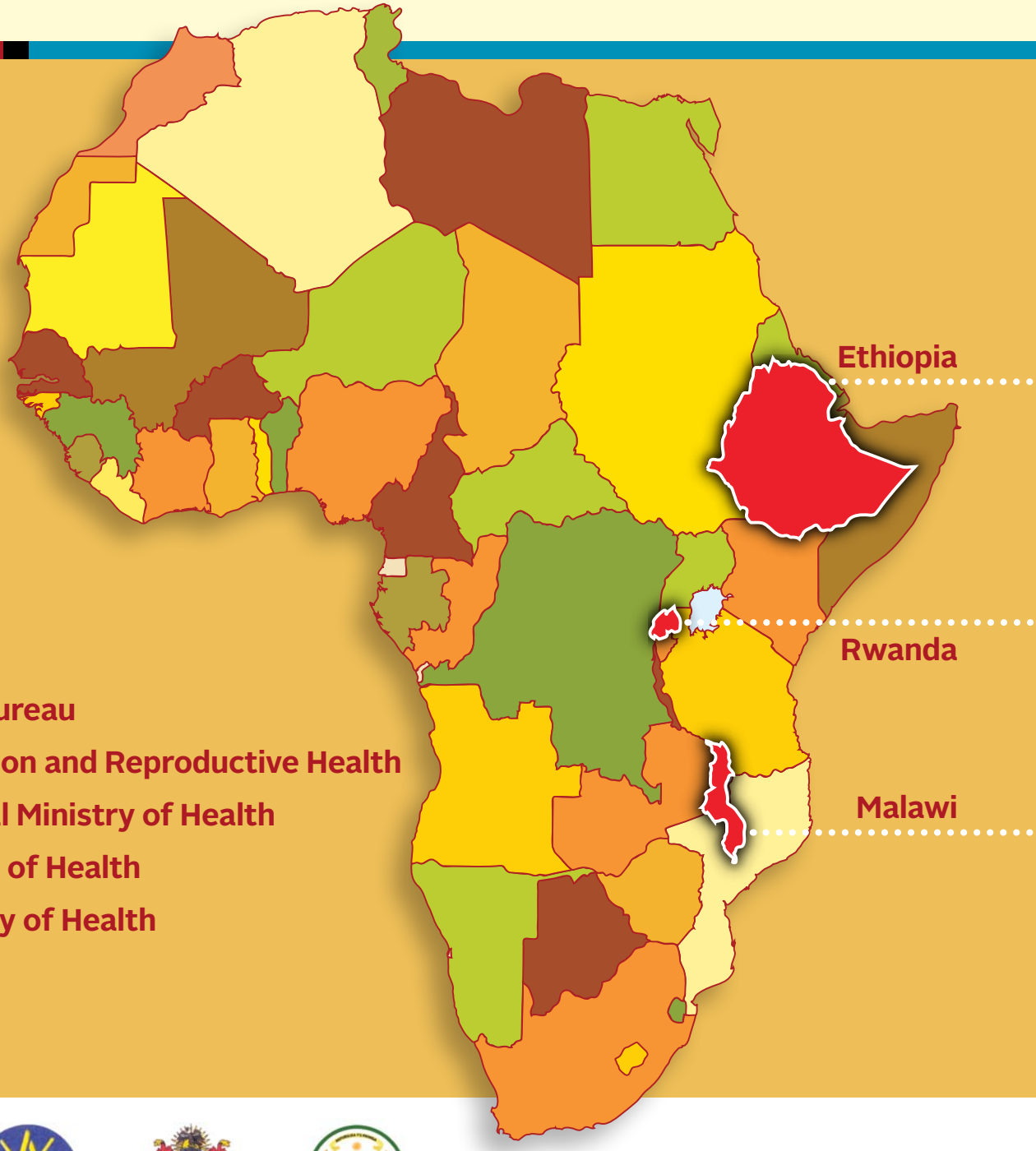
# Three Successful Sub-Saharan Africa Family Planning Programs:

## Lessons for Meeting the MDGs




Compiled by:

**USAID/Africa Bureau**

**USAID/Population and Reproductive Health**

**Ethiopia Federal Ministry of Health**

**Malawi Ministry of Health**

**Rwanda Ministry of Health**

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# Introduction

An analysis of modern contraceptive prevalence rates (CPR) in recent Demographic and Health Surveys shows that three countries have achieved a much more rapid increase in CPR than any other countries in sub-Saharan Africa: Ethiopia, Malawi, and Rwanda. The *annual increase* in CPR of modern methods among married women of reproductive age was 2.3% in Ethiopia (2005-2011), 2.4% in Malawi (2004-2010), and a dramatic 6.9% in Rwanda (2005-2010), according to the DHS reports for the years noted.

Millennium Development Goal 5B calls for universal access to reproductive health, including family planning. These three countries are moving more rapidly toward this goal than any others in sub-Saharan Africa. Such progress is helping these countries move closer to what the development community calls "the demographic dividend," a concept highlighted in the 2011 International Conference on Family Planning (ICFP) in Dakar that links progress in family planning with larger development goals.

How did these three countries make such great strides in recent years? What are the similarities and differences in how the countries made these strides? What do the data suggest, and perhaps more importantly, what is the story behind the data – what some refer to as the "backstory"? How important is individual leadership, financing systems, and country-specific geo-political and demographic issues? Are the systems in place to sustain that progress? And, what lessons can other countries learn from the Ethiopia, Malawi, and Rwanda experiences? In preparation for the 2011 ICFP, the Africa Bureau of the U.S. Agency for International Development (USAID) with the USAID Office of Population and Reproductive Health began exploring these questions.

The Africa Bureau worked with the Ministry of Health and the USAID Mission in Ethiopia, Malawi, and Rwanda, along with the three country teams that attended the ICFP meeting in Dakar. FHI 360 and EngenderHealth provided technical assistance in the process. The methodology included a desk review of DHS data and key documents related to each of the three countries, and structured key informant interviews in each country. From this process, Ministry of Health officials presented a summary of the findings at a USAID meeting on November 28, 2011, just before the ICFP opened in Dakar. About 125 people attended the USAID meeting, including teams from 21 sub-Saharan Africa

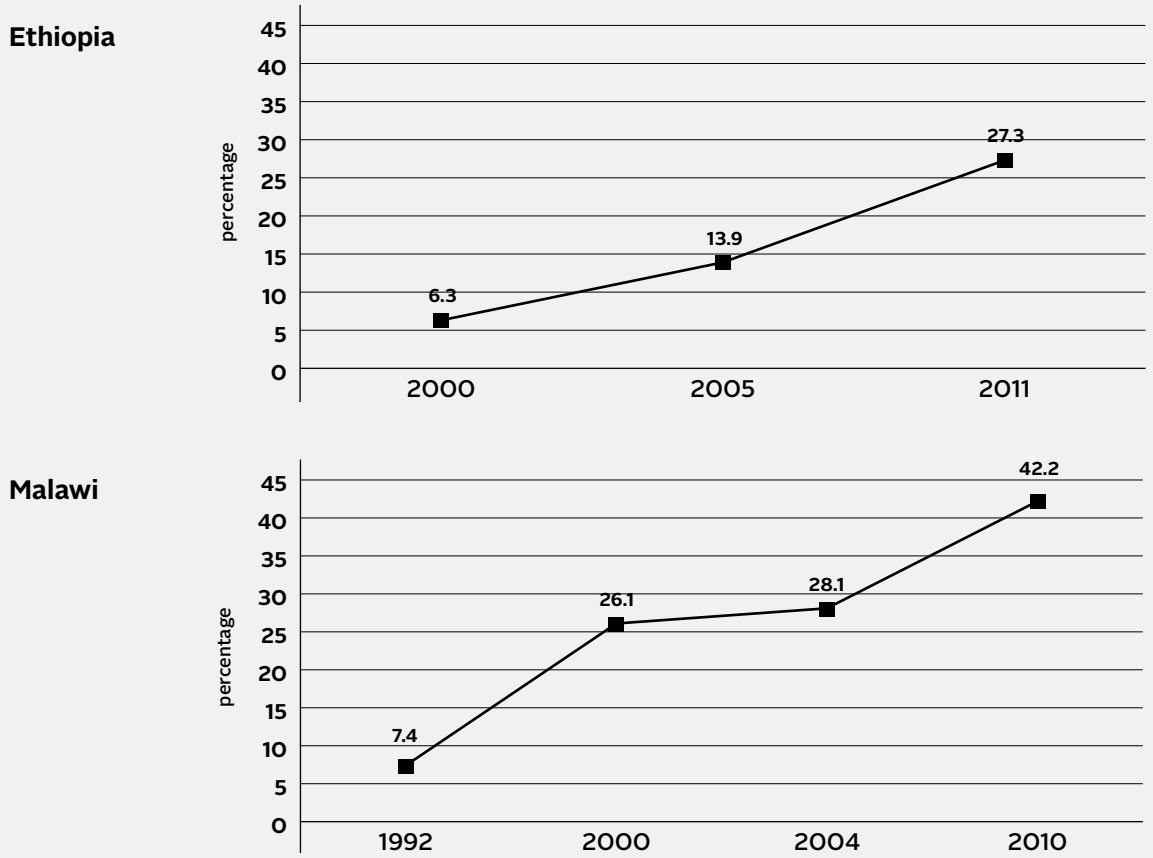
countries. FHI 360 provided assistance to the Ethiopia and Rwanda teams in synthesizing information for those country presentations and presented a summary of the findings from all three countries for discussion; EngenderHealth supported the Malawi team in that presentation.

