congo on the west, Burundi on the south, Tanzania on the east, and Uganda on the north. It became independent in 1962 after colonisation in 1884 by Germany and, following the end of World War I, by Belgium as a League of Nations Mandated Trust Territory and, from 1946, under Belgium as a UN Trust Territory.

The 2002 census yielded a population of 8.2 million people (National Institute of Statistics, 2000), and a population growth rate currently estimated at 2.75%. As of 2007, there are an estimated 9.3 people in Rwanda. The proportion of women to men, at 91.3 males per 100 females, reflects the results of the 1994 genocide and higher death rates for males at birth and low life expectancy (National Institute of Statistics, 2003). With a population density of 322 people per square kilometre, Rwanda is the most densely populated country in Africa. Arable land is under considerable pressure, and in many areas even marginal land has been put under cultivation. For animals, zero grazing is practiced in all areas except the east, with a lower population density.

One-third of Gross Domestic Product comes from agriculture, and over 80% of all households are principally dependent on agriculture for their livelihoods. Services, including Government services, comprise some 40% of GDP, with the remainder covered by a narrow range of industries (UNDP, 2007).

Despite the significant gains made in the past decade, Rwanda remains one of the world’s poorest countries, ranked 103rd out of 172 countries in terms of human development. Over half of the population lives below the poverty line, life expectancy is low, and infant and under-five mortality rates are high. Poverty in highest in the densely-populated Southern Province (47.2% of the population lives in extreme poverty, compared to a rural average of 40.9%), and is lowest in the city of Kigali (11.1%) (National Institute of Statistics, 2006). The 2005 DHS found higher rates of under-five mortality for rural households (192/1000 live births for rural households, and 122/1000 for urban), households where the household head had lower levels of education (210/1000 for those with no education, 179/1000 for those with only primary education, and a much lower 95/1000 for those with secondary or higher education). Under-five mortality rates were highest for those in the lowest income quintile (213/1000, compared to the highest income quintile (122/1000). The difficult situation facing many of Rwanda’s households is highlighted by rates of malnutrition, where 2005 data showed that 45.8% of all underfives were malnourished, and an additional 19.3% were severely malnourished (Government of Rwanda, 2005a).

1.2 Development Context

Rwanda’s response to development challenges is guided by Vision 2020, as well as the recently adopted Economic Development and Poverty Reduction Strategy (EDPRS). Key objectives of Vision 2020 were as follows (Government of Rwanda, 2000a; 2; see also MINCOF, 2002):

- **Good political and economic governance:** “Good governance is essential to successful development. Security is an absolute prerequisite, as Rwanda’s experience has clearly shown. Respect for human rights and increased popular participation in Government, through the bottom-up approach to democratisation, are critical. Equally important is the establishment of sound economic management and macroeconomic stability.”
- **Rural economic transformation:** “In order to raise agricultural incomes and generate opportunities to earn incomes outside agriculture, the rural economy needs to be recapitalised and transformed. This can be achieved by building on the traditional strengths of the rural Rwandese economy and by introducing new technologies.
- **Development of services and manufacturing:** “As incomes rise, we need to develop other engines of growth and to transform our economy. We therefore need to increase competitiveness in services and industry. Key sectors identified are the re-establishment of Rwanda as a regional trade and service centre, by strengthening our use of information and communication technology (ICT) and by encouraging the development of tourism. In the manufacturing sector there are...”
opportunities to expand the production of mass consumer goods, in particular of garments."

"...Rwanda has limited land, natural and mineral resources on which to base its development strategy. Rwanda must invest in its people and build the country’s human capital to be able to decrease poverty in the long run. Investing in education will help build the basis of a knowledge economy, but will also strengthen the social capital and help create the conditions for long-term peace and democracy". UNDP, 2007.

- Human resource development: “Rwanda currently imports human resources within the region and has scarce human capacity. An increase in educational attainment is needed at all levels. Better health care is needed to reverse the decline in health indicators and to confront the major killer diseases, HIV/AIDS and malaria.”
- Development and promotion of the private sector: “Private sector development calls for further liberalisation, privatisation and enhanced public private partnerships. In order to lower risks of doing business in Rwanda, and to encourage the formalisation of existing informal enterprises, the whole legal framework for business needs to be reviewed.”
- Regional and international economic integration: “Rwanda has joined the Common Market for Eastern and Southern Africa (COMESA) with a three year phasing in period of the free trade area. We are committed to joining the East African Community [Rwanda joined in 2007] and to exploiting the opportunities offered by international trade agreements, including the World Trade Organisation and the recent Africa Growth and Opportunities Act (AGOA) in the USA.”
- Poverty reduction: “The reduction of poverty is not a separate objective, but the effect of the achievement of out other objectives. A concern with the reduction of inequality needs to be a focus for all public actions. This includes reducing inequalities arising from gender and age.”

1.2.1 Economic Development and Poverty Reduction Strategy

According to the most recent Integrated Living Conditions Survey 2005/2006 (known by its French acronym EICV) (National Institute of Statistics, 2006), 56.9% of Rwanda’s population lives in poverty. Poverty is substantially higher in rural areas (62.5%) than in Kigali city (31.3%) or other urban areas (41.5%), and is high across all rural areas, but most severe in the densely populated south. The depth of poverty is also most severe in rural provinces, and is higher for female-headed than male-headed households (62.2% versus 54.3%, respectively) while the depth of poverty is also more severe for female-headed than male-headed households (27.1% versus 21.3%, respectively), were in ‘severe poverty’ nationwide; see (UNDP, 2007). Nevertheless, while still extremely high, poverty levels reflect an improvement since the first EICV was conducted in 2000/2001, when 60.4% were living in poverty, and the depth of poverty more severe.

The 2007 National Human Development Report (UNDP, 2007) on “Turning Vision 2020 into Reality” highlighted the continued challenges to human development in Rwanda. Indeed, the decline in human development prior to and after the genocide resulted in Human Development Index (HDI) rating in 1995 well below 1975 figures (1995 = 0.337, 1975 = 0.342). From the late 1990s, HDI progress has risen again, to 0.426 in 2000 and 0.450 in 2004. The report notes that, in part, this comes from significant improvements in health and education from the late 1990s. But, the report cautions (UNDP, 2007: 1), “… it will take some time before these efforts translate into substantial improvements in the Human Development Index…” . Even the 2004 figure reflecting a low 158th out of 177 countries.

Map 7: Percentage of the Population Living in Poverty


Government recently adopted the Economic Development and Poverty Reduction Strategy (EDPRS; MINICOFIN, 2007). The EDPRS represents a comprehensive strategy to tackle poverty, and was the result of an extensive consultative process and the involvement of a variety of stakeholders. Priority areas, linked to Vision 2020, were as follows:

1. Poverty and vulnerability reduction.
2. Institutional capacity building and social capital formation.
3. Sustainable management of the natural environment.
4. Good governance and enhanced efficiency and accountability of the public sector.
5. Enhanced performance of the private/service sector focusing on information communications technology.
6. Economic infrastructure development, specifically transport, energy, water and information communications technology.
7. Rural development and agricultural transformation.

Of these, points 1 and 2 are especially relevant to the OVC response, as will be seen in following chapters. Under point 1, social protection was included, with the national priority being “sustainable progress to ensure that social protection is accessible to all, with an emphasis on the existing poor and vulnerable”, linked to a Social Protection Policy adopted in 2003. Further, the EDPRS specifically notes the need to address children’s issues in a coherent manner, and in a manner that reinforces the social inclusion of OVC in society, and specifically focuses on improving access to education. In this respect, it is relevant that the EDPRS classified social protection under the Theme 3 working group on Human development during EDPRS development, reflecting the view that social protection was intended to yield a productive adult population. However, it should be highlighted that the EDPRS design process did not specifically include consideration of children’s issues as a cross-cutting theme, but was rather bundled under other cross-cutting themes. The EDPRS process was nevertheless informed by recommendations made at the third annual children’s summit which took place during the EDPRS development process.

1.2.2 Decentralisation

Central to Government’s strategy for national development has been the decentralisation of responsibility and authority. Government adopted a Decentralisation Policy in 2000 and thereafter an Implementation Strategy for National Decentralisation Policy (MINALOC, 2001b), and has shown considerable commitment to effecting the administrative and financial decentralisation. The Policy has three main goals: 1) promoting democratic governance at local level; 2) strengthening pro-poor service delivery; and 3) creating a basis for sustainable participatory community development. These three goals are reinforced in the 2001 Community Development Policy (MINALOC, 2001a). A Common Development Fund was established, in an effort to turn fiscal control over priorities to local government. Resource allocation to the fund has doubled each year, and it is intended that 10% of all development spending be sourced via the fund. Serious problems remain, most notably limited human resources and poor planning skills and, as a consequence, difficulties in moving funds and implementing programmes.
Having said this, a concerted effort has been made over the past fourteen years to improve the lives of all of Rwanda's people, including the OVC care and caregiving households. In the mid-1990s, a number of programmes were put into place to support OVC and caregiving households affected by the genocide, as well as other affected households, notable among them the Fond d’Assistance aux Rescues du Genocide (FARG). Following this, Government began a process of systematically addressing the policy and strategy gaps in the national OVC response. Emerging coherent policy and programmatic responses to development challenges -- from land reform to economic growth, from social protection to information technology, from agricultural development to small enterprise support development -- from land reform to economic growth, from social protection to information technology, from agricultural development to small enterprise support development strategies in decentralisation, education, health, justice, poverty reduction and reconciliation.

1.4 The Rwandan Response

To better respond to the needs of OVC and OVC caregiving households, Government passed the National Policy on OVC in 2003 (Government of Rwanda, 2003d). In the years following, it designed and thereafter adopted, in 2007, the National Strategic Plan of Action for Orphans and Other Vulnerable Children (NSP). Government has also prepared a national policy on gender-based violence, including violence against children, mapped current OVC interventions, prepared criteria to identify vulnerable children, and prepared a national guide on a package of minimum services for OVC and OVC caregiving households. The review of the situation of OVC in the NSP highlights the fact that Rwanda has made enormous progress in responding to the needs of its children, particularly those who were affected by the genocide. Indeed, many of the children orphaned due to the genocide have received support for years, as have some children orphaned since then, and progress has been made on a number of fronts in protecting caregiving households through expanded social service provision and economic development efforts.

The 2003 Policy on OVC (Government of Rwanda, 2003d) detailed the different ways in which children's rights to protection, development, participation and survival were supported by laws and policies and international instruments. The Constitution stipulates that parents have the right, and the obligation, to care for their children, and noted that the family was the natural basis of life in Rwanda. Rwanda is a signatory to the United Nations Convention on the Rights of the Child, as well as two optional protocols to the Convention (Involvement of Children in Armed Conflict, Child Trafficking, Child Prostitution and Child Pornography). The four principles guiding the protection and development of the child are specified in the CRC, and comprise the principles of the best interest of the child, non-discrimination, survival and development, and participation of the child in the actions and decisions that concern her/him. In Rwanda, these four principles have been supplemented by the following specific principles which further guide policy and programme development for OVC (Government of Rwanda, 2003d):

- Programmes and services take into account the cultural practices of Rwanda, as well as the overall development strategies in decentralisation, education, health, justice, poverty reduction and reconciliation.
- A legal framework will guide all actions associated with responding to the needs of OVC.
- Co-ordination and monitoring systems maximise the support for OVC and help to ensure their well-being.
- Programmes and services follow standard practices and clearly defined standards of quality.
- Research and consultation of the concerned target groups forms the basis for all programmes in favour of OVC.
- Gender aspects must be included in all programmes.
- Staff with the appropriate capacities ensure the well-being of OVC.
- A focus on community-based approaches, including children in consultation and decision-making.
- The care and protection of vulnerable children should remain within the family and community, while institutional solutions should be the exception.
- The integration of OVC issues into the national budget and poverty reduction strategies.

Rwanda is also a party to the following international accords that have an impact on children:

- The UNESCO World Declaration on Education for All.
- The UN Convention on the Elimination of All Forms of Racial Discrimination.
- The International Labour Convention Convention 182 on the Worst Forms of Child Labour.
- UN Resolution 48/96 on Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.

Having said this, there are a few key gaps in the legal response, notably the following:

- There is no Children's Act, nor a bill that has been prepared to be considered for passage as an act.
- The legal definition of a child varies across laws, from 18 to 21, and in some cases, 16.
- Law 27 of 2001 was found to have a number of gaps associated with children's rights and protection from violence, and as a result is expected to be revised in the near future.
- The legal status of fostered children is not clear.

Perhaps of equal importance is the inability to apply the laws, due to the overwhelming of the judicial system, and the lack of mechanisms at community level to resolve problems. Indeed, in many African countries, traditional authorities often play a central role in dealing with these matters but, in Rwanda because of recent history, this cadre's involvement in legal matters is lacking. Further, awareness of rights is quite low, and awareness of what one would do to secure their rights equally lacking, especially for poorer and more remote households.

The Vision of the National Policy for OVC (Government of Rwanda, 2003d: 13) is that "Orphans and other vulnerable children will be assisted to reach their full potential and have the same opportunities as all other children to active and valued participation in home and community life". The Mission of the Government of Rwanda in this respect is as follows: "The Government is committed to implement laws, policies and programmes to ensure that children in different circumstances are integrated in a socially, economically sustainably community". Policy objectives (Government of Rwanda, 2003d: 20) comprised the following:

1. Ensure that children enjoy their rights by protecting them from all forms of abuse and exploitation.
2. Ensure access to health services necessary for survival and development.
3. Ensure the access to free primary education as well as to continued education beyond basic primary education to include secondary and technical vocational training.
4. Ensure the provision of psychosocial support to children in difficult circumstances.
5. Identify and strengthen the capacity of families, communities and social service providers to care for and protect vulnerable children.
6. Reinforce the socio-economic situation of orphans, vulnerable children and their families through support to income generating activities, access to credit, and improved living conditions.
7. Enhance the co-ordination of all programmes and interventions concerning orphans and other vulnerable children to ensure systematic monitoring and evaluation.

Following approval of the OVC policy, Government, in collaboration with its development partners, prepared a National Strategic Plan for OVC. Developed during 2005-2006 and adopted in late 2007, the NSP restates the vision, mission, and objectives of Government defined in the Policy on OVC. The vision of the OVC response, as elaborated by Government and noted in the NSP, is that “OVC will be assisted to reach their full potential and have the same opportunities as all other children to active and valued participation in home and community life."

In a case study of a child-headed household in Musanze District, a seventeen year old girl lived alone. She has no siblings, and has lived alone since her parents died. Her father died when she was young, and her mother died of AIDS in 2003. In the early days following the death of her mother, she lived with her father's brother (she did not know any of her mother's relatives), but this was only for a small period of time.

She feels herself lucky to be living somewhere where the neighbours are very kind to her, with some providing moral support, and others sometimes helping with food and other material support. She has not received any outside support. She is a member of an informal group of women who get together to farm each other's lands on a rotational basis and, at certain times of the year, selling labour to other farmers. She noted that she was fortunate to have learned farming from her mother before she passed away.

She left school in primary grade 5 because her months could not afford to send her any more. She has no hope of returning to school. She inherited her parent's house, which is well constructed.

Despite having lived along for some time, she still feels lonely. When life is especially stressful, she feels that she does not have anyone she can turn to...
The main objective of the Strategic Plan was to “protect the rights of the child and to ensure the physical and psychosocial long term development of orphans and other vulnerable children”. The main objective reflected the multiple focus on OVC as rights holders, and therefore as decision-makers worthy of influence and respect, as vulnerable children in need of assistance, and as children who need to grow up to be productive adults able to contribute to society, and who will have the skills relevant for Rwanda’s vision as a central for information communications technology. In its elaboration, the Strategic Plan also highlights the mix of external transfers and support and, the strengthening of local systems, that will yield better opportunities for OVC.

Six strategic objectives were agreed:

7. To create a supportive environment for OVC through increased awareness on all matters concerning OVC addressing children, parents, caretakers, service providers, decision makers and the general population.

8. To ensure a protective environment for OVC through enhanced policy, legislation, procedures and regulations.

9. To provide protection, care and support to OVC by establishing and strengthening family and community based support structures.

10. To ensure access to essential services for OVC, including shelter, education, health and nutrition, social protection, water and sanitation and birth registration.

11. To build and strengthen the capacity of government, civil society and service providers to respond to the situation of OVC.

12. To establish co-ordination, implementation and monitoring and evaluation mechanisms.

The NSP defined vulnerable children quite broadly, and included the following:

- Children living in households headed by children.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who live or work on the street, including children involved in sex work.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, HIV positive.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children who have one or more parents/caregivers HIV+ positive.
- Children who are married before they legally become adults.
- Children from families who have been brought back together after the trauma of separation.
- Children living in households headed by children.
- Children who have one or more parents/caregivers HIV+ positive.
- Children who are married before they legally become adults.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who live or work on the street, including children involved in sex work.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, HIV positive.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Children who have one or more parents/caregivers HIV+ positive.
- Children who are married before they legally become adults.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who live or work on the street, including children involved in sex work.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, HIV positive.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children who are married before they legally become adults.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who live or work on the street, including children involved in sex work.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, HIV positive.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children who are married before they legally become adults.
- Children in fostering care.
- Children living and/or working on the street.
- Children living in centres.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who live or work on the street, including children involved in sex work.
- Children in conflict with the law.
- Children with disabilities.
- Children affected by armed conflict.
- Children who are sexually exploited and/or abused.
- Children who work.
- Children affected by HIV/AIDS, HIV positive.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Malnourished children.
- Children who are married before they legally become adults.

In early 2008, a study commissioned by MIGEPRO to define vulnerability suggested that vulnerability be recast to consider households and children with the potential to become vulnerable, as well as those who already vulnerable. Unfortunately, this list was made available to the situation analysis team well after completion of all fieldwork. Categories were as follows:

**Category A: Children at high risk of vulnerability**

- Children from families with unsafe housing that cannot protect them from bad weather.
- Children from families without enough land and/or employment or other sources of reliable and sufficient income.
- Children from child-headed households.
- Children living in households with a single adult (widows and widowers, divorced/separated persons who are not remarried or are not living with another adult, single parents/caregivers, and the elderly), as well as families that have been brought back together after the trauma of separation.
- Children whose parents/caregivers fight.
- Children whose parents/caregivers fail to fulfill their duties towards their children because of other factors (e.g., alcohol abuse, lack of desire to care for the child, etc.).
- Children with one or more parents/caregivers who suffer from chronic or intermittent poor health, including those who are physically or mentally disabled.
- Children who have one or more parents/caregivers HIV+ positive.

**Category B: Clinically vulnerable children**

- Malnourished children.
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance).
- Children suffering from chronic or intermittent poor health.
- HIV+ positive children.
- Children who are emotionally traumatised.
- Children who are sexually or otherwise physically or emotionally abused.
- Children who live or work on the street, including children involved in sex work.
- Children who abuse alcohol or drugs.
- Girls who are teenage mothers.

