Republic of Rwanda

NISR
NATIONAL INSTITUTE OF STATISTICS OF RWANDA

The RWANDA DHS 7 DEMOGRAPHIC AND HEALTH SURVEY

Key Indicators Report

December, 2025

Key Indicators Report

The 2025 Rwanda Demographic and Health Survey (2025 RDHS) was implemented by the National Institute of Statistics of Rwanda (NISR) in collaboration with the Ministry of Health (MOH). The funding for the 2025 RDHS was provided by the Government of Rwanda, United Nations Rwanda, Rwanda Biomedical center (RBC), The World Bank, The Gates foundation, World Health Organization, World Food Programme, UNICEF, UNDP, UNFPA, Partners in Health, Plan International, Clinton Health Access Initiative, Expertise France, National Child Development Agency (NCDA), World Vision, AIDS Healthcare Foundation (AHF).

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral therapy
ASFR	Age-specific fertility rate
BCG	Bacille Calmette-Guérin
CAPI	Computer-assisted personal interviewing
CBR	Crude birth rate
CPR	Contraceptive prevalence rate
CSPro	Census and Survey Processing
DHS	Demographic and Health Survey
DPT	Diphtheria, pertussis, and tetanus vaccine
EA	Enumeration area
FCT	Field check tables
HepB	Hepatitis B
Hib	Hemophilus influenzae type B
HIV	Human immunodeficiency virus
IPV	Inactivated poliomyelitis vaccine
IUD	Intrauterine contraceptive device
IYCF	Infant and young child feeding
LAM	Lactational amenorrhea method
MMR	Maternal mortality ratio
MOH	Ministry of Health
NISR	National Instute of Statistics of Rwanda
NN	Neonatal mortality
NRL	National Referral Laboratory
OPV	Oral polio vaccine
ORS	Oral rehydration salts
PCV	Pneumococcal conjugate vaccine

PIH	Partners in Health
PNC	Postnatal care
PNN	Postneonatal mortality
PSU	Primary sampling unit
RBC	Rwanda Biomedical Centre
RDHS	Rwanda Demographic and Health Survey
RDT	Rapid diagnostic test
RNEC	Rwanda National Ethic Committee
RPHC	Rwanda Population and Housing Census
SD	Standard deviation
SDG	Sustainable Development Goal
SDM	Standard days method
STI	Sexually transmitted infection
TFR	Total fertility rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nation Children Fund
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

FOREWORD

The national Institute of Statistics of Rwanda (NISR) has a pleasure to present the Key Indicators Report of the Seventh Rwanda Demographic and Health Survey (RDHS-VII). This report provides the first set of results from the most recent nationally representative survey designed to generate reliable and timely data on population, health, and nutrition indicators that are critical for Rwanda's development agenda.

The RDHS-VII was implemented by the National Institute of Statistics of Rwanda (NISR) in close collaboration with the Ministry of Health (MoH) and Rwanda Biomedical Centre (RBC). The survey was conducted with technical assistance from ICF through the DHS Program and with financial support from the Government of Rwanda and development partners. The successful completion of this survey demonstrates Rwanda's continued commitment to evidence-based planning, monitoring, and evaluation of health and social sector programs.

This Key Indicators Report presents preliminary findings on fertility, family planning, maternal and child health, nutrition, knowledge about HIV/AIDS, mortality, and other selected indicators. The results provide an early snapshot of progress made and remaining challenges in achieving national priorities, including the National Strategy for Transformation (NST), Vision 2050, and the Sustainable Development Goals (SDGs). These indicators will support policymakers, program managers, researchers, and development partners in assessing trends and informing immediate policy and programmatic decisions while awaiting the final comprehensive report.

The NISR would like to express sincere appreciation to all stakeholders and development partners for their substantial contribution and financial support. Namely, special thanks go to the Government of Rwanda, the World Bank Group, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), UN Women, the World Food Program (WFP), the World Health Organization (WHO), the Rwanda Biomedical Center (RBC), Partners in Health, Plan International, the Clinton Health Access Initiative, Expertise France, the National Child Development Agency (NCDA), World Vision, the Bill and Melinda Gates Foundation, the United Nations Development Program(UNDP) and the AIDS Healthcare Foundation (AHF). Their respective contributions has been a backbone for the successful completion of RDHS- VII.

NISR also acknowledges the role of households and individuals who generously gave their time and information during the survey. Their contribution has been a cornerstone for the success of the survey. Most importantly, NISR commends the dedication and professionalism of the field staff, supervisors, data processors, and technical staff from NISR, MoH and RBC whose efforts ensured the quality and integrity of the data.

It is our hope that the findings presented in this report will be widely used to strengthen health and population programs and to guide effective interventions aimed at improving the well-being of all Rwandans.

Murenzi Ivan

Director General

National Institute of Statistics of Rwanda

SURVEY GENERAL INTRODUCTION

Chapter

1

INTRODUCTION

The 2025 Rwanda Demographic and Health Survey (RDHS) represents the seventh round of the Demographic and Health Survey (DHS) conducted in Rwanda, following those implemented in 1992, 2000, 2005, 2010, 2014-15, and 2019-20. The survey was implemented by the National Institute of Statistics of Rwanda (NISR) in collaboration with the Ministry of Health (MOH) and Rwanda Biomedical Centre (RBC). Data collection was carried out from June 5 to October 25, 2025. This Key Indicators Report presents an initial overview of selected findings from the 2025 RDHS. A comprehensive analysis of the survey data will be presented in the final report in 2026.

Survey Objectives

The main goal of the 2025 RDHS is to provide current estimates of basic demographic and health indicators. Specifically, the survey collected information on fertility, awareness and use of family planning methods, breastfeeding practices, nutritional status of women, men and children, maternal and child health, adult and childhood mortality, women's empowerment, domestic violence, awareness and behavior regarding HIV and AIDS and other sexually transmitted infections (STIs), and other health-related issues. It also conducted anthropometry measurements and tests to measure the prevalence of anemia and HIV.

The data gathered through the 2025 RDHS aims to support policymakers and program managers in developing and assessing programs and strategies to enhance the health of the population. Additionally, the survey provides indicators relevant to the Sustainable Development Goals (SDGs) for Rwanda.

Chapter 2

SURVEY IMPLEMENTATION

2.1 Sample Design

The sampling frame used for the 2025 RDHS is the Fifth Rwanda Population and Housing Census (RPHC), which was conducted in 2022 by the NISR. The sampling frame is a complete list of Enumeration Areas (EAs) covering the whole country, provided by the National Institute of Statistics of Rwanda (NISR), the implementing agency for the RDHS. An EA is a natural village, or a part of a village, created for the 2022 RPHC, which served as the counting unit for the census.

The 2025 RDHS followed a two-stage sample design and was intended to produce estimates of key indicators at the national level, for urban and rural areas, four provinces and the City of Kigali, and each of Rwanda's 30 districts for some limited indicators. The first stage involved selecting sample points (clusters) consisting of EAs delineated for the 2022 RPHC. A total of 560 clusters were selected, 198 in urban areas and 362 in rural areas.

The second stage involved systematic sampling of households. A household listing operation was undertaken in all selected EAs from December 18, 2024 up to March 5, 2025, and households to be included in the survey were randomly selected from these lists. Twenty-six households were selected from each sample point, for a total sample size of 14,560 households. Before producing survey results, weighting factors were added to the data file so that the results are proportional at the national level.

All women age 15-49 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed. In half of the households, all men age 15-59 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed. Children under age 5 in all sampled households were eligible for anthropometry. In the subsample of households selected for the men's survey, women age 15-49 and men age 15-59 were eligible for height and weight measurements and HIV testing. In the same subsample, women age 15-49 and children age 6-59 months were eligible for anemia testing. The domestic violence module for men was implemented in households selected for male interview (50% of sampled households), and the domestic violence module for women was implemented in the remaining sample of 50% of households that were not selected for the male interview.

2.2 Questionnaires

Five questionnaires were utilized in the 2025 RDHS: the Household Questionnaire, the Woman's Questionnaire, the Man's Questionnaire, the Biomarker Questionnaire, and the Fieldworker Questionnaire. Based on The DHS Program's standard Demographic and Health Survey questionnaires (DHS-8 version), these instruments were adapted to reflect the population and health issues relevant to Rwandan context. Feedback was solicited from a range of stakeholders, including government ministries and agencies, non-governmental organizations, and development partners. The survey protocol was reviewed and approved by the Rwanda National Ethics Committee (RNEC). Once all questionnaires were finalized in English, they were translated into Kinyarwanda. Data collection for the 2025 RDHS was conducted using computer-assisted personal interviewing (CAPI) technology.

The Household Questionnaire listed all members and visitors within selected households. For each listed individual, basic demographic information were collected, including age, sex, marital status, educational attainment, and relationship to the head of household. For children under 18 years of age, parental survival status was determined. Data on age and sex of household members were used to identify women and men eligible for individual interviews. Additionally, the Household Questionnaire gathered information on characteristics of the dwelling unit, including the primary source of drinking water, the type of sanitation facility, materials used for flooring, external walls, and roofing. Information was also collected on household ownership of various durable goods and on disabilities among household members.

The Woman's Questionnaire was administered to all eligible women aged 15-49. These women were asked questions on the following topics:

- Background characteristics (including age, education, and media exposure)
- Birth history and childhood mortality
- Knowledge, use, and source of family planning methods
- Antenatal, delivery, and postnatal care
- Vaccinations and childhood illnesses
- Breastfeeding and infant feeding practices
- Women's minimum dietary diversity
- Marriage and sexual activity
- Fertility preferences (including the desire for more children and the ideal number of children)
- Knowledge, awareness, and behavior regarding HIV and other sexually transmitted infections (STIs)
- Knowledge, attitudes, and behavior related to other health issues (e.g., smoking)
- Early childhood development
- Human Papilloma Virus vaccination
- Cervical cancer screening
- Adult and maternal mortality
- Domestic violence

The Man's Questionnaire was administered to all men aged 15-59 within a selected subsample of households. This instrument captured much information across many of the same domain as the Woman's Questionnaire, though it was shorter because it did not contain detailed reproductive history or questions on maternal and child health.

The Biomarker Questionnaire was used to record the results of anthropometry measurements and other biomarker for women, men, and children. Anthropometric measurement for children were conducted to all households. However, testing for anemia and HIV was administered to only 50% of the selected subsample of the households designated for men's interview. For children aged 6-59 months, testing proceeded only after obtaining consent from a parent or guardian. Blood samples were collected from consenting, eligible women and men. Consent procedures were followed for young people aged 15-17 who had never been married, requiring both parental or gurdian consent followed by the assent of the youth.

The Fieldworker Questionnaire collected background information on the interviewers, serving as a tool for subsequent analyses of data quality. Each interviewer completed this self-administered questionnaire after the final selection and prior to starting fieldworker. No personal identifiers were attached to the 2025 RDHS fieldworker data file.

Data collection was conducted using tablets. The tablets were equipped with Bluetooth technology, enabling remote electronic transfer of files. This facilitated the remote dissemination of assignments from team leaders to interviewers, the distribution of questionnaires to survey team members, and the submission of completed questionnaires from interviewers to team leaders. The computer-assisted personal interviewing (CAPI) data collection system used for the 2025 RDHS was developed by The DHS Program, utilizing a mobile version of CSPro, and was adapted by the technical team at NISR.

2.3 Anthropometry, Anemia, and HIV Testing

Anthropometry measurements were obtained for all children aged 0-5 in the sampled households. Within the subsample of households selected for the male survey, anemia testing was performed for children age 6-59 months and for women aged 15-49 years. Furthermore, both anthropometry and HIV testing were performed for both eligible men aged 15-59 and women aged 15-49 years within these households.

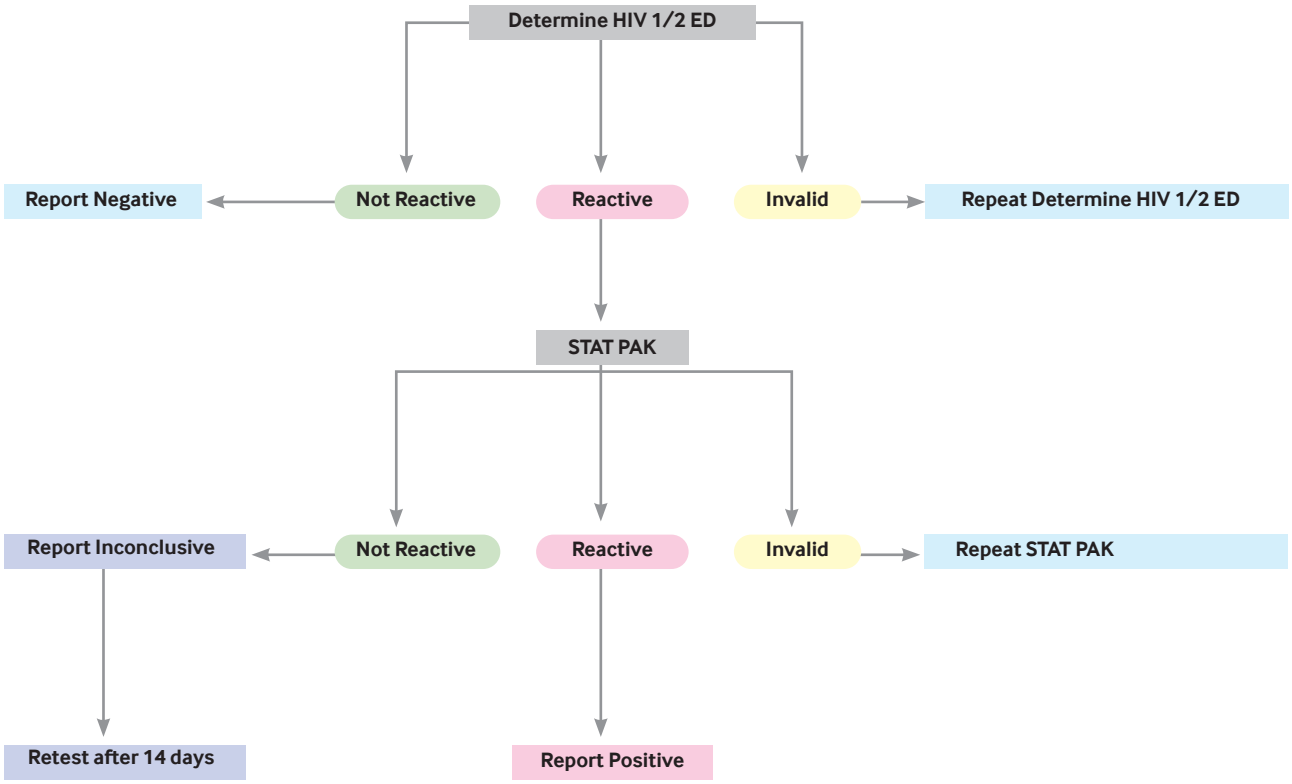
Anthropometry: Height and weight measurements were obtained for children aged 0-5 (under five years) and for eligible women and men aged 15-49 and 15-59, respectively. To enhance data quality, the 2025 RDHS implemented real-time quality assurance protocols during data collection. These procedures included the re-measurement on a subsequent day for two groups: (1) all children whose initial measurement fell outside pre-specified flagged values, and (2) a randomly selected 10% of all measured children.

Anemia testing: Venous blood specimens for hemoglobin measurement were collected from consenting women aged 15-49 and from children aged 6-59 months for whom consent was obtained from a parent or guardian. A drop of blood via venous puncture was collected in a microcuvette. On-site Hemoglobin analysis was carried immediately using a battery-operated portable HemoCue 201+ analyzer. All results were communicated to participants both verbally and in writing. Participants with hemoglobin levels below 7 g/dl were referred for follow-up health facility care. For children, guardiaans were instructed to seek care at health facility, while eligible women received referral instructions. Anemia results will be published in the final survey report.

HIV testing: In the subsample of households selected for the men's survey, all women and men who completed an individual interview were eligible for HIV serology testing. The survey featured a parallel testing system for HIV testing, in which a rapid diagnostic testing algorithm (RDT) was performed in the household for respondents wishing to know their status, and the collection of dried blood spot (DBS) specimens in the household for subsequent anonymous laboratory testing. For HIV rapid testing, venous blood was drawn from any respondent who consented. HIV prevalence for the survey will be based on the laboratory test results.

For participants consenting to know their results, venous blood was drawn for RDT. This process adhered to Rwanda's national HIV testing algorithm (see figure 1). Dedicated nurse counselors provided pre- and post-test counseling and conducted the rapid testing. Results were returned immediately, and individuals with a positive or inconclusive result were immediately retested and were given a referral form to the nearest health facility for further care, treatment and management.

Figure 1 Algorithm for home-based testing for HIV



For laboratory testing for HIV, interviewers explained the testing procedure, the confidentiality of all data, and the fact that the lab test results would not be returned to respondents. Following verbal consent for specimen collection, five blood spots were collected from the venous blood draw on a standard filter paper card to create a dried blood spot (DBS) specimen. DBS specimens were dried overnight and packaged for secure storage the following morning. Approximately every 2 weeks, or less, central office supervisors collected all DBS samples from field teams and transported them to the National Referral Laboratory (NRL) in Kigali. At the NRL, each blood sample was logged into the CSPro HIV Test Tracking System database and stored at -20˚C until tested. In accordance with the HIV testing protocol stipulated, blood could be tested only after all questionnaire data collection was completed, the data had undergone verification and cleaning, and all individual unique identifiers had been removed from the specimens. Following laboratory testing, DBS specimen are stored at -80^0 C for long-term conservation. Results for HIV prevalence will be published in the final 2025 RDHS report.

All households, irrespective of their inclusion in biomarker subsamples, were given an informational brochure explaining the causes and prevention of anemia. Additionally, each respondent was provided with a list of local facilities offering voluntary counseling and testing (VCT) services for HIV. Respondents who consented to HIV testing were issued transportation voucher to facilitate their access to free VCT services.

