FAMILY PLANNING IN RWANDA

HOW A TABOO TOPIC BECAME PRIORITY NUMBER ONE

INTRAHEALTH INTERNATIONAL

June 2008

By Julie Solo

With special thanks to the William and Flora Hewlett Foundation for its support.

Table of Contents

Acknowledgments

The author would like to thank the many people who assisted in making this report possible. Just as it takes many people working together to improve family planning in Rwanda, it takes many people to help tell the story.

First of all, this report would not have been possible without so many people generously offering their time and ideas; their voices fill this report, their names are listed in Appendix 2.

Staff from IntraHealth International's Rwanda offices and from the headquarters in North Carolina assisted with all aspects of this project, from planning to logistics to analysis to editing. In particular, Sara Stratton and Jana Scislowicz from North Carolina and Laura Hoemeke and Laura Shemeza from Rwanda provided invaluable support.

Finally, we greatly appreciate the funding from The William and Flora Hewlett Foundation as part of its ongoing support to family planning efforts around the world.

List of Acronyms

ARBEF	Association Rwandaise pour le Bien-être Familial
BTC	Belgian Technical Cooperation
CHAMP	Community HIV/AIDS Mobilization Program
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DFID	Department for International Development
DHS	Demographic and Health Survey
DIF	District Incentive Fund
DMPA	Depot Medroxyprogesterone Acetate
EDPRS	Economic Development and Poverty Reduction Strategy
FAM	Fertility Awareness-Based Methods
FP	Family Planning
FPTWG	Family Planning Technical Working Group
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
ICAP	International Center for AIDS Care and Treatment Programs
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OJT	On-the-Job Training
ONAPO	The National Office of Population
PAQ	Partenariat pour l'Amélioration de la Qualité
PBF	Performance-Based Financing
PEPFAR	The President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-To-Child Transmission
RH	Reproductive Health
RPRPD	Rwandan Parliamentarians' Network for Population and Development
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

"Family planning is a tool of development," states the minister of health of Rwanda. The experience of this country over the past several years shows what an important role family planning plays in a country's development and what kinds of challenges must be faced to make a family planning program work. There are very particular challenges in this small land of a thousand hills.

It has been 14 years since the genocide in Rwanda.

When you visit the Kigali Memorial Centre, you understand that the pain of the past is still so present. Fourteen years is not a long time.

And yet Rwanda has achieved so much in this short period. This is particularly clear in the achievements of their family planning program.

Before the genocide, a 1992 Demographic and Health Survey (DHS) found that 13% of married women were using modern contraceptive methods. This dropped to only 4% in 2000, after the destruction of so much of the country's infrastructure. By 2005, contraceptive use had increased to 10%. Preliminary results from a mini-DHS conducted in early 2008 indicate that this rate has almost tripled, reaching 27%.

Map of Rwanda and Key Indicators[1]

Population: 9.3 million

Total Fertility Rate (TFR): 5.5

Contraceptive Prevalence Rate (CPR): 27%

% Urban: 17%

Population Density: 355 per sq. km.

Infant Mortality Rate: 62

Maternal Mortality Ratio: 750

HIV Prevalence (15-49 years): 3%

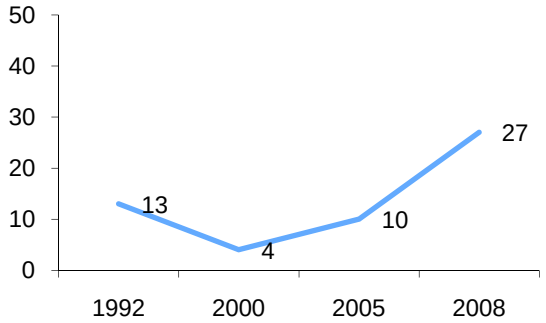
This has been achieved in spite of daunting challenges. Beyond rebuilding the country's health system, there were also tremendous social and cultural barriers. After so much death, people wanted to bring new life. "The government was shy to talk about family

[1] Data from Population Reference Bureau *2007 World Population Data Sheet* except for the maternal mortality ratio, which is from the 2005 DHS, and CPR, TFR and IMR which are from the 2008 mini-DHS.

planning because so many families had lost loved ones," as a USAID staff member explains. The culture had always been strongly pronatalist; a traditional wedding toast encourages newly married couples, "Be fruitful, may you have many sons and daughters." And the Catholic Church has been a vocal critic and barrier to family planning.

But in this context, President Kagame has declared family planning a national priority. In the words of the minister of health, "Family planning is priority number one—not just talking about it, but implementing it."

Changes in modern method CPR among married women in Rwanda, DHS 1992-2008



How did this happen?

It has been a combination of hard work, government commitment, coordination and partnership and the fact that family planning was recognized as essential for the most densely populated country in Africa. There are 355 people per square kilometer, as compared to an average of 32 per square kilometer in sub-Saharan Africa as a whole: "There is no spare meter where you won't meet a person," one donor explains.

The government has recognized that family planning is necessary for poverty reduction and the development of the country. The goals are ambitious, and the speed of progress—particularly in the past few years—has been striking. There is a mentality of "the faster we move forward, the faster we leave the past behind," explains an IntraHealth International staff member.

Of course, this is not a finished story but a work in progress. As the minister of health explains, he will not consider this a success until he sees concrete improvements in health—reduction of infant and maternal mortality—and a decrease in the population growth rate.

But Rwanda certainly seems to be on a path to achieve these goals. This report describes what has been done to improve family planning in Rwanda, what the keys to success were, what challenges were faced, what lessons have been learned and what gaps remain.

Methodology

In order to tell the story of Rwanda's family planning program, we used two sources of information: 1) review of key documents, including government policies, surveys and project reports [Appendix 1]; and 2) interviews with key informants, including government officials, program managers and implementers, health providers and family planning clients [Appendix 2]. In-depth interviews were conducted with 35 individuals in Rwanda and four staff members at IntraHealth International headquarters in North Carolina. In addition, we visited three health centers (two urban, one rural), interviewed six clients and conducted a group discussion with nine members of a community-provider partnership group affiliated with the Kabarondo Health Center in Rwamagana District.

The following question guide was used for in-depth interviews:

1. What do you feel have been the main achievements and successes of the family planning program in Rwanda in the past ten years?

2. What were the main reasons for these achievements and successes (including program factors, policies and societal/cultural factors)?

3. What were the main challenges or constraints encountered in implementing the family planning program?

4. How were these challenges addressed?

5. Are there any regions of the country or segments of the population that have been more challenging to effectively provide services to? If so, what has been done to meet their needs?

6. What are the current priorities for the family planning program in Rwanda?

7. What do you see as the main lessons learned from the work on family planning in Rwanda?

This report relies primarily on qualitative data, though quantitative data are used where possible. It is difficult to identify which interventions are most important in a context where multiple projects are going on simultaneously in overlapping locations. In addition, detailed findings from the 2008 mini-DHS are not yet available, and these would have helped in looking at variations among the different districts. However, by consulting with a wide range of stakeholders and implementers, as well as reviewing numerous documents, there were clear themes that emerged regarding the key elements of success and the remaining challenges in improving family planning in Rwanda.

What was achieved?

Increases in contraceptive use

The family planning story in Rwanda is one of gain and loss, followed by rebuilding to regain lost ground and then achieving even greater progress. As noted in the introduction, the contraceptive prevalence rate (CPR) fell after the 1994 genocide, from 13% in 1992 to only 4% in 2000. By 2005, the rate had increased to the point where 10% of married women were using modern contraception. Many expected to see dramatic improvements in the 2008 interim DHS, particularly in the CPR: "We have this trend going up, and we don't think it's going to stop," in the words of one respondent. They were not disappointed; preliminary results indicate that modern method CPR among married women has increased to 27%.

In the 2005 DHS, contraceptive prevalence among married women was 17% for any method and 10% for any modern method. The most frequently used modern methods were injectables (5%) and the pill (2%). There was higher use of modern contraceptive methods in urban areas vs. rural (21% vs. 9%), among women with higher levels of education (29% of women with secondary education or higher vs. 6% of women with no education), and among wealthier women (22% among the highest wealth quintile as compared with 6% among the poorest). Use was also higher in City of Kigali (23%) compared with other provinces: West (10%), North (10%), East (8%) and South (8%). It will be important to use the data from the mini-DHS to determine changes, improvements in addressing inequities, and remaining gaps.