In looking at the two, there is a certain amount of overlap, as well as some categories that only apply to one or the other. Where both documents agree on the definition, this is marked in blue italics, and is contained in the same row. Where the documents do not agree on a definition, this is left in black regular type. Findings are indicated in the following table:

<table>
<thead>
<tr>
<th>Definitions in the NSP</th>
<th>Definitions from the 2007/8 Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in households headed by children</td>
<td>Children living in households headed by children</td>
</tr>
<tr>
<td>Children in fostering care</td>
<td>Children living in households headed by children</td>
</tr>
<tr>
<td>Children living and/or working on the street</td>
<td>Extended as follows: Children who live or work on the street, including children involved in sex work</td>
</tr>
<tr>
<td>Children living in centres</td>
<td>Children living in centres</td>
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<tr>
<td>Children in conflict with the law</td>
<td>Children in conflict with the law</td>
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<tr>
<td>Children with disabilities</td>
<td>Children with disabilities</td>
</tr>
<tr>
<td>Children affected by armed conflict</td>
<td>Children affected by armed conflict</td>
</tr>
<tr>
<td>Children who are sexually exploited and/or abused</td>
<td>Children who are sexually exploited and/or abused</td>
</tr>
<tr>
<td>Children who live or work on the street, including children involved in sex work</td>
<td>Children who work</td>
</tr>
<tr>
<td>Children in conflict with the law</td>
<td>Children affected by HIV/AIDS, or HIV positive</td>
</tr>
<tr>
<td>Children with disabilities</td>
<td>Children who have one or more parents/caregivers HIV+ positive</td>
</tr>
<tr>
<td>Children affected by armed conflict</td>
<td>and HIV positive</td>
</tr>
<tr>
<td>Children living in centres</td>
<td>Infants with their mothers in prison</td>
</tr>
<tr>
<td>Children in very poor households</td>
<td>Children in very poor households</td>
</tr>
<tr>
<td>Refugees and displaced children</td>
<td>Children who are sexually or otherwise physically or emotionally abused</td>
</tr>
<tr>
<td>Children of single mothers</td>
<td>Extended as follows: Children living in households with a single adult (widows and widowers, divorced/separated persons who are not remarried or are not living with another adult, single parents/caregivers, and the elderly), as well as families that have been brought back together after the trauma of separation</td>
</tr>
<tr>
<td>Children who are married before they legally become adults</td>
<td>Children who are married before they legally become adults</td>
</tr>
<tr>
<td>Children from families with unsafe housing and that cannot protect them from bad weather</td>
<td>Children from families with unsafe housing and that cannot protect them from bad weather</td>
</tr>
<tr>
<td>Children from families without enough land and employment or a source of regular income</td>
<td>Children from families without enough land and employment or a source of regular income</td>
</tr>
<tr>
<td>Children whose parents/caregivers fight</td>
<td>Children whose parents/caregivers fail to fulfill their duties towards their children because of other factors (e.g., alcohol abuse, lack of desire to care for the child, etc.)</td>
</tr>
<tr>
<td>Children with one or more parents/caregivers who suffer from chronic or intermittent poor health, including those who are physically or mentally disabled</td>
<td>Children with one or more parents/caregivers who suffer from chronic or intermittent poor health, including those who are physically or mentally disabled</td>
</tr>
<tr>
<td>Malnourished children</td>
<td>Malnourished children</td>
</tr>
<tr>
<td>Children with problems related to education (not in school, poor attendance, drop-outs, poor performance)</td>
<td>Children with problems related to education (not in school, poor attendance, drop-outs, poor performance)</td>
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<tr>
<td>Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled</td>
<td>Children suffering from chronic or intermittent poor health, including those who are physically or mentally disabled</td>
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<tr>
<td>Children who are emotionally traumatised</td>
<td>Children who are emotionally traumatised</td>
</tr>
<tr>
<td>Children who abuse alcohol or drugs</td>
<td>Children who abuse alcohol or drugs</td>
</tr>
<tr>
<td>Girls who are teenage mothers</td>
<td>Girls who are teenage mothers</td>
</tr>
</tbody>
</table>

The lack of a match between the two listings is associated with two key factors:

- Elaboration and/or clarification of vulnerability, in effect making the definition more precise.
- The old definition focused more on conditions, while the latter focused more on factors that would enable vulnerability.

Nevertheless, as will be seen from the results of the situation analysis, the gaps between the two are actually less than might otherwise seem to be the case, because the situation analysis yielded information on almost every aspect noted as vulnerable in the new definition. In part this arose from an expanded interpretation of what the initial definitions implied, for example including households where there was fighting or where there was alcohol abuse, but it also arose from the fact that the questionnaire used for the situation analysis considered a number of vulnerability factors based on past experience, and based on the international literature.
Introduction and overview

of cultural values and traditional support, and review of existing policies and laws, the promotion (Government of Rwanda, 2003d: 2007):

implementation of the Policy through eight strategies the situation analysis endeavours to consider, as possible, to, meaning that some OVC, and some circumstances problems, can be dealt with in a programmatic manner. community/ neighbourhood level and, if viewed as priority of OVC is important, for programmatic purposes, it is strategic purposes knowing the number and distribution of OVC is important, for programmatic purposes, it is important to rely on local systems of identification of OVC, and this means of prevention.

Table 2: Updated OVC Definition

<table>
<thead>
<tr>
<th>Vulnerable Children</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Children who have lost one or both parents, including children whose parental status remains uncertain</td>
<td></td>
</tr>
<tr>
<td>Children living in households headed by children</td>
<td></td>
</tr>
<tr>
<td>Children who live or work on the street, including children involved in sex work</td>
<td></td>
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<tr>
<td>Children who are sexually or otherwise physically or emotionally abused</td>
<td></td>
</tr>
<tr>
<td>Children who have one or more parents/caregivers HIV positive and HIV positive children</td>
<td></td>
</tr>
<tr>
<td>Children living in households with a single adult (widows and widowers, divorced/sepia/insped persons who are not remarried or one living with another adult, single parents/caregivers, and the elderly), as well as families that have been brought back together after the trauma of separation</td>
<td></td>
</tr>
<tr>
<td>Children from families with unsafe housing and that cannot protect them from bad weather</td>
<td></td>
</tr>
<tr>
<td>Children from families without enough land or employment or a source of regular income</td>
<td></td>
</tr>
<tr>
<td>Children whose parents/caregivers fight</td>
<td></td>
</tr>
<tr>
<td>Children whose parents/caregivers fail to fulfill their duties towards their children because of other factors (e.g., alcohol abuse, lack of desire to care for the child, etc.)</td>
<td></td>
</tr>
<tr>
<td>Children with one or more parents/caregivers who suffer from chronic or intermittent poor health, including those who are physically or mentally disabled</td>
<td></td>
</tr>
<tr>
<td>Malnourished children</td>
<td></td>
</tr>
<tr>
<td>Children with problems related to education (not in school, poor attendance, drop-outs, poor performance)</td>
<td></td>
</tr>
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<td>Children suffering from chronic/intermittent poor health</td>
<td></td>
</tr>
<tr>
<td>Children who are emotionally traumatised</td>
<td></td>
</tr>
<tr>
<td>Children who abuse alcohol or drugs</td>
<td></td>
</tr>
<tr>
<td>Girls who are teenage mothers</td>
<td></td>
</tr>
</tbody>
</table>

It is also important to note that, while for planning and strategic purposes knowing the number and distribution of OVC is important, for programmatic purposes, it is important to rely on local systems of identification of OVC, with the criteria for vulnerability only serving as guidelines for local action and national response. Indeed, it must be recognised that a number of vulnerability criteria do not easily allow the pre-identification of children because they are illegal or undesirable (e.g., fighting, alcohol abuse, involvement in sex work), but much of this is known at community/ neighbourhood level and, if viewed as priority problems, can be dealt with in a programmatic manner. This is especially important because it is not realistic to expect that all aspects of vulnerability can be responded to, meaning that some OVC, and some circumstances need to be prioritised. With this in mind, the remainder of the situation analysis endeavours to consider, as possible, factors that are considered in the 2008 report as aspects of vulnerability.

The NSP goes on to provide a framework for the implementation of the Policy through eight strategies (Government of Rwanda, 2003d: 2007):

1. Raise awareness on all matters concerning orphans and other vulnerable children addressing children, parents, caretakers, service providers and the general population. This includes the promotion of the rights of the child as well as the review of existing policies and laws, the promotion of cultural values and traditional support, and dialogue with caregivers on their responsibilities.
2. Conduct information campaigns on HIV/AIDS and reproductive health. Encourage utilisation of voluntary counselling and testing services in order to better understand levels of HIV infection in children, and to improve an understanding of means of prevention.
3. Undertake research on OVC to inform the development of appropriate programmes and interventions based on solid evidence, and the participation of rights-holders.
4. Develop legislation, procedures and regulations in order to assure consistent and coherent interventions, and programmes and services that emphasise children’s rights.
5. Establish community-based support structures for the protection of children, the prevention of separation of family members, and for the follow up of service provision. These structures will take into account Government’s commitment to decentralisation, and the roles of civil society organisations and community-based organisations.
6. Strengthen the capacity of staff and organisations involved in service provision to OVC and OVC caregiving households.
7. Establish co-ordination mechanisms for all aspects pertaining to OVC.
8. Facilitate access to basic services for OVC, such as education, health, nutrition, housing, extension services, income generation and credit provision. Promote the establishment of psychosocial counselling services.

Strategic and specific objectives are noted as follows:

1. Strategic Objective 1: To create a supportive environment for OVC through increased awareness on all matters concerning OVC addressing children, parents, caretakers, service providers, decision-makers and the general population.
   a. Specific Objective 1.1: Establish the scale and nature of the OVC situation and response in Rwanda by undertaking a national situation analysis, mapping the situation of OVC and the support provided to OVC and research on specific issues.
   b. Specific Objective 1.2: Scale up the response to OVC by identifying and building on existing good practice nationally and within the eastern and southern African region in the care, protection and support of OVC.
   c. Specific Objective 1.3: Mobilise the government and media to ensure awareness of the scale and nature of the OVC situation.
   d. Specific Objective 1.4: Mobilise and support OVC, families and communities to development community-based responses to the situation of OVC.

2. Strategic Objective 2: To provide a supportive and protective environment for OVC through enhanced policy, legislation, protocols and regulations.
   a. Specific Objective 2.1: Ensure all OVC issues are integrated in existing and new national policies, legislation, strategic plans, protocols and regulations.
   b. Enhance supportive and protective policy and legislative environment through the development, dissemination and utilisation of the OVC minimum package of care, protection and support for OVC.

3. Strategic Objective 3: To provide protection, care and support to OVC by establishing and strengthening family and community-based support structures.
   a. Specific Objective 3.1: Strengthen the economic, human and financial capacity to co-ordinate the OVC Policy and the nSP.
   b. Specific Objective 3.2: Ensure all OVC are protected from abuse, exploitation, property dispossession and stigma.
   c. Specific Objective 3.3: Strengthen the capacity of OVC, families and communities to provide psychosocial care and support for OVC including preventive and curative measures to increase compliance with this policy and the nSP.
   d. Specific Objective 3.4: Strengthen the capacity of OVC to provide care, protection and support for each other.
   e. Specific Objective 3.5: Ensure all OVC have access to early childhood development opportunities to enhance their survival, growth, well-being and development.

4. Strategic Objective 4: To ensure access to essential services for OVC including education, nutrition, social protection, water and sanitation and birth registration including development of linkages and referral across services.
   a. Specific Objective 4.1: Ensure access for OVC to protective and preventive social protection measures to ensure basic needs of the most vulnerable OVC and their households are met.
   b. Specific Objective 4.2: Improve enrolment and retention of OVC at primary and secondary school.
   c. Specific Objective 4.3: Ensure access to birth registration for all OVC.
   d. Specific Objective 4.4: Enhance access to basic health and nutrition services for OVC.
   e. Specific Objective 4.5: Ensure access to safe and gender sensitive water and sanitation and hygiene education for OVC at home and at school.
   f. Specific Objective 4.6: Ensure OVC outside of family care are placed in a family situation and fostered or adopted OVC and their families are provided with ongoing support.

5. Strategic Objective 5: To build and strengthen the capacity of government, civil society and service providers to respond effectively to the situation of OVC.
   a. Specific Objective 5.1: Strengthen the technical, financial and human resource capacity of national and decentralised government structures to respond effectively to the situation of OVC.
   b. Specific Objective 5.2: Strengthen the capacity of NGOs, FBOs and CBOs to respond effectively to the situation of OVC.
   c. Specific Objective 5.3: Strengthen the capacity of service providers such as health care providers, police, employers and teachers to provide care, protection and support to OVC.

6. Strategic Objective 6: To establish co-ordination, implementation and monitoring and evaluation mechanisms.
   a. Specific Objective 6.1: Establish national co-ordination mechanism and ensure technical, human and financial capacity to co-ordinate the OVC Policy and the nSP.
   b. Specific Objective 6.2: Establish and ensure the capacity of the Ministry of Environment and Sector co-ordination and implementation mechanisms to implement the OVC Policy and the nSP.
   c. Specific Objective 6.3: Establish mechanisms to ensure the participation of OVC.
   d. Specific Objective 6.4: Develop and implement data collection, monitoring and evaluation mechanisms at community, district and national levels.
Currently a key constraint in the national response to OVC is problems with MIGEPROF. The Ministry itself only has two officers at the national level, and relies on officers seconded by NGOs. In ten years, the Ministry has been restructured seven times, and only became MIGEPROF in 2006. Only 60 officers nationwide are employed to deal with ‘social matters’ that include OVC, all of whom fall under the Ministry of Local Government.

1.5 The Challenge Remaining
Despite the establishment of institutions, systems, policies and plans to tackle the problem of OVC, and despite the considerable reach of Government and NGO programmes to respond to the dramatic impacts of the genocide, many challenges remain. The majority of Rwanda’s children are OVC, and levels of poverty are extreme. Many orphans and other vulnerable children and their caregiving households remain in poverty, and just over 10% of OVC have received two or more components from a ‘minimum package’ of support they need. In a situation where social capital remains weak following the severe stresses resulting from the genocide, rebuilding this social capital and a sense of community, in order to be able to meet these needs through local initiatives, is problematic.

1.6 Rationale for a Situation Analysis of OVC

Despite considerable policy, strategy, and programmatic progress, a major gap in responding to the problem of OVC in Rwanda was a dearth of information for advocacy, planning, monitoring, and evaluation purposes.

2007 National Strategic Plan for OVC in Rwanda included, among six priorities, the conduct of a Situation Analysis of OVC.

One key aim of the NSP is to ensure that the OVC response in Rwanda is based on solid evidence. Such an evidence-based approach is central to building a more effective response, and is central to a more efficient response to OVC. Such an evidence-based approach is central to building a more effective response to OVC.

The Situation Analysis represents one key tool aimed at considering where Rwanda is today in responding to the needs and potential of orphans and other vulnerable children, where the gaps are, and to establish the strengths and weaknesses of various interventions. In the absence of considerable data, Government commissioned an extension situation analysis that included wide-ranging activities including the design and implementation of a...
quantitative questionnaire covering a variety of topics around OVC, the collection of household listing data to determine the proportion of orphans and other vulnerable children as compared to all children, focus group discussions, stakeholder consultations, key information interviews, an extended review of materials, and case studies of child-headed households.

After a tendering process, the contract was awarded to a Namibian firm, Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd. (SIAPAC), experienced in the conduct of numerous OVC-related assessments in Mozambique, Zambia, Swaziland, Tanzania, Lesotho, Botswana, Namibia and Angola, and previous experience in Rwanda. The award was issued in late August, 2007, with completion over an eight month timeframe.

The aim of the Situation Analysis of OVC in Rwanda is to “Support implementation of the National Strategic Plan for OVC by providing information of relevance to assessing status and progress on desired objectives”.

The goal of the Situation Analysis of OVC in Rwanda is to “inform the National Strategic Plan and support an enhanced OVC response in Rwanda by providing robust, statistically generalisable quantitative data, as well as important qualitative insights, through the conduct of an OVC assessment and preparation of a user-friendly situation analysis report”.

The broad objectives of the situation analysis are as follows:

- Assess and describe the status, experience and underlying causes of children orphaned and made vulnerable living in households (with or without adults, institutions and in/on the street in Rwanda).
- Identify the responses of families, communities and institutions coping with orphans (children left with only one parent or no parents) and vulnerable children (using defined vulnerability criteria); assess capacities, problems and the root causes of these problems (e.g. fostering practices).
- Assess existing models of care and identify successes, best practices, and areas for further development, focusing on what is already done in Rwanda.
- Describe the roles, programmes, coverage and approaches of government bodies, international organisations, NGOs, religious bodies, civil society organisations and grass roots groups currently involved with children orphaned or made vulnerable.
- Recommend to the Government, the OVC technical working group, and other partners appropriate strategies for addressing the needs of communities coping with orphaned children; identify priority interventions, geographical areas and needed effective laws and policies to address critical needs.

The specific objectives of the situation analysis are as follows:

- To provide information for key indicators listed in the National Plan of Action for Orphans and Other Vulnerable Children.
- Provide Rwanda with data of relevance to its reporting on MDG progress concerning orphans.
- Provide quantitative data from which to establish reach and the effectiveness of targeting.
- Review the National Plan of Action for Orphans and other Vulnerable Children, and package information from the Situation Analysis so that this information will be specifically useful to measuring progress in Plan activities.
- Working with TRAC and the CCD, update orphan projections associated with AIDS, and provide an estimate of the proportion of children orphaned due to AIDS and those orphaned due to other causes, projecting this into the future. This projection should carefully consider the quantitative impact of genocide orphans reaching the age of 18 on the model.
- Assess the living conditions of OVC caregiving households.
- Assess the particular situations facing orphans and other vulnerable children in households caring for orphans, and households caring for other vulnerable children.
- Determine the percentage and number of OVC who are living in child-headed households, as well as children living “rough”, and other children who may be in similar severe circumstances.
- Estimate the number of orphans living in caregiving institutions.
- Provide an overview of coping strategies adopted by households caring for OVC. Consider where coping strategies have failed, and how households, communities, and the authorities have tried to overcome these problems, and to what extent they have succeeded. Consider entry points in terms of local Government and GBO response opportunities.
- Disaggregate the OVC population to establish those most vulnerable and in need of urgent support, those in critical need of support but less vulnerable, and those in need of general social service support.
- Consider transition issues as children become orphans, and establish what mechanisms are employed by households, extended families, neighbours and others to ease this transition.
- Establish when transition coping mechanisms are unsuccessful, and what the implications of this are for orphans.
- Determine the percentage of OVC reached by services, the nature and character of this support, and perceived impacts.
- Establish the extent to which OVC caregiving households have been reached by support networks through their extended families, communities, informal and formal community-based organisations, non-governmental organisations, regional authorities, and other actors.
- Consider the perceived importance of this support by those being reached, and establish priority areas for review.
- Determine the relevant importance of each in the lives and well-being of OVC.
- Consider entry points to strengthen informal and formal systems of community-level support.
- Establish awareness of support opportunities among OVC caregiving households, and the extent to which these sources of support have been approached.
- Obtain district plans associated with OVC support and establish the extent to which the actions indicated therein covary with outreach to affected households in these districts.
- Assess ‘best practices’ currently being implemented in Rwanda in supporting OVC, and consider best practices from other countries.
- Consider how best practices can be scaled up to reach more OVC, with specific attention devoted to strengthening local responses.
- Measure other variables of relevance to the lives and well-being of OVC, including immunisation status, use of mosquito nets, and related variables.
- Assess the extent to which social ills/social pathologies affect households caring for OVC (e.g., abuse, neglect, etc.), and the impacts of these problems on OVC.
- Recommend to the Government of Rwanda, NGOs and development partners appropriate strategies that would address the needs of communities and households supporting OVC, identify priority interventions, geographical areas and effective policies to address critical needs. To the extent possible, suggest funding mechanisms best practiced to provide such support.
- Consider the results of the OVC situation analysis in terms of implications for the National Multi-sectoral Strategic Plan on HIV and AIDS, and the Economic Development and Poverty Reduction Strategy.

Key benefits of the situation analysis are intended as follows:

- Effective Planning - With the Situation Analysis of OVC, Rwanda is in a position to consider, in a well informed manner, how to improve the efficiency and scope of service delivery in the OVC arena.
- Advocacy - The Situation Analysis is particularly important in helping to strengthen Rwanda’s already strong national OVC response. The momentum exhibited since the establishment of multi-sectoral initiatives and CNIL. In this manner, the OVC investigation fits into a broader integrated framework of evidence-based, participatory consultations designed to effect policy development and reform and programme innovation.
- Comprehensive - The investigation included an assessment of the care and protection of orphans and other vulnerable children. Through a primary data collection activity focusing on OVC caregiving households, supported by qualitative insights into these households, the OVC themselves, and key stakeholders, Rwanda has prepared one of the most comprehensive OVC investigations, a central element to achieve the goal, aim and objectives and help Rwanda better meet the needs of OVC.
- Evidence-Based Planning - The Situation Analysis means that the situations facing OVC have an empirical basis. This should help to support access to finance for proposed activities, significantly strengthening plan implementation.
- Participation - One key aim of the investigation is to consider how to directly involve OVC and caregivers in desired interventions not just as beneficiaries but also as involved parties. The 2007 National Strategic Plan for OVC highlights how this has occurred to date, and this situation analysis report shows how the situation analysis process can strengthen such involvement.