2.4 Pretest

A pretest was conducted from April 1 to 26, 2025, comprising theoretical training and field practice. The pretest training was deliverd in two parallel sessions: one focused on questionnaire interviews with 20 nurses, and the other on biomarker protocols for 8 laboratory technicians. Field practice followed the pretest training to test data collection materials including CAPI data collection applications and biomarker collection forms.

The pretest training lasted for the first two weeks and included various approaches such as power point presentations, mock interviews, group work, and in-class practice sessions. Additionally, CAPI training focused on interview procedures using CAPI technology. The biomarker training covered theoretical and practical aspects of anthropometry measurement, anemia and HIV, and venous blood sample collection, and included a standardization exercise for anthropometry. Trainings were conducted by a team of trainers from NISR, MOH/RBC, and international consultants.

A three-day field practice was held in selected rural and urban villages of Musanze district. Based on lessons learned during field practice, final adjustments were made to both the questionnaires and the CAPI applications before the main survey.

2.5 Training of Field Staff

The main training for the 2025 Rwanda DHS began on May 5 and concluded on June 3, 2025. A total of 173 participants, comprising 121 nurses and 52 lab technicians, were selected based on merit to attend the training. Based on post-training test scores, 20 nurses were selected as team leaders and 101 nurses as interviewers. The training sessions took place in the main auditorium of the NISR's training center and were conducted by NISR staff, MOH/RBC representatives, and three international consultants. The training utilized various learning approaches including plenary lectures on technical aspects of data collection tool using CAPI for nurses and other hands on demonstrations of the process of biomarker collection, printed instructions on how to fill out the questionnaires and other related tools for lab technicians. In addition, break-out sessions were held on a daily basis whereby trainees had the opportunity for hands-on practice with both adults and children on different procedures of biomarker testing. Anthropometry standardization exercises were carried out in health centers. Field supervisors were trained on using Field Check Tables (FCT) to monitor the status, process, completeness, and quality of field data collection.

2.6 Fieldwork

Data collection was conducted by 20 field teams, each provided with two field vehicles. Fieldwork for the 2025 RDHS commenced on June 5, 2025 and concluded on October 25, 2025. The DHS survey was conducted in 560 clusters across all 30 districts of Rwanda. Throughout the fieldwork, the team operations and data quality were closely supervised by field supervisors.

Fieldwork monitoring was a crucial aspect of the 2025 RDHS, with multiple rounds of monitoring conducted by survey supervisors from NISR and MOH/RBC. These supervisors were trained to use the Field Check Tables (FCT) to monitor fieldwork progress. The FCT reports were generated regularly from the team leaders' tablets and accessed by all supervisors, enabling them to track team progress and provide timely feedback.

2.7 Data Processing

The processing of the 2025 RDHS data began almost as soon as the fieldwork started. As data collection was completed in each cluster, all electronic data files were transferred to the NISR central office in Kigali. These data files were registered and checked for inconsistencies, incompleteness, and outliers. The field teams were alerted to any inconsistencies and errors. Secondary editing, carried out in the central office, involved resolving inconsistencies and coding the open-ended questions. The NISR data processor coordinated the exercise at the central office. The biomarker paper questionnaires were compared with electronic data files to check for any inconsistencies in data entry. Data entry and editing were carried out using the CSPro software package. The concurrent processing of the data offered a distinct advantage because it maximized the likelihood of the data being error-free and accurate. The availability of field check tables instantaneously on demand allowed for effective monitoring. The secondary editing of the data was completed in the first week of November, 2025.

Throughout this report, figures presented in the tables reflect weighted numbers. Percentages based on 25 to 49 unweighted cases are shown in parentheses, while percentages based on fewer than 25 unweighted cases are suppressed and replaced with an asterisk, to caution readers when interpreting data that a percentage based on fewer than 50 cases may not be statistically reliable.

SURVEY KEY FINDINGS

Chapter 3

KEY FINDINGS

3.1 Response Rates

Table 1 presents the response rates for the 2025 RDHS. From a total sample of 14,560 selected households, 14,434 were found to be occupied. Interviews were successfully completed in (14,427) of these occupied households, yielding a response rate of 99.9%. Within these interviewed households, 14,396 women aged 15-49 were identified as eligible for individual interviews. Completed interviews were obtained from 14,283 eligible women, yielding a response rate of 99%. For the male survey subsample, 7,280 households were selected, of which 7,218 were occupied. All but four occupied households (7,214) were successfully interviewed, corresponding to a household response rate rounding up to 100%. From these households, 6,667 men aged 15-59 were identified as eligible, and interviews were completed with 6,548 men, yielding a men's response rate of 98%.

Table 1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Rwanda 2025

	Residence		
Result	**Urban**	**Rural**	**Total**
Household interviews			
Households selected	5,148	9,412	14,560
Households occupied	5,076	9,358	14,434
Households interviewed	5,073	9,354	14,427
Household response rate	**99.9**	**100.0**	**100.0**
Interviews with women aged 15–49			
Number of eligible women	5,344	9,052	14,396
Number of eligible women interviewed	5,295	8,988	14,283
Eligible women response rate	**99.1**	**99.3**	**99.2**
Household interviews in subsample			
Households selected	2,574	4,706	7,280
Households occupied	2,539	4,679	7,218
Households interviewed	2,538	4,676	7,214
Household response rate in subsample	**100.0**	**99.9**	**99.9**
Interviews with men aged 15–59			
Number of eligible men	2,397	4,270	6,667
Number of eligible men interviewed	2,324	4,224	6,548
Eligible men response rate[2]	97.0	98.9	98.2

1 Households interviewed/households occupied.
2 Respondents interviewed/eligible respondents.

3.2 Characteristics of Respondents

Table 2 shows, the weighted and unweighted numbers, along with the weighted percentage distributions, of women and men aged 15-49 interviewed in the 2025 RDHS, disaggregated by background characteristics. More than half of the sampled women (52%) and men (53%) are under 30 years of age .

Table 2 Background characteristics of respondents

Percent distribution of women and men aged 15–49 by selected background characteristics, Rwanda 2025

	Women			Men		
Background characteristic	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15–19	20.3	2,897	2,919	22.7	1,337	1,353
20–24	17.4	2,489	2,491	17.3	1,019	1,010
25–29	14.2	2,032	2,014	12.8	754	739
30–34	13.2	1,879	1,882	13.0	766	771
35–39	13.4	1,911	1,890	13.2	779	761
40–44	12.1	1,730	1,735	12.4	731	750
45–49	9.4	1,344	1,352	8.6	505	497
Religion						
Catholic	37.2	5,317	5,402	41.6	2,453	2,463
Protestant	47.2	6,739	6,658	40.2	2,370	2,356
Adventist	12.3	1,762	1,762	12.2	716	721
Muslim	1.5	221	229	2.5	146	140
Traditional	0.0	1	1	0.0	3	2
Jehovah witness	0.8	121	114	0.6	35	34
Other	0.0	5	4	0.0	1	1
No religion	0.8	117	113	2.8	167	164
Marital status						
Never married	38.5	5,505	5,558	47.1	2,772	2,786
Married	30.0	4,290	4,354	28.6	1,684	1,715
Living together	21.8	3,119	3,012	22.1	1,299	1,248
Divorced/separated	7.7	1,097	1,073	2.0	120	116
Widowed	1.9	272	286	0.3	16	16
Residence						
Urban	32.0	4,570	5,295	32.1	1,889	2,128
Rural	68.0	9,713	8,988	67.9	4,002	3,753
Province						
Kigali	16.0	2,290	1,752	17.3	1,020	772
South	21.6	3,087	3,424	22.4	1,317	1,482
West	20.6	2,949	3,227	18.7	1,100	1,205
North	14.6	2,089	2,228	14.6	862	927
East	27.1	3,868	3,652	27.0	1,591	1,495
Education						
No education	6.5	929	936	5.9	347	346
Primary	55.3	7,893	7,750	58.9	3,469	3,425
Secondary	33.7	4,810	4,909	29.6	1,741	1,740
More than secondary	4.6	651	688	5.7	334	370
Wealth quintile						
Lowest	18.5	2,642	2,641	17.0	1,003	1,012
Second	19.2	2,738	2,676	17.3	1,021	1,018
Middle	19.2	2,746	2,688	19.8	1,167	1,144
Fourth	20.2	2,885	2,859	21.7	1,281	1,252
Highest	22.9	3,272	3,419	24.1	1,419	1,455
Total 15–49	100.0	14,283	14,283	100.0	5,891	5,881
50–59	na	na	na	na	657	667
Total 15–59	na	na	na	na	6,548	6,548

Note:
Education categories refer to the highest level of education attended, whether or not that level was completed.
na = Not applicable.

Over 90% of respondents identify as Christians, namely Catholic, Protestant, and Adventist denominations. 39% of women and 47% of men have never been married, while approximately half of the respondents are either formally married or living together with a partner (52% of women and 51% of men). Women are more likely to report being divorced or separated (8%) than men (2%).

Furthermore, 2% of women are widowed, compared to less than 1% of men. Regarding residence, 68% of respondents live in rural areas. In terms of educational attainment, 7% of women and 6% of men report never

having attended school. A majority of 55% women and 59% of men have received some primary education, while 34% of women and 30% of men attended secondary school. Education beyond the secondary level has been attained by 5% of women and 6% of men.

3.3 Fertility

Total fertility rate:

The average number of children that a woman would have by the end of her childbearing years if she bore children at the current age-specific fertility rates. Age-specific fertility rates are calculated for the 3 years before the survey based on detailed pregnancy histories provided by women.

Sample: Women aged 15–49

To generate data on fertility, all interviewed women were requested to report the total number of sons and daughters to whom they had ever given birth. To ensure accurate reporting, women were asked separately about children living at home, those living elsewhere, and those who had died. A complete birth history was then gathered, including details on the sex, birth date, and survival status of each child. Additionally, the age at death for deceased children was recorded.

Table 3.1 Current fertility

Age-specific and total fertility rates, general fertility rate, and the crude birth rate for the 3 years preceding the survey, according to residence, Rwanda 2025

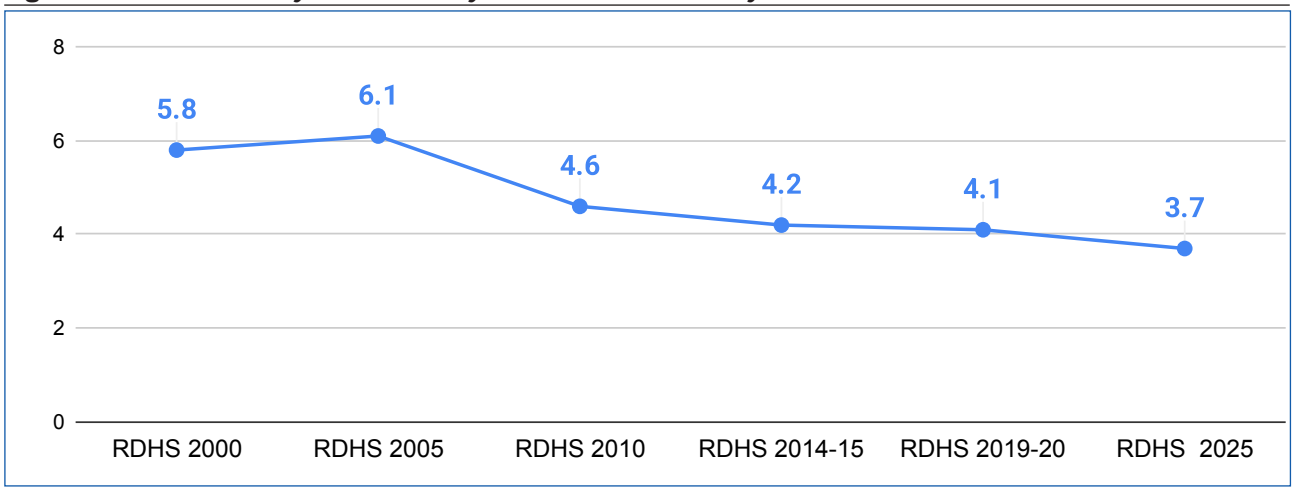
	Residence		
Age group	Urban	Rural	Total
10–14	[0]	[0]	[0]
15–19	30	44	39
20–24	112	165	145
25–29	161	189	179
30–34	146	163	156
35–39	149	124	131
40–44	60	72	69
45–49	[15]	[16]	[16]
TFR (15–49)	3.4	3.9	3.7
GFR	108	122	117
CBR	29.9	26.9	27.7

Notes:
Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates are for the period 1–36 months preceding the interview. Rates for the 10–14 age group are based on retrospective data from women aged 15–17.
TFR: Total fertility rate expressed per woman
GFR: General fertility rate expressed per 1,000 women aged 15–44
CBR: Crude birth rate, expressed per 1,000 population

Table 3.1 demonstrates the age-specific fertility rates (ASFRs) among women categorized by 5-year age groups, during the 3-year period preceding the survey. The age-specific rates, along with the Total Fertility Rate, were computed directly from birth history data, considering live births only.

The TFR is interpreted as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the currently observed age-specific rates. In Rwanda, if fertility rates remain constant, a woman would bear an average of 3.7 children in her lifetime.

Figure 2 Trends in fertility rate for the 3 years before each survey



As shown in Figure 2, the TFR has declined from 6.1 children per woman in the 2005 RDHS to 3.7 children per woman in the 2025 RDHS. Fertility rates continue to be higher among rural women than among urban women. Rural women are expected to have approximately 0.5 more children during their reproductive years compared to their urban counterparts (with TFR of 3.9 and 3.4, respectively).

Table 3.2 Current Fertility by Province

Total fertility rates for the 3 years preceding the survey by province, Rwanda 2025

Province	TFR
Kigali	3.1
South	3.8
West	3.9
North	3.4
East	4.0
Total	3.7

Notes: Rates are for the period 1–36 months preceding the interview.
TFR: Total fertility rate expressed per woman.

According to Table 3.2 the TFR is the highest in the East province (4.0) and the lowest in Kigali (3.1).

3.4 Teenage Pregnancy and Motherhood

Teenage pregnancy

Percentage of women aged 15–19 who have ever been pregnant.

Sample: Women aged 15–19

Adolescent fertility presents a significant health and social concern. Children born to very young mothers face an elevated risk of sickness and death. Furthermore, teenage mothers are more likely to experience adverse pregnancy outcomes and experience greater constraints in pursuing educational opportunities compared to their young women who delay childbearing.

Table 4 illustrates the percentage distribution of women aged 15-19 by pregnancy experience, specifically, those who have ever had a live birth, experienced a pregnancy loss, were pregnant with their first child at the time of the survey, or have ever been pregnant according to selected background characteristics. Overall, 8% of women aged 15-19 have ever been pregnant. Among these, 6% have had a live birth, less than 1% have experienced a pregnancy loss, and 2% were pregnant at the time of the interview. The proportion of teenagers who have ever been pregnant rises rapidly with age, rising from less than 1% at age 15 to 20% at age 19. Teenagers in the lowest wealth quintile tend to start childbearing earlier than other teenagers. Teenagers in the East province are more likely to start childbearing earlier than their counterparts in other provinces.

Table 4 Teenage pregnancy

Percentage of women aged 15-19 who have ever had a live birth, percentage who have ever had a pregnancy loss, percentage who are currently pregnant, and percentage who have ever been pregnant, according to background characteristics, Rwanda 2025

	Percentage of women aged 15-19 who:				
Background characteristic	Have ever had a live birth	Have ever had a pregnancy loss[1]	Are currently pregnant	Have ever been pregnant	Number of women
Age					
15	0.6	0.0	0.2	0.8	561
16	1.2	0.0	1.0	2.2	613
17	4.5	0.4	0.9	5.5	575
18	8.1	1.1	4.0	12.3	577
19	14.0	1.6	5.6	19.9	570
Residence					
Urban	4.1	0.5	1.6	5.9	864
Rural	6.3	0.7	2.6	9.0	2,033
Province					
Kigali	4.8	0.0	1.8	6.6	395
South	5.0	0.8	1.8	7.0	643
West	4.7	0.6	1.7	6.6	591
North	2.5	0.9	1.7	4.7	397
East	8.5	0.7	3.6	12.1	870
Education					
No education	(12.4)	(0.0)	(8.9)	(21.3)	28
Primary	8.8	1.1	3.7	12.7	1,337
Secondary	2.7	0.2	1.0	3.8	1,523
More than secondary	*	*	*	*	8
Wealth quintile					
Lowest	11.3	1.2	3.5	14.7	488
Second	5.6	0.9	2.8	9.0	583
Middle	6.9	0.8	3.3	10.3	569
Fourth	3.5	0.3	2.2	5.8	583
Highest	2.3	0.0	0.3	2.6	675
Total	5.6	0.6	2.3	8.1	2,897

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

1 Stillbirth, miscarriage, or abortion

3.5 Fertility Preferences

Desire for another child

Women were asked whether they wanted more children and, if so, how long they would prefer to wait before the birth of the next child. Women who are sterilized are assumed not to want any more children.

Sample: Currently women in marital union aged 15–49

Information on fertility preferences is critical for assessing the potential demand for family planning services aimed at either spacing or limiting future births. To gather information on fertility preferences, all currently married women (irrespective of pregnancy status) were asked several questions regarding their desire for additional children and, if so, their preferred timing.

As presented in **Table 5**, 13% of women desire to have another child soon (within the next 2 years), while 37% wish to do so at a later time (in 2 or more years). 47% of women want no more children, this group includes 3% who have already been sterilized, and 2% who were declared infecund.