This paper expands on the four presentations made at the USAID meeting in Dakar. First, a summary of key DHS data over time shows the major common trends in the three countries. The long middle section of the paper includes three separate case studies, addressing some of the questions posed above. The paper concludes with a discussion of common themes and differences, which hopefully can provide lessons for other countries as they seek to move toward meeting the MDG Goal 5B and moving toward the demographic dividend.

# **Common Measures of Success:** What DHS Data Show

In this paper, unless noted otherwise, the term "CPR" refers to use of *modern* contraceptive methods among married women of reproductive age, as defined by the DHS (which include condoms). Figure 1 shows the central common theme for this paper: the CPR has risen steadily from a low starting point and moved upward sharply in most years in all three countries. The notable exceptions are the decline in CPR in Rwanda in the years after the 1994 genocide, and the slow increase in Malawi from 2000 to 2004.

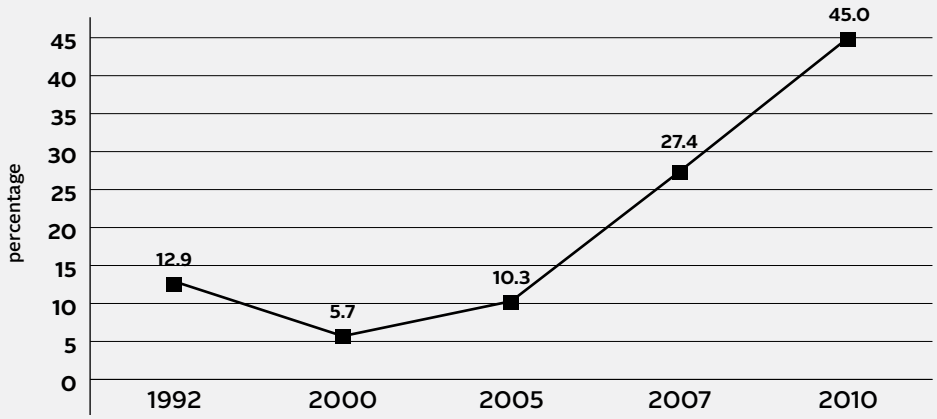
**Figure 1.** Modern Contraceptive Prevalence: Sharp Rise in All Three Countries




**Source:** DHS; married women of reproductive age (MWRA)

**Figure 1.** *continued* Modern Contraceptive Prevalence: Sharp Rise in All Three Countries

**Rwanda**

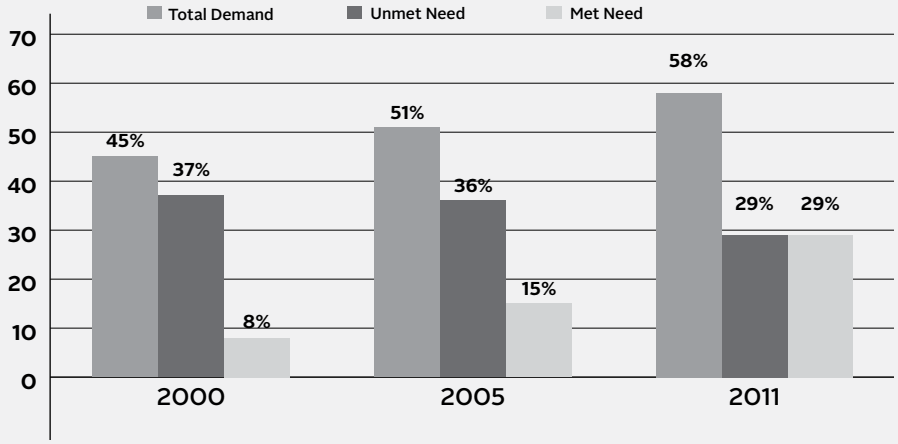



**Source:** DHS; married women of reproductive age (MWRA)

A second major common theme among the three countries in the DHS reports involves demand and unmet need. The overall demand for family planning in all three countries has increased in recent years, and even with this increase, unmet need has declined steadily (see Figure 2). Unmet need for family planning (counting all methods) is 29% in Ethiopia, 26% in Malawi, and 24% in Rwanda – still sizable percentages. But in Ethiopia and Rwanda, the decline in unmet need has been remarkably sharp according to the DHS, from 36% to 29% in Ethiopia (2005 to 2011) and from 39% to 24% in Rwanda (2005 to 2010). The decline has not been as sharp in Malawi, but demand there has jumped to 72%.

**Figure 2.** Total Demand, Unmet Need, and Met Need (Use) for Family Planning (married women of reproductive age, all methods)

**Ethiopia**

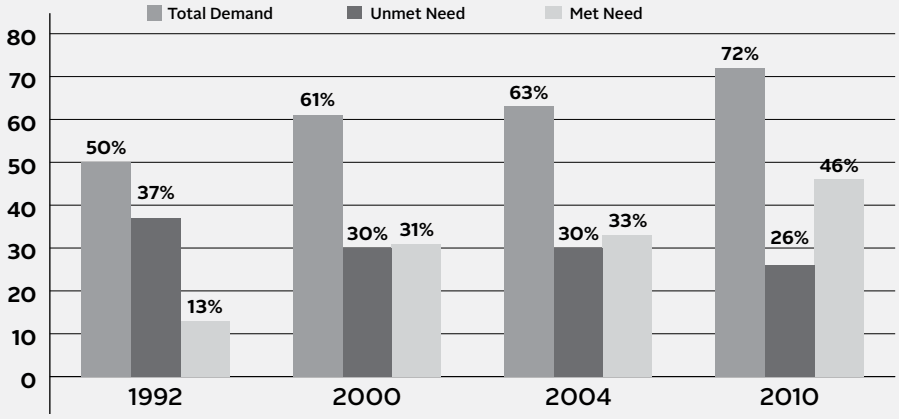



**Source:** DHS

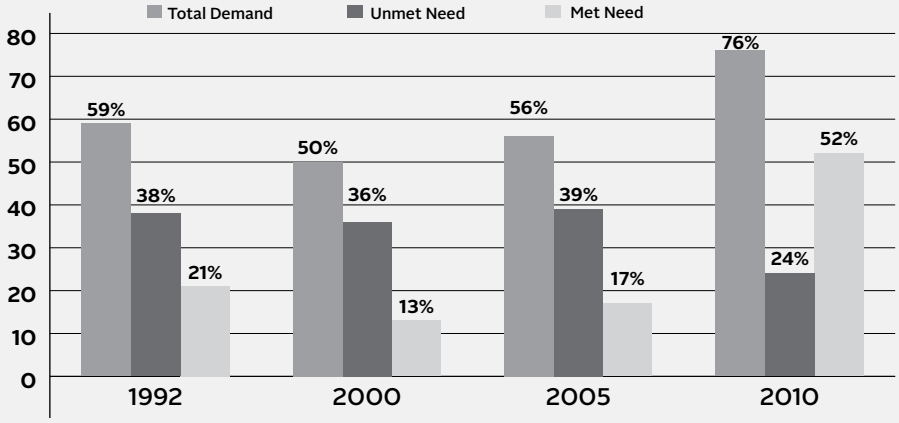
**Figure 2.** *continued*

**Total Demand, Unmet Need, and Met Need (Use) for Family Planning (married women of reproductive age, all methods)**

**Malawi**




**Rwanda**




**Source:** DHS

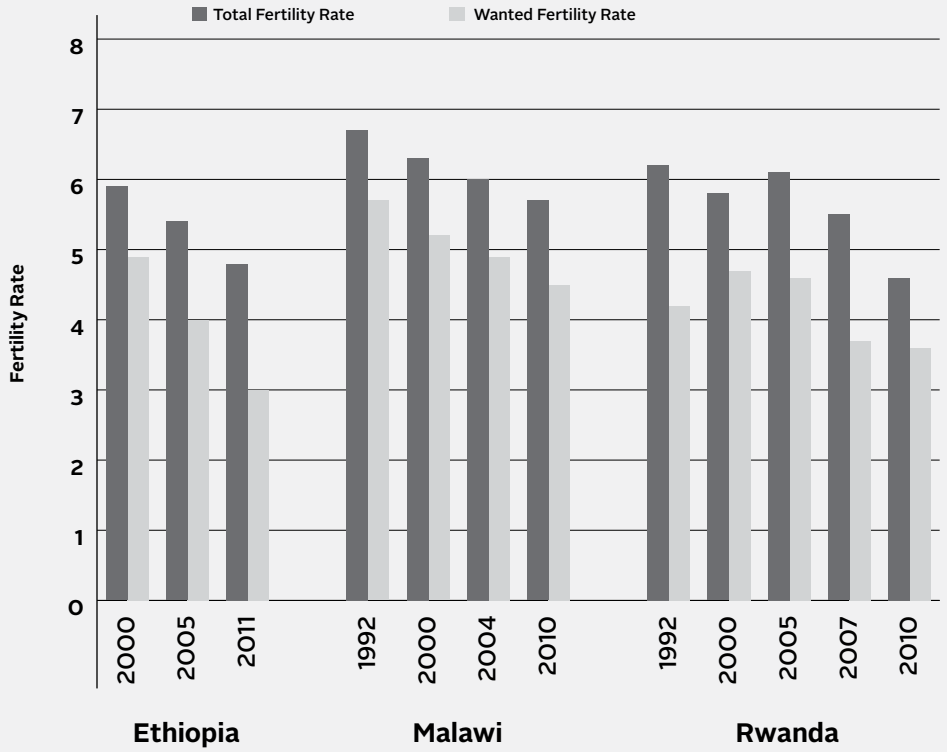
**Unmet Need for Family Planning: Numbers Reported Here Have Small Variations from Published DHS Reports**

The percentages shown in Figure 2 on unmet need and subsequent references to these percentages in this report are slightly different from those in the published DHS reports. This is because global experts, coordinated by the DHS group, have updated and simplified the method used to calculate unmet need and have applied the new methodology to past DHS reports. The revised definition of unmet need for family planning produces comparable measurements of unmet need for family planning across countries and years. The new methodology produces slightly higher levels of unmet need compared with the original definition. For more information on the changes and the reason for using them, please see *Revising Unmet Need for Family Planning. DHS Analytical Studies No. 25* (2012), available at: *http://www.measuredhs.com/pubs/pdf/AS25/AS25[12June2012].pdf*

The increase in demand suggests that family planning has essentially become a cultural norm in all three countries. The remaining unmet need, while still sizeable, can be seen not only as an indicator of "challenge" to a family planning program but also as an indicator of "success" because so much demand for family planning has been generated.