In addition to the impressive 2008 DHS preliminary data, there are other clear indications of the increase in contraceptive use. Data from the USAID-funded DELIVER Project show the increase in couple years of protection (CYP) from 2004 to 2008 (see Table 1—numbers for 2004-07 are actual CYP while 2008 numbers are projections). As the 2005 DHS found, the injectable is the dominant method, accounting for 57% of CYP in 2007. While CYP has increased for all methods, the increase is most striking for implants, particularly in 2007 and in projections for 2008.

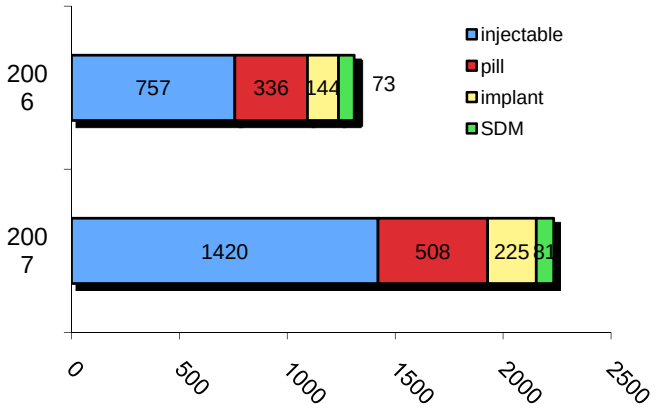
Table 1: Couple Years of Protection by Method and by Year

Year	Methods				
	Pill	*Injectable*	*Condoms*	*IUD*	*Implant*
2004	19,816	37,544	4,131	3,600	6,043
2005	24,189	56,367	5,395	3,343	7,220
2006	36,635	96,416	6,792	4,549	15,829
2007	49,956	153,793	13,779	6,694	46,011
2008	62,549	207,574	20,308	8,810	80,906

According to data from the performance-based financing project (discussed in detail later in the report), from January 2006 to December 2007, there was an increase in contraceptive prevalence from 3.89% to 10.63%, a 173% relative increase. It should be noted that these numbers include only pills and injectables and so are an undercount of actual modern method contraceptive prevalence.

At a facility level, we saw these dramatic changes in clinic visits. At the Gitega Health Center, located in Kigali, there has been close to a doubling in family planning clients from 2006 to 2007 (from 1,312 to 2,234, see Figure 1). Kimironko Health Center, also in Kigali, had 7,217 client visits for family planning in 2007, almost two-thirds (64%) of which were for Depo Provera. A rural facility—Kabarondo Health Center—had a similar method mix among its 1,541 clients in 2007: 1,178 Depo Provera users, 202 taking oral contraceptives, 134 implants and 27 condom users. Figure 1 also shows the increasing use of the Standard Days Method, or cycle beads. This method has been introduced by the Fertility Awareness-based Methods (FAM) Project and is an important addition to the method mix in a country with a large Catholic population.

Figure 1: Increases in family planning use from 2006 to 2007 at Gitega Health Center



Other improvements in health

The minister of health explained how his interest was in improving the health of the population, so he would not call family planning a success until he saw evidence of improvements in infant and maternal mortality. "What I want," he explained, "is the good health of my people."

Table 2: Regaining lost ground: changes in health indicators, 1992-2008

Indicator	1992	2000	2005	2008
Infant mortality	85	107	86	62
Under-five mortality	150	196	152	103
Maternal mortality	--	1071	750	--

When the 2000 DHS found increases in infant and under-five mortality rates (see Table 2), it was clear that there was an urgent need to improve health services. The maternal mortality ratio was also found to be extremely high at 1,071. Family planning was seen as a way to address all of these health issues, as better birth spacing improves both maternal and child health. By the time of the 2005 DHS, many health indicators had returned to pre-genocide levels. Preliminary results from the 2008 DHS show further improvement, with infant mortality declining from 86 to 62 and under-five mortality decreasing from 152 to 103.

What was done?

A respondent from United Nations Population Fund (UNFPA) used the analogy of comparing family planning with an office: you need to have 1) a cupboard with all the methods; 2) a chair for the provider—it is not enough to have the method in the cupboard if you do not have a trained provider to offer it; 3) a client motivated to come for services—the services only have meaning if clients come to use them. And overall, you need to support these three components with government commitment in terms of appropriate policies, materials, training, supervision and advocacy. There have been efforts to address all of these areas, as described in the rest of this report, beginning with the overall context of government support.

The following timeline shows selected key events in the family planning program, as well as changes in fertility and contraceptive prevalence over time. While much of this report will focus on policy and programmatic efforts over the past ten years, it is important to note that family planning work began earlier. As one respondent who worked on family planning in Rwanda in the 1980s pointed out, "They are building this on a country with a family planning history." The turning point in the program seems to be in 2005 when there was significant donor and government support and programs began to systematically work towards implementation at a national scale.

Rwanda Family Planning Timeline

Year	Events/Activities	Indicators
1962	• First family planning (FP) program offering modern contraception established	
1970	• Fertility Survey conducted	TFR: 7.7
1977	• FP goals included for first time in five-year plan (1977-1981)	
1981	• National Office of Population (ONAPO) established to implement population programs and begin program to integrate FP services into all health facilities	
1983	• Fertility Survey conducted	TFR: 8.5
1986	• ARBEF founded as local International Planned Parenthood Federation (IPPF) affiliate	
1990	• National Population Policy and plan of action adopted, goals of reducing TFR from 8.6 to 4.0 and increasing CPR from 2 to 48% by 2000	
1992	• DHS conducted	TFR: 6.2 CPR: 13%
1994	• Genocide	
1995	• Government issues policy to guide reconstruction of the health system	
1997	• ONAPO conducts study on attitudes and strategies for population in Rwanda	
1999	• The Rwandan government begins to encourage the creation of community-managed mutual health organizations, or *mutuelles*.	
2000	• DHS conducted • PRIME II begins assistance to Ministry of Health (MOH) to build capacity of primary providers	TFR: 5.8 CPR: 4%
2002	• Qualitative assessment of FP in Rwanda conducted • DELIVER begins project to improve contraceptive logistics (JSI prime contractor) • Rwandan Parliamentarians' Network for Population and Development (RPRPD) formed	
2003	• July: First National Reproductive Health Policy signed by minister of health • ONAPO closed	
2004	• PEPFAR funding begins in Rwanda	
2005	• DHS conducted • Twubakane Program launched in 12 districts (IntraHealth prime contractor), including support to FP/reproductive health (RH) service delivery • PSI begins family planning program, working with private sector and community-based distribution • May: RAPID model presented to parliamentarians • Sept: HIV/Performance-Based Financing (PBF) project begins (Management Sciences for Health—MSH—prime contractor)	TFR: 6.1 CPR: 10%
2006	• Jan: draft of Quality Assurance Policy (which includes PAQs—community-provider partnerships) • Jan: new districts created • Mar: National FP Policy and its five-year strategies (2006-2010) produced by MOH • April: performance-based contracts introduced with district mayors • May: Capacity Project begins support for FP service delivery in 11 districts (IntraHealth prime contractor)	

Year	Events/Activities	Indicators
	• UNFPA begins support for FP in six districts • June: Initiation of FP secondary posts • July: District Incentive Funds officially launched • PSI introduces Confiance, oral contraceptives and three-month injectable	
2007	• Training of district-level trainers in FP by UNFPA, Twubakane, Capacity Project • Government declares FP to be a development priority • Feb: PSI organizes meeting with religious leaders on FP • June: Draft Law on Family Planning • Sept: Economic Development and Poverty Reduction Strategy, 2008-2012 emphasizes importance of FP and sets target of 70% CPR by 2012	
2008	• Mini-DHS conducted • Feb: Study tour to Uganda to see community-based distribution of DMPA • March: Capacity Project begins on-the-job training (OJT) for FP in four districts	TFR: 5.5 CPR: 27%