Table 5 Fertility preferences by number of living children

Percent distribution of currently married women aged 15–49 by desire for children, according to the number of living children, Rwanda 2025

	Number of living children[1]							
Desire for children	**0**	**1**	**2**	**3**	**4**	**5**	**6+**	**Total**
Have another soon[2]	91.2	22.8	14.1	8.8	4.7	3.3	1.6	13.2
Have another later[3]	2.3	73.4	60.8	29.4	12.5	5.9	2.8	36.8
Have another, undecided when	0.0	0.2	0.2	0.1	0.2	0.0	0.0	0.1
Undecided	1.7	0.3	1.3	2.4	2.7	2.2	2.1	1.7
Want no more	0.0	2.9	22.5	56.7	72.9	78.3	82.9	44.0
Sterilized[4]	0.7	0.1	0.3	1.4	5.0	6.2	7.4	2.5
Declared infecund	4.1	0.3	0.9	1.2	2.1	4.0	3.0	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	215	1,364	1,780	1,461	1,178	712	698	7,410

[1] The number of living children includes a woman's current pregnancy
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilization

Fertility preferences are closely related with the number of living children a woman has. 91% of married women with no living children desire a child soon, compared to 23% of those with one child. In general, women with more children are significantly more likely to want no additional children.

3.6 Family Planning

3.6.1 Contraceptive Use

Contraceptive prevalence

Percentage of women who use any contraceptive method.

Sample: Currently women in marital union aged 15–49 and sexually active unmarried women aged 15–49

Modern methods

The methods of contraception include male and female sterilization, injectables, intrauterine devices (IUDs), contraceptive pills, implants, female and male condoms, emergency contraception, the standard days method, and the lactational amenorrhea method.

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilization, male sterilization, the pill, the intrauterine device (IUD), injectables, implants, male condoms, female condoms, lactational amenorrhea method (LAM), and standard days method (SDM). Methods such as rhythm and withdrawal are defined as traditional.

Table 6 shows the percent distribution of currently married women and sexually active unmarried women by the contraceptive method they currently use. Overall, 69% of currently married women use a method of family planning, with 64% using modern method and 5% using traditional method. Among currently married women, the most popular methods are implants (34%), injectables (14%), and the pill (7%). The contraceptive prevalence rate (CPR) among married women varies with age, rising from 38% among women aged 15-19 to a peak of 75% among women aged 25-29 before declining to 71% among women aged 40-44, and 53% among women aged 45-49.

Contraceptive use among married women shows a disparity by residence, with a slightly higher prevalence in rural areas than in urban areas (71% and 65%, respectively). Use of contraception is the highest among currently married women in the North province (76%) and the South province (71%) and the lowest in Kigali (66%). The association between contraceptive use and educational attainment is non-linear, with a higher prevalence among women with a primary education (70%). Furthermore, women in the highest wealth quintile are less likely to use a contraceptive method (64%) than those in the lowest-four quintiles (69% to 73%).

As indicated in **Table 6**, sexually active unmarried women are less likely than currently married women to use a contraceptive method. Among this group, 54% of sexually active unmarried women report using any method, with 52% using a modern method. The most popular modern method are implants (25%) followed by injectables (14%). Male condoms and pills are used by 8% and 3% of sexually active unmarried women, respectively.

The CPR among currently married women in Rwanda increased from 64% in the 2019-20 RDHS to 69% in the 2025 RDHS.

Table 6 Current use of contraception according to background characteristics

Percentage distribution of currently married women and sexually active unmarried women aged 15–49, by contraceptive method currently used, according to background characteristics, Rwanda 2025

	Modern method														Traditional method						
Background characteristic	Any method	Any modern method	Female sterilization	Male sterilization	IUD	Injectables	Implants	Pill	Male condom	Female condom	Emergency contraception	SDM	LAM	Other	Any traditional method	Rhythm	Withdrawal	Other	Not currently using	Total	Number of women
CURRENTLY MARRIED WOMEN																					
Number of living children																					
0	2.2	2.2	0.1	0.3	0.0	0.4	0.7	0.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.8	100.0	356
1–2	71.8	69.3	0.1	0.1	2.1	15.9	42.0	6.4	1.4	0.1	0.1	0.7	0.4	0.0	2.5	0.9	1.5	0.0	28.2	100.0	3,108
3–4	75.9	69.9	2.8	0.2	3.6	15.5	34.0	8.2	3.1	0.0	0.1	1.6	0.5	0.1	6.0	2.0	3.9	0.1	24.1	100.0	2,584
5+	68.9	58.0	6.9	0.2	1.4	12.0	26.3	5.5	3.5	0.1	0.1	1.4	0.7	0.0	10.8	3.6	7.1	0.2	31.1	100.0	1,361
Age																					
15–19	38.0	38.0	0.0	0.0	0.0	5.7	24.7	6.0	0.0	0.0	0.0	0.0	1.6	0.0	0.0	0.0	0.0	0.0	62.0	100.0	92
20–24	66.8	65.8	0.0	0.0	0.3	11.4	47.5	5.2	0.7	0.0	0.1	0.3	0.3	0.0	1.1	0.3	0.8	0.0	33.2	100.0	839
25–29	74.6	73.1	0.1	0.1	1.8	17.1	45.6	6.1	1.4	0.0	0.0	0.6	0.4	0.0	1.5	0.7	0.9	0.0	25.4	100.0	1,293
30–34	72.9	70.3	0.8	0.1	3.4	15.8	38.5	7.7	2.3	0.0	0.1	0.7	0.8	0.1	2.6	0.3	2.3	0.0	27.1	100.0	1,427
35–39	74.0	68.8	2.8	0.1	3.6	16.6	32.5	8.7	2.6	0.2	0.1	1.3	0.4	0.0	5.2	2.1	3.1	0.1	26.0	100.0	1,482
40–44	71.1	61.1	5.5	0.3	2.0	14.5	27.5	5.5	3.5	0.0	0.0	1.4	0.7	0.0	10.1	2.9	7.1	0.1	28.9	100.0	1,304
45–49	52.6	41.7	4.7	0.3	2.3	8.2	14.9	4.9	3.4	0.1	0.2	2.6	0.1	0.0	10.8	4.6	6.0	0.3	47.4	100.0	974
Residence																					
Urban	65.1	60.9	2.4	0.0	5.2	15.2	26.5	7.4	2.3	0.1	0.1	1.4	0.2	0.0	4.2	1.7	2.4	0.1	34.9	100.0	2,166
Rural	71.1	65.6	2.3	0.2	1.2	14.0	37.6	6.2	2.4	0.0	0.1	1.0	0.6	0.0	5.5	1.7	3.7	0.1	28.9	100.0	5,244
Province																					
Kigali	65.8	61.3	2.0	0.1	6.0	16.6	25.2	7.4	2.3	0.2	0.0	1.1	0.2	0.0	4.5	2.4	2.0	0.1	34.2	100.0	1,030
South	70.5	63.7	2.8	0.1	2.6	12.5	32.9	8.3	2.8	0.0	0.0	1.3	0.5	0.0	6.7	2.2	4.4	0.1	29.5	100.0	1,595
West	67.0	61.0	3.3	0.3	1.0	14.7	33.3	4.5	1.7	0.0	0.1	1.5	0.5	0.1	6.1	1.7	4.4	0.0	33.0	100.0	1,559
North	76.1	72.1	1.2	0.1	2.0	13.4	45.9	5.5	2.6	0.0	0.0	1.3	0.2	0.0	4.0	2.0	1.9	0.0	23.9	100.0	1,173
East	68.1	64.0	2.0	0.1	1.7	14.8	34.3	7.0	2.4	0.0	0.2	0.7	0.7	0.0	4.2	0.9	3.1	0.1	31.9	100.0	2,053
Education																					
No education	64.3	59.4	3.0	0.4	1.0	11.2	35.9	3.4	2.7	0.0	0.0	1.1	0.6	0.0	4.9	1.5	3.4	0.1	35.7	100.0	603
Primary	70.2	64.4	2.5	0.2	1.2	14.3	36.4	6.3	2.2	0.1	0.0	0.8	0.4	0.0	5.8	1.8	3.9	0.1	29.8	100.0	4,587
Secondary	69.3	66.2	1.6	0.0	3.3	15.9	32.6	8.1	2.6	0.0	0.2	1.3	0.6	0.0	3.1	1.1	2.0	0.0	30.7	100.0	1,866
More than secondary	67.2	59.4	2.1	0.3	16.0	12.1	14.2	7.1	2.2	0.0	0.4	4.3	0.6	0.1	7.7	4.5	3.0	0.3	32.8	100.0	353
Wealth quintile																					
Lowest	68.8	65.0	1.3	0.1	0.6	10.4	45.0	4.6	1.7	0.0	0.0	0.4	1.0	0.1	3.8	0.9	2.9	0.0	31.2	100.0	1,419
Second	71.7	66.2	2.4	0.1	0.5	13.4	41.0	6.3	1.6	0.0	0.1	0.8	0.2	0.0	5.5	2.0	3.5	0.0	28.3	100.0	1,457
Middle	73.0	67.4	1.9	0.2	1.3	17.3	36.7	5.7	2.8	0.0	0.1	0.8	0.5	0.0	5.6	1.4	4.0	0.1	27.0	100.0	1,499
Fourth	69.0	63.9	3.2	0.2	1.1	16.4	29.9	8.0	3.1	0.2	0.0	1.2	0.5	0.0	5.2	1.6	3.4	0.1	31.0	100.0	1,526
Highest	64.2	58.7	2.7	0.1	8.2	14.0	20.1	8.0	2.6	0.0	0.2	2.4	0.3	0.0	5.5	2.7	2.7	0.1	35.8	100.0	1,509
Total	69.3	64.2	2.3	0.1	2.4	14.3	34.3	6.6	2.4	0.0	0.1	1.1	0.5	0.0	5.1	1.7	3.3	0.1	30.7	100.0	7,410
SEXUALLY ACTIVE UNMARRIED WOMEN[1]																					
Residence																					
Urban	52.9	52.2	1.8	0.0	0.2	15.4	24.6	3.3	3.9	0.0	2.8	0.2	0.0	0.0	0.7	0.7	0.0	0.0	47.1	100.0	191
Rural	54.8	51.7	0.9	0.0	0.3	12.5	25.4	1.9	10.3	0.0	0.0	0.4	0.0	0.0	3.1	0.0	3.1	0.0	45.2	100.0	249
Total	54.0	51.9	1.3	0.0	0.3	13.7	25.0	2.5	7.5	0.0	1.2	0.3	0.0	0.0	2.0	0.3	1.7	0.0	46.0	100.0	440

Note: If more than one method is used, only the most effective method is considered in this tabulation.
SDM = Standard days method
LAM = Lactational amenorrhea method
[1] Women who have had sexual intercourse within 30 days preceding the survey.

3.6.2 Need and Demand for Family Planning

Unmet need for family planning

Percentage of women who (1) are not pregnant and not postpartum amenorrheic, are considered fecund, and want to postpone their next birth for two or more years or stop childbearing altogether but are not using any contraceptive method; or (2) have a mistimed or unwanted current pregnancy; or (3) are postpartum amenorrheic and their most recent birth in the past 2 years was mistimed or unwanted.

Met need for family planning

Current contraceptive use (any method).

Sample: Currently married women aged 15–49 and sexually active unmarried women aged 15–49

Total demand for family planning:	Unmet need for family planning + met need (current contraceptive use [any method])
Proportion of demand satisfied:	Current contraceptive use (any method) / Unmet need + current contraceptive use (any method)
Proportion of demand satisfied by modern methods:	Current contraceptive use (any modern method) / Unmet need + current contraceptive use (any method)

The proportion of women who desire to stop childbearing or space their next birth is a crude measure of the extent of the need for family planning, given that not all of these women are exposed to the risk of pregnancy, and some may already be using contraceptive method. This section discusses a more refined extent of need and the potential demand for family planning services. Unmet need for family planning is defined as occurring among fecond women who are not pregnant or postpartum amenorrheic, who wish to postpone their next birth by two or more years or to stop childbearing entirely, and who are not currently using a contraceptive method. Additionally, pregnant women are considered to have an unmet need for spacing or limiting if their pregnancy was mistimed or unwanted, respectively. Similarly, amenorrheic women are categorized as having an unmet need if their most recent birth was mistimed or unwanted. Women who are currently using a contraceptive method are described as having a met need for family planning. The total demand for family planning services comprises both the met need and unmet need categories.

Table 7 presents data on unmet need, met need, and total demand for family planning among currently married women in Rwanda. These indicators serve to evaluate the extent to which family planning programs meet the demand for services. Among currently married women, 9% have an unmet need for family planning services, while 69% are currently using a contraceptive method. Therefore, 78% of currently married women have a demand for family planning. Thus, if all married women who expressed a desire to space or limit childbirth were to use a family planning method, the Contraceptive Prevalence Rate (CPR) would increase from 69% to 78%. At present, 89% of the potential demand for family planning is being met, with 82% of this demand satisfied through the use of a modern contraceptive method.

The unmet need for family planning is the highest in the West and East provinces (11% and 10%, respectively) and lowest in the North province (5%). By educational attainment, women with no formal education report the highest level of unmet need (12%).

Table 7 Need and demand for family planning among currently married women and sexually active unmarried women

Percentage of currently married women aged 15–49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, according to background characteristics, Rwanda 2025

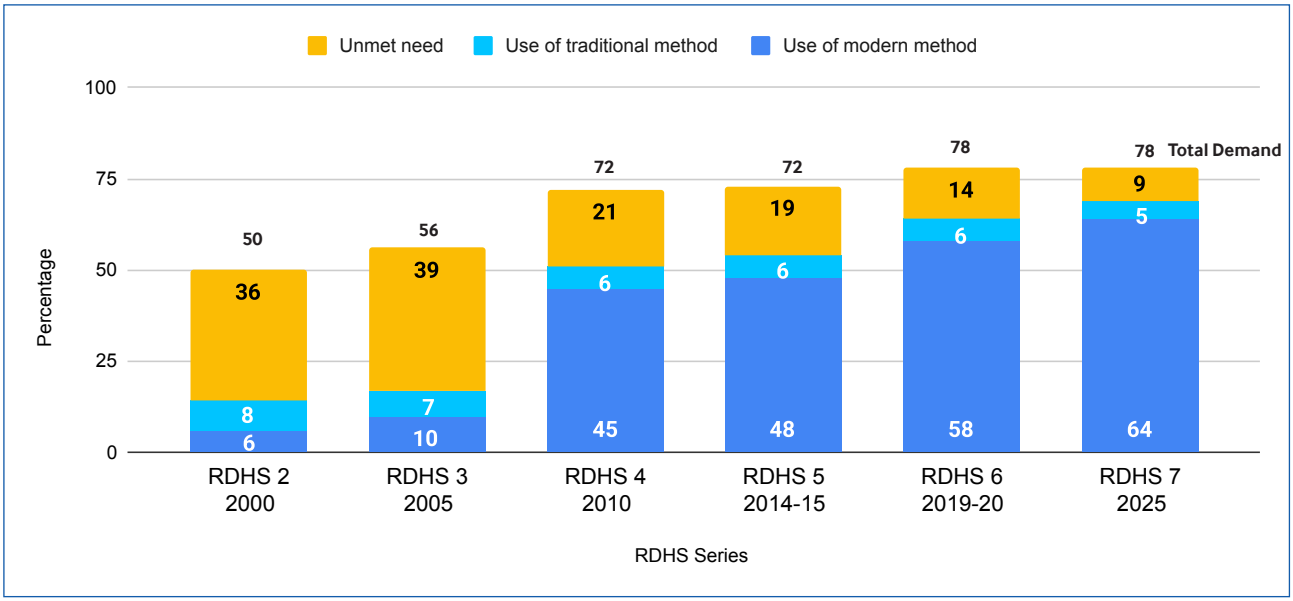
Background characteristic	Unmet need for family planning	Met need for family planning (currently using)		Total demand for family planning[3]	Number of women	Percentage of demand satisfied[1]	
		All methods	Modern methods[2]			All methods	Modern methods[2]
CURRENTLY MARRIED WOMEN							
Age							
15–19	1.4	38.0	38.0	39.4	92	96.4	96.4
20–24	4.7	66.8	65.8	71.6	839	93.4	91.9
25–29	5.5	74.6	73.1	80.1	1,293	93.2	91.3
30–34	8.3	72.9	70.3	81.2	1,427	89.8	86.6
35–39	9.9	74.0	68.8	83.9	1,482	88.2	82.0
40–44	11.5	71.1	61.1	82.6	1,304	86.1	73.9
45–49	13.5	52.6	41.7	66.0	974	79.6	63.2
Residence							
Urban	9.7	65.1	60.9	74.8	2,166	87.1	81.5
Rural	8.5	71.1	65.6	79.6	5,244	89.3	82.4
Province							
Kigali	8.5	65.8	61.3	74.3	1,030	88.5	82.5
South	8.5	70.5	63.7	79.0	1,595	89.2	80.7
West	11.1	67.0	61.0	78.1	1,559	85.8	78.1
North	5.4	76.1	72.1	81.5	1,173	93.3	88.4
East	9.6	68.1	64.0	77.7	2,053	87.7	82.3
Education							
No education	12.0	64.3	59.4	76.3	603	84.2	77.8
Primary	9.1	70.2	64.4	79.3	4,587	88.5	81.2
Secondary	7.8	69.3	66.2	77.1	1,866	89.9	85.8
More than secondary	5.7	67.2	59.4	72.9	353	92.1	81.5
Wealth quintile							
Lowest	9.8	68.8	65.0	78.6	1,419	87.5	82.6
Second	8.1	71.7	66.2	79.8	1,457	89.8	82.9
Middle	7.8	73.0	67.4	80.8	1,499	90.4	83.4
Fourth	9.8	69.0	63.9	78.8	1,526	87.6	81.1
Highest	8.9	64.2	58.7	73.1	1,509	87.8	80.4
Total	8.9	69.3	64.2	78.2	7,410	88.7	82.1
SEXUALLY ACTIVE UNMARRIED WOMEN[4]							
Residence							
Urban	31.0	52.9	52.2	83.9	191	63.0	62.2
Rural	32.7	54.8	51.7	87.5	249	62.7	59.1
Total	32.0	54.0	51.9	85.9	440	62.8	60.4

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al., 2012.
[1] Percentage of demand satisfied is met need divided by total demand.
[2] Modern methods include female sterilization, male sterilization, IUD, injectables, implants, pill, male condom, female condom, emergency contraception, standard days method (SDM), lactational amenorrhea method (LAM) and other modern methods.
[3] Total demand is the sum of unmet need and met need.
[4] Women who have had sexual intercourse within 30 days preceding the survey.