How has the increased demand for family planning and use of contraception affected fertility rates, both actual and desired? Figure 3 shows that fertility is dropping very quickly in Rwanda – 1.5 in 5 years, with its actual fertility in 2010 equal to its wanted fertility in 2005 – a very noteworthy achievement. Ethiopia's fertility has also dropped fairly rapidly to a level just below the level of wanted fertility in 2000. Also, the wanted fertility rate in Ethiopia has gone down steadily from about 5 in 2000 to 4 in 2004 to 3 in 2011. Although Ethiopia has a CPR (27%) that is 15 percentage points lower than Malawi's CPR (42%), Ethiopia has a substantially lower TFR as well (4.8 compared to 5.7 for Malawi). That is, despite Malawi's impressive increases in CPR, the falls in TFR have been steady but quite modest, and well above wanted fertility – only achieving levels of wanted fertility of 1992 – a disappointment many Malawians remark upon and say they must address.

**Figure 3.** Total and Wanted Fertility Rates




**Source:** DHS

# Ethiopia
## Bringing Services to the Doorstep

The Federal Democratic Republic of Ethiopia, located in the Horn of Africa, is the second-most populous nation in Africa, with over 77 million inhabitants, and is the most populous land-locked nation in the world. Ethiopia is bordered by Eritrea to the north, Djibouti and Somalia to the east, Sudan and South Sudan to the west, and Kenya to the south.

After a series of challenges in the 1980s, the country began to recover, and today Ethiopia has the biggest economy by total gross domestic product (GDP) in East and Central Africa. The population has almost doubled since 1980, going from 38 million to more than 77 million in 2011. Although urban growth is rapid due to migration, still about four of every five live in rural areas. The country has a decentralized federal structure with nine regional states and two city administrations.

Family planning services began in the 1966 in Ethiopia with the establishment of the Family Guidance Association of Ethiopia (FGAE), an International Planned Parenthood Federation affiliate. Not until the 1980s did the Federal Ministry of Health (FMOH) add family planning to its maternal and child health program. In the first national survey in 1990, the CPR was only 2.3%. Given this history, the progress in Ethiopia is a remarkable success story, given the change shown in the DHS of 2000, 2005, and 2011.

In 2000, only 6.3 percent of married Ethiopian women were using any modern contraceptives, and those were predominately urban women using pills and injectables. Nongovernmental organizations (NGOs) and the FMOH began expanding community-based distribution of family planning services to improve access through Community Reproductive Health Agents, who are volunteers with minimal training. They provided pills and condoms.

The 2002 Health Sector Development Program II began to prioritize family planning

### Ethiopia at a Glance

- **Total population:** 77 million
- **Total fertility rate (TFR):** 4.8
- **Contraceptive prevalence rate (CPR):** 27.3%
- **Percent urban:** 17%*
- **Infant mortality rate (IMR):** 59
- **Maternal mortality ratio (MMR):** 676
- **Unmet need for family planning Urban:** 15.0%; **Rural:** 27.5%

*Data sources:* Ethiopia DHS *(2011) except for total population (Central Statistics Agency of Ethiopia), and the item with (*) from PRB,* World Population Data Sheet *(2011).*

services. It introduced a Health Extension Package of essential health services focusing on preventive health measures targeting households, particularly women/mothers at the village level. Over the next several years the Health Extension Package was refined and implemented. The government established five health posts for each health center and designed this system so that two Health Extension Workers (HEWs) would manage each health post.

The government made a massive investment to expand the health infrastructure, especially building new health centers and health posts. This investment greatly increased access to health services. By 2005, the use of injectables tripled, while other methods remained the same, doubling the CPR, and the use of modern methods *by rural women* rose from 6.3% to 10.6%. The 2005 DHS showed the national CPR had doubled to 13.9%. Even so, high government officials were beginning to focus on family planning and saw this figure as inadequate to achieve the MDGs pertaining to maternal mortality and child survival. Documents and officials also began to note high unmet need for contraception (36%) and the lack of access to family planning services, particularly in rural areas.

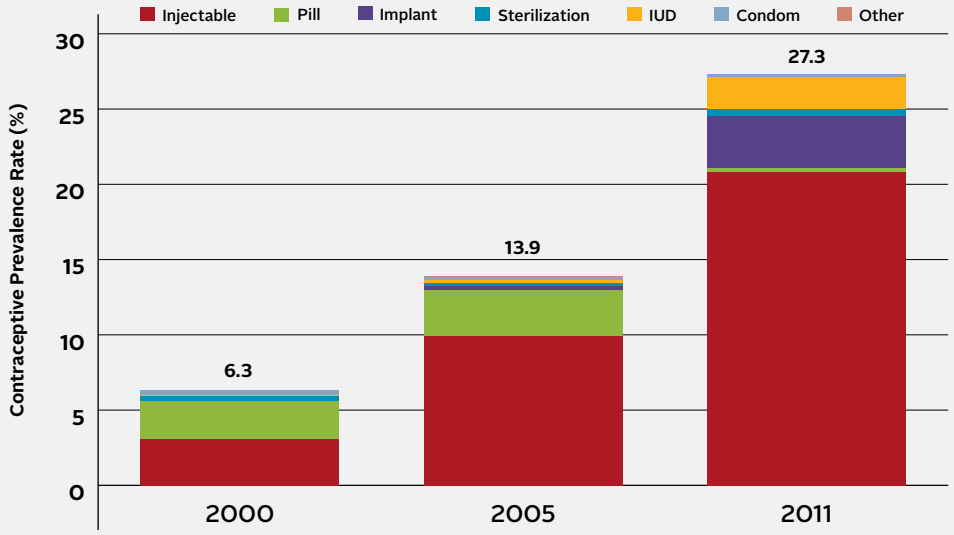
The Health Sector Development Program III 2005 – 2010 provided for vigorous implementation of the Health Extension Program, improving the logistic management system; strengthening

**Table 1.**

**Use of contraception in urban and rural areas, percent of currently married women age 15-49**

| | 2000 | 2005 | 2011 |
|---|---|---|---|
| Urban | 28.3 | 42.2 | 49.5 |
| Rural | 3.3 | 10.6 | 22.5 |
| **Total** | **6.3** | **13.9** | **27.3** |

**Figure 4.** Ethiopia Contraceptive Prevalence Rate Trends, by Method




**Source:** DHS; CPR modern methods, married women of reproductive age

government, donor, NGOs, and private sector collaboration; and specifying that HEWs could provide short-acting methods (including injectable contraceptives) and single rod implants (Implanon).

By 2011, modern CPR had doubled again to 27.3% with the use of injectables doubling and implants and IUDs becoming popular, while the use of pills declined. Although the urban modern contraceptive use (49.5% CPR) still exceeded the rural CPR (22.5%), the biggest increase was in the rural areas, where most of the population lives.

## Health Extension Workers

Health Extension Workers are credited with the achievement of doubling contraceptive prevalence from 2005 to 2011. The HEWs are a new cadre of paid Ministry of Health workers. They are female, with a minimum of a 10th grade education, originating from the community where assigned. They receive a one-year training in a Regional Training Center (Technical Education and Vocational Training School) and learn to implement 16 health packages, one of which is family planning (see box). They are assigned two per health post, and are supervised by personnel in the health center. Each health center manages five health posts with ten HEWs.

Each HEW is expected to work two days a week in her health post, and spend three days in the community, conducting house to house visitation. There are approximately 500 households per Health Extension Worker. The HEWs provide pills, condoms, and injectables. Notably, training for HEWs to provide the implant Implanon began in the four major regions of the country in 2009 before being scaled up nationally in 2010. This is the first non-professional cadre to insert implants in Africa, which has led to considerable attention from other country leaders and the international family planning community. The health centers are responsible for removing the implants.

### Sixteen Packages of the Ethiopian Health Service Extension Program

**A. Hygiene and Environmental Sanitation**

- Proper and safe excreta disposal system
- Proper and safe solid and liquid waste management
- Water supply safety measures
- Food hygiene and safety measures
- Healthy home environment
- Arthropods and rodent control
- Personal hygiene

**B. Disease Prevention and Control**

- HIV/AIDS prevention and control
- TB prevention and control
- Malaria prevention and control
- First aid

**C. Family Health Services**

- Maternal and child health
- Family planning
- Immunization
- Adolescent reproductive health
- Nutrition

Important functions of the HEWs are to address misconceptions concerning family planning in the community, to counsel clients on all family planning methods, and to provide short acting methods. Direct interpersonal communication is the most effective means of behavior change communication. Since these women are from the communities they serve, they understand the local issues around family planning and can remove barriers to acceptance caused by misconceptions.