1.7 Approach to the Situation Analysis

As per the TOR, the approach to data collection for the situation analysis comprised:

- Materials assembly and review.
- Formative research - qualitative and participatory data collection and consultation, in part to inform quantitative data collection.
- Quantitative data collection.
- Analysis, write-up and stakeholder consultation.

The collection of valid, statistically generalisable information on the situation of OVC and their caregiving households is central to an accurate understanding of the situation of OVC, and the lack of such data has hampered planning and implementation to date. For this reason, a quantitative data collection exercise proved central to primary data collection. Supported by insights obtained during formative research comprising materials review and the use of qualitative and participatory approaches and discussions with stakeholders, these data accurately reflect the dimensions of the problem, the extent of OVC in greatest need, and their situation. Further, based on a household listing approach described below, the number and distribution of OVC and OVC caregiving households has been established. In addition, there has been broader consideration of
available materials that contextualise the situation of OVC, a description of various agencies that are (or could be) involved in helping OVC and caregivers respond to their situations, an assessment of the potential for an expanded response from these various agencies, a review of programmatic responses and policies, consideration of needed programmes and policy reforms/initiatives, and a review of policies and legislation of relevance to OVC.

Fortunately, there is an emerging consensus about how to approach the conduct of a Situation Analysis of OVC. In 2004, a detailed document was prepared by USAID, with assistance from Family Health International (USAID, 2004): “Conducting a Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: A Framework for Evaluation Purposes.” Based on these objectives, and considering best practices learned from elsewhere, three basic approaches to collect primary data, ensuring that the Situation analysis of OVC is extremely well informed to allow evidence-based planning and implementation to take place, and to provide data for evaluation purposes.

1. Primary Data Collection: Conduct a situation analysis and measure other livelihoods and socio economic status variables through household interviews. Employ both quantitative and qualitative approaches to collect primary data, ensuring that the Situation Analysis of OVC is extremely well informed to allow evidence-based planning and implementation to take place, and to provide data for evaluation purposes.


3. Soliciting Opinions and Information: A broad range of key informant interviews were conducted specifically to fill information gaps and solicit insights from actors involved in the OVC arena. These took place at the national and provincial, and district levels.

1.8 Methodology

1.8.1 Secondary Materials Assembly and Review

A comprehensive review of available documents was conducted at start-up, and this informed both the formative research stage and quantitative data collection. The documents consulted are included in the bibliography at the end of this volume.

1.8.2 Primary Data Collection

Primary data collection was divided into two components: 1) formative research at start-up, including secondary materials review, key informant interviews (national and district), focus group discussions, and live-in case studies; and 2) informed by the formative research, the design and conduct of a quantitative survey.

In a case study of a child headed household in Nyagatare District, the household was comprised of four girls. The children lived in exile with their mother and father in Uganda. The father died in 1990 in the struggle to liberate Rwanda, and the mother died after her return to Rwanda in 1994 of cancer. They live in a house made of informal materials, and it is very crowded. The house is quite old, has no windows, and is falling apart. They do not have a toilet, and use the bush. When they can afford to purchase water, they do so at a public standpoint. When they do not have money, they rely on a small stream which is far away.

Because of support from Government, they are able to attend school. However, because of their school and home responsibilities, they have little time but anything else but school and chores and earning income when they can. Two have dropped out because of their many responsibilities, and also because they had to find a way of earning money.

They have not received any counseling, despite their problems. The children all reported ‘problems with men’, with one falling pregnant at a young age, and others exposed to ill treatment, and in some cases of difficulty have had to exchange sex for goods or money. They do know quite a bit about HIV/AIDS, but feel that they sometimes have little choice. As they noted, ‘girls who come from poorer families are caught in situations of doing whatever possible in order to solve their immediate problems and therefore may be tempted to engage in sexual behaviour’.

Despite their situation, the two still in school have high hopes of furthering their education and getting jobs, while one of the two who had dropped out gets access to catering training, where she obtained a certificate, and she hopes to secure a job.

The following primary data collection took place.

Formative

- Implementation of a National (30) Level Key Informant Interview Instrument.
- Implementation of a District (15) Level Key Informant Interview Instrument nationwide.

Quantitative

- Implementation of a highly-structured Quantitative Questionnaire (9,600) nationwide.

Consultative

- Implementation of a Focus Group Discussion (23) lement nationwide. Same discussion groups were assembled in most cases, while in other cases, groups of males and females were grouped. For those under the age of eighteen, only same sex discussion groups were assembled.
- Implementation of a Case Study (13) Guide in orphan caregiving households nationwide.
- Review of the results of the recently-completed Children’s Forum.
- Stakeholder consultative workshop following submission of the draft report.
- Implementation of School-based essays (150) – 15 per school across 10 secondary schools.

The essays were marked by two teams, both experienced lecturers, under the guidance of the Management Committee. Their recommendations were presented to the OVC Technical Working Group. The issues raised and the quality of the presentation were assessed against the United Nation’s Child Status Index, and points allocated. For each point raised and clearly elucidated, one point was allocated (the highest score could be thirty points). The highest score was 29 out of 30.

1.8.2.1 Quantitative Questionnaire

A highly-structured Quantitative Questionnaire was developed, based on the following procedures:

- A review of information needs as noted in the OVC National Strategic Plan.
- Indicators identification activity with the Client and partners in development via the Technical Working Group for OVC and a smaller Working Group.
- A review of Rwanda materials of relevance to OVC, HIV/AIDS, and related areas.
- A review of secondary materials and relevant websites.
- Consideration of earlier quantitative questionnaires focusing on OVC.
- A review of the information already available on OVC, and consideration of how this information can be supplemented.
- Preparation of a pre-training draft version of the Quantitative Questionnaire.
- Discussion of the pre-training draft with the Client, and revision and preparation of the training draft.
- Enumerator training and field pre-testing, and consequent questionnaire revision.
- Final Client comments and finalisation of the questionnaire.

Through such a process, the Quantitative Questionnaire was developed that included valid indicators (measuring what they are intended to measure) converted to questions that were implemented in a reliable fashion (implemented consistently across enumerator and across provinces). This yielded Version 16, prepared in English and translated into Kinyarwanda.

Quality control is central to the success of the investigation. Therefore, teams of enumerators were overseen by a supervisor, and two teams of enumerators were overseen by a field manager. Quality control over the process of field implementation of the Quantitative Questionnaire procedures and quality control over data entry yielded a clear set of questionnaires where most problems that arose were resolved in the field in a timely manner. In some cases, especially in the early days, this included sending enumerators back to an interviewee to deal with any unexpected missing values. Any issues outstanding were checked at data entry, and resolved with the supervisors and field managers.

Final checks were conducted and the dataset cleaned and exported to the Statistical Package for the Social Sciences, where an additional check was conducted. In the final dataset, there were some four million data points, and 127 final errors were found in the Statistical Package for the Social Sciences (SPSS) data check (an error rate of 0.0028%). In addition, to further support quality control, a retreat involved the Management Committee and the Field Managers and Team Leader took place following the first days of implementation.

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS). Data were weighted to accommodate the actual proportion of orphan and vulnerable children caregiving households in the sampled locations, and thereafter generalised to the district and to the nation. As cautioned in the inception report, data were statistically generalisable to the district level, and thereafter generalised in a non-statistical manner to the national level, as the survey only covered 11 of Rwanda’s 30 districts. In the dataset, missing values were minimal, at less than
Introduction and Overview

Statistics (nIS), a two-stage random cluster design approach would allow such analysis. Analysis was therefore only conducted when the sample size would allow such analysis.

1.8.2.1.1 Sample Frame Identification and Sampling

After extensive discussions with the National Institute of Statistics (NIS), a two-stage random cluster design approach was adopted, and the sample pulled by NIS. Sampling involved the purposeful selection of eleven of Rwanda’s thirty districts (all three districts in Kigali Province, and two districts in each of the remaining four districts of eastern, southern, western and northern), with one district intended to represent locations where there was little outreach for OVC and particularly difficult economic conditions, and the second to represent districts that were understood to be better reached with services for OVC, and which had better economic conditions. In the end, the following districts were selected:

- **Kigali Province**
  - Nyarugenge
  - Kicukiro
  - Gasabo
- **Northern Province**
  - Musanze
  - Gakenke
- **Southern Province**
  - Kamonyi
  - Nyanguru
- **Western Province**
  - Rubavu
  - Karongi
- **Eastern Province**
  - Bugesera
  - Nyaruguru
  - Musanze

At the second stage, all Primary Sampling Units in each cluster were listed and a random starting number identified and an interval established, with thirty clusters for each district. The number of interviews for each cluster was established by NIS. In each cluster, all households were listed and divided into three types of households, based on pre-defined criteria: households with orphans (with or without other vulnerable children); households with no orphans but with other vulnerable children; and households with no OVC. From these lists, households were randomly selected from within each of the first two lists: orphans; and vulnerable children. In a few cases, the cluster selected was found to be non-existent, occurring because of lack of up-to-date records. In these cases, a neighbouring cluster would be selected to replace it.

Child-headed households were covered in the survey as per their representation in the population of the sampled locations overall, and they were classified as either orphan or other vulnerable children households, and were not classified as ‘not vulnerable’ due to the child-headed status (whatever their socio-economic status). In addition, children living without any fixed home were also included in the sample, and the household defined as a grouping of children defined by themselves as their ‘caregiving family’. Sex of household head was recorded, and a variety of gender issues were considered in the situation analysis.

### Modelling and OVC Projections

Working with TRAC and the CDC, the team’s modeller prepared updated orphans projections associated with AIDS, and the result is the collection of statistically generalisable data up to the district level, and the non-statistical generalisation of data to the province and national levels. Following the conduct of the initial survey, Rwanda intends to scale-up the survey to cover the remaining nineteen districts, so that data are available for all thirty districts, all five provinces, and the nation overall.

The sample size was calculated based on three considerations: 1) an acceptable sampling error; 2) an assumption that there would be a repeat-measures assessment in the future that would require a sample sufficiently large to allow the measurement of change over time (as part of evaluation); and 3) a sample size that would yield sufficient numbers of interviews for sub-analysis of the majority of variables (for example, if someone says yes, that the orphan came from another household, it would be possible to assess what this means for other variables on transition problems, social pathologies, education status, etc.) and analysis by each of the five provinces.

For each province, 720 interviews were conducted, yielding a total of 3600 interviews overall. The calculation per district was as follows:

<table>
<thead>
<tr>
<th>Given</th>
<th>Components of the Formula</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1= (Proportion at Baseline: late 2007)</td>
<td>0.4005</td>
<td>0.3950</td>
</tr>
<tr>
<td>P2=(Expected Proportion at Next Measure: late 2009)</td>
<td>0.270</td>
<td></td>
</tr>
<tr>
<td>P2-P1 (Desired Change During Period)</td>
<td>-0.130</td>
<td>0.2228</td>
</tr>
<tr>
<td>alpha (Z 95%)</td>
<td>1.650</td>
<td></td>
</tr>
<tr>
<td>beta (power: B 80%)</td>
<td>0.840</td>
<td>0.2460</td>
</tr>
<tr>
<td>Adjust for Non-Response Rate</td>
<td>0.05</td>
<td>0.1971</td>
</tr>
<tr>
<td>Adjusted for Sampling Purposes</td>
<td>0.4371</td>
<td></td>
</tr>
</tbody>
</table>

The only groups of children systematically excluded based on such an approach were institutionalised children, including children in prison, and Rwandan children living outside the country. Estimates for each of these populations were obtained through key informant interviews, and are noted in this report. It should be noted at the outset that these populations are quite small in relation to other populations of OVC.

1.8.3 Modelling and OVC Projections

Map 8: Districts Included in the 2007 Survey

1.8.4 Constraints to the OVC Situation Analysis

Perhaps the main constraint to the conduct of the OVC situation analysis was budget limitations that affected the number of interviews conducted (3600), and the number of districts where survey work could take place. This principally affected measurement of outreach to OVC caregiving households which, at under 10%, meant that there were insufficient numbers to elaborate on who was providing which services. Other limitations tended to affect sub-questions where there was a desire to explore the situation for respondents who gave a particular response (e.g., for those who were looking after children who were not biologically related to anyone in the household, how did this affect older children receiving psycho-social support services).

Fieldwork implementation was slowed due to the complexity of the survey and household listing procedures, but also due to the fact that the bulk of interviews took place during the heavy rains, making access difficult. Indeed, there were cases where roads had completely washed away, and teams had to arrange the rebuilding of basic paths to secure access to sampled communities.

Overall, the teams worked very hard, and worked well together. The co-operation of local authorities was extremely high, and access was secured in all cases. Further, there were no cases of refusals to be interviewed out of the 3600 interviews conducted.

1.9 Summary

As part of its commitment to improving the lives of OVC, the Government of Rwanda, with support from UNICEF/Rwanda, commissioned a situation analysis of OVC in Rwanda. Overseen by a Technical Working Group, the situation analysis comprised extensive field consultations in 11 of Rwanda’s 30 districts, along with consultations at the national level. The OVC response in Rwanda has strengthened in recent years, and the policy and strategic context for an effective response has improved with adoption of relevant policies and, in 2007, the adoption of the National Strategic Plan for OVC. The enhanced response is taking place within the context of an expanded, decentralised development response under the guidance of an increased commitment to a decentralised response. While still extremely limited due to financial and human resource constraints, a more positive environment for a decentralised response to OVC issues is emerging.

One key aim of the National Strategic Plan (NSP) was to ensure that the OVC response in Rwanda was based on solid evidence. An evidence-based approach, central to building a more effective and efficient response, was therefore one of the eight priorities of the NSP. The aim of the situation analysis was to “support implementation of the NSP for OVC by providing information of relevance to assessing status and progress on desired objectives”.

The situation analysis was anchored around a highly-structured quantitative questionnaire administered to 3600 randomly-selected households in 11 of Rwanda’s 30 districts. The 11 districts were purposefully selected to include districts with perceived weak responses, and districts with perceived strong responses. Sampling was undertaken by the National Institute of Statistics of the Government of Rwanda. The design of the quantitative questionnaire itself was informed by a formative research stage comprising an extensive literature review and a series of qualitative investigations, and discussions with the Technical Working Group. Modelling was also undertaken to establish the viability of the national non-statistical generalisation of the data from the 11 districts, and then projecting the number of OVC into the future.

Analysis was conducted using the Statistical Package for the Social Sciences (SPSS), following weighting of the data to accommodate findings from the household listing process, and generalised in a non-statistical manner to the national level. It is intended that the remaining 19 districts will be reached through the roll-out of the quantitative survey to the rest of the country, allowing statistical generalisation of the study findings to the nation.
The Extent of the OVC Problem and the National Response

2.1 Introduction

The 1994 genocide significantly increased the number of OVC in Rwanda, and appreciably worsened the situation of these children and those who care for them. Coupled with high death rates arising from various health and livelihood challenges, the genocide compounded an already serious problem. Indeed, with the genocide in the mid-1990s, Rwanda had the highest proportion of orphans as a percentage of all children aged 0-17 in the world.

While the proportion of children who are vulnerable remains high, the considerable development achievements over the past decade, including controlling the rise in HIV infection and reducing malaria rates, is projected to have had a positive impact on the number of OVC. Further, many of the children orphaned or made vulnerable due to the 1994 genocide have already grown up (and will all have grown up by 2012). As a result, the proportion of OVC will decline as a percentage of all children and, encouragingly, the number of OVC overall will decline.

In this chapter, the number and distribution of OVC as of late 2007 is outlined, and projections are made in terms of future numbers. This is followed by a presentation of projections of OVC due to HIV/AIDS and other causes. As pointed out in Chapter 1, it should be noted that the 2007 survey was not a national survey, as it covered 11 of Rwanda’s 30 districts. Nevertheless, as will be shown below, findings on the number of orphans in particular suggest that these non-statistical generalisations are quite accurate.

2.2 Number and Distribution of Orphans and Other Vulnerable Children

Based on projections from the 2002 census, and assuming a population growth rate of 2.75% (the rate used by the National Institute of Statistics), as of 2007 there were 3,955,374 children aged 0-17 in Rwanda (3.4m). Based on estimates from the survey, of these, 824,065 were orphans, 2,001,669 were vulnerable children, and 569,639 were neither orphans nor vulnerable non-orphans. Overall, there were 2,825,735 OVC (2.8m) in Rwanda as of late 2007. This means that 24.3% of all children in Rwanda are orphans, and 59.0% are non-orphan vulnerable children. Findings for orphan numbers are consistent with the findings from the 2005 DHS, at 25%, and are consistent with trends suggesting a reduction in the number of orphans; see Government of Rwanda, 2005a. Projections made by the modelling on the situation analysis team suggest that the proportion of orphans versus other vulnerable children will remain stable over time, levelling at around 25% for orphans and 75% for other vulnerable children.

Most of these vulnerable children are vulnerable due to high levels of poverty, with only one-in-six vulnerable due to HIV/AIDS (NIS and Macro, 2006). This yields 83.3% OVC, and 16.7% non-OVC. Of interest, this was remarkably consistent with estimates from many of the national level key informants, most of whom estimated figures of 70-85%. Based on an income calculation of those who live in households earning less than US$1 per day, some 85% of all orphans are vulnerable.

There are also a small number of OVC who are not living in the general population, notably children in prison, children living in institutional case, child soldiers and street children. Perhaps more significant are returning refugees who have yet to leave the camps, and refugees from neighbouring countries, mostly the Democratic Republic of the Congo and Burundi. Data made available from Government in early 2008 shows that there are 35,413 refugee children living in Rwanda at this time, out of 54,701 refugees in total. Therefore, 64.7% of all refugees registered in Rwanda are children.

The number of children in prison has grown steadily from 2005-2007 (Ministry of Internal Affairs data provided to the team, mimeo), from 965 in 2005, 1,072 in 2006, and 1,139 in 2007. Consistent with the situation worldwide,
the vast majority of children in prison are boys (539 in 2007 compared to 81 girls). For all age groups, including infants, there were 1,139 children in prison in 2007; a breakdown regarding the reasons why the children were in jail was not available. Infants who are in prison with their mothers are currently removed from prison when they reach the age of four (considered to be the age at which breast-feeding stopped), and turned over to other caregivers (in all but one case so far, family members had been located, in the one case the children had been turned over to an institution). For 2007, 419 of the 1,139 in prison were infants, and 720 were serving time for crimes (or charged with crimes). A follow-up interview with an officer from the Department of Prisons noted that the boys were kept in a separate, secure facility once they were convicted of crimes, to prevent sexual and other physical assault. Those who continue to serve their sentences upon reaching the age of 18 are shifted to prisons containing adults. For girls, there was less concern about assaults, and therefore the girls were kept in the same facilities as adult women. The interviewee noted that food, toys and other needs were inadequately met, and that some support was offered by NGOs, but not enough to reach all the children in need. Older children were taught technical skills, but children in prison are not enrolled in formal education. In addition to these children in prison, there are also children who are in prevention centres that focus on training and skills development (MIGEPROF, mimeo, excel file).