The unmet need for family planning decreased from 36% in 2000 to 14% in 2019-20, and then further decreased to 9% in 2025 (**Figure 3**). Over the last 5 years, the use of modern contraceptive methods has risen from 58% to 64%. Meanwhile, the total demand for contraception remained constant at 72% in both 2010 and 2014-15, before increasing to 78% in 2019-20 and remaining at this level in 2025. The proportion of demand satisfied by modern methods increased from 75% in 2019-20 to 82% in 2025.

Figure 3 Trends in use, need, and demand for family planning

Percentage of currently married women aged 15-49



3.7 Early Childhood Mortality

Neonatal mortality:	the probability of dying within the first month of life.
Postneonatal mortality:	The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality).
Infant mortality:	the probability of dying before the first birthday
Child mortality:	the probability of dying between the first and the fifth birthday
Under-5 mortality:	the probability of dying between birth and the fifth birthday

Infant and child mortality rates are basic indicators of a country's socioeconomic situation and quality of life (United Nations Development Program [UNDP] 2007). Estimates of child mortality are based on information collected in the birth history section of the women's questionnaire, which includes questions about aggregate number about childbearing experience, that is the number of sons and daughters living with their mother, those living elsewhere, and those who died.

Table 8 presents estimates for three consecutive 5-year periods preceding the 2025 RDHS. The rates are estimated directly from the birth history data on children's birth dates, survival status, and age at death for children who died.

All rates are expressed per 1,000 live births with the exception of child mortality, which is expressed per 1,000 children surviving to age 12 months.

Table 8 Early childhood mortality rates

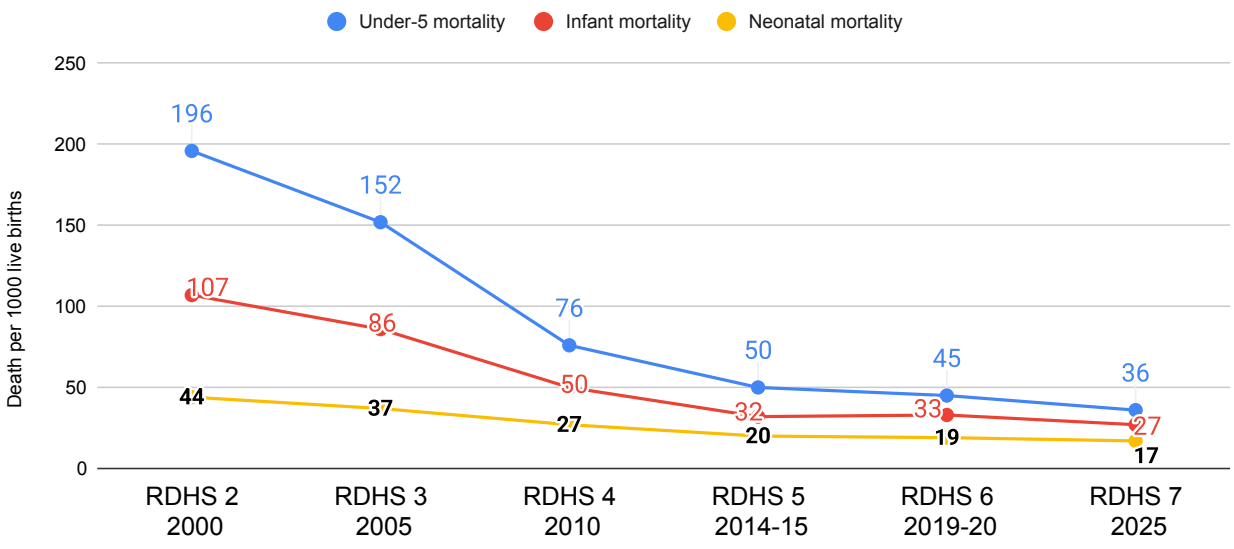
Neonatal, post-neonatal, infant, child and under-5 mortality rates for 5 year periods preceding the survey, Rwanda 2025

	Neonatal mortality (NN)	Post-neonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
Years preceding the survey					
0–4	17	10	27	9	36
5–9	18	11	30	9	38
10–14	17	15	32	14	46

[1] Computed as the difference between the infant and neonatal mortality rates

As shown in **Table 8**, during the 5 years immediately preceding the survey, the infant mortality rate was 27 deaths per 1,000 live births. The child mortality rate was 9 deaths per 1,000 children surviving to age 12 months, while the overall under-5 mortality rate was 36 deaths per 1,000 live births. Additionally, 75% of all deaths among children under age 5 in Rwanda take place before a child's first birthday, with 47% occurring during the first month of life.

Figure 4 Trends in childhood mortality



The 2025 RDHS reports that the under-5 mortality rate continues to decline from 45 deaths per 1,000 live births in the 2019-20 RDHS to 36 deaths per 1,000 live births in the current survey. However, there is a slight decline in childhood mortality rates among newborns and infants (Figure 5). In fact, the overall infant mortality rate has dropped in the most recent 5-year period from 33 deaths per 1,000 live births to 27 deaths per 1,000 live births. The neonatal mortality rate has decreased from 19 deaths per 1,000 live births to 17 deaths per 1,000 live births during the same period.

3.8 Maternal Care

Proper care during pregnancy and delivery is crucial for ensuring the health of both mother and child. In the 2025 RDHS, women who had given birth in the two years preceding the survey were asked a number of questions about maternal care. Mothers were asked whether they had received antenatal care during the pregnancy for their most recent live birth in the two years preceding the survey and whether they had received tetanus diphtheria injections while pregnant. For each live birth over the same period, mothers were also asked what type of assistance they received at the time of delivery. Finally, for birth in the two years before the survey, women were asked if they had received a postnatal check-up within two days of delivery. Table 9 summarizes information on the coverage of these maternal health services.

3.8.1 Antenatal Care

Antenatal care from a skilled provider

Pregnancy care received from skilled providers, such as doctors, nurses/midwives.

Sample: Women aged 15–49 who had a live birth or stillbirth in the two years before the survey

Antenatal care (ANC) from a skilled provider, is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, delivery, and the postnatal period (42 days after delivery). The 2025 RDHS results show that 95% of Rwandan women who gave live birth in the two years preceding the survey received antenatal care from a skilled provider at least once for their last birth. 78% of women had four or more ANC visits.

Women with higher levels of education are more likely to receive ANC from a skilled provider compared to those with lower levels of education. For example, 95% of women with no education received ANC from a skilled provider, while 99% of women with more than a secondary education did. The proportion of women receiving ANC from a skilled provider does not vary based on women's wealth status.

Table 9 Maternal care indicators

Among women aged 15–49 who had a live birth and/or a stillbirth in the two years preceding the survey, percentage who received antenatal care (ANC) from a skilled provider for the most recent live birth or stillbirth, percentage with four or more ANC visits for the most recent live birth or stillbirth, percentage who took any iron-containing supplements during pregnancy, and percentage whose most recent live birth was protected against neonatal tetanus; among all live births and stillbirths in the two years before the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women aged 15–49 with a live birth or stillbirth in the two years preceding the survey, percentage who received a postnatal check during the first two days after giving birth, according to background characteristics, Rwanda 2025

	Women who had a live birth and/or a stillbirth in the 2 years preceding the survey					Live births and stillbirths in the 2 years preceding the survey			Women who had a live birth and/or a stillbirth in the 2 years preceding the survey	
Background characteristic	Percentage receiving antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage who took any iron-containing supplements during pregnancy[2]	Percentage whose most recent live birth was protected against neonatal tetanus[3]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage of women with a postnatal check during the first 2 days after birth[4]	Number of women
LIVE BIRTHS										
Mother's age at birth										
<20	94.4	70.3	89.0	62.6	212	98.1	98.7	214	64.4	212
20–34	95.8	79.7	92.0	79.1	1,936	98.3	98.3	1,999	68.0	1,936
35–49	94.6	73.6	91.7	77.5	706	97.8	97.5	726	69.6	706
Residence										
Urban	94.6	72.6	91.7	79.7	850	98.6	98.6	877	71.6	850
Rural	95.7	79.6	91.7	76.6	2,004	98.0	97.9	2,063	66.7	2,004
Province										
Kigali	94.9	67.3	92.3	80.2	400	97.6	97.9	410	73.3	400
South	99.2	83.4	93.8	79.2	616	98.2	98.0	634	66.2	616
West	97.6	79.3	94.3	81.9	598	98.0	98.2	622	67.5	598
North	86.9	76.0	91.5	79.9	390	99.6	99.6	397	73.0	390
East	95.2	77.4	88.1	70.9	851	97.8	97.5	876	65.4	851
Mother's education										
No education	94.8	64.2	88.8	78.2	141	93.9	93.9	142	65.5	141
Primary	94.9	76.7	90.9	75.7	1,719	98.2	98.0	1,775	66.1	1,719
Secondary	96.0	79.6	93.6	80.0	887	98.5	98.7	912	70.9	887
More than secondary	98.9	90.2	93.3	85.3	108	100.0	100.0	110	80.5	108
Wealth quintile										
Lowest	95.4	73.7	88.7	72.7	684	96.7	96.2	701	62.9	684
Second	95.9	79.3	91.0	79.2	586	98.4	98.1	600	68.2	586
Middle	94.9	78.7	93.9	77.5	536	98.3	98.4	559	68.1	536
Fourth	95.6	75.8	91.8	78.6	561	98.6	99.0	577	69.5	561
Highest	95.1	81.3	94.2	81.1	487	99.2	99.4	503	73.9	487
Total	95.4	77.5	91.7	77.5	2,854	98.1	98.1	2,939	68.1	2,854
STILLBIRTHS										
Total	(98.6)	(53.0)	(90.8)	na	32	(95.4)	(95.4)	32	(60.1)	32
LIVE BIRTHS AND STILLBIRTHS5										
Total	95.4	77.3	91.7	na	2,880	98.1	98.1	2,971	68.1	2,880

Notes: If more than one source of assistance was mentioned, only the provider with the highest qualifications is considered in this tabulation. Stillbirths are fetal deaths in pregnancies lasting 28 or more weeks. When pregnancy duration is reported in months, stillbirths are fetal deaths in pregnancies lasting 7 or more months. Figures in parentheses are based on 25–49 unweighted cases.
na = Not applicable
[1] Skilled provider includes a doctor, a nurse/midwife, and an auxiliary midwife
[2] Iron tablets, iron syrup or multiple micronutrient supplement.
[3] Includes mothers with two injections during the pregnancy of her most recent live birth, or two or more injections (the last within 3 years of the most recent live birth), or three or more injections (the last within 5 years of the most recent live birth), or four or more injections (the last within 10 years of the most recent live birth), or five or more injections at any time prior to the last live birth
[4] Includes women who received a check from a doctor, nurse/midwife, auxiliary midwife, traditional birth attendant, community health worker, or community health worker in charge of mother and child.
[5] For women who had both a live birth and a stillbirth in the 2 years preceding the survey, data on antenatal care and postnatal checks are tabulated for the most recent birth only.

3.8.2 Tetanus diphtheria

Protection against neonatal tetanus and diphtheria

The number of tetanus diphtheria injections needed to protect a baby from neonatal tetanus and diphtheria depends on the mother's vaccinations. A baby is protected against neonatal tetanus and diphtheria if the mother has received any of the following:

- Two tetanus diphtheria injections during pregnancy
- Two or more injections, with the last one within 3 years of the birth
- Three or more injections, with the last one within 5 years of the birth
- Four or more injections, with the last one within 10 years of the birth
- Five or more injections at any time prior to the birth

Sample: Women aged 15–49 with a live birth in the 2 years before the survey

Tetanus diphtheria injections are administered to women during pregnancy to prevent neonatal tetanus and diphtheria. Tetanus is a significant cause of early infant mortality in many developing countries, often resulting from a lack of adherence to hygienic practices during childbirth. Table 9 indicates that 78% of women who had a live birth in the two years preceding the survey received sufficient doses of tetanus diphtheria to safeguard their last live birth against neonatal tetanus and diphtheria. The proportion of women whose last live birth was protected from tetanus and diphtheria varies on their wealth status. Women in the lowest wealth quintile are slightly less likely to have ensured protection for their last birth against tetanus and diphtheria. For instance, 73% of women in the lowest wealth quintile had their last birth protected from tetanus and diphtheria, compared to 81% of women in the highest wealth quintile.

3.8.3 Delivery Care

Institutional deliveries

Deliveries that occur in a health facility.

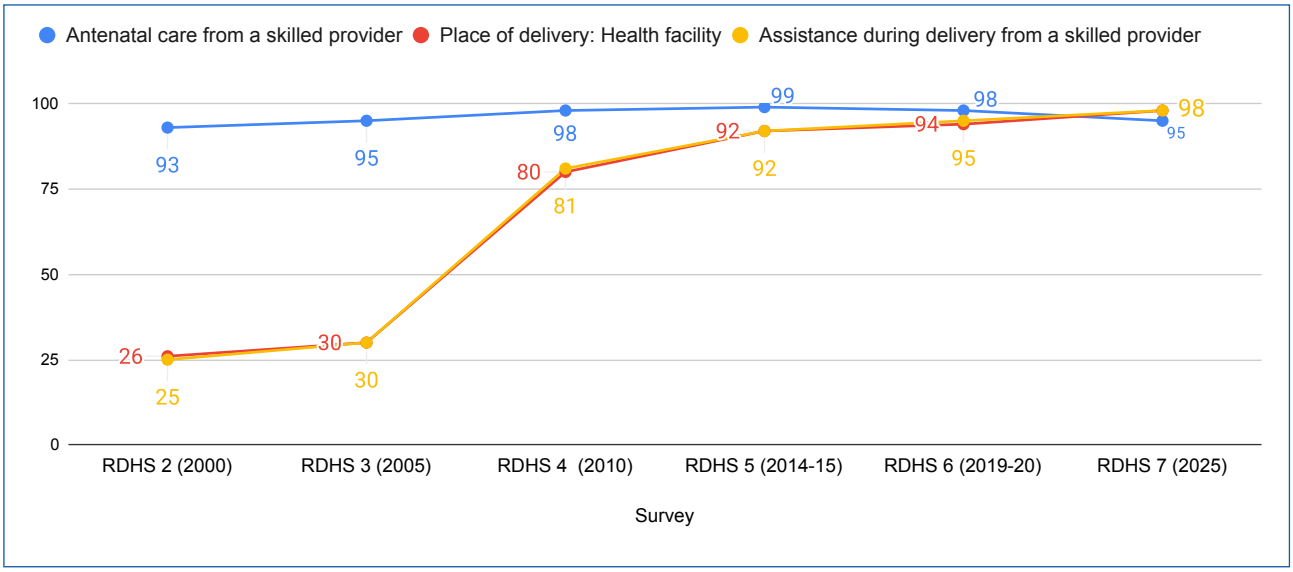
Sample: All live births and/or stillbirths in the two years before the survey

Skilled assistance during delivery

Births delivered with the assistance of a doctor/clinical officer/medical assistant or a nurse/midwife.

Sample: All live births and/or stillbirths in the two years before the survey

Figure 5 Trends in maternal care indicators



Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother and/or baby (Van Lerberghe and De Brouwere, 2001; WHO, 2006). The survey data show that, in Rwanda, 98% of the births in the two years preceding the survey were delivered by a skilled provider and 98% were delivered in a health facility (**Table 9**, **Figure 6**).

Mothers' educational status correlates with whether their delivery is assisted by a skilled provider and whether the birth is delivered in a health facility. For instance, 94% of births to mothers with no education were assisted by a skilled provider and were delivered in a health facility, as compared to 100% of births to mothers with more than a secondary education. There is not much variation in delivery assistance by urban-rural residence or wealth.

There has been a gradual improvement in maternal healthcare indicators over the past decades. The percentage of births delivered in a health facility and attended by skilled providers has been consistently above 90% since the 2014-15 RDHS, and is nearly universal (98%) in the 2025 RDHS (**Figure 6**).

3.8.4 Postnatal Care for the Mother

A large proportion of maternal and neonatal deaths occur within the first 48 hours after delivery. Therefore, timely postnatal care (PNC) for both the mother and the child is crucial to address any complications that may arise from childbirth and to provide essential guidance to the mother on caring for herself and the baby.

Safe motherhood programs recommend that all women receive a postnatal health check within two days of delivery. To evaluate the utilization of postnatal care in Rwanda, respondents were asked, about their most recent birth within the two years prior to the survey, if they had received a postnatal checkup after delivery and the timing of that first checkup. According to Table 9, 68% of women reported having received a PNC checkup within the first two days after delivery.

The percentage of women receiving a postnatal checkup within two days of delivery is slightly higher in urban areas compared to rural areas and notably increases with higher levels of education and wealth.

3.9 Vaccination Coverage

The 2025 RDHS collected data on several key child health indicators, including vaccinations for young children. Universal immunization of children against six common vaccine-preventable diseases namely tuberculosis, diphtheria, pertussis (whooping cough), tetanus, polio, and measles is crucial for reducing infant and child mortality. In Rwanda, vaccines against *Hemophilus influenza* type B and hepatitis B are combined with vaccines against diphtheria pertussis and tetanus (DPT), and the combined vaccine is called pentavalent. Therefore, the coverage of the pentavalent vaccine is also considered coverage for DPT. The pneumococcal conjugate vaccine (PCV), inactivated poliomyelitis vaccine (IPV) and rotavirus vaccine were added to the national routine immunization schedule to protect against severe pneumonia, meningitis, and other illnesses due to *Streptococcus pneumoniae* bacteria, polio, and diarrhea caused by rotavirus infection, respectively.