Since 2005, 34,000 HEWs have been trained by the Ministry of Health with support from development partners, to work in 17,000 new health posts. This represents a massive investment for a developing country. They are paid by the Regional Health Bureaus, which manage the program within the Federal MOH guidelines. The pay for HEWs is on average 800 Birr per month, about US$46, which is an entry-level salary for civil servants with a vocational training after grade 10 education. Various developmental partners have assisted the Regional Bureaus in the training and supervision of the HEWs.

A primary means for promoting family planning in Ethiopia is through interpersonal communication by the HEWs. At the same time, key informant interviews including staff from DKT, UNFPA, and the Population Directorate of the Ministry of Finance and Economic Development report the importance of using media, especially radio, to urge couples to plan their families. However, the 2011 DHS reported that exposure to media in Ethiopia is low; only 22% of women and 38% of men listen to radio. Community events including educational sessions in community gatherings, churches, mosques, and youth clubs have played a role in the promotion of family planning in Ethiopia.

## Supply Chain and the Private Sector

In addition to massive investments in infrastructure and human resources in order to get services out to the doorstep, the Ministry of Health has revised the supply chain management systems, increasing the availability of contraceptives. UNFPA reported the percent of facilities reporting a contraceptive stock out was 5% in 2011, down from 40% in 2006. Development partners and government pooled funds are used to procure contraceptives nationally, and some health regions are directly procuring their contraceptives. Social marketing partners also provide emergency supplies to the public sector when needed. Parliament has removed all duty and taxes on imported contraceptives to reduce the time they spent in customs because family planning was considered key for the country's development. This change in duty/taxes happened following an intensive advocacy effort by the Federal Ministry of Health, Ministry of Finance and Economic Development, development partners, and NGOs.

The Ministry of Health has also been focusing on improving the quality of the existing health centers and hospitals through training and management. The health centers are focusing on longer acting family planning methods, especially implants and intrauterine contraceptive devices (IUDs), now that the HEWs are taking care of many of the hormonal methods. An implant expansion was undertaken in 2010 and an IUD expansion in 2011. Development partners are assisting in the training and equipping facilities for the new procedures. The FMOH notes that while the use of implants and IUDs has begun to affect the Ethiopian DHS data, these are new programs that will continue to roll out and should boost CPR even more. The FMOH is also planning to increase access to permanent contraceptive methods.

Although the private sector is underdeveloped in Ethiopia, the FGAE is the second largest family planning service provider next to the public sector. In addition, franchising of for-profit family planning services, socially marketing contraceptives, and NGO clinics play an increasing role in meeting the need of family planning services. The Health Sector Development Program specifically supports private sector and NGO programs, and the partners report good relationships with the public sector. Marie Stopes International (MSI) has a "Blue Star" program which supports 253 Blue Star private clinics providing family planning as a profitable service. MSI provides training, materials, and supervision to the clinics in the Blue Star program; it expects to expand three-fold by 2015, to about 780 franchise clinics. In addition, the DKT social marketing program provides pills and condoms to pharmacies, and implants and IUDs to NGOs and private providers.

## Leadership and Improved Systems Key to Success

The impressive growth of family planning use and systems in Ethiopia, especially among rural populations, resulted from concerted work from high level policymakers down to the local level, the development of an innovative delivery system, and improvements in the overall health system. The support for family planning started at the top, according to key informant interviews.

Prime Minister Meles Zenawi was looking for a way to improve the country in the wake of a number of challenges including the war with Eritrea, prolonged drought, and food shortages in specific regions. A massive effort by the government ensued, including increased attention to family planning as a means of meeting the MDGs and collaborating with USAID, UNFPA, and others. He appointed Dr. Tedros Adhanom, a dynamic leader, to the post of Minister of Health in October of 2005, which led to many of the positive changes.

Dr. Tedros had been Head of the Tigray Regional Health Bureau, where he was involved with the development of the Health Extension Program. Dr. Tedros led a tremendous expansion of the Health Extension Program and focused on increasing the quality of the family planning program through training, logistics, and management.

The phrase Minister Tedros used again and again in the expansion process was: "When you plan, be ambitious. Do it at scale."

The leadership of the Federal Ministry of Health, and especially that of Minister Tedros, is a major factor in the success of the Ethiopian Family Planning Program. The broad plans are set in the Health Sector Development Program, and resources are decentralized to the regions. The FMOH and regions coordinate with the development partners to ensure that support goes where needed without duplicating resource allocation. Partners collaborate on regional and national task forces under the leadership of the FMOH.

Many Ethiopian leaders, including the Prime Minister and Minister of Finance, remain concerned with the rate of population growth, as population has doubled since the late 1980s. Those interviewed for this project noted that the country needed what one called a "quick win" to improve Ethiopia's international reputation, as well the lives of its population. Addressing the MDGs gave the FMOH and the larger government such a goal. Family planning is not a stand-alone activity in Ethiopia, but is integrated into general rural development, decentralization, and a focus on women and girls. The main

implementers of family planning in Ethiopia, the HEWs, are seen as an essential part of a larger rural development strategy.

No active religious opposition to family planning has emerged in Ethiopia, with the Orthodox, Protestant, and Muslim religions all supporting the HEWs. Also, family planning activities are being incorporated into other health programs such as HIV/AIDS and pre- and post-natal care.

Challenges that remain include the remaining high unmet need for family planning, the fact that Ethiopia is a large country with difficult terrain in many areas, and the low utilization of family planning among the nomadic pastoralist community. Financial constraints remain a challenge in continuing to support the Health Extension Program, as does expanding the method mix with greater method choice.

When asked to name the prime factors in Ethiopia's family planning success, key points mentioned by the respondents were:

- Personal commitment and leadership of the Minister of Health and Prime Minister
- Bringing services to the doorstep in the rural areas through the Health Extension Workers
- Improvements in infrastructure, especially health centers and health posts
- Improvements in health system quality, especially logistics and supervision
- Inclusion of the health partners and NGOs in the program
- A sense of pride, purpose, and optimism that Ethiopia is on its way to meeting the Millennium Development Goals

# Malawi
## The Story Behind The Success

Malawi's achievements in rapidly expanding the use of modern methods of contraception reflect a set of broad-based and mutually reinforcing improvements in family planning policy and program implementation. High-level political commitment, improved financing mechanisms, expanded and innovative service delivery options, and receptive communities and clients have combined to make family planning more acceptable, accessible, and affordable to Malawian households.

### Political Commitment to Family Planning Reflected in Core National Policies

Core national policies reflect the commitment of the Government of Malawi to reduce population growth by improving and increasing access to reproductive health services, including family planning. This commitment has been recently articulated in RAPID Population and Development, the 2010 analysis of the impact of rapid population growth on socio-economic development and poverty reduction, produced by the Population Unit of the Ministry of Development Planning and Cooperation and the Reproductive Health Unit (RHU) of the Ministry of Health. The paper affirms and expands upon the government's goal under the Malawi Growth and Development Strategy (MGDS) 2006-2011 to provide accessible, affordable, and comprehensive reproductive health services.

### Malawi at a Glance

- Malawi is among the poorest countries in the world with Gross National Income (GNI) per capita of USD 753.*
- From 2004 to 2010, the country's population increased in size from nearly 12.5 million to almost 15 million.*
- The total fertility rate (TFR) has declined from 6.7 births per woman in 1992, but remains high at 5.7 births in 2010.
- If the fertility rate remains constant the country's population will more than triple by 2040.**
- Positively, the demand for family planning is high and growing; in 2010, almost three out of every four married women reported a demand for FP.
- Married women use injectables (26%) and female sterilization (10%) when choosing a modern method for spacing and limiting.

*Data from DHS except: * UN Development Program; ** Malawi Ministry of Development Planning and Cooperation*

Alongside national leaders across Africa, the Government further acknowledges that significant improvements in sexual and reproductive health are central to attaining the Millennium Development Goals (MDGs). In response, the Heads of State and Government of the African Union endorsed the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) in Khartoum in January 2006, and in a special session of the African Union Conference of Ministers of Health in September 2006 adopted the Maputo Plan of Action (MPoA) 2007-2010 to operationalize the framework. One of the six key strategies of the MPoA is the "repositioning of family planning as an essential part of the attainment of health MDGs." As the rationale of the MPoA emphasizes, "high unmet need for family planning with rapid population growth often outstrip[s] economic growth and the growth of basic social services (education and health), thus contributing to the vicious cycle of poverty and ill-health."

Recognizing the importance of the MPoA to national development, the Government of Malawi ratified the Plan in June 2007 and acted promptly to domesticate the Plan. The principal national instrument that contextualizes the MPoA in Malawi is the Sexual and Reproductive Health and Rights (SRHR) Policy 2009 which was developed under the leadership of the RHU to provide guidance to all actors in implementing SRHR services. The RHU is responsible for the dissemination and implementation of SRHR policies, guidelines, and strategies, and for providing technical support, advice, and coordination for SRH services with the assistance the SRH Technical Working Group. Many key informants interviewed for this case study described these policy agreements as well as strong leadership within the MOH as important factors for improvements in the program. Specifically, the Director of the RHU from 2008 to 2011, Dr. Chisale Mhango, was an outspoken champion for expanding access and use of family planning methods and led the way to igniting the program during his tenure.

## Financing the Health Sector: A Sector-Wide Approach (SWAp) and Decentralization

Most recently, Malawi's reproductive health program was part of the six-year Joint Program of Work (PoW) for a Health Sector-Wide Approach (2004-2010) implemented by the government with the assistance of development partners for two main objectives: i) to establish and deliver an Essential Health Package (EHP) (including family planning) to be provided free of charge to all Malawians; and ii) to implement an Emergency Human Resources Program (EHRP) to address the human resource crisis in the health sector. The UK Department for International Development (DfID), the largest donor in Malawi, committed (and is on track in disbursing) £109 million to the health SWAp over six years, with £94 million provided as sector budget support and £15 million as technical cooperation. Key informants for this study credit the EHP and EHRP highly in improving access to reproductive health services.