Key Family Planning Partners

Government

√ Ministry of Health (MINESANTE)
√ Ministry of Finance (MINECOFIN)
√ Ministry of Local Administration (MINALOC)
√ Ministry of Education (MINEDUC)
√ Ministry of Gender and Women in Development (MIGEPROF)
√ The Rwandan Parliamentarians' Network for Population and Development

Technical Assistance Agencies/Projects

√ IntraHealth International
  - o Twubakane Decentralization and Health Project, 2005-2009 [partners: RTI, Tulane University, EngenderHealth, VNG, RALGA and Pro-Femmes]
  - o Capacity Project, 2006-2010 [partners: LATH and MSH]
  - o HIV Clinical Services Program, 2007-2011 [partners: University of North Carolina Institute for Global Health and Infectious Diseases and Mildmay International]
  - o ACQUIRE Project, 2004-2005
  - o PRIME II, 2000-2004

√ John Snow Inc. (JSI)/DELIVER
√ Management Sciences for Health
  - o HIV/Performance-Based Financing Project [partners: IntraHealth International, Cordaid and HealthNet TGP]

√ PSI
√ The Institute for Reproductive Health, Georgetown University
  - o Fertility Awareness-Based Methods (FAM) Project

√ Family Health International (FHI)
√ International Center for AIDS Care and Treatment Programs (ICAP) (Columbia University)

√ Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
√ Community HIV/AIDS Mobilization Program (CHAMP)
√ Partners in Health
√ ACCESS/Millennium Villages Project (Columbia University)

Local NGO
√ Association Rwandaise pour le Bien-Etre Familial (ARBEF), local IPPF-affiliate

Donors
√ United States Agency for International Development (USAID)
√ Deutsche Gesellschaft für Technische Zusammenarbeit (gtz)
√ Belgian Technical Cooperation (BTC)
√ UNFPA
√ Department for International Development (DFID)
√ The William and Flora Hewlett Foundation

Policy and Government Support

Leadership

When asked about achievements in family planning, most respondents began by talking about the high level of political support, particularly since 2006. Just how was this achieved, particularly given the challenging context of a country that had lived through a recent genocide? An important factor is that the government recognized the need to address population issues, so the policies were not imposed from outside but were embraced and supported internally. This differed from the past: "A detailed analysis of successive population policies in Rwanda demonstrates that they were mostly flawed by their passivity and lack of vision. Both the formulation of the policies themselves and their enactment were invariably slow. In addition, they were most often decided upon under pressure from international donors… rather than internally motivated." [May J., 1996]

Many respondents mentioned the importance of the 2005 presentation of the RAPID[2] model to parliamentarians. Developed by the Futures Group, this model has been used frequently, starting in the 1980s, to describe the impact of high population growth rates and advocate for support for family planning programs. Some described how it had a powerful impact because it put a positive spin on things by talking about the advantages of having smaller families in terms of improved health and education opportunities. "The cabinet thought this is the right message to get to the population" as compared with talking about limiting the number of children and only giving the more grim messages of the negative consequences of rapid population growth. The draft law on

[2] RAPID projects the social and economic consequences of high fertility and rapid population growth for such sectors as labor, education, health, urbanization and agriculture. This model is used to raise policymakers' awareness of the importance of fertility and population growth as factors in social and economic development.

family planning shows the central importance of population issues for the development of the country:

> "In order for our country to realize development targeted in the 2020 Vision, where at least every Rwandan should have a per capita income of 900$ per year, it is clear that this can only be achieved if each family had below 4 children instead of the existing 6.1 per family on average."

The RAPID model brought home the idea that the goals of poverty reduction simply could not be met with high rates of population growth, and that lowering fertility—in part through family planning programs—was essential. In Rwanda, the numbers presented in this model had a powerful effect since they had such a tangible impact on people's lives—everyone could literally see and feel the high population density in the country—rather than it only being a theoretical concept.

Interestingly, the first Poverty Reduction Strategy Paper (2002-2005) did not even mention family planning. But addressing population growth became a prominent issue in the next iteration, the Economic Development and Poverty Reduction Strategy, 2008-2012 (EDPRS). Staff from the Ministry of Finance expressed an idea that many politicians have embraced: "If you don't address population levels you will remain with high poverty levels." And these are high in Rwanda, with over half of the population (56%) living below the poverty line, and 37% living in extreme poverty. Respondents talked about family planning as both a health and an economic intervention, with multiple benefits: "Family planning is a way to reduce poverty and maybe even prevent conflict."

The RPRPD was formed in 2002 to support the government in its actions to strengthen family planning. After the presentation of the RAPID model, the group became particularly active, providing support for many parliamentarians to go out and talk with their constituencies about the importance of population issues and family planning.

Many respondents talked about cultural aspects of Rwanda that made government statements have even more of an impact. When the president or the minister of health supports family planning, people listen: "Rwanda is a bit different from other countries as far as coordination—when a decision is taken at the central level it goes quickly to lower levels. That is why we wanted the president to say something." Or, as another person put it, "People have a high propensity to listen to authority. This may be good or bad. There is a high level of obeying what the government says." The minister of health has been a consistently strong advocate, even doing condom demonstrations on television and publicly reprimanding religious leaders for their failure to support family planning.

The EDPRS 2008-2012 lays out ambitious goals, including reaching a contraceptive prevalence rate of 70% by 2012. "People say no, you can't do that. But here you don't say never when there is government commitment," states a UNFPA staff member. There was some concern expressed about the need to not go too fast. While ambitious

goals are a positive thing, there is concern about potential coercion in the rush to meet this goal. In addition, it is important to build strong sustainable systems rather than implementing only short-term solutions.

Decentralization

The Government of Rwanda embarked on an ambitious territorial and administrative reform between November 2005 and December 2006. The territorial reform policy aimed to strengthen decentralized governance for the benefit and development of local populations and to streamline service delivery to be more effective, efficient and responsive to local communities. Table 3 shows changes brought about by this policy.

This process has led to changes in how interventions are implemented and has facilitated innovative efforts, such as performance-based contracts and District Incentive Funds, which are discussed later. These changes make some comparisons over time difficult, given the changes in definitions of districts. In addition, there is a need to ensure equality, that all areas are covered: "It could be a problem if there is different support for different areas." An IntraHealth International staff member explains that "the biggest challenge now is harmonizing and having national coverage because we are not going at the same pace."

Table 3: Administrative changes after territorial reform policy

Unit of Governance	2001 to 2005	2006
Provinces	11 + City of Kigali	4 + City of Kigali
Districts	106	30
Sectors	1,545	416
Cells	9,165	2,148
Health districts	40	0

Coordination

There are a number of different partners working on family planning in Rwanda. In early 2005, the Family Planning Technical Working Group (FPTWG) was formed to improve coordination and minimize duplication of effort. This group was initially proposed by USAID and has been chaired by gtz. While this mechanism has worked fairly well, many respondents talked about the need for the government to take the lead in coordination and that this might require some additional staff at the central level of the Ministry of Health. In the past, ONAPO served as the coordinator of population activities, but just who takes on that role now? "With the implementation of the previous [population] policy we had ONAPO in charge—so that is a major issue to be tackled," said a Ministry of Finance staff member. As many pointed out, family planning is spoken about in different ministries, and there are many implementing partners, but there is still a question of who exactly coordinates and how such coordination is managed.

Many key informants mentioned the limited staff at the central level of the Ministry of Health, as a result of the decentralization process, as a constraint to work. "Even though the government has said it's a priority, they haven't matched that with staff." The Ministry of Health, says one person, needs to "give themselves the right budget, the right personnel, and the right coordination," things that have not necessarily followed the strong statements regarding the importance of family planning. Coordination is a challenge due to the sheer number of partners and initiatives, as several respondents stated.

There appears to be a desire both from government and from partners that there be one clear joint action plan, defined by and owned by the government, and that all partners feed into that plan. Some felt that currently the situation was more of the reverse, with partner activities being defined outside of a government plan. People tend to focus on their own projects, their own immediate objectives. There is a need for someone who can step back, look at the whole picture, see the whole connected circle, as the minister of health describes it—and this should be someone or some entity within the government. The minister of health emphasizes the need for common understanding rather than a specific coordinating body: "It is like following a law—when I drive my car, I have to respect the rules and every other driver will also have to behave like me. We have to know exactly what we are coordinating, and then people fit into that plan." There is an ongoing attempt to set up an inter-ministerial committee—this met once in 2007 but then stalled. With support from the Hewlett Foundation, this initiative is being re-started and could be an important entity to improve coordination.