Rwanda follows a vaccination schedule based on the World Health Organization guidelines for administering all basic childhood vaccines. Traditionally, vaccination coverage has been measured by the percentage of children aged 12-23 months who have received all basic vaccinations. Children are considered to have received all basic vaccinations if they have received a bacille Calmette-Guérin (BCG) vaccination against tuberculosis, three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus, at least three doses of polio vaccine (excluding the dose given at birth), and one dose of measles vaccine within the first year of life.

BCG and oral polio vaccine (OPV) zero should be administered shortly after birth or at the first clinical contact, while OPV and pentavalent vaccines should be given around 6 weeks, 10 weeks, and 14 weeks of age.

Rotavirus vaccine should be given at 6 weeks and 10 weeks of age and IPV has to be given at 14 weeks and 9 months of age. The measles and rubella vaccine should be administered at 9 and 15 months of child age.

Children aged 12-23 months are considered to have been vaccinated according to the national immunization schedule if they have received all basic vaccinations along with, a birth dose of hepatitis B and OPV, two doses of IPV though one was captured in the data collection, three doses of pneumococcal vaccine and two doses of rotavirus vaccine. Similarly, Children aged 24-35 months are considered to have been vaccinated according to the national schedule if they have received a second dose of measles at 15 months in addition to all of the vaccinations on the national schedule relevant for a children aged 12-23 months.

In the 2025 RDHS, vaccination coverage information was collected through vaccination cards, vaccination information from e-tracker/e-registry, and mothers verbal reports. For all children born since January 2023, interviewers requested mothers to show the official card where vaccination dates are recorded . If a physical vaccination card was not available, the interviewer requested for vaccination code from the mother to access the children electronic information from e-tracker system. In cases where neither a card nor electronic data could be accessed, then vaccination information was based on the mother's recall. If both vaccination card and electronic information indicated that a child had not received all basic vaccinations, mothers were asked if the child had received any additional vaccinations not recorded on the card, these were then noted.

Specifically, mothers were asked to recall whether the child had received the-BCG, hepatitis B (birth dose), polio, pentavalent, pneumococcal, inactivated polio vaccine, rotavirus, and measles vaccines, mothers who mentioned that the child had received the polio, pentavalent, pneumococcal, rotavirus, or measles vaccine, were also asked to report the number of doses received. Therefore, the results presented are based on vaccination cards, and–for children without cards electronic vaccination information from e-tracker and mothers' recall. During the 2025 RDHS, vaccination cards were available for 80% of children aged 12-23 months and 85% of children aged 24-35 months (data not shown).

3.9.1 Basic Antigen Coverage

Fully vaccinated: basic antigens

Percentage of children who received specific vaccines at any time before the survey (according to a vaccination card, e-tracker information or the mother's report).To have received all basic antigens, a child must have received all of the following: one dose of BCG vaccine, which protects against tuberculosis; three doses of polio vaccine given as oral polio vaccine (OPV) excluding polio vaccine given at birth; three doses of DPT-containing vaccine, which protects against diphtheria, pertussis (whooping cough), and tetanus; and one dose of measles-containing vaccine given as measles-rubella.

Sample: Children aged 12–23 months

Historically, an important measure of vaccination coverage has been the proportion of children receiving all "basic" antigens. Children are considered fully vaccinated against all basic antigens if they have received the BCG vaccine, three doses each of polio vaccine and DPT-containing vaccine, and a single dose of measles-containing vaccine.

Overall, 94% of children aged 12–23 months are fully vaccinated with basic antigens (**Table 10**). Firthermore, 98% of children have received BCG, 97% have received three doses of DPT-containing vaccine, and 97% have received three doses of OPV. Coverage of vaccination against measles is 97%.

Table 10 Vaccinations by background characteristics

Percentage of children aged 12-23 months and children aged 24-35 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), percentage with all basic vaccinations, and percentage with all age appropriate vaccinations, according to background characteristics, Rwanda DHS 2025

	Children aged 12-23 months:																		Children aged 24-35 months:		
		DPT-HepB-Hib			Polio				Pneumococcal			Rotavirus		Measles & Rubella 1	Fully vaccinated (basic antigens)[2]	Fully vaccinated (according to national schedule)3	No vaccina-tions	Number of children	Measles & Rubella 2	Fully vaccinated (according to national schedule)[4]	Number of children
Background characteristic	BCG	1	2	3	0 (birth dose)[1]	1	2	3	IPV	1	2	3	1	2							
Sex																					
Male	98.2	98.8	98.5	96.9	91.6	98.6	97.3	96.3	91.3	98.7	97.8	96.2	98.6	97.3	96.8	93.2	79.8	0.7	714	92.4	79.9	675
Female	98.0	99.0	99.0	98.1	93.4	99.1	98.6	97.8	91.2	98.8	98.2	96.9	98.8	97.9	96.9	95.3	83.3	0.9	689	92.7	81.3	702
Birth order																					
1	97.5	98.8	98.8	97.0	91.4	98.2	97.6	97.1	91.0	98.5	97.7	96.0	98.7	97.9	97.8	94.3	80.9	1.0	429	94.8	83.6	423
2-3	98.4	98.9	98.7	98.2	93.8	99.3	97.8	97.4	91.9	98.8	98.2	97.2	98.7	97.8	96.9	94.9	83.3	0.7	581	94.1	81.2	559
4-5	98.0	99.1	99.1	97.5	92.6	98.7	98.4	96.8	91.7	99.1	98.0	96.3	99.1	97.2	95.0	92.4	80.0	0.9	272	93.5	80.9	272
6+	99.0	98.9	98.1	96.2	89.8	99.5	98.7	95.7	87.9	98.9	98.1	96.2	98.0	96.2	97.9	94.8	78.5	0.0	122	76.2	66.9	123
Vaccination card[6]																					
Seen	98.8	99.7	99.6	99.1	92.8	99.9	99.7	99.0	91.4	99.8	99.7	99.1	99.6	99.1	98.0	96.7	83.9	0.0	1,118	94.7	83.7	1,173
Not seen or no longer has	94.2	95.5	94.8	91.1	91.3	94.2	90.7	89.1	93.8	93.9	90.9	87.2	94.8	90.6	91.6	83.8	73.8	4.5	150	83.7	66.6	169
Never had	96.7	96.0	96.0	91.7	90.8	95.6	91.7	89.4	86.7	96.0	92.2	85.9	96.0	92.7	93.4	85.6	70.6	3.3	136	(65.2)	(46.1)	35
Residence																					
Urban	97.9	98.5	98.5	96.9	95.1	98.1	96.9	96.7	93.4	98.1	97.9	96.3	98.5	96.6	95.8	92.6	85.0	1.5	414	92.5	83.9	438
Rural	98.2	99.1	98.8	97.8	91.4	99.2	98.4	97.2	90.3	99.0	98.0	96.7	98.8	98.0	97.3	94.9	80.1	0.5	990	92.6	79.1	939
Province																					
Kigali	95.5	96.4	96.4	95.1	94.5	96.8	95.5	95.5	92.1	96.8	96.8	95.6	96.8	93.8	92.6	88.8	83.7	3.2	188	88.8	81.1	203
South	98.5	99.9	99.2	98.5	93.5	99.5	98.2	97.9	93.6	99.9	98.4	97.7	99.1	98.4	98.4	95.7	84.6	0.1	291	95.7	82.7	294
West	99.3	100.0	100.0	98.7	91.5	99.7	99.0	98.2	93.2	99.3	98.2	96.6	100.0	99.5	98.5	96.2	82.7	0.0	290	93.4	81.2	308
North	98.4	98.5	98.5	98.5	95.1	99.0	98.5	98.5	94.6	98.3	98.3	98.1	98.0	98.0	98.0	97.4	89.4	1.0	210	96.0	86.9	189
East	98.0	98.7	98.7	96.5	90.1	98.7	97.9	95.6	86.2	98.7	98.0	95.5	98.7	97.2	96.1	92.7	73.8	0.6	425	89.9	75.2	382
Mother's education																					
No education	94.6	96.2	95.0	92.1	85.7	96.2	92.6	89.7	85.6	95.0	95.0	92.1	96.2	92.5	93.2	86.7	72.7	3.8	79	82.9	71.0	93
Primary	98.6	99.5	99.5	98.4	91.6	99.4	98.9	98.0	90.9	99.4	98.8	97.5	99.4	98.8	97.2	95.0	80.3	0.3	872	92.6	80.7	824
Secondary	98.0	98.3	98.0	96.8	95.2	98.5	97.3	96.7	92.6	98.5	97.2	95.6	97.9	96.2	96.9	94.1	84.8	0.9	410	94.5	81.7	389
More than secondary	95.9	95.9	95.9	95.9	95.3	95.9	93.5	93.5	94.8	95.2	95.2	95.2	95.9	95.9	95.9	93.5	90.9	4.1	43	94.9	86.5	70
Wealth quintile																					
Lowest	97.5	98.9	98.9	96.3	87.1	99.0	98.0	95.7	89.9	98.9	97.8	95.3	98.9	97.8	95.3	92.4	75.0	0.8	354	89.3	74.0	303
Second	98.9	99.7	99.0	98.5	91.6	99.6	97.6	97.1	90.0	99.6	98.0	97.6	99.2	97.1	99.2	95.6	78.9	0.0	281	93.0	83.3	270
Middle	98.4	98.6	98.6	97.9	96.6	99.1	99.1	97.9	88.9	98.2	97.4	96.3	98.6	97.7	94.9	94.3	82.2	0.9	262	93.7	81.6	268
Fourth	98.3	99.2	99.2	98.3	94.0	98.5	97.6	97.6	93.2	99.1	99.1	98.0	99.2	99.2	97.9	94.2	87.1	0.4	269	94.9	82.0	272
Highest	97.4	97.9	97.9	96.9	95.1	97.9	97.3	97.3	94.9	97.9	97.7	96.2	97.5	95.8	97.4	95.3	87.2	2.1	237	92.5	83.0	264
Total	98.1	98.9	98.7	97.5	92.5	98.9	97.9	97.0	91.2	98.8	98.0	96.6	98.7	97.6	96.9	94.2	81.5	0.8	1,404	92.6	80.6	1,377

Note: Figures in parentheses are based on 25-49 unweighted cases. Children are considered to have received the vaccine if it was either written on the child's vaccination card or reported by the mother. For children whose vaccination information is based on the mother's report, date of vaccination is not collected. The proportions of vaccinations given during the first and second years of life are assumed to be the same as for children with a written record of vaccination.

BCG = Bacille Calmette-Guérin

DPT = Diphtheria-pertussis-tetanus

HepB = Hepatitis B

Hib = Hemophilus influenzae type b

[1] Polio 0 is the polio vaccination given at birth.

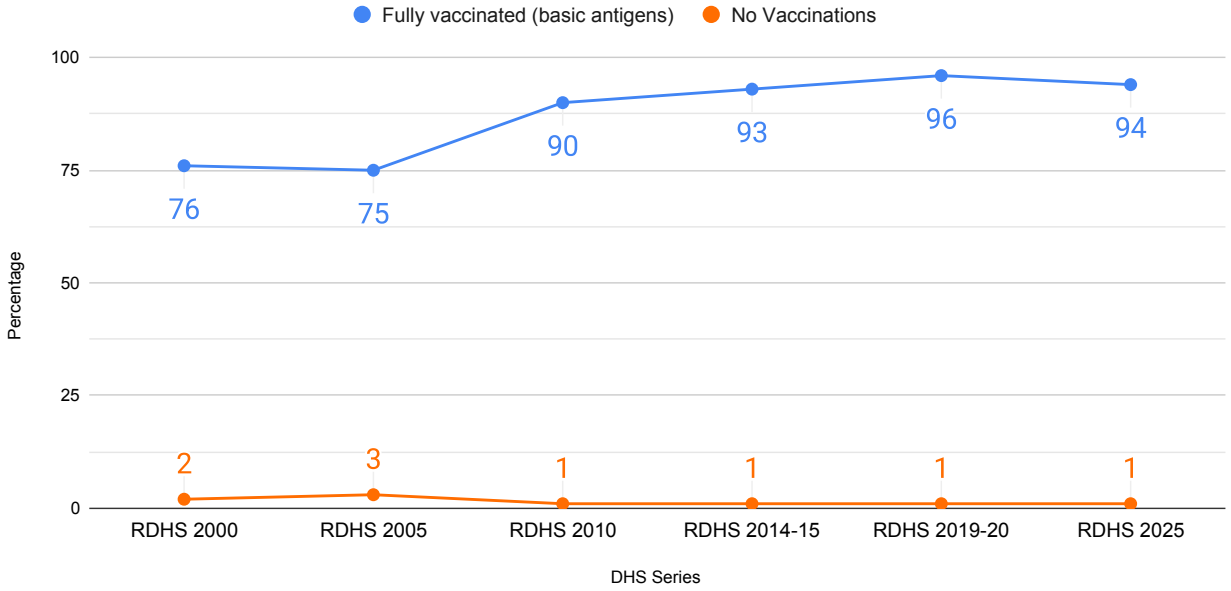
2 BCG, three doses of DPT-HepB-Hib (pentavalent), three doses of polio vaccine (excluding polio vaccine given at birth), and one dose of measles

3 BCG, hepatitis B (birth dose), three doses of DPT-HepB-Hib (pentavalent), four doses of oral polio vaccine, one dose of inactivated polio vaccine, three doses of pneumococcal vaccine, and one dose of measles

4 BCG, hepatitis B (birth dose), three doses of DPT-HepB-Hib (pentavalent), four doses of oral polio vaccine, one dose of inactivated polio vaccine, three doses of pneumococcal vaccine, and two doses of measles

Figure 6 Trends in childhood vaccinations

The percentage of children aged 12–23 months who have been fully vaccinated against all basic antigens reached 90% in 2010 and has remained above 90% for the past 15 years (Figure 7). The percentage of children with no vaccinations decreased from 3% to 1% between 2005 and 2010 and afterwards remained constant untill 2025.



3.9.2 Vaccination Coverage according to the National Schedule

Another measure of vaccination coverage is the percentage of children aged 12–23 months and 24–35 months who are fully vaccinated according to the national schedule. In this report, a child aged 12–23 months is considered fully vaccinated according to the national schedule if the child has received all basic antigens as well as a birth dose of OPV, a dose of IPV, three doses of Hepatitis B and Hemophilus Influenzae type B (HepB-Hib) (given as pentavalent vaccine), three doses of the pneumococcal vaccine, and two doses of the rotavirus vaccine. Children aged 24–35 months are considered fully vaccinated according to the national schedule if they receive a second dose of the measles-rubella vaccine in addition to all the vaccinations relevant for children aged 12–23 months.

- Overall, 92% of children aged 12–23 months received a birth dose of OPV vaccine, 91% received a dose of IPV, 97% received three doses of DPT-HepB-Hib, 96% received three doses of the pneumococcal vaccine, and 97% received two doses of the rotavirus vaccine. Additionally, 93% of children aged 24–35 months received two doses of the measles-rubella vaccine.

– 82% of children aged 12–23 months are fully vaccinated according to the national schedule.
– 81% of children aged 24–35 months are fully vaccinated according to the national schedule.
– 1% of children age 12–23 months have received no vaccinations.

3.10 Care Seeking for and Treatment of Child Illness

Acute Respiratory Infections (ARI), fever, and dehydration from diarrhea are significant contributing factors to childhood morbidity and mortality in developing countries (WHO 2003). Prompt medical attention when a child exhibits symptoms of these illnesses is crucial in reducing child deaths. Tables 11 and 12 provide information on care -seeking behavior for ill children in Rwanda. Overall, of the 7,056 children under the age of 5, about 2% of children under the age of 5 displayed symptoms of an ARI, 16% had a fever, and 15% experienced diarrhea in the two weeks preceding the survey (data not shown).

Advice or treatment was sought for 84% of children with symptoms of ARI in the two weeks before the survey (Table 11).

Advice or treatment was sought for 68% of children with fever in the two weeks before the survey.

Advice or treatment was sought for 65% of children with diarrhea in the two weeks before the survey.

36% of children with diarrhea received oral rehydration salts (ORS), 49% received zinc supplements, 27% received both ORS and zinc supplements, and 11% received ORS, zinc supplements, and continued feeding.

Table 11 Treatment for acute respiratory infection, fever, and diarrhea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had fever during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought; and among children under age 5 who had diarrhea during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, percentage given a fluid made from oral rehydration salt (ORS) packets or given pre-packaged ORS fluid, percentage given zinc, percentage given ORS and zinc, and percentage given ORS, zinc, and continued feeding, according to background characteristics, Rwanda 2025

	Children with symptoms of ARI[1]		Children with fever		Children with diarrhea					
Background characteristic	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet or pre-packaged ORS fluid	Percentage given zinc	Percentage given ORS and zinc	Percentage given ORS, zinc, and continued feeding[3]	Number of children
Age in months										
<6	*	8	57.8	60	(37.3)	(5.9)	(13.2)	(2.5)	(0.0)	32
6–11	*	18	67.0	145	61.8	34.8	37.5	19.3	5.2	158
12–23	*	23	74.4	286	67.3	36.5	52.1	28.6	11.8	359
24–35	(74.9)	32	66.3	227	65.5	35.1	50.8	28.2	8.4	223
36–47	(87.7)	25	67.8	221	64.6	40.4	59.3	34.9	15.5	154
48–59	*	19	65.4	171	65.1	40.2	50.2	27.7	18.2	103
Sex										
Male	79.6	70	68.6	568	64.7	34.1	49.5	26.7	11.4	564
Female	89.0	56	67.8	542	64.2	38.2	48.9	27.7	10.3	465
Residence										
Urban	(72.8)	26	69.5	260	65.2	31.9	44.9	21.4	6.4	267
Rural	86.7	100	67.8	849	64.3	37.4	50.8	29.1	12.4	762
Province										
Kigali	*	8	67.9	93	61.0	28.6	41.0	16.7	0.0	107
South	(93.1)	37	68.5	301	63.8	38.4	50.0	30.0	12.1	224
West	(76.7)	24	63.4	175	65.8	35.8	54.5	28.9	10.1	225
North	*	19	65.2	163	57.8	38.7	41.2	24.9	13.4	124
East	(84.1)	38	71.5	377	67.6	35.7	50.8	28.1	13.0	349
Mother's education										
No education	*	7	56.4	66	68.2	43.6	59.4	35.5	18.8	78
Primary	86.1	91	65.8	721	62.7	33.7	48.8	25.9	10.2	700
Secondary	*	22	76.0	291	67.9	40.9	46.5	29.1	11.0	229
More than secondary	*	6	(76.2)	31	*	*	*	*	*	22
Wealth quintile										
Lowest	(80.2)	31	60.3	322	58.5	31.8	44.0	24.8	12.4	316
Second	(83.3)	39	70.5	230	62.1	37.4	51.4	30.2	10.3	215
Middle	*	24	69.5	204	65.0	38.5	53.2	30.0	12.9	179
Fourth	*	14	69.9	199	73.0	37.8	51.2	25.6	10.1	200
Highest	*	18	77.1	155	69.7	37.4	50.2	25.8	6.1	119
Total	83.8	126	68.2	1,110	64.5	35.9	49.3	27.1	10.9	1,029

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Symptoms of ARI include short, rapid breathing which was chest-related and/or difficult breathing which was chest-related.