Management Sciences for Health (MSH) assisted in implementing the EHRP for retaining, training, and deploying health staff. Immediate supplemental strategies included increasing salaries by 52% and deploying temporary, volunteer, and international personnel (from Voluntary Service Overseas Federation and other partners). For longer-term sustainability, revisions of service delivery guidelines and job descriptions were undertaken in a move towards "task-shifting and

task-sharing" (see the next section for details). An evaluation of the EHRP found that across the program's 11 priority cadres, the total number of health workers increased 53%, from 5,453 in 2004 to 8,369 in 2009. Over this period, the number of physicians in the country increased by 516% (43 to 265), clinical officers by 61% (594 to 958), and nurses by 39% (3,456 to 4,812). In addition, the number of community-based health surveillance assistants (HSAs) rose by 115%. Overall, the total health provider density increased 66% from 0.87 per 1,000 people to 1.44 in 2009.

The direct impact of the SWAp on health sector outputs related to family planning is more difficult to assess. Much of the funding for the EHP was channeled to HIV and AIDS support. Commitments to non-HIV and AIDS interventions rose from 10% to 15% but with considerable variability between years. Family planning was supported over the years by the USAID, UNFPA, the European Union (EU), the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the World Bank, and WHO.

Reforms in the health sector including decentralization of decision-making and financing to the local level were further noted as an additional force in improving health services. For example, support for District Health Management Teams led by District Health Officers helped these professionals to design and implement District Implementation Plans that reflected local needs. Some informants posited that since politicians – i.e., District Assemblies and District Commissioners – are now in charge of budgets and plans, they must keep their constituents happy. Decentralization also allowed different donors to work with district assemblies directly including supporting health sector activities without necessarily funding central systems. The US government's Millennium Challenge Corporation (MCC) initiative provided additional funding to strengthen the country's decentralized financial systems to facilitate economic growth and development.

## Transforming the Delivery of Family Planning Services

Since 2004, the Government has made significant advances in improving health service delivery by: i) investing in human resources and training; ii) deploying lower cadres of health professionals (clinical officers, midwives, nurses, health surveillance assistants) and volunteers to provide services at the community level; and iii) expanding outreach and mobile services through public-private partnerships. Different modes of service delivery have been put in place to realize the goal of making family planning accessible and affordable to all Malawian women and men.

One of the major strategies under the EHRP was the training and deployment of lower-level cadres to provide clinical services in the public and private sectors. With respect to the provision of family planning services, in 2005, the standards and guidelines were revised to allow clinical officers as well as physicians to perform female sterilizations, and they allowed nurses to provide long-acting FP methods, including Jadelle implants and IUDs.

With the vast majority (81%) of Malawians living in rural areas, FP stakeholders in the government and private sector concur that information and services need to be as close to the people as possible. From the early 1990s to today, the establishment of culturally appropriate and effective modes of service delivery has been the bedrock of success in family planning in Malawi. A core component of this approach

has been the training of Health Surveillance Assistants, the lowest-level cadre of full-time salaried workers in the Ministry of Health, and volunteer community-based distribution agents (CBDAs) on how to provide family planning information and supply specific contraceptives at the community level. CBDAs are permitted to provide pills and condoms, and, in 2008, the Ministry of Health allowed HSAs to provide injectables (DMPA).

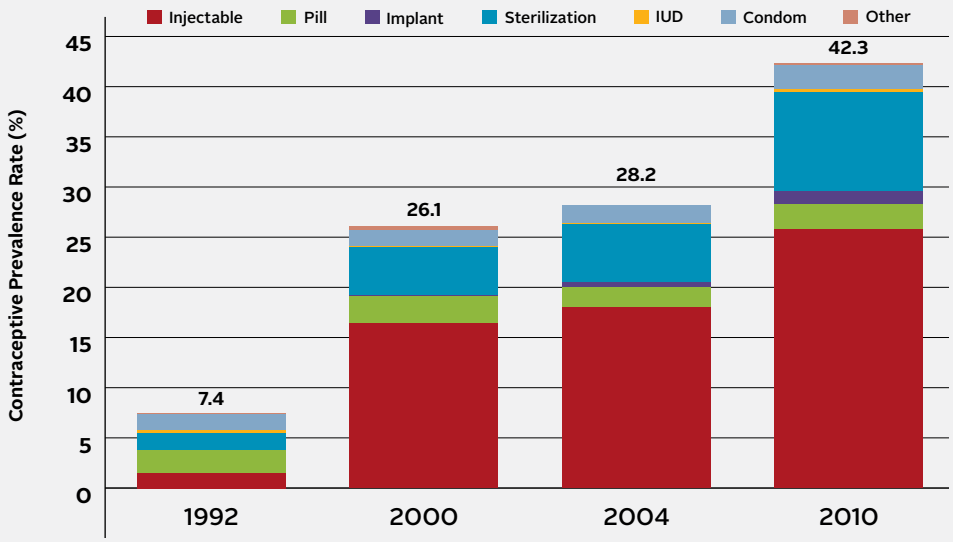
HSAs and CBDAs counsel clients on the modes of action and side effects of the different family planning methods. They inform clients that long-acting and permanent methods are available at the district hospital (and many workers accompany the clients). The community health workers further help schedule and announce when mobile outreach services will be visiting their communities – and that these services are free of charge. Some key informants referred to this community-based approach as the "demedicalization of family planning." As one CBDA interviewed for this study remarked, "We can't have a medical approach to a social need." These significant shifts in policy and human resource deployment have dramatically improved access to a full range of family planning methods.

A USAID-supported pilot of community-based provision of DMPA provides strong evidence of the effectiveness of task-shifting the provision of family planning services by HSAs. Conducted between November 2008 and November 2009, the pilot program trained 545 HSAs and 100 supervisors in nine of Malawi's 28 districts. The program evaluation found that the number of clients accessing DMPA per quarter rose from 3,210 in March 2009 to 101,885 in March 2011, a 31-fold rise in uptake of DMPA in just two years.

Nongovernmental organizations (NGOs) complement government health services, especially in terms of mobile outreach services. In particular, Banja la Mtsogolo (BLM) addresses community and clinic-based needs country-wide. Starting with one clinic in 1987, BLM now operates 31 clinics in 22 of Malawi's 28 districts. BLM also provides mobile outreach family planning services via 37 outreach teams on a rotating basis and in collaboration with local communities to rural areas in 27 districts. BLM offers a full array of methods including long-acting and permanent methods (LAPMs). The mobile services are free while services in the BLM static clinic sites cost a nominal fee (if the BLM site has a government contract, the services are free). In an innovative public-private partnership, BLM provides periodic mobile family planning services in government health centers that may not have the trained providers, medical equipment, instruments, and expendable supplies to offer LAPMs daily. All female sterilizations are performed by clinical officers, not by doctors. From 2008 to 2011, BLM provided more than 170,000 female sterilizations. In the first eight months of 2011, BLM also provided 9,000 implants to rural clients, up from 2,600 in 2010. A second important public-private partnership involves the Christian Hospitals Association of Malawi (CHAM). CHAM provides family planning services and has community-based distribution programs tied to some of its facilities.

Data in the MDHS 2010 show that one-third of all female sterilizations are provided by BLM and a further 10% by CHAM. These data indicate the critical importance of innovative public-private partnerships with strong, well-established NGOs in expanding access to FP methods, especially LAPMs. Nationally, the proportion of married women choosing female sterilization

**Figure 5.** Malawi Contraceptive Prevalence Rate Trends, by Method




**Source:** DHS; CPR modern methods, married women of reproductive age

(as a share of the method mix) has increased to 21%, and the proportion of women using implants almost doubled between 2004 and 2010, albeit from a low base level.

The figure above shows the trends in contraceptive prevalence by methods. It shows the strong and sustained uptrend in the use of injectables, long-acting, and permanent methods over short-acting and traditional methods of contraception. The proportion of women choosing to use injectables increased almost five-fold between 1992 and 2000 to about 55% of users, and has stayed at that proportion even as the CPR has increased sharply since 2000. The use of implants and IUDs has doubled since 2004 but still accounts for less than 4% of users. Female sterilization now accounts for more than one-fifth of contraceptive users.

## "Culture of Acceptance" for Family Planning

Key informants noted that perhaps the greatest contribution to the success of the family planning program is the culture of acceptance for family planning at the community level. As Figure 2 (page 5) shows, close to three-quarters of married women reported a demand for family planning in 2010, which strongly suggests that family planning is increasingly becoming a social norm in Malawi. In explaining this shift, a senior MOH official said that in recent years the Government of Malawi had made concerted efforts to disseminate the benefits of modern family planning to all communities with emphasis on the idea that "modern contraception can help mothers avoid pregnancies that may be too early, too frequent, too many, and too late." The close collaboration of family planning programs with community leaders, including Catholic and Muslim clerics, has also been critically important

to providing a supportive environment for contraceptive use. For example, FP program managers in the public and NGO sectors have held meetings to listen to the concerns of religious leaders and have agreed that natural family planning has a place in the method mix.

In general, Malawian women and men are knowledgeable about family planning; they know many types of modern methods, where to get different methods at the community and/or district levels, and when mobile services will be coming. Radio is a major source of information about family planning. The 2010 MDHS reported that 56% of women and 76% of men age 15-49 years had heard a radio program about family planning. Along with greater acceptance and increased knowledge about family planning, a fuller range of modern methods has become more available through expanded services at health facilities, in community-based programs, and via mobile outreach services.