Supplies

No product, no program is the mantra of the DELIVER project. Recognizing this truth—that is, the need to have contraceptives in the cupboard—USAID provided support to the DELIVER project to help the Ministry of Health develop strong logistics systems for contraceptives. This has led to important improvements in all elements of the logistics system, from procurement to reporting to supervision. Before DELIVER, the man in charge of family planning commodities used to store them in his office, so "when districts came to order products, if he wasn't there, they had no luck." As a result of the improved systems, stockouts have been reduced, although the increasing popularity of Jadelle implants has led to continuing stockout problems with this method. Another indication of the strengthened logistics system is the dramatic improvement in reporting; when the DELIVER project began, the reporting rate from the district to national level was only 8%, and this has now improved to 100%.

As a sign of its success, DELIVER will soon scale up to support logistics management for an expanded range of products, including other reproductive health and child survival commodities. This will enable them to increase their staff, but given the amount of work, it might be necessary to add at least one more staff member. Currently, DELIVER, with its two staff members, is acting as a body of the Ministry of Health that directly

implements all contraceptive-related activities. An interviewee pointed out that supervision of 380 health centers is a big challenge with only two staff. This lack of staffing is partly a function of decentralization, which, as mentioned previously, led to a major shrinking of staffing at the central level. But given the importance of procurement and logistics as a centrally organized function, there should be consideration of different staffing patterns for this unit.

The dramatic increase in funding of contraceptive supplies is evidence of the growth in demand and use of contraceptives. In 2006, USAID planned to spend $500,000 for contraceptives, but by 2007 this was clearly not enough, and the amount quadrupled to $2 million. For 2008, USAID has budgeted $2.7 million. It should be noted that a significant part of this increase is due to Jadelle, an expensive method. In fact, in projections for commodities in 2008, roughly 50% of the $5.7 million total budget for contraceptives for Rwanda is for Jadelle.

The Government of Rwanda included a line item in the budget for contraceptives of $200,000 in 2007 and increased this to a projected $900,000 in 2008. While this is an important step, this is only a fraction of the current and projected costs of commodities for Rwanda. Given the trend of increasing use, there was widespread concern about meeting the existing and growing costs of contraceptives. USAID and UNFPA have been the two primary supporters of contraceptive procurement, but the Rwandan government is now reaching out to other donors to help cover the increasing costs.

An important outcome of improved logistics is that women are offered a range of methods. And choice is essential to meet the needs of all clients. Respondents mentioned the importance of wider—and reliably available—choice as a factor in the increase in CPR. In part, this is because the availability of the product is "encouraging to users."

Having such choice was much less common in 2001, as shown in findings of the Service Provision Assessment. This assessment found that oral contraceptives and progesterone-only injections were the most commonly available temporary methods of family planning, but that long-term methods such as the intrauterine device (IUD) and implants were offered at less than 10% of facilities, mostly hospitals, with few of these facilities having the method available on the day of the survey. In addition, only 53% of facilities had all methods they offered on the day of the survey [Service Provision Assessment]. Projects such as the Twubakane Program and the Capacity Project have included a focus on improving access to long-term methods, such as the IUD and implants, and have seen impressive success in getting these methods available at the health-center level.

Services

The public sector has been the most significant provider of family planning services: according to the 2005 DHS, 73% of women received their contraceptive methods from government services (13% from hospitals, 58% from health centers, and 1% from other

public facilities), 14% cited the private sector as their source[3], and 13% obtained methods from other sources (this was mostly accounted for by condoms from shops/kiosks). Interviewees indicated that they expect this breakdown to remain fairly similar in the mini-DHS as the public sector is still the dominant provider of services, with minimal private sector options, particularly outside of Kigali.

A number of important elements have contributed to improving service delivery in Rwanda. These are described in detail below and include in-service and pre-service training, on-the-job training, PBF, District Incentive Funds, performance-based contracts, and community-provider partnerships (PAQs), among others. In most districts, there have been multiple interventions, making attribution of impact difficult. Some additional research coming out later this year should help clarify some issues concerning which elements have had the greatest impact on improving service delivery. These include the 2008 DHS, an evaluation of PBF conducted by the World Bank and an assessment of integration efforts by FHI. When DHS data are available, it would be useful to analyze by district, looking at the different inputs and impact. It is important to note the interaction and synergy among the different interventions. For example, PBF and performance-based contracts are not effective on their own but require training and other inputs, and likewise, the impact of training efforts is maximized through motivational processes like PBF and performance-based contracts.

Table 4 shows the obstacles to delivering high-quality family planning services, as identified in a 2002 study, and links the interventions to these obstacles, showing how most of these are being addressed. This is not to say that these obstacles have been completely removed but rather that programs are taking them into account. Two of the fifteen obstacles identified in 2002 remain significant gaps: the limited number of staff at the central level of the Ministry of Health and the limited access to reproductive health services for adolescents.

Table 4: At health service delivery points, what are the obstacles in delivering quality family planning services? [Advance Africa, 2002]

Obstacle	Actions
1. Insufficient human resources for FP service provision	√ Pre-service training √ In-service training √ Development of national training curriculum √ Development of national training team
2. Inadequate technical staff at the Division of Reproductive Health	STILL AN OBSTACLE (MOH restructured in early 2006. Now there is one FP staff member under the Maternal and Child Health Task Force, and the Division of RH no longer exists.)

[3] This is probably mostly accounted for by ARBEF, the Rwandan IPPF affiliate which runs seven clinics offering a range of RH services. According to the National FP Policy of 2006, in 2004 ARBEF provided 7.7% of contraceptives in Rwanda.

Obstacle	Actions
3. Inadequate counseling	√ Training √ Supervision
4. Lack of method choice	√ Improved logistics system √ Re-introduction of long-term methods at health-center level √ Government budget line for contraceptives √ Increased donor support for commodities
5. Limited access to RH for adolescents	STILL AN OBSTACLE
6. FP not perceived as a priority by some district health managers and health providers	√ Advocacy by parliamentarians and others √ Performance-based contracts
7. FP services not available every day in each health center	√ With more trained providers, services are available more regularly.
8. Information, education and communication (IEC) services at service delivery sites are very weak.	√ Standardized IEC materials produced and distributed
9. Cost of utilizing FP services	√ *Mutuelles*
10. Limited collaboration between health centers and health animators and traditional birth attendants	√ Improved through PAQs
11. Weak private sector involvement	√ PSI programs have increased absolute numbers, though still minor role relative to public sector
12. FP services not standardized in the country	√ Coordination through FPTWG √ National training curricula, IEC materials, etc.
13. Catholic health centers do not offer modern methods.	√ Creation of secondary health posts
14. National NGOs' involvement in FP is limited.	√ ARBEF is an active part of national FP, but no other NGOs are active in RH.
15. Limited integration of FP into existing services	√ HIV/AIDS partners agreed on ways to integrate though this still needs to be put into practice more fully.

It is important to note that efforts since 2005 have been at a national scale while previously technical assistance agencies operated at a smaller scale. For example, under the PRIME II project, family planning service delivery support was only focused on about one quarter of the country. This national scale is possible due to increased support. With the PRIME II project, USAID committed between $1-2 million a year for family planning; now USAID's funding for family planning has increased to a $6 million annual investment.

Skills

Training has played a central role in efforts to improve family planning services. There have been impressive efforts at coordinating training, from a national training of district-level trainers conducted by three of the primary technical assistance partners in family planning (the Capacity Project, Twubakane and UNFPA) to the development of a curriculum to be used by all partners in training.

The process has been different than in the past given the context of decentralization: "Now we've been developing district trainers. Before it was national level trainers, and a very top-down approach." As a result of the training, one nurse explained that "there is trust from the clients because the quality is better since you know what you're talking about." Training has included a focus on long-term methods (particularly the IUD and Jadelle implants) so as to expand access to these methods to the health-center level; previously these methods were typically only available in hospitals. After developing district-level trainers, the goal was to train two providers at each health facility.