[2] Includes advice or treatment from the following sources: Public sector, private medical sector, and shop. Excludes advice or treatment from traditional practitioner, a church, or friends/relatives.

[3] Continued feeding includes children who were given more, same as usual, or somewhat less food during the diarrhea episode.

3.10.1 Prevalence, Diagnosis, and Prompt Treatment of Fever among Children

Care seeking for children under age 5 with a fever

Percentage of children under age 5 who had fever in the two weeks before the survey for whom advice or treatment was sought from a health provider, a health facility, or a pharmacy..

Sample: Children under age 5 with who had fever in the two weeks before the survey

Diagnosis of malaria in children under age 5 with a fever

Percentage of children under age 5 who had a fever in the two weeks before the survey who had blood taken from a finger or heel for testing. This is a proxy measure of diagnostic testing for malaria.

Sample: Children under age 5 who had a fever in the two weeks before the survey.

Artemisinin-based combination therapy (ACT) for children under age 5 with a fever

Percentage of children under age 5 who had a fever in the two weeks before the survey who received ACT.

Sample: Children under age 5 who had a fever in the two weeks before the survey who took any antimalarial drug.

- 16% of children under the age of 5 had fever in the 2 weeks before the survey (Table 12).
- Among children with fever, 68% sought advice or treatment, and 44% had blood drawn for testing.
- Of children with fever who were administerd any antimalarial drug, 75% received ACT.

Table 12 Prevalence, diagnosis, and prompt treatment of children with fever

Percentage of children under age 5 who had fever in the 2 weeks preceding the survey; among children under age 5 with fever, the percentage for whom advice or treatment was sought, the percentage who had blood taken from a finger or heel; and among children under age 5 with fever who took any antimalarial drug, the percentage who took any artemisinin-based combination therapy (ACT), according to background characteristics, Rwanda DHS 2025.

	Children under age 5		Children under age 5 with fever			Children under age 5 with fever who took any antimalarial drug	
Background characteristic	Percentage with fever in the 2 weeks preceding the survey	Number of children	Percentage for whom advice or treatment was sought[1]	Percentage who had blood taken from a finger or heel for testing	Number of children	Percentage who took any ACT	Number of children
Residence							
Urban	12.1	2,149	69.5	45.7	260	*	17
Rural	17.3	4,907	67.8	43.8	849	(70.9)	48
Province							
Kigali	9.2	1,013	67.9	61.0	93	*	16
South	19.9	1,518	68.5	48.2	301	*	15
West	11.4	1,541	63.4	31.7	175	*	5
North	16.6	979	65.2	38.1	163	*	3
East	18.8	2,004	71.5	45.5	377	*	26
Wealth quintile							
Lowest	20.2	1,590	60.3	36.8	322	*	18
Second	16.5	1,399	70.5	46.0	230	*	10
Middle	14.8	1,378	69.5	47.9	204	*	19
Fourth	14.6	1,363	69.9	46.8	199	*	9
Highest	11.7	1,326	77.1	49.0	155	*	9
Total	15.7	7,056	68.2	44.2	1,110	74.9	65

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
1 Includes advice or treatment from the public medical sector, private medical sector, kiosk/shop, church, friend/relative; and excludes advice or treatment from traditional healers.

The prevalence of fever is higher among children in rural areas compared to children in urban areas (17%

and 12%, respectively). Seeking advice or treatment for fever is more common among children in urban areas than in rural areas (70% and 68%, respectively). Fever prevalence over the last 2 weeks shows a slight decrease with increasing household wealth, being highest among children in the lowest wealth quintile (20%) and lowest among those in the highest quintile (12%).

3.11 Child Nutritional Status

Anthropometry is commonly used to measure child nutritional status, with anthropometric measurements gathered to report on child growth indicators. The distribution of height and weight for children under the age of 5 was compared with the WHO Child Growth Standards reference population (WHO 2006b). The distribution of a well-nourished population will be similar to that of the reference population, while the distribution of a poorly nourished population will not.

The indices height-for-age, weight-for-height, and weight-for-age can be expressed in standard deviation units (z scores) from the median of the reference population. Values that are more than two standard deviations below the median of the WHO Child Growth Standards are used to define malnutrition.

Stunting (assessed via height-for-age)

Height-for-age is a measure of growth faltering. Children whose height-for-age z score is more than two standard deviations below the median of the reference population (−2 SD) are considered short for their age (stunted). Children whose z score is more than three standard deviations below the median (−3 SD) are considered severely stunted.

Sample: Children under age 5

Wasting (assessed via weight-for-height)

The weight-for-height index measures body mass in relation to body height or length and describes acute undernutrition. Children whose weight-for-height z score is more than two standard deviations below the median of the reference population (−2 SD) are considered thin (wasted). Children whose z score is more than three standard deviations below the median (−3 SD) are considered severely wasted.

Sample: Children under age 5

Underweight (assessed via weight-for-age)

Weight-for-age is a composite index of height-for-age and weight-for-height that takes into account both wasting and stunting. Children whose weight-for-age z score is more than two standard deviations from the median of the reference population (−2 SD) are classified as underweight. Children whose z score is more than three standard deviations from the median (−3 SD) are considered severely underweight.

Sample: Children under age 5

Overweight (assessed via weight-for-height)

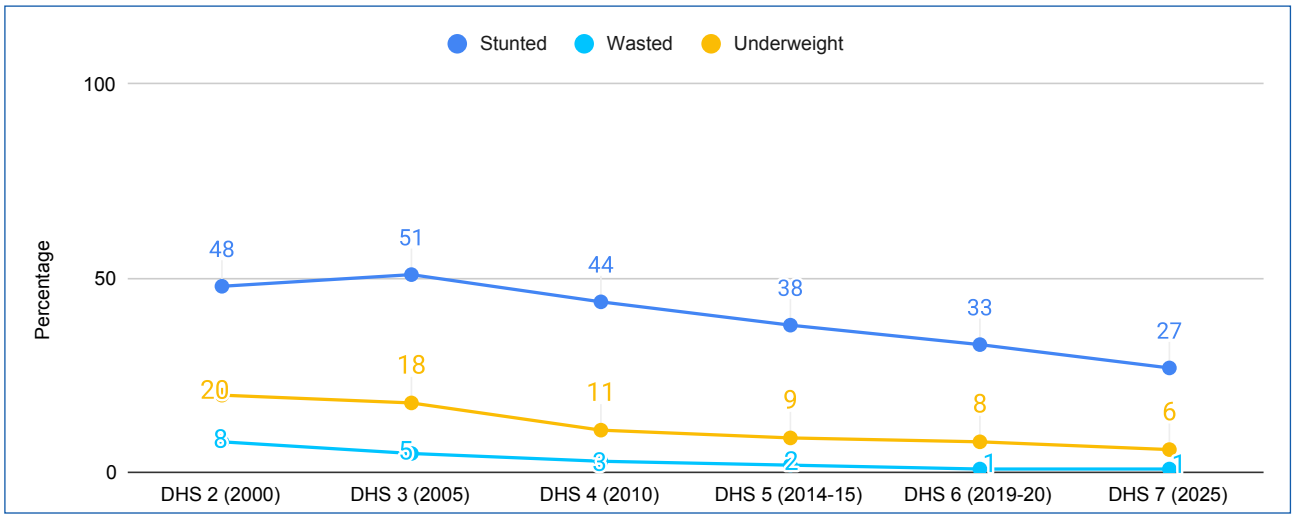
Children whose weight-for-height z score is more than two standard deviations above the median of the reference population (+2 SD) are considered overweight.

Sample: Children under age 5

The 2025 RDHS identified 7,310 children under the age of 5 who were eligible for height and weight measurements. Ninety-nine percent of children had valid data for height-for-age, weight-for-height, and weight-for-age (data not shown).

Figure 7 : Trends in nutritional status of children

A comparison of the anthropometric measurements with data from previous RDHS surveys indicates that the prevalence of stunting declined from 51% in 2005 to 33% in 2019–20 and continues to drop further to 27% in 2025 (**Figure 7**).



Stunting generally increases with age during the first months of a child's life, peaking at 46% among children aged around 22 months (Figure 8).

Figure 8: Nutrition Status Among Children

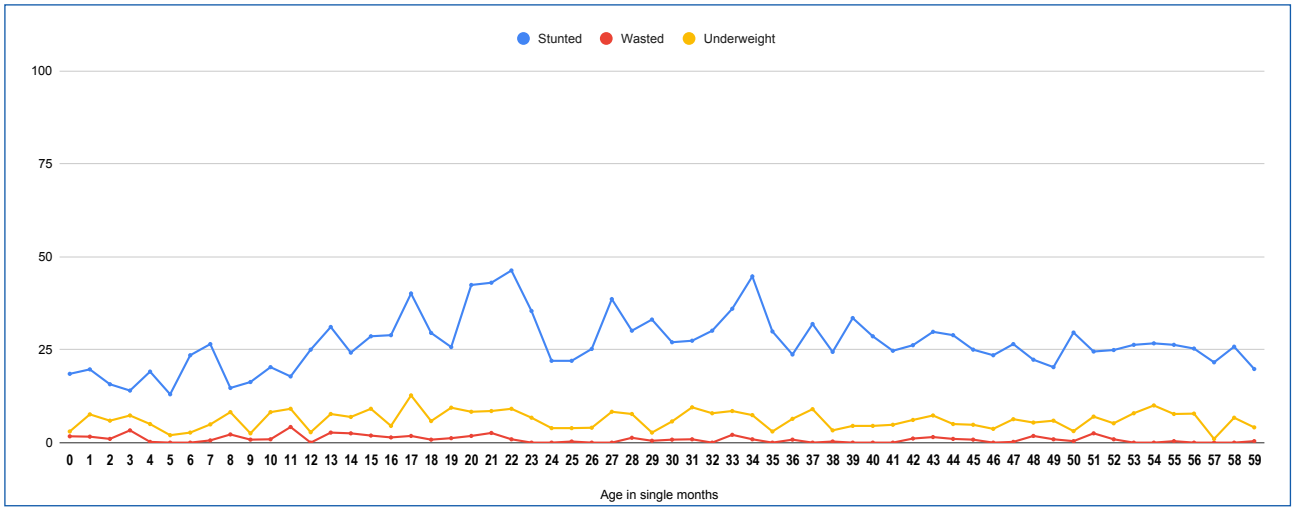


Table 13 shows the nutritional status of children under the age of 5 according to the three anthropometric indices. 27% of children under age 5 are stunted, 1% wasted, 6% underweight and 5% overweight.

Stunting generally increases through the first year of life, peaking at 33% among children aged 12-23 months. Significant disparities are observed by residence and provinces. The proportion is higher among children in rural areas (30%) than in urban areas (19%). Similarly, children residing in the North and West provinces are more likely to be stunted (33% each) compared to those in other provinces. Stunting is strongly correlated with the mother's education level. Children of women with no education are more likely to be stunted than those whose mothers have attended school. Stunting is inversely related to wealth quintile; 40% of children in the lowest wealth quintile are stunted, compared with 9% of children in the highest quintile.

Table 13 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of child growth: height-for-age, weight-for-height, and weight-for-age, according to background characteristics, Rwanda 2025

	Height-for-age[1]				Weight-for-height					Weight-for-age			
Background characteristic	Percentage below -3 SD	Percentage below -2 SD[2]	Mean z score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean z score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Mean z score (SD)	Number of children
Age in months													
<6	4.3	16.7	-0.9	717	0.2	1.2	16.8	0.9	714	2.3	5.0	-0.0	718
6–11	4.0	19.8	-1.2	731	0.8	1.4	5.9	0.4	732	1.0	5.8	-0.4	731
12–23	9.0	33.2	-1.5	1,414	0.5	1.4	4.3	0.3	1,412	1.0	7.5	-0.5	1,413
24–35	7.1	30.6	-1.4	1,457	0.1	0.6	4.9	0.4	1,460	0.4	6.0	-0.5	1,459
36–47	6.0	27.2	-1.4	1,545	0.0	0.5	3.2	0.4	1,546	0.6	5.5	-0.5	1,549
48–59	5.6	24.6	-1.3	1,429	0.0	0.6	1.8	0.2	1,427	0.5	6.0	-0.6	1,429
0–23	6.6	25.6	-1.3	2,862	0.5	1.4	7.9	0.5	2,858	1.3	6.5	-0.3	2,862
24–59	6.2	27.5	-1.4	4,431	0.0	0.6	3.3	0.4	4,433	0.5	5.8	-0.6	4,437
Sex													
Male	7.7	29.3	-1.4	3,654	0.3	1.0	6.2	0.5	3,653	0.9	6.3	-0.5	3,659
Female	5.0	24.1	-1.3	3,638	0.1	0.8	4.0	0.4	3,638	0.7	5.8	-0.5	3,640
Mother's interview status													
Interviewed	6.2	26.5	-1.3	6,737	0.2	0.9	5.3	0.4	6,732	0.8	6.0	-0.5	6,741
Not interviewed, but in household	4.4	18.4	-1.1	71	0.0	1.5	2.4	0.2	71	1.5	6.0	-0.4	71
Not interviewed, not in household[3]	9.2	32.0	-1.5	485	0.2	0.2	3.0	0.4	488	0.6	6.6	-0.6	487
Residence													
Urban	3.3	18.6	-0.9	2,120	0.3	1.3	5.3	0.4	2,120	0.7	5.0	-0.3	2,123
Rural	7.6	30.1	-1.5	5,173	0.2	0.7	5.0	0.4	5,170	0.8	6.5	-0.6	5,176
Province													
Kigali	2.0	14.2	-0.8	975	0.2	0.8	3.7	0.3	975	0.4	5.4	-0.2	975
South	5.6	26.1	-1.4	1,622	0.2	0.7	4.0	0.3	1,622	1.1	6.8	-0.6	1,623
West	9.2	32.6	-1.5	1,593	0.2	1.0	7.1	0.6	1,592	0.8	5.4	-0.5	1,596
North	5.4	32.7	-1.5	1,008	0.1	0.6	6.0	0.6	1,007	0.4	4.2	-0.4	1,008
East	7.3	25.8	-1.3	2,094	0.3	1.1	4.6	0.3	2,094	1.0	7.3	-0.5	2,096
Mother's education[4]													
No education	9.9	37.8	-1.7	435	0.3	1.5	4.8	0.4	435	1.6	8.7	-0.7	437
Primary	7.3	29.9	-1.5	4,141	0.2	0.7	5.4	0.4	4,140	0.9	6.8	-0.5	4,143
Secondary	3.6	19.6	-1.1	1,928	0.1	1.3	5.4	0.4	1,926	0.6	4.6	-0.3	1,929
More than secondary	0.7	5.8	-0.3	303	0.3	1.4	3.5	0.3	302	0.3	1.4	0.1	303
Wealth quintile													
Lowest	12.0	39.8	-1.8	1,647	0.3	0.8	4.2	0.3	1,647	1.3	9.7	-0.8	1,648
Second	6.7	32.1	-1.6	1,487	0.3	0.7	5.4	0.5	1,487	0.9	7.0	-0.6	1,488
Middle	6.9	28.9	-1.4	1,460	0.1	0.6	5.2	0.5	1,460	0.7	5.4	-0.5	1,461
Fourth	3.7	19.9	-1.2	1,380	0.1	1.0	5.6	0.4	1,377	0.8	4.7	-0.4	1,381
Highest	1.1	9.2	-0.6	1,320	0.2	1.3	5.2	0.4	1,320	0.3	2.7	-0.1	1,320
Total	6.4	26.8	-1.3	7,293	0.2	0.9	5.1	0.4	7,291	0.8	6.1	-0.5	7,299

Note: Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards.