There are an estimated 1539 child soldiers who remain unreached, and who are understood to still be with rebel forces. A total of 661 child soldiers have been reunited with their families, and 30 children are living at a rehabilitation facility once they were convicted of crimes, to prevent sexual and other physical assault. Those who continue to serve their sentences upon reaching the age of 18 are shifted to prisons containing adults. For girls, there was less concern about assaults, and therefore the girls were kept in the same facilities as adult women. The interviewee noted that food, toys and other needs were inadequately met, and that some support was offered by NGOs, but not enough to reach all the children in need. Older children were taught technical skills, but children in prison are not enrolled in formal education. In addition to these children in prison, there are also children who are in prevention centres that focus on training and skills development (MIGEPROF, mimeo, excel file).

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According to figures from MIGEPROF (mimeo, excel file), there are 29 registered orphanages nationwide in Rwanda. These orphanages care for 4,107 orphans, or around 0.5% of all orphans in the country. The number of street children is unknown, but the OVC situation analysis suggests that 0.6% of all OVC do not live in a family environment, and are likely to at least work in streets or in other forms of exploitative child labour. At this percentage, this would give just under 17,000 in this situation. According to MIGEPROF (mimeo showing 2007 figures), there are some 4,068 street children who are reached with services of one form or other, suggesting that only a minority are reached.

Veteran children in particular tend to be in larger households. Therefore, while 59% of all children were vulnerable, they lived in 45.8% of all households. Overall, there are an estimated 240,204 orphan caring households (some of which include other vulnerable children, and some that do not), 583,460 vulnerable children households, and 166,042 households with children who are not OVC. Of the vulnerable children, 31.5% live in households that contain at least one orphan, with the remaining 68.5% living in households with only vulnerable children (and no orphans). Findings highlight the vulnerability of non-orphan children in households with orphans.

In terms of criteria associated with listing vulnerable households as vulnerable, the majority (81.8%) were classified as vulnerable due to severe poverty and the inability to meet the basic needs of children in the household. This was followed by children of single mothers (12.5%), children living in foster care (2.1%), and children living with disabilities (1.5%). While the majority of children were in families that met the criteria, there is a large discrepancy between children who appear to be vulnerable and those who are actually vulnerable. According to the latest survey figures, only 55.2% of children are in vulnerable households, and 44.8% are in non-vulnerable households. Among these households, 29 are registered orphanages throughout the country.

In 2008, an estimated 21,000 Rwandans died of AIDS-related illnesses, and some 150,000 Rwandans were living with HIV/AIDS in 2007. Of all children aged 0-17 as of 2008, an estimated 22% (185,238) are estimated to be orphaned due to AIDS. While 57% of all those HIV+ were estimated to be women, this is consistent with their proportion of the population. As of 2007, there were an estimated 200,000 HIV positive Rwandans, of which there are some 19,000 HIV positive children aged 0-14. Of these, an estimated half die before the age of two.

The national response is co-ordinated by the National AIDS Control Commission (CNLS), taking under the Office of the President. The health response is co-ordinated by the Treatment and Research on HIV/AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC). Under CNLS, a decentralised response is in the process of being strengthened, co-ordinated through District AIDS Control Committees (DCDLS). The role of CNSL was to help define, and co-ordinate, national policy in responding to HIV/AIDS, co-ordinate the design and implementation of strategies and plans across sectors, support mobilisation efforts, and monitor the management of development partner inputs.

Rwanda has established a solid policy environment for responding to HIV/AIDS, as well as other key health challenges. The country has developed a Health Sector Policy (2005), a Health Sector Strategic Plan covering the period 2005-2009, a Multisectoral HIV/AIDS Control Plan covering the period 2005-2009, an HIV/AIDS Treatment and Care Plan (2003-2007) which is in the process of being updated, a National HIV/AIDS Monitoring and Evaluation Plan (2005-2009), and a National Reproductive Health Policy (2000). A Policy Statement on TB/HIV Collaborative Activities has also been developed, in anticipation of a policy document in the near future. The same holds true for a national policy on gender-based violence.

The Multisectoral HIV/AIDS Control Plan 2005-2009 has just been updated and is based on data, lessons and best practices from the previous period (2000-2004) strategic plan. The key objective is to reduce the transmission of HIV and other STIs, and mitigate the impacts of AIDS by:

- Reducing the adult HIV prevalence rate below actual figures (3%).
- Increasing adolescent (15-19) condom use.
- Increasing VCT coverage to 80% of all health centres.
- Improving management of opportunistic and associated diseases.
- Reducing mother-to-child transmission.

VCT coverage is currently estimated at 72.3% of those in need, PMTCT services were estimated to cover 61.4% of those in need, 59% of all health facilities offer VCT, PMTCT, and ARV services, condom delivery meets an estimated 58.8% of current demand, and 18.2% of those who should be members of PLHIV associations are currently members.

Rwanda started conducting HIV Seroreivalence Surveys, measuring seroreivalence among women attending antenatal clinics, as early as 1999. The current survey sites are two urban and two rural sites. The number of sites was increased and more equally distributed across geographical areas in the early 2000s, resulting in 25 sites (12 urban and 13 rural) in 2002, and 31 sites (15 urban and 16 rural) in 2005.

The 2002 survey was the first survey with truly national coverage that included both urban and rural sites in all of the country’s 12 provinces. The 2005 DHS (Government of Rwanda, 2005a) included the 2002 twenty-five sites as well. The most recent finding on HIV prevalence was from Rwanda’s third DHS in 2005, showing a national adult prevalence of 3% with a variation between the sexes of 2.3% for males and 3.6% for females, and a remarkable variation between geographical area of 7.6% in urban areas and 2.2% in rural areas. The national adult prevalence found during the DHS was lower than findings from the 2005 Seroreivalence Surveillance which found 4.05% prevalence among pregnant women attending antenatal clinics. This reflects a consistent trend, across countries, showing that Seroreivalence Surveys tend to overestimate levels of HIV seroreivalence.

The trend of HIV prevalence based on previous sentinel surveys suggest a sharp increase in adult prevalence from the early 1980s to the early 2000s, and thereafter a sharp decrease from 2001 to 2005. Both the increase and the decrease, however, need to be interpreted with caution, because of the measurement methods and methodologies that were used until 2001. Indeed, it can be concluded that data from sites prior to 2000 are not reliable (TRAC noted this in 2004). Nevertheless, having said this, available evidence suggests that the HIV seroreivalence rate is decreasing.

In early February, 2008, CNLS released draft findings from a demographic modeling exercise conducted by CNLS, TRAC, NS, UNAIDS, WHO, and USAID with the Health Policy Initiative. The demographic modeling exercise made use of the Spectrum Group of Models and Estimation and Projection Package (EPP) that are used to assess and project the demographic impact of HIV and AIDS on national populations and trends in HIV prevalence. The
DemProj model was used to project demographic indicators in the absence of HIV and AIDS, while AIM was used to project demographic indicators taking HIV and AIDS into consideration. EPP was used to develop an adult HIV prevalence trend, which was then exported into the AIDS Impact Model (AIM) to determine the consequences of HIV and AIDS on demographic indicators such as Total Fertility Rates (TFR), Life Expectancy (LE), total population, death rates, orphan numbers, etc.

The modellers used data from surveillance surveys and the DHS to feed into EPP in order to determine the most logical national HIV adult prevalence trend for Rwanda. The draft document on the model results the first three rounds of surveillance were conducted in 1988, 1991 and 1996. For this period, the median HIV prevalence was 25.7% in Kigali, 9.9% in other urban sites and 2.6% in rural sites. In 2002, the surveillance system was reinforced and more sites were added. In urban sites, the median of HIV prevalence went from 6.9% in 2002, to 6.3% in 2003, and 5.4% in 2005. In rural sites, the median went from 3.0% in 2002, to 2.8% in 2003, and 2.1% in 2005. The median prevalence at urban and rural sites were subsequently calibrated with the DHS prevalence data point for the general population in 2005 which were 7.3% in urban areas, 2.2% in rural areas, and 3.0% at the national level.

The curves were created in EPP with the median prevalence because some data points appeared to be extraneous outliers. In addition, uncertainty analysis on urban and rural prevalence data was modelled to provide a range of results. The most logical results were therefore used as the national HIV prevalence for Rwanda as per the figure below.

**Figure 2: Projected National Adult Prevalence Rates (15 – 49 Years) (1983-2012)**


Findings show that adult HIV prevalence increased sharply from the first infection in 1983 at the Centre Hospital in Kigali (National Policy on HIV/AIDS, MINSANTE, 2003). The adult prevalence rate for 15 – 49 year olds increased from 0.15% in 1983 to the highest prevalence in 1989 at 9.5%. It decreased to 8% in 1993, continued decreasing to 3.7% in 2003 and 2.6% in 2008. It is projected to continue to decrease, to 2.1% in 2012. The prevalence peak, according to the projections, was experienced in the late 1990s at 24,000, with a decreased prevalence rate into 2008, to just fewer than 19,000, which is projected to be approximately 15,000 people infected with HIV by 2012. It was projected that the number of people infected started stabilising this year (2008). It was projected that there will be approximately 150,000 people infected with HIV in the early 1990s, while it was projected that the number of people infected started stabilising this year (2008).

Currently, there are an estimated 150,000 people living with HIV or AIDS in Rwanda. Most of these infections occurred in urban areas due to in-migration in pursuit of employment, but other factors also played a role such as high levels of poverty, urbanisation, culture, gender and lack of behaviour change. More than 250,000 people were projected to be infected with HIV in the early 1990s, while it was projected that the number of people infected started stabilising this year (2008). It was projected that there will be approximately 150,000 people infected with HIV by 2012.

The age group with the highest percentage of infections in urban and rural areas is the 20 – 24 age cohort, followed by 25 - 29 and 30 - 34 year olds.
The number of new infections among adults (defined as those aged 15 years of age and above) is projected to continue to increase slightly from 7,000 in 2008 to 7,100 in 2012, in effect a levelling of new infections. As people with previous HIV infections die, and as more people are infected, the HIV rate in Rwanda will mean that mortality rates nationally will continue to increase even when a decrease in prevalence and infection rates is experienced. While HIV prevalence has reached its peak, the time lag between infection and death means that the AIDS epidemic is a number of years behind HIV infections. Further, with ART and PMTCT, peoples lives are prolonged, which means that AIDS-related deaths are also postponed. The cumulative AIDS death rate is therefore projected to continue to increase as long as people are infected with HIV and die from AIDS-related illnesses, as shown in the following figure:

Cumulative AIDS deaths are estimated to grow to over 400,000 by 2012, with some 9,000 deaths due to AIDS per annum between now and 2012, but the growth will continue to slow, reflecting reduced levels of HIV infection. The cumulative number of AIDS deaths, decreased life expectancy, decreased total fertility, increased child mortality will inevitably result in a slower national and provincial population growth.

The first national population census in Rwanda took place in 1978, followed by another census in 1991 and the latest one in 2002. In 2006, an intercensal survey took place, but data are not yet available. Past national censuses show that the population grew from close to 5 million in 1978 to 7 million in 1991 and over 8 million in 2002. It should be noted that Rwanda implemented a major administrative and territorial reform during the 2002 census which significantly modified provincial boundaries, and resulted in the transfer of people and territory. “This notwithstanding, it must be noted that the huge loss in human life as well as the massive internal and external displacements and resettlement of populations that occurred as a result of the war and genocide in 1994, significantly disrupted the normal evolution of the population of almost all of the Provinces of the country” (National Institute of Statistics, 2003: 17). This made the projections by province difficult for the time being, but NES has settled on a growth rate of 2.75%, in the absence of alternative information.

Taking the above adult HIV prevalence rate into consideration as well as the 1994 genocide, international migration, total fertility rate, life expectancy, the Age Specific Fertility Rate, tuberculosis, and treatment for HIV/AIDS such as Anti-Retroviral Therapy (ART) and Prevention of Mother to Child Transmission (PMTCT), the following total population is projected for Rwanda. Using the SPECTRUM Group of models, and calibrating the projections to the 2002 census resulted in the following population projections for Rwanda.

Currently (2008) the population of Rwanda is projected to be 9.3 million, taking HIV and AIDS into consideration. Findings are indicated in the following figure:

---

**Figure 4: Variation of HIV Infections by Age and by Geographical Setting**


**Figure 5: Projected Cumulative AIDS Deaths (1981 – 2012)**


**Figure 6: National Population Projections With and Without HIV and AIDS, Rwanda (1983-2012)**

The population is projected to increase to 10.6 million in 2012. In the absence of HIV and AIDS the population was currently (2008) projected to have been 9.8 million, rising to 11.2 million in 2012. This means that there is a population deficit of 5% attributed to HIV and AIDS. But it is not just the population deficit that is an issue. Importantly, the population deficit will largely occur within the economically active age group, resulting in less human resources available for productive activities.

The above table also shows that Rwanda has more females than males and that this trend will continue into the future. In 2002, the sex ratio stood at 91.5 males for every 100 females. In 1991 it was much higher at 95.1. The male deficit worsened during the last intercensal period, largely as a result of the higher male mortality and male out-migration during the period of the war and genocide (National Census Service, 2003:19) Kigali City was the only province where the sex ratio has gone above 100, because males migrated to Kigali City in pursuit of better employment opportunities.

The figure shows that the total number of orphans (all types of orphans are included) in 2007 was 852,795. This is quite close to the 2007 figure calculated from the household listing process and quantitative interviews (824,065), and suggests that the generalisations from the eleven districts to the nation is reasonable accurate and, conversely, that the model results are quite accurate. In 2007, 86,809 new orphans were projected, and roughly stabilising thereafter (85,052 for 2008; 83,772 for 2009; 85,395 for 2010; 87,705 for 2011; and 89,346 for 2012).

Of these total orphans, 22% (185,238) are currently projected to be children orphaned by AIDS while the remainder (692,597) are children orphaned due to other causes. The total number of orphans who are orphaned due to all causes is projected to continue to increase until 2012, while the number of children orphaned due to AIDS had already reached its peak (in 2002). By 2012, children orphaned due to AIDS will constitute a lower 15% of the total number of orphans in Rwanda, down from 22% in 2008.

Details on the number of orphans are provided in the following table:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children Orphaned by AIDS</th>
<th>Number of Children Orphaned Due to Other Causes</th>
<th>All Orphans</th>
<th>% of All Children Orphaned by AIDS out of Total All Orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>97</td>
<td>593,268</td>
<td>593,348</td>
<td>0.0</td>
</tr>
<tr>
<td>1986</td>
<td>604</td>
<td>594,256</td>
<td>594,758</td>
<td>0.1</td>
</tr>
<tr>
<td>1987</td>
<td>2,378</td>
<td>595,518</td>
<td>597,877</td>
<td>0.4</td>
</tr>
<tr>
<td>1988</td>
<td>6,608</td>
<td>593,980</td>
<td>599,589</td>
<td>1.1</td>
</tr>
<tr>
<td>1989</td>
<td>11,287</td>
<td>594,333</td>
<td>605,618</td>
<td>2.0</td>
</tr>
<tr>
<td>1990</td>
<td>3,394</td>
<td>594,313</td>
<td>599,697</td>
<td>0.6</td>
</tr>
<tr>
<td>1991</td>
<td>10,398</td>
<td>592,547</td>
<td>602,945</td>
<td>3.2</td>
</tr>
<tr>
<td>1992</td>
<td>40,207</td>
<td>594,422</td>
<td>615,631</td>
<td>6.5</td>
</tr>
<tr>
<td>1993</td>
<td>62,105</td>
<td>579,073</td>
<td>641,178</td>
<td>9.9</td>
</tr>
<tr>
<td>1994</td>
<td>92,468</td>
<td>579,468</td>
<td>659,434</td>
<td>14.1</td>
</tr>
<tr>
<td>1995</td>
<td>125,313</td>
<td>585,733</td>
<td>692,121</td>
<td>18.1</td>
</tr>
<tr>
<td>1996</td>
<td>157,794</td>
<td>597,688</td>
<td>733,777</td>
<td>21.5</td>
</tr>
<tr>
<td>1997</td>
<td>180,435</td>
<td>609,368</td>
<td>768,719</td>
<td>23.7</td>
</tr>
<tr>
<td>1998</td>
<td>194,313</td>
<td>614,710</td>
<td>806,013</td>
<td>26.5</td>
</tr>
<tr>
<td>1999</td>
<td>211,317</td>
<td>622,912</td>
<td>834,229</td>
<td>28.6</td>
</tr>
<tr>
<td>2000</td>
<td>219,918</td>
<td>629,908</td>
<td>849,826</td>
<td>29.1</td>
</tr>
<tr>
<td>2001</td>
<td>224,483</td>
<td>635,849</td>
<td>860,332</td>
<td>29.7</td>
</tr>
<tr>
<td>2002</td>
<td>225,292</td>
<td>641,018</td>
<td>866,264</td>
<td>29.7</td>
</tr>
<tr>
<td>2003</td>
<td>222,907</td>
<td>646,904</td>
<td>869,811</td>
<td>26.6</td>
</tr>
<tr>
<td>2004</td>
<td>218,229</td>
<td>653,736</td>
<td>871,965</td>
<td>26.0</td>
</tr>
<tr>
<td>2005</td>
<td>217,208</td>
<td>662,092</td>
<td>879,300</td>
<td>25.6</td>
</tr>
<tr>
<td>2006</td>
<td>205,365</td>
<td>671,269</td>
<td>876,634</td>
<td>24.2</td>
</tr>
<tr>
<td>2007</td>
<td>197,421</td>
<td>681,729</td>
<td>879,150</td>
<td>23.2</td>
</tr>
<tr>
<td>2008</td>
<td>185,238</td>
<td>692,597</td>
<td>875,835</td>
<td>21.7</td>
</tr>
<tr>
<td>2009</td>
<td>169,661</td>
<td>704,213</td>
<td>873,874</td>
<td>19.9</td>
</tr>
<tr>
<td>2010</td>
<td>154,601</td>
<td>716,584</td>
<td>871,185</td>
<td>18.2</td>
</tr>
<tr>
<td>2011</td>
<td>140,974</td>
<td>729,970</td>
<td>859,944</td>
<td>16.5</td>
</tr>
<tr>
<td>2012</td>
<td>128,159</td>
<td>744,032</td>
<td>872,191</td>
<td>15.0</td>
</tr>
</tbody>
</table>
2.5.1 OVC Caregiving Households and HIV&AIDS

In the poorest households in Rwanda, AIDS-related illness and death lowers total household spending power by approximately 40%. Even if these impacts are mitigated, spending power still decreases by some 15%. Pyneis, 2005.

Table 6: HIV&AIDS Attitudes

<table>
<thead>
<tr>
<th>Response</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV&amp;AIDS really haven’t hit this community/neighbourhood too hard</td>
<td>4.6</td>
<td>38.8</td>
<td>35.8</td>
<td>7.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Orphans from parents who died of AIDS are treated no differently than orphans from other causes</td>
<td>5.8</td>
<td>39.1</td>
<td>33.2</td>
<td>3.7</td>
<td>18.2</td>
</tr>
<tr>
<td>Households that are looking after children orphaned due to AIDS are stigmatised by other households in the community</td>
<td>2.4</td>
<td>13.4</td>
<td>50.2</td>
<td>19.7</td>
<td>14.3</td>
</tr>
<tr>
<td>A friend of my family became infected with the AIDS virus, I would want this to remain a secret</td>
<td>13.8</td>
<td>37.6</td>
<td>35.9</td>
<td>12.0</td>
<td>0.8</td>
</tr>
<tr>
<td>A friend of my family became infected with the AIDS virus, I would be willing to care for them</td>
<td>30.2</td>
<td>64.0</td>
<td>4.0</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td>I would still be willing to purchase fresh vegetables from a shopkeeper if they had the AIDS virus</td>
<td>30.7</td>
<td>58.0</td>
<td>7.2</td>
<td>2.6</td>
<td>1.6</td>
</tr>
<tr>
<td>A female teacher has the AIDS virus, but is not sick, she should be allowed to continue teaching in school</td>
<td>37.6</td>
<td>53.0</td>
<td>6.6</td>
<td>1.6</td>
<td>1.3</td>
</tr>
</tbody>
</table>

SA = strongly agree, A = agree, D = disagree, SD = strongly disagree, DK = do not know

Respondents were ambivalent about whether HIV&AIDS was a problem in their community. They were also ambivalent about whether they would want an infection within their family to remain a secret, while almost all indicated that they would be willing to care for someone who was HIV positive.