Figure 2: Family planning provider at Gitega Health Center, Kigali

While the focus has been on long-term methods, there have also been efforts at increasing access to permanent methods. For example, the Capacity Project is currently providing assistance to two district hospitals to provide vasectomy services. Knowledge of this method in the 2005 DHS was low for both men (34%) and women (23%). There was some success with vasectomy services in the past: for example, in 1991 AVSC (now EngenderHealth) supported efforts that led to 93 vasectomies being performed over a one-year period, more than had been performed in any other African country at that time [Gold, 1992].

In-service training is being expanded through an OJT model. In March, the Capacity Project piloted this approach in four districts, and OJT will be adopted by Twubakane beginning in July. This will help move beyond having only one or two trained providers at a facility—with the goal of training ten providers at each site—thereby allowing health centers to offer family planning every day and to every client, better integrating services and facilitating systematic screening of all clients for family planning. The approach also will lessen the disruption to services caused by more centralized trainings.

Improving the availability of skilled providers is not just a question of having staff trained, but there is also the fundamental problem of not having enough staff in general. Because of this situation, there has also been a focus in Rwanda on improving pre-service training, both in terms of quality and quantity. This work was started by PRIME II with a

performance needs assessment at five nursing schools in 2005. This has continued under the Capacity Project with renovation, developing libraries, computer labs, faculty development and strategic planning with these five schools plus one in Kigali. Each of the six nursing schools will graduate 40 nurses a year, for a total of 240. The Capacity Project is also providing important support to the government for its national human resource plan and a human resource information system. This helps to improve the health system broadly, including family planning.

It is also essential to follow up training with adequate supervision. The Twubakane Project works with district supervisors to conduct visits, using the nationally approved supervisory tools. In addition, the Capacity Project has one family planning coordinator in each of the 11 districts where it supports family planning. Given the cost implications of this additional staff, it would be useful to conduct an assessment to see the costs and benefits of having these coordinators to see whether this should be expanded to other districts.

Motivation

Performance-Based Financing. The idea of PBF is to motivate better performance of health facilities through payments; as a staff member of the project explains, you essentially purchase indicators. Several donors supported pilot projects between 2002-2005; the model was then modified and scaled up to cover 23 districts through the USAID-funded HIV/PBF Project, beginning in September 2005 with MSH as the lead partner. This model takes both quantity and quality into consideration—the payment that goes to a facility depends on the number of various services provided multiplied by scores of quality: "The money is the carrot. The stick is the quality measure." As the name indicates, the PBF project is an HIV/AIDS project, funded under PEPFAR, but the idea was to "come up with a system where we can purchase HIV services without having a harmful effect on other services." The continued support of the Belgian Technical Cooperation, the World Bank and other donors has allowed the approach to cover a full range of services.

The program has been having an impact: "This PBF really motivates providers." Over 20 months of performance data are available through the PBF database, with data from 290 health centers in 23 districts, with 98.2% data completeness for 2006 and 100% data completeness for 2007. Selected national performance results include a 194% average increase in family planning new acceptors, a 193% average increase in family planning existing users and a 57% increase in deliveries in health centers.

Most respondents acknowledge that PBF has contributed to the family planning achievements, but there is concern about the sustainability of such an initiative. There is an "ethical question," explains a UNFPA staff member, "if you are a service provider, you are paid to do your job. Do you only do your job if you are paid more? Because it's expensive [note: roughly $9-10 million annually]—we can use it to change a mentality, then you have to phase it out, stop little by little." A World Bank study currently being conducted will shed some light on how well PBF is working; this study is

comparing the 23 PBF districts with seven districts that were simply given additional money for health facilities without the intensive process of PBF. Results should be available in late 2008.

Performance-based contracts—*Imihigo*. *Imihigo*, a traditional concept in Rwanda (see box) has been adapted to design performance-based contracts signed between the president of the Republic and the 30 district mayors on behalf of their constituents. Engagement is recorded publicly in a written contract that presents a set of development targets backed by specific performance indicators over a period of one year, including one for family planning use. One respondent from the Ministry of Health explained how these were effective because they were not just empty promises but were concrete and specific targets that the mayors were accountable for meeting. Introduced in April 2006, this is still a fairly new program but already shows great promise in improving a range of health issues, as Table 5 shows. It provides important incentive to "be seen as a leader who performs… If you need to build your career, you need to perform," stated a respondent from the Ministry of Health.

Imihigo: traditional Rwandan practice, in which an individual publicly states and demonstrates what he or she can do and is committed to, and then be held accountable to his words, actions and deeds

Table 5: Achievements of indicators in performance-based contracts, selected districts, 2006-2007*

District	% of population using modern contraception	% of deliveries in health centers	% of children under five sleeping under insecticide-treated nets
Ruhango	From 9% to 39%		From 60% to 70%
Nyarugenge		From 35% to 55.7%	From 48% to 70%
Nyamagabe	From 7.2% to 18.4%	From 23.8% to 65.2%	From 25% to 73.7%
Rwamagana	From 11% to 13.6%	From 30% to 77%	

***National health management information system data, mid-2007**

It should be noted that it is not just the contracts per se that lead to these improvements, but it is the activities that the contracts inspire. For example, in a presentation on *Imihigo* [Uwimana and Swerdlin, 2007], the presenters explain that for family planning, district activities included:

√ training of health providers in modern family planning methods in the health centers
√ training of trainers in family planning
√ long-term methods (IUDs and implants) available in health centers
√ community health workers trained in family planning
√ local leaders sensitized
√ family planning secondary posts created near Catholic health facilities.

District Incentive Funds. The Twubakane Program includes a component for district-level capacity building called District Incentive Funds. Launched in July 2006, the District Incentive Funds grants are one of the Twubakane Program's main tools for providing funding to districts and strengthening their budget and planning capabilities. Each district

received $150,000 for a variety of activities, including equipping health facilities, supporting community mobilization, building public latrines and supporting income-generating activities to increase membership in community-based health insurance. Many districts are selecting interventions that encourage greater use and access to family planning services. Challenges have included difficulties in management and accounting procedures in many districts.

Linkages

Secondary posts. An important barrier to family planning services is the fact that many religiously affiliated health facilities, especially Catholic-supported facilities, do not offer modern contraception. This is particularly important since 40% of facilities in Rwanda are religiously affiliated, and 18% are Catholic. To address this, secondary posts have been created, using available space in sector and district offices near the larger health centers, where providers spend some of their time, and modern methods of family planning are offered. This approach was used in the late 1980s and early 1990s and now has been brought back as a way to address the limitations of many religious facilities. There are currently 34 secondary posts, and the Capacity Project is providing assistance to renovate an additional 14 posts; Twubakane will initiate an additional 12. Many people praised this initiative but also questioned the appropriateness of possibly building a parallel health system and pointed out the continuing access issues since these posts are typically only open for limited hours. The minister of health expresses these mixed feelings about this approach: "We have to go that route. But I tell the Bishop that is money we are putting into a parallel infrastructure instead of building up that health center… you talk about integration, but then you have to go another kilometer to get that service."

Integration. There have been increasing efforts to more effectively integrate family planning with HIV/AIDS services. This is important, in part, due to the dramatic imbalance in funding: PEPFAR funding for HIV/AIDS in 2007 was $104.7 million as compared with USAID's allocation of $6 million for family planning. Also, from the standpoint of the client, it is important to meet a range of needs as efficiently as possible. This discussion of integration is not new. Starting in March 2002, PRIME II provided assistance for prevention of mother-to-child transmission (PMTCT) of HIV services, which included family planning counseling. Some feel that greatest success has been made in PMTCT. However, reporting on this work does not actually talk about how effective this family planning/PMTCT integration was.

"We want the HIV clinical partners to have this holistic approach," says staff from USAID. But how much is it happening? "It is prominent at the policy levels, but not sure in practice." Integration is difficult given the existence of vertical programs and the difficulty of having these vertical programs see things from another perspective. This is a "structure we helped create. We have created powerful vertical structures." Services should be organized around clients' needs so that clients get the services they need with the highest quality. In a recent meeting of the HIV clinical partners, they developed a framework with the idea of looking at "a day in the life of a client" to determine the

best points of intervention. A respondent from an HIV clinical partner organization explained that "all staff should be able to ask women about family planning."