[1] Recumbent length is measured for children under age 2; standing height is measured for all other children

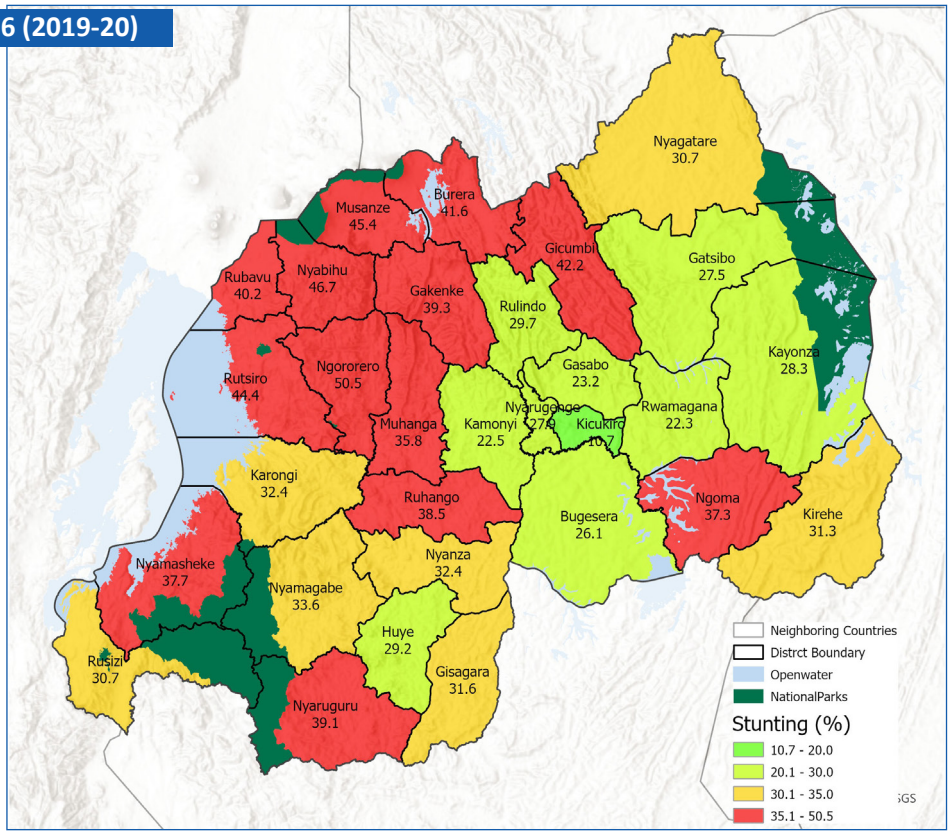
[2] Includes children who are below -3 SD from the WHO Growth Standards population median

[3] Includes children whose mothers are deceased

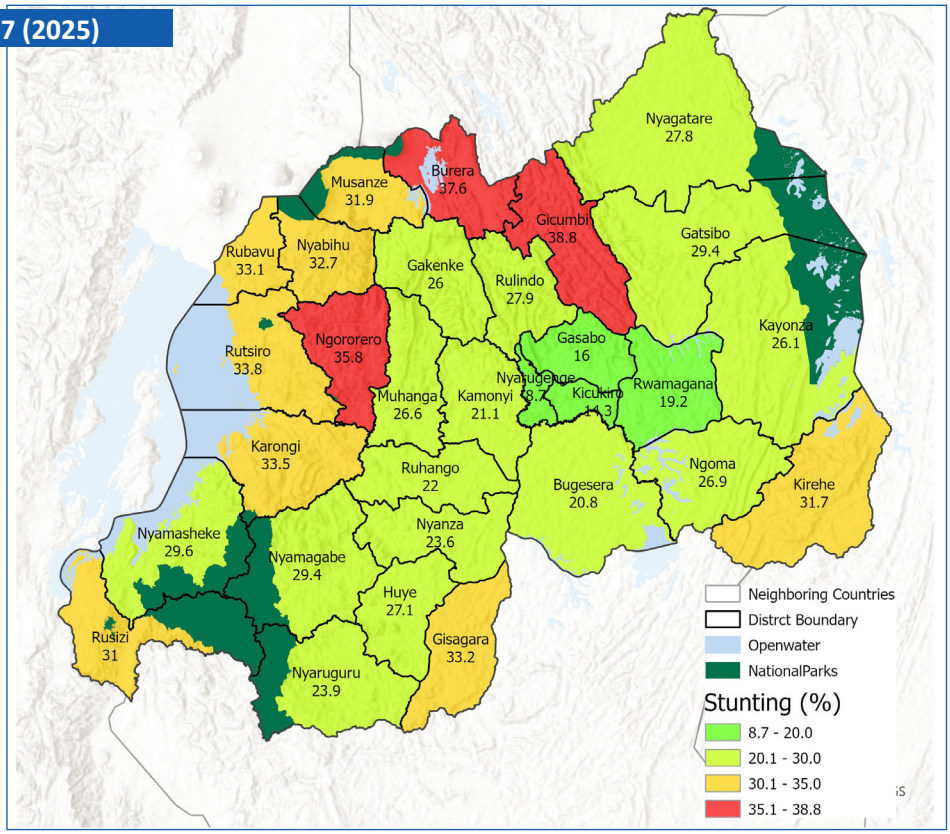
[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Figure 9. Prevalence of stunting among children under age 5 and changes between 2019-20 and 2025

RDHS 6 (2019-20)



RDHS 7 (2025)



3.12 Infant and Young Child Feeding

Early initiation of breastfeeding

Percentage of children born in the past 2 years who were put to the breast within one hour of birth.

Sample: Children born in the past 2 years

Exclusive breastfeeding under 6 months

Percentage of children aged 0–5 months who were fed exclusively with breast milk during the previous day.

Sample: Youngest children aged 0–5 months living with their mother

Minimum dietary diversity

Percentage of children aged 6–23 months who were fed a minimum of five out of eight defined food groups during the previous day. The eight food groups are breast milk, grains, roots, and tubers, legumes and nuts, dairy products (milk, yogurt, and cheese), flesh foods (meat, fish, poultry, and organ meat), eggs, vitamin A-rich fruits and vegetables, and other fruits and vegetables.

Sample: Youngest children aged 6–23 months living with their mother.

Table 14 Infant and young child feeding (IYCF) indicators

Percentage of children fed according to various IYCF practices, Rwanda 2025

Indicator	Indicator numerator and denominator	Value
Early initiation of breastfeeding[1]	Percentage of children born in the last 2 years who were put to the breast within 1 hour of birth	79.2
	Number of children born in the last 2 years	2,939
Exclusive breastfeeding under 6 months	Percentage of children aged 0–5 months who were fed exclusively with breast milk during the previous day	81.8
	Number of youngest children age 0–5 months living with the mother	709
Minimum dietary diversity 6–23 months	Percentage of children aged 6–23 months who were fed foods and beverages from at least 5 out of 8 defined food groups during the previous day	43.5
	Number of youngest children aged 6–23 months living with the mother	2,066
Sweet beverage consumption 6–23 months	Percentage of children aged 6–23 months who were given a sweet beverage during the previous day	33.9
	Number of youngest children aged 6–23 months living with the mother	2,066
Unhealthy food consumption 6–23 months	Percentage of children aged 6–23 months fed unhealthy foods during the previous day	25.5
	Number of youngest children aged 6–23 months living with the mother	2,066

[1] Includes children born in the 2 years preceding the survey regardless of whether the children are living or dead at the time of interview

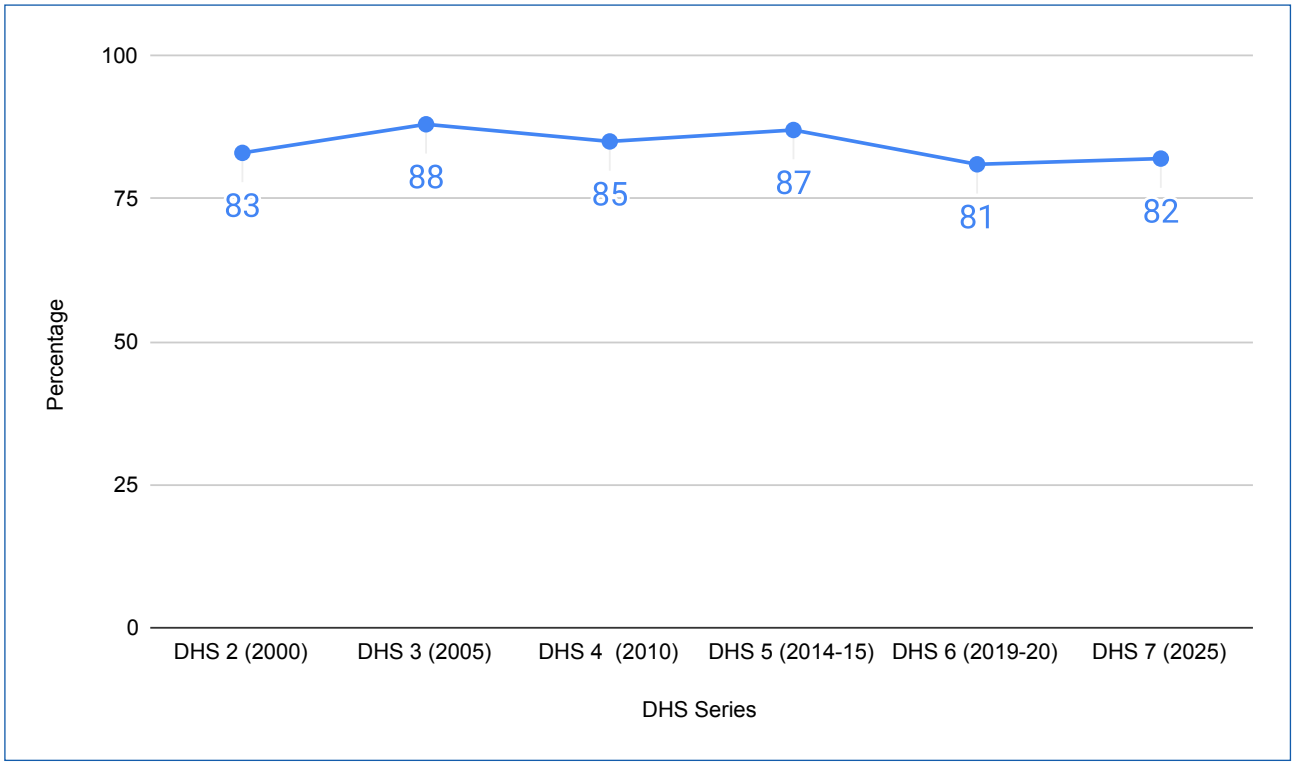
Table 14 presents data on key Infant and Young Child Feeding (IYCF) indicators.

Overall, 79% of children aged 0–23 months were breastfed within one hour of birth.

- 44% of children aged 6–23 months are fed with the minimum dietary diversity.
- 82% of children under 6 months of age are exclusively breastfed.

Figure 10 Trends in exclusive breastfeeding

Exclusive breastfeeding among children aged 0–5 months has remained at a similar level (between 80% and 90%) since 2000 (Figure 10).



Unhealthy IYCF practices should be avoided as they can promote unhealthy weight gain and replace nutritious foods that provide important nutrients for children. Consumption of sweet foods and beverages by infants and young children increases the risk of dental caries and childhood obesity. The indicator definition below for unhealthy food consumption describes sentinel unhealthy foods, which are high in sugar, salt, or unhealthy fats and are commonly consumed by infants and young children (WHO and UNICEF 2021).

Sweet beverage consumption

Percentage of children aged 6–23 months who were given a sweet beverage during the previous day.

Sample: Youngest children aged 6–23 months living with their mother

Unhealthy food consumption

Percentage of children aged 6–23 months who were fed sentinel unhealthy foods during the previous day.

Sample: Youngest children aged 6–23 months living with their mother

- 34% of children aged 6–23 months drank a sweet beverage during the previous day.
- 26% of children aged 6–23 months consumed unhealthy foods during the previous day.

3.13 HIV and AIDS Awareness, Knowledge, and Behavior

3.13.1 Prevention Knowledge

Knowledge about HIV prevention

Proportion of respondents who know that consistently using condoms during sexual intercourse and having just one uninfected, faithful partner can reduce the chances of getting HIV, know that a healthy-looking person can have HIV, and reject two major misconceptions about HIV transmission: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.

Sample: Women and men aged 15–24

Comprehensive knowledge of HIV transmission is crucial for enabling individuals to avoid HIV infection. This is especially important for young people aged 15-24, a group often at a higher risk due to factors such as shorter relationships and engagement with multiple partners or other risky behaviors. As shown in Table 15, the percentage of young women and men aged 15-24 with comprehensive knowledge of HIV prevention is 57% and 53% respectively.

Table 15 Knowledge about HIV prevention methods among young people

Percentage of young women and young men aged 15–24 with knowledge about HIV prevention, according to background characteristics, Rwanda 2025

	Women aged 15–24		Men aged 15–24	
Background characteristic	Percentage with knowledge about HIV prevention[1]	Number of women	Percentage with knowledge about HIV prevention[1]	Number of men
Age				
15–19	53.9	2,897	46.8	1,337
15–17	50.0	1,749	42.2	810
18–19	60.0	1,148	54.0	526
20–24	61.3	2,489	60.5	1,019
20–22	59.4	1,593	58.3	652
23–24	64.6	897	64.4	367
Marital status				
Never married	56.5	4,339	52.3	2,174
Ever had sex	60.1	1,191	58.3	760
Never had sex	55.1	3,147	49.0	1,414
Ever married	61.0	1,048	58.4	182
Residence				
Urban	62.2	1,758	63.2	657
Rural	55.0	3,628	48.7	1,699
Province				
Kigali	63.2	878	70.1	331
South	58.9	1,116	51.2	592
West	51.5	1,095	43.0	428
North	59.9	778	51.6	338
East	55.7	1,519	52.3	667
Education				
No education	32.4	70	(40.2)	51
Primary	50.3	2,460	46.8	1,302
Secondary	63.2	2,727	60.6	962
More than secondary	80.4	129	(71.9)	41
Wealth quintile				
Lowest	50.8	908	46.1	372
Second	54.6	1,022	51.4	427
Middle	55.8	1,041	46.0	493
Fourth	60.6	1,110	56.7	539
Highest	62.4	1,305	60.8	524
Total 15–24	57.3	5,386	52.7	2,356

Note: Figures in parentheses are based on 25–49 unweighted cases.

[1] Knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting two common misconceptions about transmission or prevention of HIV: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.

3.13.2 Sexual Behavior

- Information on sexual behavior is essential in designing and monitoring intervention programs to control the spread of HIV.
- 2% of women aged 15–49 had two or more partners in the past 12 months, and 42% of these women reported using a condom during their most recent sexual intercourse (Table 16.1).
- 11%t of women aged 15–49 had sexual intercourse with a person who was neither their husband nor lived with them, and 45% of these women reported using a condom during their most recent sexual intercourse with such a partner.
- Among women aged 15–49 who have ever had sexual intercourse, the mean number of lifetime sexual partners is 2.1.
- 6% of men aged 15–49 had two or more partners in the past 12 months, and 30% of these men reported using a condom during their most recent sexual intercourse (Table 16.2).
- 15% of men aged 15–49 had sexual intercourse in the past 12 months with a person who was neither their wife nor lived with them, and 69% of these men reported using a condom during their most recent sexual intercourse with such a partner.
- Among men aged 15–49 who have ever had sexual intercourse, the mean number of lifetime sexual partners is 3.3.

Table 16.1 Multiple sexual partners and higher-risk sexual intercourse in the last 12 months: Women

Among all women age 15-49, percentage who had sexual intercourse with more than one sexual partner in the last 12 months, and percentage who had intercourse in the last 12 months with a person who was neither their husband nor lived with them; among those having more than one partner in the last 12 months, percentage reporting that a condom was used during last intercourse; among women age 15-49 who had sexual intercourse in the last 12 months with a person who was neither their husband nor lived with them, percentage who used a condom during last sexual intercourse with such a partner; and among women who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, Rwanda 2025

	All women			Women who had 2+ partners in the last 12 months		Women who had intercourse in the last 12 months with a person who was neither their husband nor lived with them		Women who ever had sexual intercourse1	
Background characteristic	Percent- age who had 2+ partners in the last 12 months	Percent- age who had inter- course in the last 12 months with a person who was neither their husband nor lived with them	Number of women	Percent- age who reported using a condom during last sexual inter- course	Number of women	Percentage who reported using a condom during last sexual intercourse with such a partner	Number of women	Mean number of sexual partners in lifetime	Effectif de femmes
Age									
15-24	2.0	13.0	5,386	47.1	108	47.4	702	2.0	2,239
..15-19	1.3	9.4	2,897	(36.8)	37	43.0	272	1.9	577
..20-24	2.9	17.3	2,489	52.3	71	50.2	431	2.1	1,662
25-29	2.3	13.3	2,032	(45.0)	47	48.1	270	1.9	1,866
30-39	1.9	9.9	3,790	39.8	70	43.2	376	2.4	3,694
40-49	1.4	7.1	3,074	(27.5)	43	35.3	219	1.9	3,037
Marital status									
Never married	2.3	19.1	5,505	54.3	129	47.0	1,052	2.9	2,058
Married/living together	0.8	1.2	7,410	10.1	61	47.3	91	1.6	7,409
Divorced/separated/ widowed	5.8	31.1	1,369	45.5	79	39.1	425	3.4	1,369
Residence									
Urban	2.7	14.2	4,570	39.0	125	48.7	651	3.0	3,450
Rural	1.5	9.4	9,713	44.0	143	42.1	918	1.7	7,386
Province									
Kigali	2.9	16.7	2,290	(40.9)	67	48.9	382	3.4	1,762
South	1.7	10.0	3,087	47.3	51	44.0	309	1.9	2,349
West	1.2	7.6	2,949	(40.5)	37	43.4	224	1.8	2,147
North	1.6	9.0	2,089	(46.4)	34	47.9	188	1.6	1,577
East	2.0	12.0	3,868	37.2	79	41.5	466	1.9	3,001
Education									
No education	2.3	10.0	929	*	22	24.9	93	2.6	878
Primary	2.1	11.5	7,893	43.5	168	42.1	909	2.0	6,590
Secondary	1.5	10.3	4,810	40.8	74	51.6	495	2.1	2,857
More than secondary	0.7	10.9	651	*	4	59.1	71	1.9	511
Wealth quintile									
Lowest	2.6	13.2	2,642	34.9	67	34.1	349	2.4	2,195
Second	1.5	9.6	2,738	(34.9)	41	37.1	264	1.9	2,107
Middle	2.0	9.6	2,746	51.7	54	49.3	264	1.8	2,084
Fourth	2.1	10.9	2,885	37.6	60	48.3	314	2.2	2,147
Highest	1.4	11.5	3,272	(50.9)	46	54.2	377	2.2	2,303
Total	1.9	11.0	14,283	41.7	268	44.8	1,568	2.1	10,836

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
1 Means are calculated excluding respondents who gave non-numeric responses.