## Sustaining and Building upon the Achievements to Date

Malawi has demonstrated that rapid increases in contraceptive use, including long-acting and permanent methods, can be achieved despite severe shortages of health personnel, high rates of poverty, and many competing health and development priorities. However, in its 2010 analysis of population and development, the Government notes that: "Even if fertility rates decline over the next decade, Malawi's population will continue to grow substantially due to "momentum" – the built-in growth due to the large number of couples of childbearing age – an 'echo' of past high fertility."

Sustained investment in family planning will, therefore, be required to consolidate and expand the gains made so far. In analyzing the government's achievements to date, the following four areas have been identified as important avenues to further increase the contraceptive prevalence rate and accelerate the decline in the fertility rate.

### *Reaching youth with family planning*

The country has a very young population; in 2010, 49% of Malawians were under 15 years of age. As these youth cohorts reach reproductive age, greater education and access to modern methods of contraception will be critical for couples to delay, space, and limit births. For health and personal development, delaying early marriage and pregnancy is life changing. At present, the teenage pregnancy rate is high – 26% of all Malawian women aged 15-19 years are currently pregnant or have delivered a child. Far fewer younger married women (26% of 15-19 year-olds) than older women (49% of 35-39 year-olds) practice family planning. Additionally, the median number of months between birth intervals is much higher for 35-39 year olds (38 months) than for teenagers (26 months). At a societal level, expanding the educational and economic opportunities for girls and young women will have a significant impact on early childbearing, which will, in turn, affect national fertility rates and development. Young women with no education are more than 11 times more likely to have commenced childbearing than those with secondary and higher education (45% compared with 4%).

### *Ensuring contraceptive security*

An essential component of a comprehensive family planning program is contraceptive security – i.e., when people have regular, reliable, and equitable access to a choice of high-quality contraceptive methods to meet their reproductive health needs. Presently in Malawi, family planning services in both the public and private sectors are either free

or highly subsidized. As a result, contraception has become more affordable to poorer households. In addition, the expansion of community-based distribution and mobile outreach services are making contraceptive methods more widely available and convenient to access. However, logistical problems in the supply of contraceptives have led to districts and communities experiencing stock-outs of important contraceptive methods, such as injectables, which is problematic and demoralizing for the women affected. Without adequate and consistent supplies of contraceptives and services, couples are prevented from using contraceptives effectively and may discontinue use altogether. The ongoing efforts of the Government, with the support of donors, to make structural changes to strengthen the Central Medical Store will be a cornerstone for future contraceptive and pharmaceutical security in the country.

### *Expanding use of long-acting and permanent methods*

Over the last two decades, the experience of Malawi has shown that families will choose long-acting and permanent methods of contraception when these methods are available and affordable. In 2010, almost 10% of all currently married women (representing over one-fifth of users of modern methods in this population group) had opted for female sterilization as their preferred method of contraception. LAPMs are more technically difficult to provide and up-front costs are higher, but the increased uptake of LAPMs would reduce the burden and health risks to women, as well as reducing the demands upon the health system. LAPMs are highly cost-effective. Recent research has shown that IUDs, female and male sterilization, and the new Zarin implant, also known as Sino-Implant II, which is approximately one-third of the cost of Jadelle and Implanon, all have lower service delivery costs per couple years of protection (CYP) than orals and injectables. The significant increases in use of LAPMs between 2004 and 2010 indicate the success of training and task-shifting in the public sector to allow clinical officers and nurses to provide specific LAPMs and the development of public-private partnerships dedicated to providing LAPMs. The scaling up of these two approaches has great potential to further expand access to these methods.

### *Increasing equity in access to contraception to reduce unmet need for family planning*

As Figure 2 (page 5) shows, one of every four currently married women in Malawi has an unmet need for family planning. In recent years, the differentials in contraceptive use by women's wealth and education status have fallen and the rural-urban divide has stayed about the same as the CPR has grown rapidly. Nonetheless, the overall demand for family planning among poorer, less-educated, and rural women is lower, while, at the same time, their unmet need is higher. Reaching under-served women and communities with family planning methods will be a key to future substantial gains in the CPR. Community health workers and volunteers backed by supportive supervision and strengthened contraceptive supply-chains, along with outreach and mobile services provided through public-private partnerships will continue to play major roles in improving equity in service delivery. But to capitalize on recent progress, champions for family planning at all levels of the health system and the government will be needed.

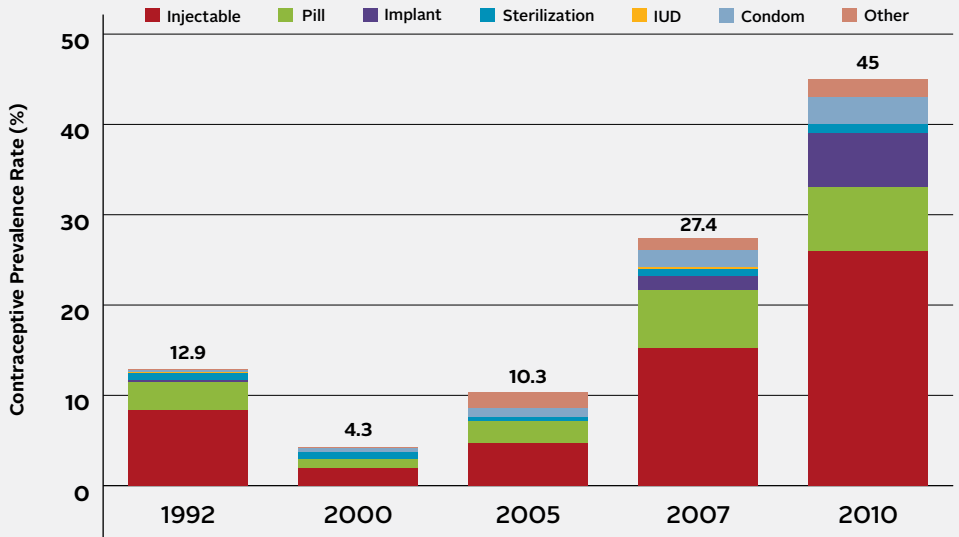
# Rwanda
## Success Story Still in the Making

Rwanda has done what no other country has done to date – increased its contraceptive prevalence rate (CPR) more than 10-fold in less than a decade. The 2000 DHS found only 4% of married women of reproductive age were using modern contraceptive methods. This low CPR was in large part a result of the destruction after the 1994 genocide when much of the country's infrastructure was destroyed. In 2005, the rate had increased to 10% and by 2010 to 45% for this group. This increase in the use of modern contraceptives has reduced Rwanda's total fertility rate (TFR) from 6.1 in 2005 to 4.6 in 2010, indicating that the National Family Planning Program in Rwanda is a phenomenal success.

Figure 6 below illustrates this dramatic increase in CPR as well as the method mix trends since 1992. The most frequently used modern methods have continued to be injectables and pills, with a five-fold jump in injectables from 2005 to 2010 (5% to 27%).

The 2010 DHS shows Rwanda is making great strides with regards to meeting the family planning need and closing the rural urban gap with regards to accessing modern family planning methods. The unmet need for family

**Figure 6.** Rwanda Contraceptive Prevalence Rate Trends, by Method




**Source:** DHS; CPR modern methods, married women of reproductive age

planning decreased by 15 percentage points since 2005 from 39% to 24% in 2010 (see Figure 2). Fertility is dropping very quickly in Rwanda – 1.5 in 5 years, with its actual fertility in 2010 equal to its wanted fertility in 2005 – a very noteworthy achievement (see Figure 3).

In addition, the 2010 DHS found there is little difference between urban and rural married women in the use of a modern method (47% and 45% respectively). These percentages are particularly impressive, given that in 2005, use of modern contraceptive methods in urban versus rural areas was 21% and 9% respectively.

If Rwanda is to attain a total fertility rate of 3.1 children per woman and achieve the ambitious CPR goals it has set for itself – 70% CPR by 2012 – there is still work to be done. "Yes, we have achieved good results in terms of the CPR increase, but we can't stop to celebrate," The Honorable Dr. Jean Damascene Ntawukururiryayo, President of the Senate and Former Minister of Health, told the Africa Bureau interview team in his Senate office shortly before the 2011 Dakar ICFP. "We have a lot more work to do with respect to family planning."

## Champions at All Levels, the National Family Planning Program

Two key reasons for the Rwanda success over the last decade emerged again and again from interviews with more than 25 key informants in the country. First, a strong government vision, with leadership and commitment to family planning has systematically created and sustained an enabling environment. Second, effective strategies and approaches affecting the health and financing systems in the country have addressed supply issues among providers, health delivery systems, and commodities – as well as the demand side from the population.

### Rwanda Key Indicators

- **Population:** 10.9 million*
- **Total fertility rate (TFR):** 4.6
- **Contraceptive prevalence rate (CPR):** 45%
- **% Urban:** 19%*
- **Population living below US $2/day:** 90%*
- **Infant mortality rate (IMR):** 50
- **Maternal mortality ratio (MMR):** 487
- **Unmet need for family planning:**
  - **Urban:** 15.5%
  - **Rural:** 19.5%

**Data for these items from PRB, Bureau* 2011 World Population Data Sheet*; other data from* 2010 DHS.

The economic development vision of Rwanda included a smaller family planning size as a key component of its work. With strong leadership from the President and the Prime Minister, Dr. Jean Damascene had the leverage and support he needed to initiate a number of innovative services as Minister of Health.