Improving integration will be essential, assuming the imbalance in funding remains. It is important to note that the funding for HIV/AIDS has led to general improvements in the infrastructure for primary health care, including family planning. This means there are indirect ways in which HIV/AIDS funding benefits family planning even if they are not explicit. A study is currently being conducted by FHI looking at integration of family planning and HIV services in five countries in Africa, including Rwanda. The study took place at 31 health centers in Rwanda. This information should be available around mid-2008 and will help shed more light on just what is happening regarding integration at the facility level.

Community health workers. Several respondents talked about the need for outreach to get services to people who have limited access and to serve as a linkage between communities and health services through referral. This is not a new intervention in Rwanda; starting in 1997-98, over a three-year period, the Ministry of Health trained 12,000 community health workers. Some talked of the need to scale up the community-based approach: "It is quite crucial to get it up the hills." After a study tour to Uganda to see a successful project where community-based distribution agents provide Depo Provera, there is now interest in Rwanda to implement this, and Twubakane plans to pilot test it in one district in mid-2008. However, there is concern about overloading these health workers, most of whom are working as volunteers. While the official policy is that community health workers are not paid, various projects provide differing reimbursements thus providing them with some forms of stipends or motivation.

Involving communities in services. In 2002, PRIME II began implementing a community-provider partnership approach called *Partenariat pour l'Amélioration de la Qualité*, or PAQ. This work continues under Twubakane. The approach brings communities and health providers together as partners to discuss the quality of health care and thereby increase community participation in the planning and management of health care and health care facilities. These PAQs unite a range of community groups, including women and youth. PAQ meetings have resulted in a number of changes at health facilities, such as extending or changing health center hours to meet clients' needs, purchasing and installing cisterns to deal with water problems, and mobilizing community members to help with a variety of renovation and maintenance activities such as painting, cleaning and gardening.

The Ministry of Health wants to expand this approach nationally. Currently there are PAQ groups associated with 128 of the 133 health centers where Twubakane works; however, these groups are rare in the other 18 districts of Rwanda. PAQs are included in the 2006 national Quality Assurance Policy, but there is a need for it to be more explicit as something that should be done, not just could be. There is a plan for a national PAQ day in 2008 to expand awareness of the initiative. The PAQ group we

spoke with would also like to see exchanges of information and experiences among the groups in different parts of the country, which could be included as part of this day.

Many people mention how there is improved trust between communities and health providers/facilities due to the improved quality of care, and the PAQs have played an important role in this. In addition to improving services, PAQs help to generate demand through sensitization efforts. Group members also talk about personal benefits for them due to their participation. For example, one woman described how her husband had died from AIDS, and she said that telling her story and encouraging other people to seek services had helped her to cope and made her feel proud.

Mutuelles. In 1999, the Rwandan government began to encourage the creation of community-managed mutual health organizations, or *mutuelles*, to make primary health care more accessible and promote community involvement in service delivery. According to a respondent, 72% of Rwandans have enrolled in these community-based health insurance schemes, though this varies greatly among districts, ranging from 40 to 100%. The *mutuelles* are beneficial in a number of ways by improving sustainability, quality and access. They contribute to sustainability by providing revenue to health facilities. Like the PAQs, *mutuelles* have offered a forum for dialogue between communities and providers regarding the quality of care of health services. They have also improved access to services, with providers noting that attendance for both preventive and curative care has increased.

> "Before, if we got sick and didn't have any financial resources, we used to have to sell our livestock or our land. Now, once we pay our contributions to the *mutuelle* we receive a membership card that we show to the health center, and we are treated without any constraints." [PRIME II Voices, 2002]

Demand

The final part of the 'office' analogy for family planning involves the client. There is wide recognition in Rwanda of the interplay between supply and demand for family planning services. While there are many acknowledged socio-cultural barriers to family planning use, there has also been a sense that it was important to create supply of services (in terms of trained providers, available commodities, etc.) to meet the high existing demand before significant efforts were made to further increase demand.

Many emphasized the fact that changing behavior and social norms is not something that happens overnight. "That is the most difficult part, to motivate a client here is not something you do one, two, three. . . . You don't go from wanting ten children today to wanting three children tomorrow."

Who comes for family planning services, and why do they choose to use modern contraceptives? Below are profiles of four family planning clients. It is interesting to note that clients use different language than the politicians but also give

economic reasons for the importance of using family planning: they simply cannot afford large families any more.

√ A 25-year-old married woman with two children had come for Depo Provera, a method she had been using for one year without her husband's knowledge. He wanted more children. She thinks there should be more sensitization and education to change men's attitudes towards family planning. [urban]

√ A 36-year-old married woman with three children came to have her Norplant removed. She had been using it for five years and hoped to switch to Jadelle after removal of the Norplant. Since there was a stockout of Jadelle, she was going to use Depo Provera until Jadelle was available. She wanted to stop at three children because "life is very expensive," so they did not have enough resources to care for more children. [urban]

√ A 26-year-old married woman with three children wanted to get the injectable. She did not want any more children because "life is becoming more and more expensive." She had used condoms previously, but she wanted something more reliable. "We never know with men, it only takes a small conflict with your partner, a misunderstanding, or the husband getting drunk. This can be a barrier to using a condom, and I can get pregnant." She thinks that she will switch to Jadelle—which several of her friends use—so that she can avoid coming back to the health center every three months. [rural]

√ A 33-year-old married woman with three children had been using the IUD for four months. She had been resistant to using family planning because of her religion; she is part of the Pentecostal Church, which thinks that using family planning is a sin. But she wanted to space her births, so she asked her sister for advice. Her sister used the IUD and advised her to use it too. She was particularly pleased with the confidentiality of the services because she was concerned about her friends finding out that she was using family planning. She also talked of economic reasons for people wanting fewer children: "Poverty is growing, and even taking care of one child is a problem. Resources are very limited." [rural]

But many women still do not use modern contraception. Now, many respondents seemed to agree, is the time to begin to more aggressively address the demand side of the equation: "Sensitizing the population is the most important and most challenging," explains a parliamentarian, continuing to say that family planning efforts have involved "mostly helping facilities, not talking so much to the population." Demand is the least addressed aspect of improving family planning, and respondents point out that while you see HIV-related posters and billboards, there is not much for family planning.

That said, there have been many efforts, including giving the issue a high profile through statements by the president, the minister of health and by parliamentarians. "But poor women in rural areas don't hear the president's speech," says one expert in health communication.

A 1997 qualitative study explored attitudes towards family planning [ONAPO, 1997]. The idea of limitation of births was not acceptable, but the concept of 'responsible parenthood'—that is having the number of children one can provide for—was perceived as logical and acceptable. In addition, there was considerable emphasis on the voluntary nature of family planning, insisting that the need for it depends on the individual situation. "Allusion is made to forced family planning under the pre-war programme." [ONAPO, 1997]

PRIME II had provided assistance to the Ministry of Health in a national IEC campaign to promote family planning. Using a logo (see figure), flipchart, posters and brochures, family planning messages were tested with providers and community members in five provinces. Key partners in this effort included UNFPA, USAID, ONAPO and WHO. These materials have been updated, with reprints of updated brochures, posters and flipcharts in 2007. The logo emphasizes the idea of responsible parenthood identified as appropriate in the 1997 study; the translation is roughly "plan your family for good health and family development."

According to the 2005 DHS, more than half of women (59%) did not see or hear a family planning message in newspapers/magazines or on radio or television. However, 41% of women did hear a family planning message on the radio, and 4% did see one on television. Only 5% of women saw a family planning message in a newspaper or magazine in the past few months.

Respondents point out that though there have been radio spots or other small-scale efforts, there has not been an actual full multi-media national campaign in the way there has been for HIV/AIDS. Some connect this to the issue mentioned earlier regarding lack of coordination and the need for someone to identify gaps and "say what do we need?" There is certainly potential for large-scale communication campaigns in Rwanda, as has been seen in addressing HIV/AIDS and also in educating the public about a new constitution. "They use communications for political things but not for social things," according to one respondent.