Most respondents did not feel that households looking after children orphaned due to AIDS were stigmatised by other households, but findings were more mixed in terms of the statement ‘orphans from parents who died of AIDS are treated no differently than orphans from other causes’. Of interest, findings were similar for households caring for orphans compared to households that were not.

Two additional stigma questions were also included, covering the purchase of fresh vegetables and being allowed to continue teaching if HIV positive. In both cases, most respondents gave responses suggesting low levels of stigma, consistent with comments about children orphaned due to AIDS, and high levels of knowledge about how HIV is not transmitted. Findings are consistent with national data from the DHS (Government of Rwanda, 2005a, tables 14.5.1 and 14.5.2). Qualitative results underline this finding, with a number of OVC and caregivers talking about how people with HIV can ‘live positively’, and that they are often known to be HIV positive within their communities, but people still interacted with them. However, a number of focus group discussion participants did note that stigma was still there, but was often ‘silent and within the home’. When explored in more detail, a number of groups argued that it was not acceptable to display signs of stigma or discriminate against those HIV positive, as this had itself become ‘socially unacceptable’, but that people still had concerns about how HIV might be spread that led them to worry, in private, about how they might be at risk if they interacted with those who had HIV.

A proxy measure of direct AIDS impacts is measuring chronic illness and premature death. Fourteen percent of all OVC caregiving households were affected by at least one member with a chronic illness, and 7.1% had at least one member die in the year before the survey. One-third of these deaths appeared to be premature, with deaths among 0-17s at 2.3% and among 18-25 year olds 3.1%. For deaths among orphans aged 0-17, these deaths were more likely in situations where the child came from a household where a parent had died of a chronic illness (chi-square significant at the .1 level; 24.496, p=.000). Of those who were ill or dying, 19.6% received external support, with most support offered by extended family members and friends and neighbours; less than 4% of all those ill or dying received support from a formal agency, the bulk of this provided by Government (compared to 12.2% for all chronically ill adults, DHS; Government of Rwanda, 2005a). The most common forms of support comprise medicines, followed by counselling and nutrition support, but it is important to remember that few received such support.

A more general question was presented to OVC caregiving households, asking them whether ‘in recent years has increased ill health or the premature death of adult household members undermined the ability of your household to cope with the socio-economic situation’. One-seventh (16.2%) argued that this was indeed the case, with orphan caregiving households significantly more likely to be affected than households looking after other vulnerable children (25.5% versus 10%, respectively; chi-square significant at the .1 level, 10200.983, p<.000). Economic and agricultural impacts were noted as ‘reduced labour available for agriculture’ (66.1%), ‘loss of source of cash income’ (64.6%), and ‘reduced domestic labour’ (58.8%). Other impacts noted were ‘increased diet, we had less food’ (68%), ‘loss of support within the household’ (60.2%), and ‘loss of emotional support’ (34.5%). Save the Children (2005), in “The Cost of Caring with Illness”, noted that poorer households had twice the illness burden of non-poor household, and were less able to cope with the illnesses.

In Rwanda for the past decade, rural households have lived with civil unrest and genocide, changing land laws, large population flows both into and out of the country, and climate threats with droughts and floods. The illness and untimely death of prime age adults from a number of health problems (increasingly HIV/AIDS) adds to the stress of these households and has lasting effects on the ability of households to survive. Households affected by adult illness and death strive to maintain their agricultural production, and work to avoid selling assets, yet some households appear to be in a downward spiral, losing assets and income earning potential. They rely heavily on social networks for labor and skills, but clearly these networks will be stretched beyond their means in any continuing epidemic. Female-headed households in particular struggle to find labor with neighbors or work more themselves” Donovan, Bailey, Myint and Weber, 2001: 1.

2.6 Orphan Status

Caregiving households looking after orphans were asked a number of questions about these orphans. Questions comprised the following:

- Type of orphan - maternal, paternal, double
- If maternal orphan, status of the father
- Sex of orphan
- Age of orphan
- Whether siblings came to the same household
- Whether siblings were sent to a different household
- The foster status of the children - fostered, adopted, neither
- Whether the children are step-children to a step-mother or a step-father
- Whether the children have physical or mental disabilities
- Whether the child is biologically related to any adult in the household
- If biologically related to anyone in the household, whether the child is living with the mother’s or the...
The type of orphan is indicated in the following figure:

![Type of Orphan](image)


Over half of the orphans had lost their fathers, at 58.5%, followed by double orphans (49.1%) and females (50.9%). There was little variation across province.

The age status of orphans is indicated in the following figure:

![Age of Orphans](image)


The sex of orphans was divided evenly across males (49.1%) and females (50.9%). There was little variation across province.

The age status of orphans is indicated in the following figure:

![Age of Orphans](image)


Only one-quarter of the orphans were under the age of ten, with the majority being teenagers. Orphans in Kigali Province tended to be younger than those in the four rural provinces.

The percent of double orphans who had been fostered or adopted is indicated in the following figure:

![Fostering or Adoption Status](image)


One-third of all double orphans had either been fostered (most common, at 27.4%) or adopted (quite uncommon, at 6.5%). Two-thirds (60.1%) had been taken in by family members, neighbours or others without any formal procedures. Fostering or adoption were most common in Western Province. Those who had been brought in by non-relatives were substantially more likely to be fostered (40.5% for non-relatives and 11% for relatives) or adopted (7.4% for non-relatives and 2.2% for relatives). Even then, however, 52.1% of those being looked after by a non-relative had not gone through any formal process. Further, wills were prepared (written or verbal) for only 15.8% of all orphan children.

Regarding transition issues, a number of questions were asked that tried to get at factors that tended to reflect more difficult transition issues. Key among these was whether the child had to care for a dying adult, whether the child was moved from one household to another, from one community to another, and from one ‘type’ of community to another (urban to rural, rural to urban), whether orphans were moved together or separated, and whether the child was biologically related to anyone in the caregiving household.

Focus group discussion participants often noted that children who were transferred from one household to another really suffer. Anger, depression, being lonely, crying unexpectedly and an inability to deal with other children were noted as common problems, while some groups argued that longer-term impacts included a loss of self-confidence, an inability to perform in school, difficulty in making decisions, and a continued inability to ‘fit in’ to their new family situation. In the early days, many of these children received help from FARG, with children identified through cell level FARG committees, and while this helped in terms of meeting basic needs and getting children back into school, it did less to help the child adjust to their new circumstances. Nevertheless, even though orphans that had to be moved tended to moved to better-off households, Stams, Subbarao and Wodon (2003; no page given) highlight that “welcoming an orphan is still likely to induce a loss in consumption for a household. According to preliminary estimates … the marginal impact of having one orphan in the household on consumption is negative.
Of children with siblings and who were moved from one household to another, 87.2% were moved together, and only 12.7% were separated. Separation was most common in Kigali Province. The literature also highlights the importance of keeping children within the extended family. A total of 93.7% of all orphans were being cared for by a biological relative, and only 6.3% were being cared for by a non-relative. This was lowest in Kigali Province, at 89%, but did not vary significantly across the four rural provinces.

Figure 12: % of Orphans Who Had to Care for a Dying Adult

In 51.2% of all cases, children were not moved either before or after becoming orphans. The remaining 48.8% had been moved. Of these, a high 59.2% had been moved from another community to their current residence. However, the majority of those had been moved from a similar ‘environment’ (71.9% rural to rural area, 4.6% urban to urban area), with only 18.8% moved from a rural area to an urban area and, of most concern, from an urban area to a rural area (4.7%). OVC who were moved were least likely to have come from the same community in Eastern Province.

Children who had had to care for a dying adult tended to have more emotional adjustment problems. The percentage of orphans who had to care for a dying adult is indicated in the following figure:

Figure 13: % of Orphans Who Had to Care for a Dying Adult by Sex of Child

One-quarter of all orphans had to care for a dying parent. It is expected that this would be the case more for girls than boys. However, as indicated in the following figure, this is not the case:

Table 6: Attitudinal Scale Statements: Orphans and Non-Orphans

Most respondents were concerned that orphans would have fewer opportunities in life than non-orphans, with only 17.2% disagreeing or strongly disagreeing with the statement. One-quarter of orphans were concerned that spirits would target households with orphans, but few felt that was a problem. Respondents were more ambivalent about whether orphans were worse off than non-orphans. Few orphan caregiving households felt that orphans were more ill-disciplined than non-orphans in their households.
2.6.1 Caregiver Status

Three questions were asked about the status of caregivers: age, health status, sex, and education status. Age status is indicated in the following figure:

Figure 14: Age of Caregivers (for orphan children)

While 0.7% of all households with OVC were child-headed, a higher 2.3% of all caregivers were aged under eighteen. While it is commonly assumed that caregivers are generally elderly, only 13.8% of caregivers were elderly (aged 60 and older). Including those aged 50 and older, 30.5% were older caregivers. This leaves two-thirds (67.1%) of caregivers aged 18-49. In part this reflects elderly household heads, but others in the same household that can care for children.

While it is commonly assumed that most caregivers are female. This was indeed the case, with 78.8% of all caregivers female. This held across age group, as shown in the following figure:

Figure 15: Caregiver’s Age by Sex

It is also commonly assumed that caregivers are female. This was indeed the case, with 78.8% of all caregivers female. This held across age group, as shown in the following figure:

Figure 16: Education Status of Caregivers

Education status of caregivers is low, as shown in the following figure:

Only 12.7% of all caregivers had had secondary education. Almost half (42.7%) had no education. Education status was highest in Kigali Province, where 31.6% had at least some secondary education (compared to levels well below 10% for all rural provinces).
Three-quarters of caregivers were healthy (76.2%), 20.2% were sick but not bedridden, and 3.6% were infirm/bedridden. Perhaps not surprisingly, most of those who were sick or infirm were older caregivers:

More than half of caregivers in their sixties were ill, and one-in-six of these were infirm or bedridden. Even among those aged 50-59, 40.1% were sick or infirm.

In such a situation, it would be expected that the number of children orphaned or made vulnerable due to HIV/AIDS would rise. However, an effective national response to HIV/AIDS has meant that, while the overall number of OVC is projected to decline, the proportion of OVC made vulnerable due to HIV/AIDS will actually decrease. For 2007, it is estimated that 23.2% of all orphans had been orphaned due to the death of a parent to an AIDS-related illness (the figure was highest in 2001-2, at 27.1%), which by 2012 is expected to decline to 15%.

Projections for orphan number show a levelling in the number, at around 850,000, between 2007 and 2012. For other vulnerable children, projections show a levelling of vulnerable children numbers as well, similar to the trend for orphans. For the period 2007 to 2012, the modelling results show no appreciable increase in the number of vulnerable children, at 2,001,669 for 2008 and 2,005,739 for 2012. The proportion of all children who were vulnerable therefore levelled at around 59% as well.

One-quarter (26.1%) of all orphans were double orphans, meaning that they had lost both their mother and father, 58.5% were paternal orphans, meaning that they had lost their father but not their mother, and 15.4% were maternal orphans, meaning that they had lost their mother but not their father. Figures ranged across the country, with the highest proportion of double orphans occurring in Kigali Province. Qualitative discussions suggest that this is due to the collapse of coping mechanisms in rural areas for double orphans, and their move to Kigali to live with more distance relatives who are perceived to be better able to afford to care for them.

In two-thirds of all cases, no formal procedures for adoption or fostering was used with the arrival of orphan children. Perhaps not surprisingly, fostering or adoption was more common in the case of non-family members, while for relatives, it was felt that cultural systems of child caregiving meant that no formal procedures were required. Wills were only prepared by parents for 15.8% of all orphan children, in 93.7% of all cases, orphans were being cared for by a biological relative. Most of these were living with the surviving parent, even for maternal orphans. Half of all orphans did not move after becoming orphans, having lived in the household usually all of their lives. For those who had been moved, most had been moved to a similar environment, one-quarter of all orphans had to care for them.

2.7 Summary

It is estimated that, as of late 2007, there were 2.8 million OVC in Rwanda. One-quarter (24.3%) of all children aged 0-17 were orphans, and 59% were vulnerable children, yielding a total of 79.3% of all children as OVC. This finding was consistent with the Demographic and Health Survey estimate for orphans, and consistent with estimates of total OVC numbers given by a number of key informants. The vast majority of these OVC are living in households with adult caregivers, with relatively small populations living as refugees, living rough on the streets, living in child-headed households, in prison, or serving as child soldiers. Overall, it is estimated that there are 240,204 orphan caregiving households nationwide, 583,460 vulnerable children caregiving households, and 166,042 households with no OVC. Most vulnerable children were vulnerable due to extreme poverty, but some also faced other aspects of vulnerability.

The 1994 genocide was a key factor in rapidly increasing the number of OVC in Rwanda. 2007 data highlight the fact that many orphans are at least 13 years old. However, by 2008, many of these children had reached the age of 18 and, while often still vulnerable, were no longer classified as OVC under the national definition. This is also reflected in a relatively small percentage of all orphans living in child-headed households, now at only 1.2% of all orphan caregiving households.

While child-headed households were relatively uncommon (at 0.7%), a worryingly high 16.7% of all orphan caregivers were other children aged under 18. Unexpectedly, only 13.8% of caregivers were elderly (aged over 59). Education status of caregivers was quite poor, with almost half having no education, and only a small percentage having any secondary schooling. One-fifth (20.2%) of caregivers with either sick or infirm...
3.1 Introduction

In this chapter, two aspects of OVC and OVC caregiving households are considered: socio-economic status, and access to services. Under socio-economic status, income (in cash and in kind) and employment are considered, as is the criteria for including households as vulnerable. Regarding social services, a key goal of the NSP for OVC is to improve access to services, so that OVC and OVC caregiving households have the same level of service delivery as non-OVC. Therefore, a broad range of issues are covered under social service access and use.

3.2 Demographic Overview

Household structure is indicated in the following table:

<table>
<thead>
<tr>
<th>Table 7: Structure of OVC Caregiving Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response All OVC Orphans Other VC</td>
</tr>
<tr>
<td>Aged &lt; 1 Year Male Female Male Female Male Female</td>
</tr>
<tr>
<td>Percentage &lt; 1 Year 3.3 2.9 2.0 1.3 4.1 4.0</td>
</tr>
<tr>
<td>Aged 1-4 Years 77398 72154 18714 18591 58884 53663</td>
</tr>
<tr>
<td>Percentage 1-4 Years 13.9 11.5 9.5 7.4 16.5 14.2</td>
</tr>
<tr>
<td>Aged 5-17 Years 237024 245935 105045 107641 131979 138294</td>
</tr>
<tr>
<td>Percentage 5-17 Years 42.7 39.1 52.8 42.7 37.1 36.7</td>
</tr>
<tr>
<td>Aged 0-18 332818 336485 127764 129395 205054 207090</td>
</tr>
<tr>
<td>Percentage aged 0-18 59.9 53.5 64.3 51.3 57.6 54.9</td>
</tr>
<tr>
<td>Grouped % aged 0-18 56.5 57% 56.2%</td>
</tr>
<tr>
<td>Aged 18-25 Years 71,419 86,445 31798 36160 39621 50285</td>
</tr>
<tr>
<td>Percentage 18-25 Years 12.9 13.8 16.0 14.3 11.1 13.3</td>
</tr>
<tr>
<td>Aged 26-49 Years 111,672 155,249 25221 55555 86451 92634</td>
</tr>
<tr>
<td>Percentage 26-49 Years 20.1 24.7 12.7 22.0 24.3 26.4</td>
</tr>
<tr>
<td>Aged 50-59 Years 22,959 29,627 6741 16302 16218 13325</td>
</tr>
<tr>
<td>Percentage 50-59 Years 4.1 4.7 3.4 6.5 4.6 3.5</td>
</tr>
<tr>
<td>Aged 60+ Years 15,177 21,483 7252 14891 8465 6592</td>
</tr>
<tr>
<td>Percentage 60+ Years 2.8 3.4 3.6 5.9 2.4 1.7</td>
</tr>
<tr>
<td>Total in OVC HHs 554,585 629,289 198776 215330 35580 376866</td>
</tr>
<tr>
<td>Mean 4.96</td>
</tr>
<tr>
<td>Median 5</td>
</tr>
</tbody>
</table>


The average OVC caregiving household had five members (median = 4.96), with over half of the members under the age of 18. Household size was smaller for orphan caregiving households, with the mean at 4.73 members, with the mean for vulnerable children caregiving households higher at 5.14. The percentage of under eighteen was similar for orphan caregiving households, and households caring for other vulnerable children. This compares with lower household averages, with 4.6 members nationally.
Two-thirds (66.5%) of all OVC caregiving households are male-headed. For most of the remainder (27.4%), females headed the household with no senior male present, while an additional 6.1% were stated as male-headed, but the male head was absent at least six months over the past twelve. OVC caregiving households were more likely to be female-headed (33.5%) than households in the general population (27.6%; see National Institute of Statistics, 2006). There was minimal variation across the five regions.

What is of most interest about this figure is the remarkable difference between orphan caregiving households and households looking after other vulnerable children. An extraordinary 59.6% of all orphan caregiving households were headed by females, compared to only 16% for other vulnerable children households (chi-square significant at the .1 level; 4926.801, p=.000), although education levels were low for both. The education status was lower for female-headed households, with half having no education. Education status was higher for household heads based in Kigali, with little variation across the four rural provinces.

This difference between male- and female-headed households held for both orphan caregiving households and household caring for other vulnerable children (chi-square significant at the .1 level, 4851.754, p=.000 for orphan households; 935.695, p=.000 for vulnerable children households), and was especially pronounced for orphan caregiving households. In part this is due to female-headed households being older (44.6 years, versus 40.2 years; f = 1465.512, p=.000), with 16.7% of all female-headed households being older (44.6 years, versus 40.2 years; f = 1465.512, p=.000), with 16.7% of all female-headed households being aged sixty or older, compared to 9.2% for male-headed households (chi-square significant at the .1 level; 3184.807, p=.000). Household heads in Kigali Province tended to be considerably younger than household heads in the four rural provinces.

3.3 Poverty, Income and Employment

3.3.1 Poverty and In-kind/In-cash Income Status

At the end of the quantitative interview, enumerators were asked to rate OVC households in terms of six poverty categories. These poverty categories were derived from the participatory poverty assessment exercises conducted as part of preparation of the first Poverty Reduction Strategy Paper (PRSP; Government of, 2002e), and thereafter second Economic Development and Poverty Reduction Strategy (EDPRS; MINEOF/INV, 2007) in 2007, and consisted of the following:

- **In abject poverty (umutindi nyakujya)** - Those who need to beg to survive. They have no land or livestock and lack shelter, adequate clothing and food. They fall sick often and have no access to medical care. Their children are malnourished and they cannot afford to send them to school.
- **The very poor (umunutandu)** - The main difference between the umunutandu and the umutindi is that this group is physically capable of working on land owned by others, although they themselves have either no land or very small land-holdings, and no livestock.
- **The poor (umukene)** - These households have some land and housing. They live on their own labour and produce, and though they have no savings, they can eat, even if the food is not very nutritious. However, they do not have a surplus to sell in the market, their children do not always go to school and they often have no access to medical care.
- **The resourceful poor (umukene wifashije)** - This group shares many of the characteristics of the umukene but, in addition, they have small incomes and their children go to primary school.
- **The food rich (umukungu)** - This group has larger landholdings with fertile soil and enough to eat. They

Forty percent of OVC caregiving household heads had no education, and almost all the remainder had primary education. The situation was worse for orphan household heads than for the heads of other vulnerable children (chi-square significant at the .1 level; 4926.801, p=.000), although education levels were low for both. The education status was lower for female-headed households, with half having no education. Education status was higher for household heads based in Kigali, with little variation across the four rural provinces.