Table 16.2 Multiple sexual partners and higher-risk sexual intercourse in the last 12 months: Men

Among all men aged 15–49, percentage who had sexual intercourse with more than one sexual partner in the last 12 months, and percentage who had intercourse in the last 12 months with a person who was neither their wife nor lived with them; among those having more than one partner in the last 12 months, percentage reporting that a condom was used during last intercourse; among men aged 15–49 who had sexual intercourse in the last 12 months with a person who was neither their wife nor lived with them, percentage who used a condom during last sexual intercourse with such a partner; and among men who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, Rwanda 2025

	All men			Men who had 2+ partners in the last 12 months		Men who had intercourse in the last 12 months with a person who was neither their wife nor lived with them		Men who ever had sexual intercourse[1]	
Background characteristic	Percentage who had 2+ partners in the last 12 months	Percentage who had intercourse in the last 12 months with a person who was neither their wife nor lived with them	Number of men	Percentage who reported using a condom during last sexual intercourse	Number of men	Percentage who reported using a condom during last sexual intercourse with such a partner	Number of men	Mean number of sexual partners in lifetime	Number of men
Age									
15–24	3.5	14.0	2,356	63.0	83	73.8	331	2.7	942
15–19	1.0	6.1	1,337	*	13	74.0	82	2.0	279
20–24	6.9	24.5	1,019	58.7	70	73.8	249	3.0	663
25–29	8.6	23.7	754	30.7	65	67.1	179	3.9	670
30–39	8.7	14.3	1,545	22.0	135	64.1	220	3.3	1,505
40–49	7.0	11.0	1,236	8.9	87	66.7	136	3.5	1,219
Marital status									
Never married	4.7	20.5	2,772	69.1	129	72.4	568	3.3	1,225
Married/living together	7.4	7.5	2,983	4.9	221	61.3	225	3.1	2,978
Divorced/separated/ widowed	14.5	54.7	135	*	20	64.5	74	6.0	134
Type of union									
In polygynous union	29.6	11.6	63	*	19	*	7	7.8	63
Not in polygynous union	6.9	7.4	2,920	4.8	202	61.9	217	3.0	2,915
Not currently in union	5.1	22.1	2,908	66.7	149	71.5	642	3.6	1,359
Residence									
Urban	7.1	19.2	1,889	40.0	133	69.6	364	3.8	1,466
Rural	5.9	12.6	4,002	23.9	236	68.3	503	3.0	2,871
Province									
Kigali	7.2	21.5	1,020	46.0	74	65.6	219	4.3	827
South	3.8	11.3	1,317	24.2	50	73.2	149	2.7	887
West	6.4	12.4	1,100	18.0	70	65.8	137	2.8	797
North	6.7	12.5	862	21.5	57	74.4	108	2.5	630
East	7.4	15.9	1,591	32.8	118	68.3	254	3.8	1,195
Education									
No education	6.3	14.2	347	*	22	62.3	49	3.5	309
Primary	6.6	13.6	3,469	24.2	230	65.3	471	3.2	2,674
Secondary	5.7	16.3	1,741	43.0	99	75.2	285	3.6	1,062
More than secondary	5.6	18.5	334	*	19	71.6	62	3.3	293
Wealth quintile									
Lowest	6.9	13.8	1,003	18.9	70	62.0	139	3.6	757
Second	6.1	12.9	1,021	19.4	62	55.6	132	3.0	751
Middle	5.8	12.8	1,167	30.6	68	75.4	149	3.0	821
Fourth	6.7	15.1	1,281	31.8	85	74.1	193	3.0	949
Highest	6.0	17.8	1,419	43.3	85	71.6	253	3.8	1,059
Total 15–49	6.3	14.7	5,891	29.7	370	68.8	867	3.3	4,337
50–59	6.7	7.9	657	(10.0)	44	42.6	52	3.7	652
Total 15–59	6.3	14.0	6,548	27.6	414	67.3	919	3.3	4,989

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
1 Means are calculated excluding respondents who gave non-numeric responses.

3.13.3 Prior HIV Testing

HIV testing programs diagnose individuals living with HIV so they can be connected to care and receive antiretroviral therapy (ART). Knowing one's HIV status also helps HIV-negative individuals reduce their risk and maintain their negative status.

Overall, 78% of women and 72% of men aged 15–49 have been tested for HIV at least once (**Table 17.1** and **Table 17.2**, respectively).Almost all individuals who were tested received their test results.

Only 29% of women and 22% of men aged 15-49 were tested for HIV in the 12 months before the survey and received the results of their most recent test.

Table 17.1 Coverage of prior HIV testing: Women

Percent distribution of women aged 15–49 by HIV testing status and by whether they received the results of the last test, percentage of women ever tested, and percentage of women who were tested in the last 12 months and received the results of the last test, according to background characteristics, Rwanda 2025

Background characteristic	Percent distribution of women by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the last 12 months and received the results of the last test	Number of women
	Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age							
15–24	45.5	1.7	52.8	100.0	47.2	21.6	5,386
15–19	24.1	1.4	74.5	100.0	25.5	11.8	2,897
20–24	70.5	2.0	27.6	100.0	72.5	33.0	2,489
25–29	92.6	1.8	5.7	100.0	94.3	38.4	2,032
30–39	96.9	1.3	1.8	100.0	98.3	37.4	3,790
40–49	96.9	0.9	2.1	100.0	97.9	25.8	3,074
Marital status							
Never married	44.7	1.4	53.9	100.0	46.1	18.4	5,505
Ever had sex	77.7	1.5	20.8	100.0	79.2	35.5	2,058
Never had sex	24.9	1.4	73.7	100.0	26.3	8.2	3,446
Married or living together	97.3	1.5	1.2	100.0	98.8	36.3	7,410
Divorced/separated/ widowed	96.2	1.0	2.7	100.0	97.3	33.0	1,369
Residence							
Urban	78.4	1.2	20.4	100.0	79.7	32.2	4,570
Rural	76.2	1.5	22.3	100.0	77.8	27.6	9,713
Province							
Kigali	81.8	1.5	16.6	100.0	83.4	33.3	2,290
South	76.9	1.3	21.8	100.0	78.2	28.3	3,087
West	74.3	0.8	24.9	100.0	75.2	29.2	2,949
North	76.4	0.7	22.9	100.0	77.1	28.4	2,089
East	76.3	2.3	21.4	100.0	78.7	27.5	3,868
Education							
No education	90.2	1.2	8.5	100.0	91.5	27.3	929
Primary	80.7	1.3	18.0	100.0	82.0	28.8	7,893
Secondary	66.5	1.7	31.9	100.0	68.2	29.0	4,810
More than secondary	88.6	1.7	9.7	100.0	90.4	35.6	651
Wealth quintile							
Lowest	79.5	1.6	19.0	100.0	81.0	27.8	2,642
Second	76.5	1.2	22.3	100.0	77.7	28.5	2,738
Middle	77.1	1.5	21.4	100.0	78.7	28.4	2,746
Fourth	77.0	1.4	21.6	100.0	78.4	30.4	2,885
Highest	74.9	1.5	23.6	100.0	76.4	30.1	3,272
Total	76.9	1.4	21.7	100.0	78.4	29.1	14,283

[1] Includes respondents who have not heard of HIV or who refused to answer questions on testing

Table 17.2 Coverage of prior HIV testing: Men

Percent distribution of men aged 15–49 by HIV testing status and by whether they received the results of the last test, percentage of men ever tested, and percentage of men who were tested in the last 12 months and received the results of the last test, according to background characteristics, Rwanda 2025

	Percent distribution of men by testing status and by whether they received the results of the last test					Percentage who have been tested for HIV in the last 12 months and received the results of the last test	
Background characteristic	Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percentage ever tested		Number of men
Age							
15–24	35.6	1.2	63.2	100.0	36.8	11.6	2,356
15–19	18.2	0.8	81.0	100.0	19.0	5.4	1,337
20–24	58.5	1.7	39.8	100.0	60.2	19.8	1,019
25–29	87.6	1.4	11.0	100.0	89.0	29.8	754
30–39	96.2	0.6	3.2	100.0	96.8	29.6	1,545
40–49	97.1	0.6	2.3	100.0	97.7	25.3	1,236
Marital status							
Never married	41.6	1.4	56.9	100.0	43.1	13.0	2,772
Ever had sex	61.1	1.7	37.2	100.0	62.8	21.9	1,227
Never had sex	26.2	1.2	72.6	100.0	27.4	6.0	1,545
Married or living together	97.4	0.4	2.2	100.0	97.8	28.7	2,983
Divorced/separated/ widowed	92.7	2.7	4.5	100.0	95.5	37.8	135
Residence							
Urban	77.2	1.0	21.8	100.0	78.2	26.0	1,889
Rural	68.1	0.9	30.9	100.0	69.1	19.5	4,002
Province							
Kigali	80.0	1.1	18.9	100.0	81.1	28.6	1,020
South	66.9	1.5	31.6	100.0	68.4	19.8	1,317
West	69.3	0.8	29.9	100.0	70.1	19.2	1,100
North	74.5	0.5	25.1	100.0	74.9	19.9	862
East	68.0	0.9	31.1	100.0	68.9	21.0	1,591
Education							
No education	81.6	1.3	17.2	100.0	82.8	22.6	347
Primary	70.5	0.7	28.7	100.0	71.3	19.2	3,469
Secondary	65.4	1.4	33.2	100.0	66.8	22.6	1,741
More than secondary	94.9	1.0	4.1	100.0	95.9	38.7	334
Wealth quintile							
Lowest	67.9	1.4	30.7	100.0	69.3	19.8	1,003
Second	69.9	0.9	29.1	100.0	70.9	19.1	1,021
Middle	68.9	0.7	30.4	100.0	69.6	19.5	1,167
Fourth	71.3	0.6	28.1	100.0	71.9	22.5	1,281
Highest	75.5	1.2	23.3	100.0	76.7	25.4	1,419
Total 15–49	71.0	1.0	28.0	100.0	72.0	21.5	5,891
50–59	94.0	1.3	4.6	100.0	95.4	20.8	657
Total 15–59	73.3	1.0	25.7	100.0	74.3	21.5	6,548

[1] Includes respondents who have not heard of HIV or who refused to answer questions on testing

3.14 Maternal Mortality

Estimates of maternal mortality for the period 0-4 years before the survey are shown in **Table 18**. Age- specific mortality rates were calculated by dividing the number of maternal deaths by years of exposure. For this survey, maternal death is defined as the death that occurrs while pregnant, childbirth, or within 42 days of the termination of a pregnancy, from any cause except accidents or violence causes. The maternal mortality ratio (MMR) is defined as the number of maternal deaths per 100,000 live births. Maternal deaths are a relatively rare occurrence, therefore, the results should be interpreted with caution.

Estimations of mortality rates requires complete accurate data regarding maternal deaths. For the 2025 RDHS, such data were collected, wherein all female respondents provided survival information for their siblings. Questions were included to determine whether any deceased sisters had died from maternity-related causes. This approach permits the estimation of maternal mortality, which serves as a key indicator of maternal health and well-being.

There were 22 maternal deaths in the reference period. The maternal mortality ratio for the 5-year period before the 2025 RDHS is estimated at 149 maternal deaths per 100,000 live births, with a confidence interval of 84 to 215 deaths per 100,000 live births. In the 2019-20 RDHS, the maternal mortality ratio was estimated at 203 (CI: 125-281).

Table 18 Maternal mortality

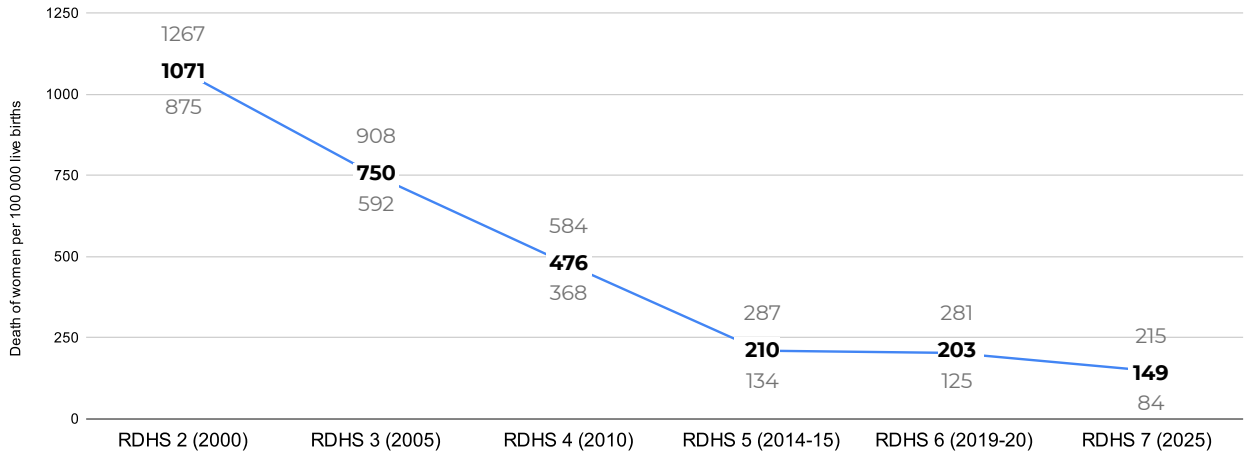
Direct estimates of maternal mortality rates for the 5 years preceding the survey, by 5-year age groups, Rwanda DHS 2025

Age	Percentage of female deaths that are maternal	Maternal deaths[1]	Exposure years	Maternal mortality rate[2]
15-19	5.5	0	19,162	0.00
20-24	20.2	1	22,221	0.05
25-29	23.0	4	21,208	0.19
30-34	10.9	7	20,398	0.36
35-39	8.5	5	18,498	0.29
40-44	3.9	3	13,139	0.23
45-49	0.0	1	7,826	0.14
Total 15-49	10.8	22	122,450	0.16
Total fertility rate (TFR)	3.7			
General fertility rate (GFR)[3]				109
Maternal mortality ratio (MMR)[4]				149 (84:215)
Lifetime risk of maternal death[5]				0.006

[1] A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause except accidents or violence
[2] Expressed per 1,000 woman-years of exposure
[3] Age-adjusted rate expressed per 1,000 women aged 15-49
[4] Expressed per 100,000 live births; calculated as the age-adjusted maternal mortality rate (shown in Table MM.3) times 100 divided by the age-adjusted general fertility rate
[5] Calculated as $1-(1-MMR)^{TFR}$ where TFR represents the total fertility rate for the five years preceding the survey

The maternal mortality ratio (MMR), obtained by dividing the age-standardized maternal mortality rate by the age-standardized general fertility rate, is often considered a more useful measure of maternal mortality since it measures the obstetric risk associated with each live birth. Table 18 shows that the maternal mortality ratio for Rwanda for the period 2020 to 2025 is 149 deaths per 100,000 live births (or alternatively, 1.49 deaths per 1,000 live births).

Figure 11: Maternal mortality ratios for the period of 0-4 years prior to the survey, RDHSs



4 REFERENCES

- Bradley, S. E. K., T. N. Croft, J. D. Fishel, and C. F. Westoff. 2012. Revising Unmet Need for Family Planning. DHS Analytical Studies No. 25. Calverton, Maryland, USA: ICF International.
- Chaparro, C. M., and P. S. Suchdev. 2019. Anemia Epidemiology, Pathophysiology, and Etiology in Low- and Middle-Income Countries. Annals of the New York Academy of Sciences 1450(1):15–31. https://doi.org/10.1111/nyas.14092.
- Haider, B. A., I. Olofin, M. Wang, D. Spiegelman, M. Ezzati, W. W. Fawzi, and Nutrition Impact Model Study Group. 2013. Anaemia, Prenatal Iron Use, and Risk of Adverse Pregnancy Outcomes: Systematic Review and Meta-analysis. BMJ 346:f3443. https://www.ncbi.nlm.nih.gov/pubmed/23794316.
- Jenkins M, Amoaful EF, Abdulai M, Quartey V, Situma R, Ofosu-Apea P, Aballo J, Demuyakor ME, Gosdin L, Mapango C, Jefferds MED and Addo OY (2024) Comparison of venous and pooled capillary hemoglobin levels for the detection of anemia among adolescent girls. Front. Nutr. 11:1360306. doi: 10.3389/fnut.2024.1360306
- Namaste SM, Baingana R, Brindle E. Hemoglobin measurement in venous blood compared with pooled and single-drop capillary blood: a method-comparison study in a controlled and survey setting in Uganda among children and women. Am J Clin Nutr. 2024 Apr;119(4):949-959
- Van Lerberghe, W., and V. De Brouwere. 2001. Of Blind Alleys and Things That Have Worked: History's Lessons on Reducing Maternal Mortality. In: De Brouwere, V., and W. Van Lerberghe, eds. Safe Motherhood Strategies: A Recent Review of the Evidence. Antwerp: ITG Press, 7–33.
- World Health Organization (WHO). 2003. The World Health Report 2003: Shaping the Future. Geneva: WHO. https://apps.who.int/iris/handle/10665/42789.
- World Health Organization (WHO). 2006a. Standards for Maternal and Neonatal Care in Health Facilities. Geneva: WHO. https://www.who.int/publications/i/item/9789241511216.
- World Health Organization (WHO). 2006b. *Child Growth Standards*. Geneva: WHO.
- World Health Organization (WHO) and United Nations Children's Fund (UNICEF). 2021. Indicators for Assessing Infant and Young Child Feeding Practices: Definitions and Measurement Methods. Geneva: WHO. https://www.who.int/publications/i/item/9789240018389.

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