Key challenges include combating pro-natalist traditions (see box), religious opposition, and post-genocide desire to replace those lost. In addition, when we asked clients why people they knew did not use family planning, the

Pronatalism in Rwanda
[Sempabwa and Hoemeke, 2006]

***Murumbuke, mubyare hungu na kobwa*: Be fruitful, may you have many sons and daughters…**
Traditional wedding toast to a newly married couple

***Abana ni umutungo:* Children are your wealth**

***Nimwonkwe kandi usubireyo nta mahwa:* Congratulations, and go back for more!**
Traditional greeting to a new mother

first thing they mentioned was fear of side effects. PSI is currently planning a campaign to address myths and misperceptions, which is an important activity to increase family planning use.

A study undertaken in 2002 [Advance Africa] looked at why Rwandan women were not using family planning services and identified the following reasons:

1. Factors associated with poverty which impact contraceptive use
2. Socio-cultural and religious influences
3. Insufficient information and counseling on family planning
4. Insufficient access to health services in general
5. Lack of decision-making power of women in the household
6. Informal relationships with multiple partners
7. Fear of side effects as a result of use of modern family planning methods
8. Rumors associated with family planning
9. Difficulty in using natural family planning methods
10. Specific problems associated with widows, separated and divorced women
11. Lack of access, awareness and support of adolescent reproductive health services
12. Perception of family planning as 'limitation of births' only
13. Impact of the genocide.

The impact of religion as a barrier to family planning was mentioned in most interviews. There have been interesting efforts to work with religious leaders. For example, PSI organized a meeting with religious leaders in February 2007, which led to the signing of a joint declaration. While this has not led to the groups necessarily actively supporting family planning, "they are not actively opposing… they have been neutralized as an active barrier," and the joint agreement was like a "non-aggression pact." Among the statements agreed to were the following:

> **Agree** that spacing children three to five years apart reduces significantly maternal and child mortality
>
> **Agree** to not oppose "contraceptive security"; that is, the notion that every person who would like to space their children has the right to accurate and unbiased information about family planning and reproductive health, and the right to choose, access and use the method of their choice.

RPRPD members talked about how the opinions of religious leaders had changed significantly:

> "Even Pastors began to interpret the Bible differently. Where they used to say 'go forth and fill the world with children' now they say 'the world is filled, what do we do?'"

The minister of health has been outspoken against religious leaders' opposition to family planning and to condom use for HIV prevention (see headline from the *New Times*, March 27, 2008), but he acknowledges the difficultly in having them change their stance: "For me, we can't change our Bishops. We need to change our people to understand. We have to empower people to understand the importance of this policy."

Minister attacks religious leaders over condom use

BY LILLIAN NAKAYIMA
WESTERN PROVINCE

KARONGI — The Minister of Health, Dr. Jean Damascene Ntawukuriryayo has castigated religious leaders in the country for what he called playing a dormant role in supporting government policies.

He said religious leaders have also neglected and at times deliberately swayed their followers away from the government's poverty eradication plans.

Dr. Ntawukuriryayo made the remarks on Monday

Ntawukuriryayo

the Pope seats people had developed simply because they adopted family planning.

"How come Catholics just next door to the Pope in Rome have not or one kid?" he asked.

For long, people have been getting infected with HIV/AIDS. When the government speaks of condom use, religious leaders regard it a sin, they preach abstinence which isn't bad, but in case of failure they should as well consider condom use as an option, he said.

kids and wife. Why would you want to lead people in such a state?" he asked. He noted that such people can not care much about Christ when they have immediate problems that need to be solved.

"When the government asks for Frw1000 for mutuelle de sante (health insurance for the patients), you don't tell our Christians, yet when it comes to offertory, you tell them," the minister castigated religious leaders urging them to collaborate with local leaders in guid-

Conclusions

Lessons Learned

When asked about the main keys to success, most people talked first about the political will behind family planning. This was achieved through a number of activities, advocacy efforts and approaches. Many people highlighted the impact of the RAPID model in driving home the link between population growth and economic development, and the need for family planning in order to achieve poverty reduction. In addition, family planning was seen as an essential way to reduce high levels of infant and maternal mortality, both of which had increased after the genocide.

√ **Advocacy with political leaders with a focus on economic arguments is an effective approach to building political will so that policies are internally supported rather than externally imposed.**

√ **An active parliamentarians' group can be important at two levels: increasing support at the policy level; and sensitization and awareness-raising in the communities they serve.**

Rwanda has a large number of partners working on family planning and reproductive health. Coordination has ensured that all districts are receiving assistance in strengthening family planning service delivery and has led to standardized training and IEC tools. While there are various mechanisms for coordination, and a number of policies in place, there is a lack of a strong central focal point for family planning within the government to ensure coordination and effectively share lessons and identify gaps.

√ **Coordination should come from the government and is necessary for ensuring efficiency, effectiveness, national coverage and sustainable improvements. There should also be a national implementation plan that translates policy into practical, clear and measurable actions.**

Both clients and providers talked about the importance of trust—trust that services will be available, appropriate and confidential. Essential steps in improving quality so that such trust is developed include ensuring that methods are there and that providers are trained.

√ **Choice matters, and improved logistics systems are essential to ensure that choice is a reality.**

√ **A decentralized training process—training a team of district-level trainers and using OJT—facilitates national coverage and minimizes disruption to services.**

√ **OJT is an important training approach to ensure that all providers at a health facility are able to provide family planning.**

√ **Groups to foster partnership between health providers and communities can be effective in bringing about changes in quality.**

There have been a number of innovative methods of providing motivation and incentives for performance, including performance-based financing, performance-based contracts and District Incentive Funds.

√ **Motivation produces results—but it can be expensive.** These projects should include exploration of how to transition to more sustainable systems of motivation over time.

Key Gaps/Challenges

⇒ **Scale up successful initiatives nationally**. This could include training in long-term methods, PAQs, District Incentive Funds, etc. But the question is, just what should be scaled up...

⇒ **Improve use of data for decision making, particularly in making decisions for national scale-up.** Promising initiatives need to be more thoroughly assessed in terms of both their costs and effectiveness for better and more efficient planning. As the minister of health says, "If we do this in a planned manner with good monitoring and evaluation and reporting, we will achieve the vision. If it is in a scattered manner, then it is effort wasted."

⇒ **Mobilize resources for commodities**. As demand and use increase, it will become more and more of a challenge to cover the costs of contraception

⇒ **Address the continuing opposition from the Catholic Church.** Efforts could build off the joint declaration signed in 2007 and move towards developing action plans with each of the main religious groups.

⇒ **Remove 'small' barriers**. There are various barriers that women face in accessing family planning services, including being denied services if they are not menstruating, being required to obtain husband's consent, or only being given one cycle of pills at a time. These barriers should be removed through necessary changes in policies and guidelines and reinforcement in training and supervision.

⇒ **Develop and conduct a national-level awareness campaign on family planning** that addresses myths and misperceptions about methods and their side effects and other barriers to family planning use.

⇒ **Include sexual and reproductive health education in schools**. This need was identified by the majority of respondents as a significant gap. "Kids are good agents of change—they are the generation of tomorrow."

⇒ **Strengthen integration of family planning and HIV by building on current momentum and enhancing accountability.** Some suggestions include having family planning indicators as part of the HIV system and developing and including integration indicators as part of PBF, *imihigo*, etc. The general idea is that this needs to be something that programs are accountable for, and then it is more likely to happen. Partners expressed excitement over recent meetings to better define integration efforts, making this an opportune moment to build on that energy: "We need to take this and run with it."

Appendix 1: References

1. Advance Africa. *Summary of Findings and Recommendations of Family Planning Qualitative Assessment in Rwanda*, May 6, 2002.

2. Blyth K, Nelson D. *Scaling-Up Services to Prevent Mother-to-Child Transmission of HIV*. 11/2003. (PRIME PAGES: RR-27)

3. Cooney K, Sempabwa E, Nelson D. *Coming Together for Quality Care: Community-Provider Partnerships* 11/2003 (PRIME PAGES: RW-5)

4. Cooney K, Sempabwa E. *Improving Service Quality through Provider-Community Partnerships* 12/2002 (PRIME PAGES: CDQ-1)

5. DELIVER. 2007. *Rwanda: Final Country Report*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

6. DELIVER. March 2007. *Focus on Results: Rwanda*

7. Draft Law on Family Planning, June 2007

8. Gold, M. 1992. "AVSC helps Rwanda prepare for expansion of services." *AVSC News*.

9. Government of Rwanda. *Health Sector Strategic Plan: 2005-2009*.

10. Government of Rwanda, Ministry of Health. March 2006. *National Family Planning Policy and its Five-Year Strategies (2006-2010)*

11. Government of Rwanda, Ministry of Health. Rwanda Rural Health Care Plan: A comprehensive approach to rural health. January 2008.