Education status was low for almost all household heads:
have livestock, often have paid jobs, and can access health care.
• The money rich (jamuure) - This group has land and livestock, and often has salaried jobs. They have good housing, often own a vehicle, and have enough money to lead and to get credit from the bank. Many migrate to urban centres.

Among the poor, the distinction is made between those who are poor but still control capital that can help them escape poverty (the resourceful poor), those who are poor but need external support in time of need (the poor), those who will remain marginal even with outside assistance (the very poor), and the destitute (in abject poverty). The critical distinction here is between households where outside support may enable them to escape poverty (the resourceful poor, and the poor), and those who will remain poor despite access to such resources (the very poor, in abject poverty). Findings are indicated in the following figure:

**Figure 20: Classification of OVC Caregiving Households by Poverty Category**

[Diagram showing the classification of OVC caregiving households by poverty category]


Of all the OVC caregiving households, all but 2.2% were rated as poor, across the four ‘poor’ categories. The majority of these households were rated as ‘very poor’ or ‘poor’, while only 7.1% were rated as ‘resourceful poor’, and only 12% were rated as ‘in abject poverty’. Assuming that some half of those classified as ‘poor’ could emerge from poverty with the right circumstances. This compared to a lower 5.7% for vulnerable children households. OVC caregiving households in Kigali Province were least likely to be in abject poverty or very poor, compared to the four rural provinces.

Households with vulnerable children are significantly more likely to be classified as poorer than households looking after orphans. Of households looking after orphans, 14.1% were not in poverty, and up to an equal number were in a situation where they could escape from poverty under the right circumstances. This compared to a lower 5.7% for vulnerable children households. OVC caregiving households in Kigali Province were least likely to be in abject poverty or very poor, compared to the four rural provinces.

Poverty findings are consistent with the findings for income status. Overall, only 13.6% had incomes/own production valued at over US$33 per day, or US$10 per month (and US$120 per annum), and most of these averaged around US$35 per month. As with findings for poverty, households looking after vulnerable children are somewhat more likely to earn less than US$10 per month than households with orphans (chi-square significant at the .1 level; 3318.389, p<.000).

A total of 8.8% of all OVC caregiving households have received some training in income generation, as had 0.4% of children in these households. Access to such training was highest in Kigali Province, at 14.8% (17.6% for orphan caregiving households, and 11.7% for vulnerable children caregiving households). A total of 15.3% had at least one member involved in a micro-finance initiative or a rotational savings and loan scheme, highest in Kigali and Northern provinces. There were no clear patterns of variation across orphan caregiving households and vulnerable children caregiving households. FGD participants noted that access to credit was extremely limited, and that this was a key problem hampering the ability of households to improve their lives, and undermined grower and marketing co-operatives.

Poverty findings are consistent with findings from situation analyses from other countries in the region (e.g., Zambia, Mozambique and Namibia), orphan caregiving households tend to be better off than households caring only for vulnerable children. Findings are indicated in the following figure:

**Figure 21: Levels of Poverty by Orphan Versus Vulnerable Children Households**

[Diagram showing levels of poverty by orphan versus vulnerable children households]


* Chi-square significant at the .1 level; 4936.992, p<.000.

An extremely high 69.9% of all households noted that they had been unable to eat on at least one occasion due to a shortage of food in the week before the survey, and an even higher 84.4% had had to substitute food types because of shortages of preferred foods; there was no variation across orphan caregiving households and households looking after other vulnerable children. Findings were similar for children in the household as well, at 60.3% for missed meals, and 83.8% for substituted food; again, there was no variation across orphan and non-orphan households. According to the Demographic and Health Survey (Government of Rwanda, 2005a), almost half of all children (45%) were malnourished, while they also found no difference between orphans and non-orphans in the population as a whole.
3.3.2 Assets

Ownership of key assets is indicated in the following table:

<table>
<thead>
<tr>
<th>Asset Type</th>
<th>All OVC</th>
<th>Orphans</th>
<th>Other Vulnerable Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electricity</td>
<td>7.0</td>
<td>11.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Television</td>
<td>3.0</td>
<td>6.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>1.6</td>
<td>3.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Phone (mobile land)</td>
<td>9.0</td>
<td>13.6</td>
<td>5.9</td>
</tr>
<tr>
<td>Car/Pick-Up</td>
<td>0.8</td>
<td>1.1</td>
<td>0.5</td>
</tr>
<tr>
<td>Bicycle</td>
<td>11.1</td>
<td>8.8</td>
<td>12.7</td>
</tr>
<tr>
<td>Radio</td>
<td>47.0</td>
<td>46.5</td>
<td>47.3</td>
</tr>
<tr>
<td>Cattle</td>
<td>9.4</td>
<td>9.0</td>
<td>9.6</td>
</tr>
<tr>
<td>Milk Cows/Sheep</td>
<td>14.6</td>
<td>13.2</td>
<td>15.5</td>
</tr>
<tr>
<td>Goats/Sheep</td>
<td>32.9</td>
<td>32.1</td>
<td>33.5</td>
</tr>
<tr>
<td>Chickens</td>
<td>21.2</td>
<td>19.4</td>
<td>22.4</td>
</tr>
<tr>
<td>Pigs</td>
<td>6.0</td>
<td>5.1</td>
<td>6.7</td>
</tr>
</tbody>
</table>


Not surprisingly, given low levels of income, most households owned few assets, with the exception of radios and goats. Cattle ownership was uncommon, and is well below national figures of some 33%, and even national figures for poor households, at 23%. For each asset, except for radio and animals, orphan caregiving households were significantly more likely to have assets than households with other vulnerable children. Radio ownership in the OVC survey of 2005/2006 (National Institute of Statistics, 2006) gave a figure of 52.9% nationally, divided into 40.6% for poor households and 67.2% for non-poor households. Assuming continued growth in ownership (ownership grew from 22.8% in 2000/2001 for poor households), figures for OVC caregiving households may be consistent with national figures. The rapid increase in cell phone ownership in the past few years may mean that the figures for OVC households are approximate to other poor households, but remain below levels for non-poor households.

Assuming continued growth in ownership (ownership grew from 22.8% in 2000/2001 for poor households), figures for OVC caregiving households may be consistent with figures for other poor households, but remain below levels for non-poor households. Bicycle and phone ownership was higher than figures for poor households in the ECV, and was more consistent with national figures. The rapid increase in cell phone ownership in the past few years may mean that the figures for OVC households are approximate to other poor households in 2007. Electricity access was low, at 7%, but is consistent with national figures (at 4.8%).

Two-thirds (68.4%) of all OVC caregiving households owned farm land. Of these, 20.3% felt that their household had adequate labour to farm effectively over the past year, and 62.2% felt that their household did not have sufficient inputs for farming (seeds, fertilisers, pest control, etc.). A very high 78.9% felt that their farm land was too small to meet their needs. There was little difference between orphan caregiving households and households looking after other vulnerable children. Crops grown varied across location, with crops included rice, sweet potatoes, beans, tomatoes, millet, sorghum, cassava, groundnuts and maize largely for home consumption. A few had animals, including chickens, rabbits, goats, and milk cows. OVC caregivers reported that they rarely had surplus crops for sale. OVC themselves supported home production, and sometimes provided labour to other households through casual labour on farm and off farm, including 'children who had no family and no where to go'.

An average of 2.6 OVC share a sleeping room, with 4% sleeping five or more in a single room. Density was higher for households looking after vulnerable children (mean = 2.8, median = 3) compared to households with orphans (mean = 2.3, median = 2).

A total of 6.2% of orphan caregiving households had been dispossessed of land. This was least common in Kigali Province, with little variation across the four rural provinces.

### 3.3.3 Employment Status

OVC caregivers were asked about the employment status of household members, and whether their households had cash income. Only 20.8% of all households reported no cash earnings. Of the remainder, the majority had one or two members earning cash (42.2% and 31.2%, respectively). Of the households with members earning cash income, 96.3% contributed cash income to the needs of the household on a regular basis (defined as at least four times per annum). Most of those in employment were involved in agricultural production for sale of at least part of the produce, reflected in the low value of income.

### 3.4 Social Services

Key social service status variables are summarised in the following table:

<table>
<thead>
<tr>
<th>Social Service Type</th>
<th>All OVC</th>
<th>Orphans</th>
<th>Other Vulnerable Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human waste system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Latrine</td>
<td>85.0</td>
<td>75.8</td>
<td>82.9</td>
</tr>
<tr>
<td>Improved Pit Latrine</td>
<td>11.8</td>
<td>14.9</td>
<td>9.7</td>
</tr>
<tr>
<td>Public Pit Latrine</td>
<td>4.6</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Bush/Forests</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Flush Toilet</td>
<td>0.9</td>
<td>1.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>0.3</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Drinking Water Source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Waterpoint</td>
<td>49.4</td>
<td>46.3</td>
<td>51.5</td>
</tr>
<tr>
<td>Surface Water</td>
<td>13.9</td>
<td>13.4</td>
<td>14.3</td>
</tr>
<tr>
<td>Tap in Yard</td>
<td>8.4</td>
<td>11.3</td>
<td>6.5</td>
</tr>
<tr>
<td>Neighbour’s Tap</td>
<td>8.2</td>
<td>8.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Spring</td>
<td>7.1</td>
<td>7.6</td>
<td>6.7</td>
</tr>
<tr>
<td>Open Well</td>
<td>7.0</td>
<td>6.1</td>
<td>7.6</td>
</tr>
<tr>
<td>Capped Well</td>
<td>4.6</td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Main Fuel Used for Cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firewood</td>
<td>86.8</td>
<td>81.8</td>
<td>90.2</td>
</tr>
<tr>
<td>Charcoal</td>
<td>11.0</td>
<td>15.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Paraffin</td>
<td>1.4</td>
<td>1.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Electricity</td>
<td>0.7</td>
<td>1.2</td>
<td>0.3</td>
</tr>
</tbody>
</table>


"When parents die while their children are still very young, their inherited land is usually controlled by relatives from the extended family who are also supposed to look after the orphans until they reach maturity but who do not always look after the land in the orphans’ best interest . . . Orphans would therefore like the government to strengthen their rights over their inherited land." (ODF and HTSPE, 2006: para 6.3.1).

In one-quarter (26.9%) of all cases, this had happened to a woman after she became a widow (this compares to one-third for all widows nationally, see National Institute of Statistics, 2006), despite legislation from the 1990s that allowed women to inherit land within marriage. Of interest, there were few cases of dispossesion of inheritance land to orphan or non-orphan children (1% and 0.4%, respectively, which did not vary across boys and girls; this may, however, be under-reported, as land grabbing may have occurred within the new caregiving household, something that key informants felt remained a problem). Few orphan children had inherited land that they rented out, suggesting that most ‘brought’ the land to the caregiving household, or (in the case of orphans who did not leave the household they were living in) retained the land. Findings suggest low levels of land loss arising from orphanhood. This finding true even for double orphans. Having said this, with discussions with OVC themselves many noted that, while double orphans indeed ‘brought land’ with them, they felt that their inheritance to the land was at risk when they grew up ‘because the adults use the land as theirs’ and seemed to have every intention of keeping the land in the future.

Having said that, however, it appears that other assets are not brought by orphans as part of inheritance. When asked about these other assets, 75.3% of orphan caregiving households noted that these assets were lost. This is despite widespread agreement (96.5%) with the attitudinal scale statement “Children should get the main inheritance if their parents die, rather than the other relatives”.

From “Results of Preparatory Field Consultations in Four Rural Districts” under Phase 1 of the Land Reform Process for Rwanda, HTSPE, 2006: 6.3.1.

"Families headed by orphans are a unique group. The majority of these families have inherited land from their parents and other relatives, and in many cases their inherited landholdings are relatively large, yet they face particular problems as a result of their relative poverty .... When parents die while their children are still very young, their inherited land is usually controlled by relatives from the extended family who are also supposed to look after the orphans until they reach maturity but who do not always look after the land in the orphans’ best interests. Orphans may be allowed to cultivate their land but cannot rent it out or sell orphans’ land and keeps the proceeds for themselves . . . .” From “Results of Preparatory Field Consultations in Four Rural Districts” under Phase 1 of the Land Reform Process for Rwanda, HTSPE, 2006: 6.3.1.

Tending livestock in one of the sampled communities
Only 2.4% of all OVC caregiving households had no access to improved means of human waste disposal, meaning that 97.6% had access to an improved means. This was slightly better than national figures for all households, where 6.4% did not have improved access, and in part reflected a more urbanised population of OVC households than the national EICV sample. Nevertheless, most households relied on unimproved pit latrines, with the consequent health risks associated with poor ventilation, poor construction, etc. Households with OVC were somewhat more likely to rely on unimproved pit latrines than the population overall (DHS results, 80% versus 66.9%, National Institute of Statistics, 2005a). There was no difference across orphan caregiving households versus vulnerable children caregiving households. Qualitative findings highlight that those without direct access to improve means of human waste disposal can rely on their neighbours.

"Most Rwandans die of diseases that could be prevented and/or cured through increased access to safe water and improved sanitation, simple health interventions and sanitisation on disease prevention, nutrition and good hygiene practices." UNDP 2008-2012 Framework, UN, 2007.

Only 20.9% of all OVC caregiving households relied on drinking water sources that were likely to be contaminated at the source (surface water and open well), which is consistent with water sources for all households (17.6%, EICV, National Institute of Statistics, 2006). An additional 7.1% relied on springs (9.3% for the EICV) and 7% on capped wells, and it is not certain whether these were safe sources. If these are assumed to be partially unsafe, this would suggest that almost one-third of all OVC caregiving households relied on water sources that were not safe at the source, compared to a slightly lower 29.6% for all households. For the remainder, most relied on improved water points. Only 16.6% had a tap in their yard or a neighbours yard, and none had water in the household.

Government of Rwanda, 2005a), and were especially less common for female OVC than females overall. A number of checks were made of birth registration and access to services. No clear patterns emerged showing the absence of birth certificates as a hindrance to service access, with one exception: those without birth certificates were slightly less likely to be attending primary school (and slightly less likely to have ever attended for those who never went to school), holding true especially for orphan children.

There was considerable variation across the five provinces, with birth registration at a very high 97% in Western Province and 93.3% in Eastern Province, compared to a much lower 43.2% in Northern Province.

3.4.2 Education

In 2006 the Ministry of Education (Ministry of Education and UNICEF, 2008) adopted a policy on education for OVC. The policy goal was (2006: 7): “to promote a quality education for all children in Rwanda through the eradication of barriers that result in inequity in schooling”. Objectives all focused on keeping OVC in school and ensuring no discrimination, as well as mobilising to support improved education access for OVC. As a recent United Nations (UN, 2006) report notes, Rwanda has made considerable progress in increasing primary school enrolment rates for both boys and girls. Males and females are equally likely to attend primary school, and girls progress on average as fast as boys. Unfortunately, some 70% of total enrolment is in grades 1 through 3, and drop out rates from grade 4 are extremely high. Those who make it to upper primary usually go on to secondary school, but even then only 15.6% of all boys and 9.5% of all girls make it to secondary school. Almost one-quarter of all Government expenditure goes to education, and over 40% of this goes to primary level education (UNDP 2007). Rwanda has in place an Education Sector Policy (2002: MINEDUC, 2002) that includes provision for ‘special needs’ groups, including orphans, street children and children from child-headed households, and more recently also prepared an education sector policy for OVC for possible adoption (see the Ministry of Education and UNICEF, 2008).

Further, MIGPROF (2005) adopted a Strategic Plan for Street Children, highlighting in particular the importance of education in improving the lives of these children. Despite the allocation of considerable funds for education by Government, as well as support from various NGOs, the costs of secondary school remains prohibitive for many students. The 2005 DHS estimated costs at around RwF168,000, or approximately US$312 per student, well beyond the means of most Rwandan households. Primary schooling, at RwF1,845, or approximately US$3.50, was still a burden for some households, with most of the cost related to the school uniform.

According to the DHS, just over 28% of all children had attended pre-school. From the survey, the figure for OVC was 20%, below the national average. Attendance was lowest in Northern Province, and highest in Kigali Province.

Respondents were asked a number of questions about the education status of 6-17 year olds in their households. Findings for orphans, as compared to other vulnerable children, are summarised in the following figure:

![Figure 23: Education Status of 6-17 Year Olds]


Just over half of all children aged 0-4 had had their births registered. Figures were higher for males than for females. Findings indicate that birth certificates are far less common among OVC than among children overall (DHS findings, 78%;
The majority of OVC aged 6-17 were attending school (85.4% for orphans, 91.6% for other vulnerable children); this compares to an overall total of 135.2% gross enrolment, see DHs, Government of Rwanda, 2005a. These findings are consistent with findings from other sub-Saharan African countries (see Case, Paxson, and Alderden, 2003), which notes that orphan school attendance is lower than non-orphan school attendance, even among other vulnerable children, even though the economic status of orphan caregiving households is better than for households looking after other vulnerable children. Re-analysis of the 2005 DHs data (personal communication, UNICEF/Nairobi) found that OVC were 25% less likely to complete primary school than non-OVC. While the DHS definition of OVC was much more constrained that the broader definition used by the Government of Rwanda, the finding does suggest that OVC access to, and completion of, education is lower than for non-OVC.

Enrolment rates were consistent with primary school rates as per the 2005/2006 EICV (National Institute of Statistics, 2006), at 85.9% for all children. However, consistent with national conditions, the bulk of the enrolment was in early national conditions, the bulk of the enrolment was in early grades 1-3, and there were a number of overage learners even at this level (described below).

School fees were the main deterrent for lack of secondary school attendance, while funds for other school-related costs (uniforms, other) were important for primary and secondary school. Poor performance in school, the need for labour at home, and emotional difficulties were cited much less commonly for both orphans and other vulnerable children. However, only 4.4% of orphans and 4% of vulnerable children who dropped out of school did so because they did not pass the P6 exam. At the secondary level, no orphans and only 0.8% of vulnerable children dropped out because they did not pass their S3 exam. Focus group discussion participants argued that the problem with access to schooling for OVC was mostly at the secondary level, and was related largely to the high cost of school fees. While a few children were receiving such support, most were not.

When presented with the statement “Really, it is more important to keep boys in school, because they have more of an ability to bring in money when they grow up”, three-quarters disagreed with the statement.

Of those who dropped out of school, 6% of orphans and 3% of other vulnerable children did proceed with non-formal education. For orphans aged 12-17 years, 1.3% received vocational training, and a higher 7.5% the same age had received apprenticeship training. For vulnerable children, 1.4% received vocational training, and 6.2% aged 12-17 had served as apprentices. Those who had served as apprentices were somewhat more likely to have gone on to earn cash income (chi-square significant at the .1 level 21.736, p<000). Of interest, households with older OVC who had either received vocational training or who had served as apprentices were more likely to have had an adult member reached with income-generation training, and considerably more likely to have been involved in a micro-finance initiative. Access to apprenticeship positions were significantly higher in Western Province compared to the other four provinces.

While most orphans and other vulnerable children were attending school, the vast majority of those attending were overage for the grade they were in, as illustrated in the following figure:

![Figure 24: Correct Grade for Age for (those in school)](image)


Over 80% of all orphans attending school, and 70% of all vulnerable children attending school are over age for the grade they are attending; over 20% of all primary school attendees were over the age of 13 when they should have left primary school (UNPDA, 2005). In such a situation, it is perhaps not surprising that 42.2% of all orphan children had repeated at least one grade, and one-in-eight (12.9%) missed at least one year of school. The findings were similar for other vulnerable children, with 40.5% repeating, and 8.1% missing a year. OVC repetition rates are higher than the repetition rates found in the EICV (National Institute of Statistics, 2006), where 18% repeated a grade from P1-P5. School performance was best in Kigali Province.