"We, with the President and Prime Minister, came to a consensus at the very highest level around 2005," explained the Honorable Dr. Jean Damascene. "We agreed that the rapid population growth rate was an issue that needed to be dealt with. If we didn't deal with it, we most certainly would have problems with achieving our vision. After that, every leader began advocating for family planning."

One of the key supportive groups in helping make family planning central to the government policy was the Parliamentary Network on Population and Sustainable Development (RPRPD), established in 2002 and still a key champion that works closely with the National Assembly.

In 2005, the RPRPD group of Parliament members received a presentation of the RAPID model, a forecasting tool developed by the Futures Group Health Policy Initiative with support from USAID. This model showed that without substantial support for family planning policies, services, and supportive systems, the population would increase by three-fold at the current fertility levels, compared to only doubling at reduced fertility levels. An extra 30,000 primary school teachers would be needed and more than 40% more metric tons of food would be required to feed the population. Potential savings in the health sector would be 384 million USD. This presentation had a powerful impact and motivated Rwanda's leadership to take the leap and advance a national family planning agenda that would promote smaller families, thereby improving health, education, and economic opportunities for the country.

This consensus by the President and Prime Minister along with the Parliamentarians leveraged political support for family planning at the highest levels, including the Finance, Education, and Health Ministries buying into FP as integral to their work.

The consensus in 2005 and the inclusion of family planning in key national planning documents are part of a series of events that led to family planning being integrated into many levels of society (see "Key Events" box). The strong government coordination led to the close coordination of development partners through the Family Planning Technical Working Group (FPTWG), minimizing duplication of efforts. And, the RPRPD remained active, today with a total of 76 parliamentarians (senators and deputies) active.

At a district and community level, local government officials also became family planning champions. They have the authority and are expected to talk about health issues, including family planning at public events, including the monthly national community work days (*umaganda*). These local officials also encourage male involvement and promote Maternal and Child Health (MCH) week, which is organized quarterly by the MOH and includes immunization campaigns and sensitization and services for family planning.

The Economic Development and Poverty Reduction Strategy (EDPRS) (2008-2012) reflect this emphasis on family planning. "High population growth is a major challenge facing Rwanda," the EDPRS document noted. "Slowing down population growth requires innovative measures, including the strengthening of reproductive health services and family planning and ensuring free access to information, education, and contraceptive services." This 2008-2012 roadmap for the government and development partners established family planning as one of its key strategies with guidance on implementation and financing.

All of these efforts contributed to institutionalizing a cultural norm of accountability through performance-based contracts (called *imihigo*), from the household level, through the health facilities, and all the way to the President. Gradually, this process led to a desire for smaller families, as evidenced by the fact that the mean desired number of children decreased from 4.6 in 2005 to 3.6 children in 2010.

## How Rwanda Has Accomplished So Much

In addition to the strong champions and policies that support the national vision, several other factors have contributed to the National Family Planning Program's success. Since 2005, Rwanda has diligently been working towards a decentralized health system. The country expanded the number of health centers at the sector level and hospitals at district level, strengthened overall training of medical personnel, and improved the availability of data for decision making. Ministries are also integrating family planning into all health services to ensure no missed opportunities, for example integration of family planning into immunization and HIV/AIDS programs.

In 2005, 73% of women received their contraceptive methods from government services, according to DHS. In 2010 this figure jumped to 92%. Table 2 (page 24) illustrates an even more important aspect of this shift to public services, the shifting of service delivery closer to the client, away from hospitals to health centers, health posts, and the community. The 2005 and 2010 comparison clearly indicates the transfer of family planning services to lower levels of the health care system, which reflects a dramatic shift in provider training, commodity logistics, and client demand in rural areas – reflecting the strengthening and expansion of health systems and service delivery approaches.

As part of the decentralization process the introduction of performance based financing (PBF) was established as an innovative health sector reform. The idea of PBF is to motivate better performance of health facilities through payment for the services they provide. 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

### Key Events, Rwanda National Family Planning Program, Central Level

**1999:** Rwandan government begins to encourage the creation of community-based health insurance (*mutuelles*)

**2002:** Qualitative assessment of family planning in Rwanda conducted, Rwandan Parliamentarians' Network for Population and Development formed (RPRPD)

**2003:** First National Reproductive Health Policy signed by the Minister of Health

**2005:** RAPID Model presented to Parliamentarians

**2006:** National FP policy and its five-year strategies (2006-2010) produced by MOH; initiation of FP secondary posts

**2007:** Government declares family planning to be a development priority; Economic Development and Poverty Reduction Strategy (2008-2012) emphasizes importance of FP and sets target of 70% CPR by 2012

**2008:** Study tour to Uganda to see community-based distribution (CBD) of DMPA

**2010:** Phase one of community-based provision of family planning services (including DMPA) conducted and nationwide scale up planned

**2011:** Rwanda Family Planning Policy and Family Planning Strategic Plan, both for 2012-2016, and National Adolescent Sexual & Reproductive Health Policy and Strategic Plan, 2011-2015, all developed with stakeholders.

**Table 2.** Location of Family Planning Services

| Location where clients received modern contraceptive methods | % Distribution of users of modern contraceptive methods 2005 | % Distribution of users of modern contraceptive methods 2010 |
|---|---|---|
| **Hospitals** (referral and district) | 13 | 5 |
| **Health Centers** | 58 | 77 |
| **Other public** (e.g. health post, outreach, CHW, etc.) | 1 | 10 |

by scores of quality. Note that the PBF payment goes to the facility and not to individual providers. This reform systematically institutionalized the cultural norm of accountability and ownership of the family planning programs through the performance contract with district mayors (*imihigo*).

Another strategy was the creation of community-based health insurance (*mutuelles*). The *mutuelles* contribute to sustainability, quality, and access to the health facilities; they provide revenue to health facilities as well as a forum for dialogue between communities and providers regarding the quality of care of health services. The *mutuelles* are now nationwide, increasing access to services and bringing more clients into the health system for both preventive and curative care. Family planning services and commodities are free in Rwanda; this financing serves to bring more people into contact with the broader health system, thus reinforcing health care in general and specifically family planning. According to the 2010 RDHS, 78% of Rwandan households have health insurance, and the vast majority of these are covered by the *mutuelles*.

In addition to these reimbursement and insurance approaches, the government is committed to ensuring availability of products and trained personnel. In coordination with its partners, Rwanda worked to strengthen the logistics management and health information systems for contraceptives, which led to an improved logistics system and reductions in stock-outs. Rwanda also worked with development partners to ensure availability of trained service providers at the health facilities to provide a wider method mix of contraceptive methods, including long-acting methods such as implants.

Rwanda recognized the need for broader access to services at the village level. The MOH launched an ambitious plan to have four CHWs work in each of the 15,000 villages, including a pair of CHWs ("binomes," one male and one female) who would be trained in providing family planning information and some methods. Training for these 30,000 CHWs in family planning provision began in 2010, with the nationwide scale-up process scheduled to be completed in 2013. Another CHW provides support for maternal and child health services, and the fourth works on community sensitization. Only the binomes (men and women) are providing family planning services (not the maternal health CHWs). While the initial goal was to train both of the binomes in family planning, due to expense associated with training, the MOH has revised that goal to one CHW per village.

All of these CHWs are attached to a health center with a catchment of 15 to 30 villages and are supervised by a Community Health Supervisor at the health center. These CHWs are volunteers; they are remunerated through the community PBF approach, which contributes funds to a local cooperative for the CHWs, not to the CHWs directly. These cooperatives are supposed to help with income generating activities for the CHWs.

One of the biggest barriers to modern FP access in Rwanda is opposition from religious leaders, particularly within the Catholic Church. Given that approximately 43% of facilities in Rwanda are religiously affiliated, and 18% are Catholic, addressing this was of utmost importance for the effective implementation of the National Family Planning Program. The Ministry of Health created health posts near the religiously affiliated health centers and the network of Community Health Workers to provide modern contraceptives.

## Conclusions and Future Goals

In just five years, from 2005 to 2010, there have been major accomplishments as a result of the Rwanda's National Family Planning Program:

- CPR increased more than four-fold from 10% to 45%
- TFR declined by a quarter from 6.1 to 4.6
- IMR declined by more than a third from 86 per 1000 to 50 per 1000
- MMR declined by more than a third from 750 per 100,000 live births to 487 per 100,000

However, despite these positive trends, about one in four women still had an unmet need for family planning in Rwanda, according to the 2010 DHS. So, there is still work to be done.

Looking ahead, a large group of stakeholders led by the MOH and the FPTWG in Rwanda has recently identified key strategies to include in their Family Planning Policy and Strategic plan for the next five years, with the goals of increasing CPR further and improving overall maternal and child care health, all part of MDG 5. In addition, a separate but complementary planning process has recently concluded with a focus on youth, integrating concerns about the population "youth bulge" and high pregnancy rates among those under age 20.

Some of the key strategies for the future in these documents and from the key respondents in this project were:

- Scale up of CHWs to provide information on all contraceptive methods and to deliver injectables, pills, condoms, and standard days method, expanding to all 30 districts in the country
- Increase access to permanent methods through the national scale up of tubal ligation and vasectomy services
- Expand and strengthen collaboration with the private sector
- Promote access to long-acting methods at health centers and secondary posts, including immediate post-partum IUDs
- Develop and implement the new National Family Planning and Adolescent Sexual and Reproductive Health strategies and policies

# **Lessons Learned:** Three Country Experiences

All three countries have enjoyed rapid rises in CPR in recent years. Injectable contraception accounts for more than half of overall family planning use in Rwanda and Malawi and almost three quarters of use in Ethiopia. Increase in injectable use has largely fueled the dramatic increases in family planning use in each country. Sterilization has also played a major role in Malawi, where 10% of all married women of reproductive age use female sterilization. By contrast, female sterilization comprises 1.8% of method use in Ethiopia and 1.6% in Rwanda. Also, in all three countries, traditional method use is a relatively small share—that is, most people using family planning are accessing modern methods.