12. Health Policy Initiative. Achieving the MDGs: The contribution of family planning. Rwanda.

13. Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. *Rwanda Demographic and Health Survey 2005*. Calverton, Maryland, U.S.A.: INSR and ORC Macro.

14. May, John. December 1996. 'Demographic Pressure and Population Policies in Rwanda, 1962-1994.' *Population and Societies*.

15. MEASURE. *Rwanda 2005 Demographic and Health Survey: Key Findings*

16. Ministry of Health [Rwanda], National Population Office [Rwanda], and ORC Macro. 2003. *Rwanda Service Provision Assessment Survey 2001*. Calverton, Maryland: Ministry of Health, National Population Office, and ORC Macro.

17. Munyakazi, A. The family planning program in Rwanda: assessment of ten years (1981-1991) and prospects. Famelle, Sante, Developpement/Imbonezamuryango, 1990 Dec.

18. Nelson D. *Building Consensus and Capacity: National Reproductive Health Policy and Training* 11/2003 (PRIME PAGES: RW-2)

19. Nelson D. *Community-Managed Health Care: Mutuelles Unify the Population* 11/2003 (PRIME PAGES: RW-3)

20. Nelson D. *Reaching More Rwandans: A Stronger Role for Primary Providers and Communities* 11/2003 (PRIME PAGES: RW-1)

21. Nelson, Daniel, Uder Antoine, Elizabeth Fischer, Maryellen Glennon. *Rwanda HIV/PBF Project: Mid-Term Evaluation.* September 2007.

22. Nyangara, Florence, Camille Hart, Ilene Speizer, Scott Moreland. Unmet Need for Family Planning in Rwanda and Madagascar: An Analysis Report for the Repositioning of Family Planning Initiatives. April 2007. MEASURE Evaluation.

23. Office National de la Population (ONAPO) [Rwanda] et ORC Macro. 2001. Enquête Démographique et de Santé, Rwanda 2000. Kigali, Rwanda et Calverton, Maryland, USA : Ministère de la Santé, Office National de la Population et ORC Macro.

24. ONAPO. August 1997. *Preliminary Report on a Qualitative Study of Attitudes and Strategies for Population in Rwanda*

25. PRIME II Voices #15, *Rwanda: Mutuelles Increase Access to Improved Services*, 12/11/02

26. Republic of Rwanda. September 2007. *Economic Development and Poverty Reduction Strategy, 2008-2012.*

27. Republic of Rwanda. *Rwanda Vision 2020*.

28. Republic of Rwanda, Ministry of Health. *Rwanda Family Planning Sub-Policy*. 6 September 2005

29. Republic of Rwanda, Ministry of Health. June 2005. *Rwanda: Population Factors and the National Vision.*

30. Republic of Rwanda, Ministry of Health. January 2007. *Rwanda: Population Factors and the National Vision.*

31. Rwanda HIV/PBF project: Quarterly Progress Report, July to September, 2007. Cambridge MA: Rwanda HIV/PBF project; Management Sciences for Health, 2007.

32. **S**empabwa, Emila and Laura Hoemeke. *Repositioning Family Planning as a Human Right in Post-Genocide Rwanda*. Presentation at APHA Annual Meeting, November 7, 2006.

33. The Capacity Project. 'The Capacity Project in Rwanda.' Country brief 7. July 2007

34. The Capacity Project. February 2008. Looking to the Future: improving family planning access and quality in Rwanda. Voices 16.

35. The Capacity Project. November 2007. The Whole Picture: strengthening health workforce policies and planning in Rwanda. Voices 13.

36. The Capacity Project. August 2007. Developing the Health Workforce: training future nurses and midwives in Rwanda. Voices 10.

37. The Capacity Project. February 2008. Capacity Rwanda Family Planning Progress Report.

38. Twubakane. Annual Report 2006. IntraHealth International Rwanda.

39. Uwimana, Antoinette and Dean Swerdlin. November 2007. *Local Politics and Health: Performance-based Contracts (Imihigo) between Mayors and the President and Impact on Selected Health Indicators in Rwanda.* Presentation at APHA Conference.

Appendix 2: List of Interviewees

Name	Title and Organization
1. Laura Hoemeke	Director, Twubakane, IntraHealth
2. Emile Sempabwa	Community Participation, Communication, and Field Activities Team Leader, Twubakane, IntraHealth
3. Andre Koalaga	Senior FP Advisor, Capacity Project seconded to MOH
4. William Twahirwa	Family Planning Team Leader, Capacity Project, IntraHealth
5. Defa Wane	Quality and Community Health Team Leader, Twubakane, IntraHealth
6. Daphrose Nyirasafali	RH/FP Coordinator, Twubakane, IntraHealth
7. Marie Rose Kayirangwa	Clinical Services Officer, HIV/AIDS Clinical Services Program, IntraHealth
8. Eric Kagame	Maternal and Child Health Specialist, USAID
9. Soukey Traore	Senior Health Advisor and Twubakane CTO, USAID
10. Elisabeth Girrbach	Health Sector Coordinator, gtz
11. Anja Fischer	Expert Associate, gtz
12. Jean Pierre Muhirwa	Director, Kimironko Health Center
13. Chantale Kwizera	Nurse, Kimironko Health Center
14. Jean Bosco Karangwa	Palliative Care Specialist, Community HIV/AIDS Mobilization Program (CHAMP), CHF International
15. Gifty Addico	Technical and Policy Advisor, UNFPA
16. Mark Ramaekers	RH Specialist, UNFPA
17. Nancy Fitch	Country Director, Elizabeth Glaser Pediatric AIDS Foundation
18. Sister Agnes Mujawincuti	Manager, Kabarondo Health Centre
19. Senator Odette Nyiramilimo	Member, RPRPD
20. Giovanni Renzaho	Member, RPRPD
21. Andre Habimana	Director of Planning, MINECOFIN
22. Francis Bahizi	Population Advisor, MINECOFIN
23. Jovith Ndahinyuka	Senior Technical Advisor, DELIVER
24. Ines Mpambara	Director, Health Communication Center
25. Staci Leuschner	Country Representative, PSI
26. Emery Nkurunziza	Family Planning Coordinator, PSI
27. Claude Sekabaraga	Director of Policy and Capacity Building Unit, Ministry of Health
28. Laurien Nyabienda	Executive Director, ABREF
29. Gyuri Fritsche	Technical Director, Rwanda HIV PBF Project, MSH
30. Karen Blyth	Director, HCSP, IntraHealth
31. Shemza Uwineza	Nurse Manager for FP, Gitega Health Center
32. Jean Damascene Ntawukuliryayo	Minister of Health
33. Eugene Rwabuneza	Family Planning Coordinator, Ministry of Health
34. Jessica Price	Country Director, FHI
35. Josh Ruxin	Director, Access Project/ Millennium Villages Project

Name	Title and Organization
	Assistant Clinical Professor of Public Health Columbia University
36. Sara Stratton	Senior Program Manager, IntraHealth/NC
37. Laura Gibney	Director of M&E, IntraHealth/NC
38. Cathy Murphy	Senior Training and Learning Advisor, IntraHealth/NC
39. Boniface Sebikali	Clinical Training Advisor, IntraHealth/NC

PAQ group discussion participants

1. Habyarimana Jerome PAQ President
2. Bimenyimana Claude PAQ Vice President
3. Ndayisenga Bernard PAQ Secretary
4. Mukabarisa Liliane PAQ Treasurer
5. Uwamahoro Divine PAQ Member
6. Musabyimana Josephine PAQ Member
7. Umwirigirwa Jeanne PAQ Member
8. Mukandoli Vestine PAQ Member
9. Munyemana Paul PAQ Member