Only 2.4% of orphans children aged 6-17 had a learning disability, as did 1.8% of vulnerable children (low numbers meant that further analysis on school attendance and learning disabilities was not possible). Further, only 1.7% of orphan children aged 6-17 and 1% of other vulnerable children aged 6-17 had a physical disability. A few orphan children had multiple physical disabilities (11.8% of those with physical disabilities had more than one). There was little variation across location.

### 3.4.3 Health Status

#### 3.4.3.1 Immunisation Status

OVC caregiving households with children aged 12-23 months were asked questions about the immunisation status of these children. Full immunisation included tuberculosis, polio (1, 2 and 3), whooping cough, tetanus, diphtheria, and hepatitis (DPT 1, 2 and 3), and measles. An extremely high 93.4% of all 12-23 year olds in OVC caregiving households were fully immunised, and virtually all of the remainder were partially immunised (6%, with 0.6% with uncertain immunisation status). In addition, 95.9% received vitamin A supplementation, which is higher than the rate for children overall only two years earlier (late 2005) as reflected in the DHS (Government of Rwanda, 2005a), at 84%. Immunisation status was lowest for Kigali Province.

#### 3.4.3.2 Diarrhoeal Diseases, Acute Respiratory Infections, Skin Diseases

Households with underfives were asked whether any underfives had had three or more watery stools at some time over the past two weeks. These same households were also asked about acute respiratory infection, noting whether “over the past two weeks, have any of your children had three or more watery stools?” to ask about skin diseases - ‘over the past two weeks, have any underfives begun to suffer from a rash on the body and/or the face and has the child scratched him/herself continuously, or had chicken pox, and perhaps has swollen glands in the neck’.

In every focus group discussion, caregivers noted that all the children they were caring for had been immunised.

![Figure 25: Disease Incidence in Underfives (two weeks prior to the survey)](image)


Based on a review of various materials and consideration of lessons learned, priority actions for education and OVC were as follows (UNAIDS and UNICEF, 2004: 2):

1. To ensure access to education for all, including orphans and vulnerable children, through initiatives such as abolishing school fees, reducing hidden costs and opportunity costs, establishing community networks, and monitoring progress.

2. To manage the supply and ensure the quality of education by strengthening education management and information systems, as well as building teacher/administrator HIV/AIDS capacity, and establishing policies and practices to reduce their own risks.

3. To expand the role of schools to provide care and support to orphans and vulnerable children through measures such as linking with community social services and networks and community networks, and monitoring progress.

4. To protect orphans and other children made vulnerable by HIV/AIDS by developing policies and practices to reduce stigma and discrimination, as well as sexual abuse and exploitation.
Respiratory infections were quite common, affecting almost half of all underfives in the two weeks before the survey. Diarrhoea affected almost one-quarter, and skin diseases 13.4%. Sisens, Subbarao and Wodon (2003), in a study assessing orphans and vulnerability compared to other children, noted that there was no difference between orphans and non-orphans in terms of diarrhoeal disease incidence (the study did not include comparisons for acute respiratory infections or skin diseases).

The seriousness of hygiene challenges at the OVC caregiving household was ranked by enumerators. In half of all cases (49.3%), the hygiene challenges were ranked at ‘very serious’ or ‘somewhat serious’.

3.4.3.3 Malaria and Mosquito Nets

An estimated 41.2% of all households had had at least one member with malaria in the year prior to the survey. Of these, 27% had had malaria in the past two weeks, yielding a figure of 11.1% of all OVC caregiving households having at least one member with malaria in the two week prior to the survey. Malaria rates were especially high for underfives, with 8.3% of all underfives having had malaria in the two weeks prior to the survey, as did a much lower 3.2% of those aged 5-17. In the year before the survey, the respective figures were 18.6% and 14% for underfives and 5-17s, respectively.

In the year before the survey, 51% of all OVC caregiving households reported that at least one member slept under a mosquito net. A very high 82.3% of all nets were treated nets. Access to mosquito nets was substantially higher in households reporting that at least some household members slept under treated nets. Of the 51% who reported that at least one member slept under a mosquito net in the past year, a remarkably high 92.1% reported that at least some household members slept under a mosquito net the night before the survey. The scaling up in the distribution of mosquito nets in the past two years has been remarkable, indeed in 2005 only 18.2% of all households owned a net, and only 15.1% had a treated net (DHS results; Government of Rwanda, 2005a).

3.5 Summary

Median household size for OVC caregiving households was 5, above the national average of 4.5. Households with underfives and children tended to be larger than households with orphans. Two-thirds (66.5%) of all OVC caregiving households were male-headed, with 33.5% female-headed, above the national average of 27.6%. However, 59.6% of orphan caregiving households were female-headed, almost twice the national rate, compared to a low 16% female-headed households for vulnerable children. Education status was low for most heads of OVC caregiving households, but was especially low for female heads.

A total of 28.1% of all OVC caregiving households were poor, divided into: ‘very poor’ (12%), ‘very poor’ (47.3%), ‘poor’ (31.5%), and ‘resourceful poor’ (7.1%). Households looking after vulnerable children were especially likely to be classified as ‘very poor’, but orphan caregiving households were twice as likely to be classified as ‘resourceful poor’, and considerably more likely to be ‘food rich’ and ‘money rich’.

One-in-ten OVC caregiving households had received some training in income generation, and one-in-seven had at least one member involved in a micro-finance initiative. Two-thirds (69.9%) of all OVC caregiving households were food short at the time of the survey, with no variation across orphan caregiving households and vulnerable children caregiving households.

Two-thirds of OVC caregiving households owned at least some farmland, almost all of which lacked labour and other inputs sufficient to be able to farm effectively. Almost 80% noted that their farmland was too small to meet needs. There was little variation across orphan caregiving households versus households caring for vulnerable children. A total of 6.2% of OVC caregiving households had been dispossessed of their land, but this was rarely associated with inheritance matters for orphan children. Asset dispossession was, however, common for orphans, where 75.3% of orphan caregiving households noted that assets had been lost following the death of a parent.

While poor, 79.2% of all OVC caregiving households reported at least some cash income over the past year, with almost all reporting income at least four times. Most of this employment related to agricultural production and sales.

Almost all OVC caregiving households had access to improved means of human waste disposal, consistent with national norms, but OVC caregiving households were more likely to rely on unimproved pit latrines than others. Four out of five OVC caregiving households had access to improved waterpoints.

Just over half (53.5%) of all OVC aged 0-4 years had a birth certificate, with the figure lowest for female orphans. This compares to 78% birth registration for all households, suggesting much high registration rates for non-OVC. For those OVC aged 12-23 months, 90.4% had been fully immunized. A total of 95.9% received vitamin A supplementation.

A total of 11.1% of all OVC caregiving households has at least one member with malaria in the two weeks prior to the survey, with many of these households having a child under the age of five with malaria (8.3%). Half (51%) of all OVC caregiving households had at least one member sleeping under a mosquito net, with 62.3% of these treated nets.

School enrolment rates for OVC were substantially below rates for non-OVC, with enrolment rates lower for orphans than for other vulnerable children. School-related costs were the main reasons for non-enrolment. For those in school, 80.6% of orphans and 69.5% of other vulnerable children were overage for the grade they were in.
Support to OVC and OVC Caregiving Households

4.1 Introduction

Respondents were asked about external support offered to OVC and OVC caregiving households to help those in need to care for their children. Questions covered the nature of support offered, the agencies involved in providing the services, perceived impacts of support offered, gaps in support, and support provided over the past year. Following a discussion of types of support obtained, respondents were asked to consider which sources were most important, second most important, etc. Questions on social networking and the strength of social capital were also included.

4.2 Awareness

As a first question, respondents were asked whether they were aware of any organisations or institutions that were involved in providing support to households with orphans and/or other vulnerable children. Only 28% of respondents indicated that they were aware of such outside support. Findings were similar for orphan caregiving households and households caring for other vulnerable children (26.8% for orphan caregiving households, and 28.9% for vulnerable children caregiving households). The average is distorted by a very high level of awareness of Eastern Province, at 62.6%, compared to figures between 18-25% for all other provinces.

For those aware of such support, 78.3% could name at least one type of support. Overall, this gives 21.9% who were aware of organisations/institutions and who knew what types of support were offered.

4.3 Assistance Received Over the Past Year

Respondents were asked whether they had received medical assistance, emotional/psycho-social support, or social/material support at any time over the past year. Findings are summarised in the following figure:

Most OVC caregiving households received no external support over the past year, holding true for orphan caregiving households as well as households looking after other vulnerable children. While low, however, medical and social/material support reflected an increase from the 2005 DHS (where 8.4% received medical assistance and 2%...
received social/material support; Government of Rwanda, 2002a). Of those who received support, medical support was most commonly mentioned, followed by social/ material support. Support tended to be more common for orphan caregiving households than for households looking after other vulnerable children for psychosocial and social/ material support (chi-square significant at the .1 level; 256.191, p=.000 for psychosocial support, and 286.850, p=.000 for social/material support). Overall, only 9.1% of OVC caregiving households have received two or more types of external assistance. There was significant variation across location, with households in Kigali, Southern and Eastern provinces (ranging up to 30%), and lowest in Western Province (7.9%).

Access to services was checked against various categories of need. Key findings are as follows:

- Poorer OVC caregiving households were more likely to have received support to access medical and social/ material services, but less likely to receive emotional support services.
- There was little variation across orphan household versus vulnerable children households in terms of access to services.
- Child-headed households were as likely as households headed by adults to have received services.
- De facto female-headed households (that is, households where the male head is absent at least six months over the past twelve months) were less likely to have received any types of services than male headed or de jure female headed households.
- Households where incoming orphans are reported to have behavioral problems were more likely to have received psychosocial support services.
- Households with OVC with reported emotional problems were more likely to have had the child received psychosocial support services than children without emotional problems.

4.3.1 Education Support

While overall support only reaches a minority of children, there is evidence of targeted support reaching select children. For example, 9.8% of all orphans attending primary school had received some support to meet primary school costs. Support was lower for other vulnerable children, at 6.6%.

Of interest, while secondary school attendance was low, at under 10%, one-third of orphan children (36.8%) who were in secondary school had received support to attend. The figure was much lower, at 18.7%, for other vulnerable children, but still high.

For primary school support, the following agencies were most commonly mentioned:
- MINALOC (15.3%)
- World Vision (15.2%)
- CRS/Cantars (14.2%)
- FARG (10.3%)
- Compassion International (7.9%)

Most recipients were offered two or more types of support (the average was 2.2 per child), with books (69.3%), paper/ pens/related (46.7%), school uniform (47.6%), and other school costs (43.3%) mentioned most commonly. In those cases where respondents could remember how long it took to obtain the support, most received support within three months. Most had heard about the support received via a local official (48.9%), followed by friends/neighbours (32.5%), public meetings (24.7%), or church groups/leaders (21.9%). When asked to note what the most important impacts, 82.7% noted that the child attended school when s/he would otherwise not have been able to, followed by improved performance in school (54.7%), adapting to school better (31.9%), and an improved view about school (28.8%). When asked about gaps in support, 41.5% felt that the support was inadequate to meet the education needs of the child, followed by the child going to school hungry (31.8%), and a lack of important school materials (30.4%). For non-orphan children, insufficient numbers received support to be able to conduct further analyses.

Regarding secondary school support to orphans, 50.8% indicated that they received support from FARG, with few other organisations mentioned. Each orphan supported for secondary school received an average of 2.3 types of support. School fees were most commonly mentioned, followed by school uniforms, books, and paper/pens/ related. Most heard from local officials, followed by friends/ neighbours and public meetings. When asked what impacts the support had had, most respondents argued that the child was able to attend school when this would not have been possible otherwise (83.3%). For non-orphans children, insufficient numbers received support to be able to conduct further analyses. Secondary school support was most commonly provided by MINALOC and FARG.

As an example of the type of education support on offer, a key informant interview was conducted with an officer from the Catch-up Programme in Nyagatare District in the north east of Rwanda. The programme is supported by ADRA, the Adventist Relief Agency, and is co-ordinated with the Ministry of Education. The aim of the programme is to get children who had dropped-out back into school, and to support young children who had not been able to attend school to so attend. Started in 2002 with three pilot school, by 2007 the programme had expanded to include 35 schools across the country, covering at least one school in each district. In Nyagatare District alone, 2537 students are supported through the Catch-up Programme.

4.3.2 Health Support

As the Ministry of Health (MINISANTE, 2004; 4) noted that “One of the most frequent reasons for the non-utilisation and failure to meet health services is the high cost of health care. Indeed, financial barriers to access care result in different forms of exclusion, including total exclusion or poverty, seasonal exclusion, temporary exclusion and partial exclusion. The risks of total exclusion or poverty are higher among the extremely poor population. The risks of seasonal temporary or partial exclusion are higher among population groups living on low and irregular income, the majority of whom are in rural areas.” In response, Government significantly expanded health insurance policy access to cover poorer household under the mutuelle de santé health support scheme, and prepared a Mutual Health Insurance Policy to this effect (adopted in December 2004).

Respondents were asked whether any children were reached by the mutuelle de santé health support scheme. Findings are indicated in the following figure:

Figure 27: Coverage by Mutuelle de Sante

Children in priority need are identified by local authorities. Objectives include eventually reaching 80% of those who dropped out before finishing primary school to complete their primary schooling, and to offer other skills training as available. Children are classified in three categories:

- Those who drop out in grades 1 or 2, who are supported until they reach grade 3.
- Those who drop out in grades 3 or 4, who are supported until they reach grade 5.
- Those who drop out in grades 5 or 6, who are supported until they reach grade 7, and thereafter supported to write their primary school leaving exams and, if passed, supporting their entry into secondary school. Those who fail their exams are supported to enrol in vocational training opportunities and other training opportunities.

At the very minimum, the children are provided with ‘competence-based training’ to help them find solutions to their daily problems. The intention is to enhance the children’s capacity to learn, value what they learn, and access to opportunities based on their performance in school. Where other education support needs are identified, to the extent that resources are available, additional resources are provided (e.g., scholastic materials).
reached through NGOs, 1.7% were reached through local government authorities, and 0.9% were reached through a community-based organisation. There was little variation in access to mutuelle de santé across province.

A number of focus group participants argued that many OVC had access to health care due to the mutuelle scheme. Of interest, some also noted that friends and neighbours often offered additional support when children were sick, such as providing them with food and helping transport them to the clinic.

For those covered by the scheme, 24.1% had their full costs covered during their last visit to a health facility, and virtually all of the remainder had costs partially covered (75.4%); only 0.5% of those covered by the scheme who took a child to a health facility did not have any costs covered. For those where costs were only partially covered or not covered at all, 57.1% indicated that they had no idea why all costs were not covered. In only 36.2% of all cases were they informed why partial costs were not eligible for coverage. Nevertheless, while 57.1% indicated that they did not know why all costs were not covered, half of those felt that the decision must have been fair, and that there were reasons, albeit not explained to them. When this was explored in more detail in focus groups, many of the participants noted that ‘special’ drugs that cost a lot of money were not fully covered. In some cases, this meant that the ‘poorest’ groups, formal health services were only accessed as a last resort. Nevertheless, the cost of medicine remains a serious constraint.

4.3.3 Support From Different Institutions

Respondents were asked a series of questions about their ability to rely on various institutions for support. Responses are summarised in the following figure. It should be noted that the responses rely on respondent’s identification of organisations, and therefore the classification into community-based organisations, faith-based organisations, and non-governmental organisations is based on their comments and identification of agencies, and the enumerator’s classification based on a listing discussed during training. With this caution in mind, support from various institutions is indicated in the following figure.

With the exception of support from Government, few OVC caregiving households have received any support over the past year. Further, in three-quarters of all cases, this support was only offered a single time from each source. For NGOs, World Vision was most commonly mentioned, followed by Compassion International, with few other agencies mentioned. NGO support was most commonly mentioned for orphans versus other vulnerable children (5.1% versus 4%, respectively), and was highest in Southern Province (14.6%), followed by Western Province (8.8%) and Eastern Province (8.4%), and lowest in Northern (3.4%) and Kigali (3.6%) provinces.

For those who received support from two or more sources, most ranked Government as the most important source, followed by NGOs and thereafter CBOs/FBOs. When asked how important the ‘value added’ was of different sources, Government was again ranked as most important, followed by NGOs and thereafter CBOs/FBOs. When friends, neighbours, extended family members, and churches and other local institutions were also included, friends and neighbours came as second most important following Government. Surprisingly, extended family members were rated as less important than both Government and NGOs in terms of the importance of the support they offered (this is discussed in more detail in the following section). CBOs/FBOs were most commonly mentioned in Eastern Province, followed by Kigali Province. For support from Government, this was least common in Western Province (8.5%, versus 23.5% overall), and highest in Eastern Province, at 32.2%.

Despite relatively low numbers of households having received direct support from NGOs, most adult FGD participants could name various NGOs that they had been involved in supporting OVC, or assisting people living with HIV. Organisations mentioned included World Relief, FARG, Haguruka, Avega, CAPITAS, CHAMP, the Red Cross, PRP+ Association of People Living with HIV/AIDS, PEPFAR, Africare, Compassion International, MAP, World Vision, and Uyiengwa N’imanzu in the north. Muslim community associations were also commonly mentioned. Further, despite low levels of support overall, qualitative findings highlight that communities where NGOs are active are often well served by these agencies, but only with a limited range of services. Finally, those directly affected by the genocide were said to have been reached for many years by FARG in particular, and that those who were still alive continued to receive support.

Beyond having heard of the organisations, most adult respondents could also explain what each organisation did. They also noted the strategic importance of this support, especially with regard to basic needs associated with food, as well as skills development and access to school. When asked about limitations, three common concerns were stated: 1) identification of children in need did not tend to involve community members, and sometimes did not reach the children most in need; 2) the range of support offered was insufficient to meet key needs; and 3) agencies did not come back and find out how things went, and what gaps remained.

In the ‘Story With A Gap’ section of the focus group discussions, respondents were asked to consider their ‘ideal future’ in ten years from now, compare this with their current circumstances, identify what was blocking them from attaining their ideal future, and ask them what was positive in current society that could be ‘built upon’ to help attain an ideal future. Across focus groups, a few key themes emerged that were felt to be central to attaining an ideal future:

- Better co-ordination of efforts by external agencies, including Government, NGOs, local non-governmental organisations, and the private sector.
- Enhanced involvement of local stakeholders, in particular caregivers and OVC themselves, in decisions made about them.
- Access to education for OVC.
- Access to credit and training for income generation.
- Access to housing materials.

The mapping exercise conducted by RAGLA (2007)

Figure 28: Support from Various Institutions

<table>
<thead>
<tr>
<th>Local Institutions</th>
<th>CBOs/FBOs</th>
<th>NGO</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.0%</td>
<td>2.1%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Orphans</td>
<td>5.3%</td>
<td>2.7%</td>
<td>6.1%</td>
</tr>
<tr>
<td>VC</td>
<td>3.1%</td>
<td>1.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>23.9%</td>
</tr>
</tbody>
</table>
were left unresolved. and support for HIV+ positive. In the rare cases where legal support (2 districts offer psychosocial support, 1 district education, nutrition, and health. only a few offer other of the fifteen districts, almost all offer support in terms of education in Kigali.