Five common themes emerge within the success stories of all three countries:

- Political commitment beyond the health sector
- Notable champion(s) and partner collaboration
- Community provision of services and scale-up vision
- Community engagement
- Establishment of effective strategies and systems

## Political Commitment beyond the Health Sector

Broad support for family planning has been essential for successful change in these three countries. In 2000, both Ethiopia and Rwanda were recovering from major disruptions, the Eritrean war, prolonged drought, and food shortages in Ethiopia, and the genocide in Rwanda. Both had strong leaders determined to improve their citizens' health and their country's international reputation. The importance of family planning on economic development had been emphasized by USAID, UNFPA, and the World Bank. Family planning also fit into national priorities on gender, women empowerment, rural development, and improved education.

The Ethiopian, Malawian, and Rwandan programs that have increased access to family planning dovetail nicely with the general government decentralization and focus on rural development with program managers and local government authorities held responsible at the local and regional levels. The HEW program in Ethiopia, the community-based health package in Malawi, and the national CHW system in Rwanda are integrated directly into the formal health care system, which facilitates referrals, reporting, and linkages. And, this health care system is a central aspect of the broader political commitment to economic development in general.

## Notable Champion(s) and Partner Collaboration

Within this broader political commitment, notable champions emerged at every level of government, from the President to Ministers of Health to members of Parliament. The Rwanda and Ethiopian Heads of State recruited strong leaders to be the Minister of Health, people who could work closely with other key ministries such as finance and education and who could develop innovative new health delivery systems. Malawi has multiple Ministries working on public health, family planning, and economic development and population initiatives. In all three countries, program managers at national, district, and community levels also emerged for various reasons, ranging from a culture of support for family planning to key leaders at various levels to performance based contracting.

Another key factor in all three countries has been the development of a strong, collaborative FPTWG, led by the MOH but functioning as a collaborative forum for health and development partners. This collaboration contributed substantially to successes in all of the countries.

## Community Provision of Services and Scale-up Vision

The most dramatic contribution of community provision of services with a vision of scale up occurred in Ethiopia, where the family planning program is "packaged" into the Health Extension Worker program (HEW), one of 16 health services provided at the community level. From the beginning, the HEW program was designed as a large scale system, not a pilot program. The emphasis on task-shifting was also a critical element, with some 34,000 HEWs being trained to work in 17,000 new health posts, a massive investment in a country as poor as Ethiopia. These auxiliary health personnel provide injectables and in recent years have begun to insert implants.

The government supports the salaries of the HEW staff from its own treasury and has drawn on other funding sources for in-service training and logistics system improvements, such as HIV/AIDS, malaria, and nutrition. The Federal MOH ensures that development partners are coordinated in financing and supporting the HEW program.

In Rwanda, a similar vision of scale up has driven the plan for providing injectables and other methods by some 30,000 CHWs in villages nationwide, and to expand access to vasectomy, postpartum IUDs, and other methods beyond major hospitals. In Malawi, the MOH is training and supporting health surveillance assistants to provide family planning information and services, including injectables, nationwide, although sufficient funding remains a challenge. Clinical officers provide female sterilization in the public and private sectors, creating greater access and use.

All three countries have developed systems that promote a referral process through CHWs for long-acting and permanent methods. Operationally, this remains challenging in many ways, however. Obstacles include ready access to clinics, sufficient numbers of trained providers in these clinics, and client awareness and demand for long-acting and permanent methods. Affordable and sustainable mobile outreach services provide another common theme in these countries, with the BLM/MSI services in Malawi providing perhaps the best example of a high-functioning public-private partnership for mobile outreach services.

## Community Engagement

Rwanda in particular has developed a number of approaches that have engaged the community in supporting family planning. Monthly workdays incorporate family planning as a required topic for discussion by officials. Leaders promote the idea of smaller families as a positive national norm. Radio and other means of community outreach promote family planning. And, all countries emphasize in the trainings of CHWs and village leaders ways to address myths about family planning. Various community-based campaigns such as maternal and child mortality reduction days support and educate the community on the values of family planning.

## Effective Strategies, Systems Established

Political will, champions, partner collaboration, community engagement, and ownership by stakeholders all require systems. These three countries have been leaders in developing new innovative systems and strengthening existing systems.

Strong logistics for contraceptive security has greatly reduced stock-outs in Ethiopia and Rwanda (but not Malawi). All three countries have substantial decentralization, with national leadership also needed to support and guide the family planning systems. Expanded services for maternal and child health have also brought more women into contact with family planning systems, through postpartum, child immunization, and other services. Public-private partnerships, including mobile services and social marketing, have contributed substantially in these countries, especially in Malawi. And, performance-based contracts for program managers and government staff in Rwanda contribute to accountability and a norm of good practice. Affordable health insurance at the community level in Rwanda results in families having greater access to health services including information on family planning (family planning services are free).

## Future Considerations

All of these countries face continuing challenges to increase CPR, reduce unmet need, and expand access to services and method choice. They also must address sustainable financing of ambitious systems, continuing support for task-shifting, and the population growth bulge of young people. At the same time, the lessons learned from the progress in these three countries can provide a roadmap of sorts for other countries.

While every country has distinct cultural, geo-political, and historical contexts, all of those working in the population field can learn something from these three countries. In the end, political commitment, champions, partner collaboration, innovative human resource strategies, community provision of services with a scale-up vision, community engagement, and effective strategies and systems are essential. These are a valuable check-list of key themes and approaches for success.

At the same time, challenges remain, including sustaining the political commitment and community engagement to support the long-term value of family planning at the individual and national levels. The innovative services need to be institutionalized at all levels. The rapidly increasing demand for family planning due to the demographic bulge among youth poses important challenges and will likely force choices about priorities of services and systems. Expanding access to a wider method choice, especially at the community level, can ensure quality and choice to meet RH intentions. Finally, countries need

realistic affordable and sustainable financing strategies, working with their own finance ministries as well as with donors.

Millennium Development Goal 5B calls for universal access to reproductive health, including family planning. These three countries are moving more rapidly toward this goal than any others in sub-Saharan Africa. The lessons offered in this paper, hopefully, can offer ideas and trigger new commitments throughout Africa to go further towards meeting MDG 5B, and with it, contribute to all of the MDGs, as only family planning can do.

# Bibliography

Listed below are selected country-specific resources that the teams used in preparing the respective case studies. In addition, all teams used extensively the Demographic and Health Surveys, especially the most recent report, and a wide array of national documents that are not easily available electronically including policies, strategies, and planning documents.

## Ethiopia

Bizuneh G, Shiferaw S, and Melkamu Y. Unmet Need and Evaluation of Programme Options to Meet Unmet Need for Contraception in Ethiopia, 2000-2005: Further Analysis of the 2000 and 2005 Ethiopia Demographic and Health Surveys. Calverton, Maryland: Macro International Inc., 2008.

Gwathin, DR, Rutstein S, Johnson K, Suliman E, Wagstaff A, and Amouzou A. Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries. Washington DC: World Bank, 2007.

Mekonnen Y, Bradley S, Malkin M, and Hardee K. Country Analysis of Family Planning and HIV/AIDS: Ethiopia. Washington, DC: The Policy Project, 2004.

Moore Z, Govindasamy P, DaVanzo J, Bizuneh G, and Themme A. Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005. Calverton, Maryland: Macro International Inc., 2008.

Yoder PS and Amare Y. Integrated Family Planning and VCT Services in Ethiopia: Experiences of Health Care Providers. Qualitative Research Studies No. 14. Calverton, Maryland: Macro International Inc., 2008.

### Malawi

Jacobstein R, Bakamjian L, Pile JM, and Wickstrom J. Fragile, Threatened, and Still Urgently Needed: Family Planning Programs in Sub-Saharan Africa. *Studies in Family Planning 2009*;40:147–54.

Edwards, L. Banja La Mtsogolo Concept Paper. Increasing Access to Long-Term and Permanent Family Planning Methods in Underserved Communities. Project Timeframe: 1 November 2010 – 31 July 2012. Unpublished Paper, Banja La Mtsogolo, 2010.

Nyirongo M, Akhter H, Management Sciences for Health. Malawi: A Scale-up Case Study for Community-Based Access to Injectable Contraceptives. Presentation, International Conference on Family Planning, 2011, Dakar, Senegal, Abstract 2010.

Republic of Malawi National Sexual and Reproductive Health and Rights (SRHR) Policy. Ministry of Health. August 2009.

### Rwanda

Community Health Desk, Department of Maternal and Child Health, Ministry of Health. Introducing Community-Based Provision of Family Planning Services in Rwanda: A Process Evaluation of the First Six Months of Implementation. Kigali, Rwanda: Ministry of Health, 2012.

Emmart P, Humuza J. Community-Based Distribution of Injectable Contraceptives in Rwanda: An Intervention to Reverse Rural Disadvantage. Washington, DC: Futures Group, Health Policy Initiative Task Order 1, 2010.

Ministry of Health. Rapid Assessment of Adolescent Sexual Reproductive Health Programs, Services, and Policy Issues in Rwanda. Kigali, Rwanda: Ministry of Health, 2012.

Solo J. Family Planning in Rwanda: How a Taboo Topic Became Priority Number One. Chapel Hill, NC: IntraHealth International, 2008.