4.4 Social Networks
As noted repeatedly in earlier chapters, almost all coping with the problems of OVC occurs within households, and thereafter to varied levels within extended families and among friends and neighbours. Most coping is local, and it relies on kinship and friendship networks, and other means of local support, particularly churches and local authorities. Sectorally, support is offered through schemes such as the mutuelle de santé scheme for health care, through the absence of school fees at the primary level, and through training schemes. The social capital so important in the lives of OVC is nevertheless strongly challenged by Rwanda’s recent history that tore communities apart and undermined trust in local systems. As one national level key

But, when asked "When you need help or have a serious problem where you need outside assistance, can you usually rely on members of your birth family for support?", only 11.9% reported that they could ‘always’ rely on them. While most reported that they could ‘sometimes’ rely on them (37.6%), half of the respondents indicated that they could ‘rarely’ (24.8%) or ‘never’ (24.7%) reply on them. Further, when presented with the attitudinal statement “My problems are many, and no one wants to listen to them”, half agreed or strongly agreed with the statement. Further, when presented with the statement “Friends and neighbours help households with someone ill at the beginning, but if the illness lasts a long time, this support fades away”, 82% agreed or strongly agreed with the statement. According to the focus group discussions, what does appear to have changed, associated with the collapse of much of the social capital systems that existed before the genocide, was that links with local authorities had significantly increased because of more community level activities, and the reduction in informal channels.

informant put it, ‘The genocide of 1994 created suspicion and mistrust among the entire population and community structures that previously cared for OVC disappeared’. In such an environment, the re-establishment and/or strengthening of local systems of social capital is doubly important. Respondents were therefore asked a number of questions trying to better understand how resilient these systems were.

Despite its importance, only 6.5% reported that they had received cash or in-kind support from extended family members in the same community in the year before the survey and, in half of these cases, this only occurred once. A similar percentage (8.6%) of extended family members from outside the community also provided support over the past year, and this was more consistent (with most 2-3 times during the past year). Access to such support was highest in the most urbanised province – Kigali Province, at 8.9% among extended family members in the community, and between 11.8% from members outside the city. Perhaps due to in-transfers associated with education for children from households outside the city sending children for education in Kigali.

Qualitative findings have highlighted high levels of poverty as a key factor in support not being offered. Having said this, in some of the focus group discussions, female caregivers noted that neighbours sometimes came together to provide combined labour so that they could be paid in crops or in cash, and that they would share the proceeds. Looking beyond economic support, respondents were asked about social networking with these members. Of those who had an extended family member nearby (72.3%), 48% reported weekly visits, and most of the remainder reported monthly visits. Further, when asked how well neighbours knew each other, some 85% reported that people knew each other ‘very well’ or ‘somewhat well’. There were similar findings when respondents were asked to rate the ‘sense of community’ in their area, referring to ‘...how much people feel that they share a common history, have a common bond, identify with each other, and respect each other ... ’, with 62.1% rating the sense of community as ‘very strong’ or ‘somewhat strong’. ‘Sense of community’ was rated lowest in Kigali Province.

For four of these districts (Nyarugenge, Kicukiro, Nyaruguru, and Musanze), the numbers listed by the districts were compared to projections made under the OVC situation analysis. The ratio of OVC identified through the district listing process versus the number of OVC calculated by the situation analysis is as follows:

- Nyarugenge - 53:1
- Kicukiro - 39:1
- Musanze - 10:1
- Nyaruguru - 3:1

Findings suggest considerable variation across location, with one out of every 53 OVC in Nyarugenge listed for support, compared to a low of one out of every 3 OVC in Nyaruguru.

It is interesting to note that the ratio does not vary significantly across the number of organisations providing support, suggesting varied reach across organisation.

Of the fifteen districts, almost all offer support in terms of education, nutrition, and health. Only a few offer other support (2 districts offer psychosocial support, 1 district offers legal support, and only a few offer shelter, training, and support for HIV+ positive. In the rare cases where legal support (2 districts offer psychosocial support, 1 district education, nutrition, and health. only a few offer other of the fifteen districts, almost all offer support in terms of

SUPPORT TO OVC AND OVC-CAREGIVING HOUSEHOLDS

One OVC focus group noted that the genocide destroyed any sense of community and that ‘people who survived no longer trust each other’. This made it difficult for the children who had lost their families to the genocide to be able to rely on others. As a result, they noted that a lot of children in their situation left their towns to go and look for work, looking beyond economic support, respondents were asked about social networking with these members. Of those who had an extended family member nearby (72.3%), 48% reported weekly visits, and most of the remainder reported monthly visits. Further, when asked how well neighbours knew each other, some 85% reported that people knew each other ‘very well’ or ‘somewhat well’. There were similar findings when respondents were asked to rate the ‘sense of community’ in their area, referring to ‘...how much people feel that they share a common history, have a common bond, identify with each other, and respect each other ... ’, with 62.1% rating the sense of community as ‘very strong’ or ‘somewhat strong’. ‘Sense of community’ was rated lowest in Kigali Province.

A Situation Analysis of Orphans and Other Vulnerable Children in Rwanda

indicated the number of OVC interventions by districts. Findings are summarised below:

- Western Province
  - Rutaro - 13
  - Ngogorero - 8
  - Rusizi - 5
- Eastern Province
  - Kayunga - 26
  - Rwamagana - 6
- Northern Province
  - Burera - 13
  - Rulindo - 9
  - Musanze - 7
- Southern Province
  - Muhanga - 12
  - Ruhango - 9
  - Huye - 7
  - Nyaruguru - 5
  - Kayonza - data not available

nyarugenge - 3
Kicukiro - 15
Kamonyi - data not available
Nyaruguru - 5
Musunze - 7
Kamonyi - data not available
nyaruguru. It is interesting to note that the ratio does not vary significantly across the number of organisations providing support, suggesting varied reach across organisation.

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Nyaruguru. It is interesting to note that the ratio does not vary significantly across the number of organisations providing support, suggesting varied reach across organisation.

4.4 Social Networks
As noted repeatedly in earlier chapters, almost all coping with the problems of OVC occurs within households, and thereafter to varied levels within extended families and among friends and neighbours. Most coping is local, and it relies on kinship and friendship networks, and other means of local support, particularly churches and local authorities. Sectorally, support is offered through schemes such as the mutuelle de santé scheme for health care, through the absence of school fees at the primary level, and through training schemes. The social capital so important in the lives of OVC is nevertheless strongly challenged by Rwanda’s recent history that tore communities apart and undermined trust in local systems. As one national level key
In such an environment, it appears that the ability of households caring for orphans to rely on family members, friends and neighbours is problematic at best. In exploring this issue further in the focus group discussions, many of the respondents noted that it was only in extreme situations, and only for very poor households (‘umudugudugudugu’, those in ‘abject poverty’).

4.4.1 Ubudehe and Registration as a Household in Need
Ubudehe is a Government programme that aims to re-establish systems of social capital and social protection. It focuses on collective action and local decision-making. Almost one-third of all households (30.9%) with OVC were registered at the umudugudugu because of their looking after OVC, with registration lowest in Kigali Province. The figure was substantially higher for households caring for orphans (43.5%) compared to households with other vulnerable children and no orphans (22.6%) (chi-square significant at the .1 level; 11728.428, p = .000). In addition, 34.6% of all OVC caregiving households had been identified as households in priority need via the Ubudehe system. Of interest, only one-third of these households were also those identified at the umudugudugu level as households in priority need, suggesting quite distinct processes of identification, or confusion about whether households can be listed in both ways (chi-square significant at the .1 level; 3082.088, p = .000). Further, the Ubudehe listing system did not bias towards inclusion of households looking after orphans. Indeed, households looking after other vulnerable children were more likely to have been included than households with orphans (36.3% versus 32.2%, respectively) (chi-square significant at the .1 level; 509.717; p = .000).

OVC focus group participants in Bugesera argued that there was such a thing as community in their area, because people let us do work such as cultivating for them in their gardens so that we do not suffer from famines.

In the table asking questions about orphan children in the household, caregivers were asked whether the child was registered with local authorities or another agency as a child in need of support. Two-thirds (65.4%) had not been registered as a child in need of support, and an additional 12.8% did not know whether this had been done, leaving only 21.8% registered. Focus group discussion participants noted that services provided following this registration occurred at times of particular stress, involving things such as feeding schemes for children and vulnerable adults. Participants noted the importance of local churches in feeding people in times of particular stress, including feeding people who were constantly food insecure such as OVC and elderly caregivers. The importance of broader support schemes that reached people through local registration was said to be related to preventing some households from falling into destitution. In the past, and in the months following the genocide when emergency relief did not reach everyone, families sold off many of their belongings, and sent their children away to provide labour to others.

4.5 Summary
Many OVC caregiving households had been enrolled in, and benefited from, the mutuelle de santé medical health insurance scheme (56.4%). Beyond this, however, few other services were provided to households in need. Just over one-quarter (28%) indicated an awareness of outside support for OVC, holding true for orphan as well as vulnerable children caregiving households. Of this 28%, 78.3% could name at least one type of support. Overall, this yields 21.9% awareness of organisations/institutions who knew what types of support were offered.

In the year prior to the survey, 17.2% of all OVC caregiving households had received medical support, 6.3% received social/material support, and 1.1% received psychosocial support. Households caring for orphans were more likely to have received all three types of services. Overall, 9.1% of OVC caregiving households had received two or more types of external assistance. OHC-headed households were equally likely to have received services as adult-headed households. Just under 10% of all orphans attended primary school had received support to attend primary school, with the figure lower for other vulnerable children at 6.6%. For those orphans who had made it to secondary school (secondary school attendance was only 10% for all children), one-third had received support to attend secondary school, with the figure much lower, at 18.7%, for other vulnerable children. PARQ was most commonly mentioned in terms of support for schooling.

Overall, Government was most commonly mentioned in terms of receipt of external support, followed by NGOs, local institutions, and finally CBOS/FSBs. NGO support was more commonly provided to orphan caregiving households.

Survey findings highlight serious limits on the ability to rely on extended family members in times of crisis, and low levels of social capital overall. Emotional support and kinship networks were nevertheless important in giving people a ‘sense of community’, but that in most cases these networks could not be relied on in times of financial need, nor when problems went on for some time (e.g., chronic illness).

Given the destruction of social institutions during the genocide, Government has devoted attention to rebuilding social capital networks at the local level. Ubudehe, a Government programme aimed at strengthening the local response, focuses on collective action and local decision-making, as do other programmes (e.g., umuganda, a community labour contribution programme). Over one-third (54.6%) of all OVC caregiving households were registered as households in need under ubudehe, which is intended to link these households with support initiatives; there was no variation across households caring for orphans or other vulnerable children.
5.1 Introduction
For each respondent household, one child was randomly selected and the caregiver asked about child discipline patterns, among other questions. A series of behavioral issues were discussed, as well as how behavioral problems were dealt with.

5.2 Engagement With Children
For each respondent household, one child was randomly selected and the caregiver asked about interactions between the child and adults in the household. Six interactions were queried: reading, telling stories, singing songs, going somewhere together for fun, playing together, and spending time naming, counting, and drawing. Findings for orphan children are summarized in the following table:

<table>
<thead>
<tr>
<th>Table 10: Interactions With Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Interaction</td>
</tr>
<tr>
<td>Read books or look at picture books</td>
</tr>
<tr>
<td>Tell stories to him/her</td>
</tr>
<tr>
<td>Sing songs with him/her</td>
</tr>
<tr>
<td>Take him/her outside the home for an outing</td>
</tr>
<tr>
<td>Play with him/her</td>
</tr>
<tr>
<td>Spend time with him/her, naming, counting and/or drawing things</td>
</tr>
</tbody>
</table>


With low literacy rates, and high levels of poverty, it is perhaps not surprising that few interactions involve books and other such materials. Perhaps more accurate measures of interaction comprise those that do not involve materials, and in these cases, just under half of all orphan children had interacted in a positive fashion with an adult in their household. However, in only 12.7% was the child taken someone for an outing, suggesting home-based interactions predominate.

5.3 Child Discipline
Respondents were asked how they responded to behavioral problems with children in their households. Responses are indicated in the following table:

<table>
<thead>
<tr>
<th>Table 11: Disciplining Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Discipline</td>
</tr>
<tr>
<td>Took away privileges, forbade something the child liked, or did not allow the child to leave the house</td>
</tr>
<tr>
<td>Explained why the behavior was wrong</td>
</tr>
<tr>
<td>Gave the child something else to do</td>
</tr>
<tr>
<td>Shouted, yelled at or screamed at the child</td>
</tr>
<tr>
<td>Called the child stupid, lazy, or another name</td>
</tr>
<tr>
<td>Shook the child</td>
</tr>
<tr>
<td>Spanked, hit or slapped the child on the bottom with a bare hand</td>
</tr>
<tr>
<td>Hit the child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object</td>
</tr>
<tr>
<td>Hit or slapped the child on the face, head or ears</td>
</tr>
<tr>
<td>Hit or slapped the child on the hand, arm or leg</td>
</tr>
<tr>
<td>Beat the child with an implement over and over</td>
</tr>
</tbody>
</table>


According to the 2005 DHS, 30.7% of all women had been exposed to at least one form of violence since the age of 15. Violence against women did not vary across wealth quintile.
According to WHO definitions, the actions on the bottom of the table were regarded as discipline that was abusive. Almost half (45.4%) had been disciplined in half of the table were regarded as discipline that was abusive. Approximately 65% had been disciplined in a manner deemed abusive in the abusive. Almost half (45.4%) had been disciplined in a manner deemed abusive in the abusive. According to WHO definitions, the actions on the bottom of the table were regarded as discipline that was abusive. Almost half (45.4%) had been disciplined in half of the table were regarded as discipline that was abusive.

A number of focus groups argued that, with low levels of social and emotional support, the ‘community eye’ that is so important in reporting cases of severe abuse was weak, and therefore severe abuse was allowed to proceed without sanction. Most groups, however, did note that things were changing largely due to sensitisation around children’s rights, but that more serious forms of abuse were still being reported. It was felt to be important, in these instances, that children be in a position to speak with each other, and report any abuse with their peers to the right authorities. Mitchell and Kanyangara (2000) noted the potential role of the education system in protection children from violence, but also noted the particular challenges in doing so in situations where there is violence in the system itself.

Key informants especially noted that sexual abuse, usually of girls, was a serious problem, but that it received little attention. Human Rights Watch (2004) noted deficiencies in the ability of girls and women to obtain justice in the case of sexual violence.

Because of the size and complexity of the quantitative questionnaire, issues around violence against children could not be explored in any detail, save measuring child discipline that was considered abusive. As noted in the previous section, almost all children in OVC caregiving households had been subjected to such an extent that it could be considered violence against children, but other types of abuse were not explored. It is interesting to note that, when discussing ‘acceptable’ discipline versus ‘unacceptable’ discipline, most focus groups (including those with OVC caregivers) argued that some forms of physical discipline, noted as ‘violence’ by the WHO definition, were socially acceptable. Being spanked or hit with a small object was generally felt to be acceptable for smaller children, while for older children physical acts of this kind were not felt to be effective (although acceptable), so verbal discipline was common. However, across focus groups of community opinion leaders, caregivers and OVC caregivers, the following were uniformly unacceptable forms of discipline: children being chained or earthed, being told that they were injured, chasing them from their home, doing heavy tasks that could harm the child’s health, burning a child, and denying them access to health care or school. Cases of beating or ‘correcting’ children were limited to cases where the child has committed a crime. Boys were felt to be more difficult to discipline, and in more need of discipline than girls.

5.3.1 Violence Against Children

To strengthen the response to violence and abuse against children, the Ministry of Local Government has appointed a child protection officer to co-ordinate child protection in each district, overseeing child protection officers appointed in most sectors. However, given the magnitude of the problem, and given that some forms of violence are not considered to be violence, it is clear that the challenge is enormous.

Focus groups with street children highlighted the difficulty situation these children faced. All argued that they were treated with disrespect and stigmatised. As one group in Butare noted, ‘some call us outlaws, others call us thieves, and others say that we deserve no rights’. ‘Some people exploit us, make us do heavy work. The girls are sold for sex work by older women’.

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5.4 Child Labour

A few questions were included in the quantitative questionnaire which relate to children aged 5-17 who were working. The questions were carefully structured to ensure that the definition of work was consistent with the International Labour Organisation’s definitions which focused on work beyond household chores and related activities that are considered a ‘normal part of growing up’. Cash income fell outside ‘normal activities’, and is classified as child labour, along with work that harmed the health of the child, or interfered with schooling and play to an extent that it harmed the child. Some forms of working for cash income was considered acceptable for children aged 15-17, as long as it was not considered harmful to the child (see Law No. 27/2001 Law Relating to Rights and Protection of the Child Against Violence; also see Article 9, Paragraph 50 of the Constitution, see Rwanda Child Labour Review Team, 2006). Law No. 27/2001 protects children against violence, including sexual violence including prostitution, pornography, drug and weapon trafficking, smuggling, sale or slavery, or forced marriage (see Rwanda Child Labour Review Team, 2006).

As noted earlier in the report, almost 80% of all households had at least one member who brought in cash income in some form. Of these households, 14.8% had at least one member aged 15-17 who was contributing cash income because local systems of justice were felt to be sometimes open to corruption, with adult offenders getting off with no punishment or only small punishment because they paid a bribe.

Street children were especially at risk because, as they aged, they were imprisoned for crimes (some of which, and they noted, they committed) or for ‘riding’, while in prison the girls were said to be abused sexually by prison staff and other prisoners, and even boys attacked and raped. Even in cases where they were taken to rehabilitation centres rather than prison, they argued that they were poorly treated. ‘Security officers at the centres treat us harshly, on the pretext that they are disciplining us. We are badly intimidated, and we live in harsh conditions’ (street children in Kigali). Having said this, the Gitagata Rehabilitation Centre in Bugesera was felt to be different. ‘At this centre, children are given training and skills. Some are trained in carpentry or tailoring, while younger ones are assisted in going back to primary school’. Some of the children in Kigali noted that, with this training, they were able to secure apprenticeship positions.

In street children focus group discussions, virtually all of the children on the streets were in some form of labour, mostly working in the informal sector and as domestics. Of all 15-17 year olds, 1.2% were working in an area that fell outside ‘normal activities’. Of all working 15-17 year olds, 8.1% were working in a dangerous/potentially dangerous area. Orphan children were slightly more likely to be involved in such labour than other vulnerable children. For 5-14 year olds, none were reported to be working in any area that was dangerous.
All children of all ages provided some labour towards meeting household needs, helping around the house, collecting firewood, collecting water, and related activities. Of those aged 15-17, over one-third of orphan children and over one-quarter of non-orphan children were contributing so much labour to these activities that there is little time for things such as playing with other children, attending school, or doing homework. Findings are indicated in the following figure:

**Figure 29: Percent of Children Aged 15-17 Who Contribute Labour to Home Activities to a Level that it Interferes with School or Play**

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Almost 40% of male and female orphans aged 15-17 were involved with so many home- and farm-related chores that it interfered with schoolwork, homework, and even play. The figure was lower for other vulnerable children, but still high, especially for females. Given that few children attend secondary school, labour allocation appears to be one important determinant (this was discussed in an earlier chapter on education). Street children in particular had little time for playing, and free time was often spent looking for work and trying to ‘escape’ from their troubles through the use of drugs and alcohol. As one group in Kigali City noted, ‘sports is for leisure and for people who have eaten enough food, well off people, not for us’.

**5.5 Summary**

Almost half (45.4%) of all children in the OVC caregiving households had been disciplined in a way that was deemed abusive by the World Health Organisation. This held true for both orphan and vulnerable children caregiving households, nor was there any variation across boys and girls. Qualitative findings highlighted what a number of adults felt were increasing discipline problems, particularly with boys, and a concern that social norms within the community no longer encouraged proper behaviour of children. Concerns about abuse were common with regard to street children.

Child labour for cash or in-kind payment was uncommon, until the child turned 15, at which age it was felt acceptable to work. For the 15-17 age group, 14.8% of OVC caregiving households had at least one child that age contributing cash income, compared to 1.2% for children aged 5-14. The figures are above the national norm for all children. Of all 15-17 year olds in OVC caregiving households, 1.2% were working in an area that was deemed dangerous, including children working the streets.

‘Normal’ child labour, contributing to basic needs at households, and including activities such as fetching water, sweeping grounds, cooking, etc., was common for the majority of children. While these normal activities are not considered by the ILO to be ‘worst forms of child labour’, it was of concern that some one-third of the children were engaged in sufficient work of this nature to interfere with their time at play or at school, or to prepare homework.


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