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# FAMILY PLANNING POLICY

GOVERNMENT OF RWANDA
MINISTRY OF HEALTH
MATERNAL AND CHILD HEALTH

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# FOREWORD

In the last five years, Rwanda has witnessed unprecedented improvement in many health outcomes, including those related to family planning (FP). This was largely a result of the government's commitment to achieving both national and international objectives. The Ministry of Health (MoH) is continuing to pioneer major health system reforms. In collaboration with development partners, the MoH has invested in innovative interventions within an increasingly decentralized health care delivery system. The international scientific and medical community recognizes that excellent improvements have been achieved in Rwanda in infant and child survival, maternal health, and HIV, TB, and malaria outcomes. Contributing to this are Rwanda's community health insurance scheme known as "*mutuelles de santé*," infrastructural developments, and FP-related outcomes such as improved modern FP uptake. The number of trained medical personnel has steadily risen, and their motivation and retention within the health care system has been addressed through unique interventions such as performance-based financing.

The MoH continues to move forward on the above priorities, among others, and is strengthening its strategic partnerships to promote relevant and sustainable interventions for the health of all Rwandans. To this end, the MoH continues to consider FP as a top priority and as one of the strategies contributing significantly to the nation's socioeconomic development.

In developing this new policy, the MoH is renewing its commitment to the importance of FP in Rwanda, providing a foundation for strategic direction on addressing FP-related challenges. The MoH remains cognizant of the complexity of many FP challenges that still need to be addressed and has articulated these challenges in this policy. Building upon the lessons of past experiences, the policy considers these challenges when formulating concerted efforts to address the population's FP needs. The policy takes a pragmatic approach, acknowledging the genuine challenges to be confronted in the years ahead. It does not consider FP in isolation; rather, it places family planning in the wider context of other national commitments and goals, including Vision 2020, the Economic Development and Poverty Reduction Strategy (EDPRS), and international plans of development such as the Millennium Development Goals, the New Partnership For African Development, the International Conference on Population and Development, the Convention on the Rights of the Child, and the Africa Health Strategy.

This policy will serve as a cornerstone from which to address the accessibility of FP services and to encourage its integration with services for HIV/AIDS, maternal health, child health, and other development initiatives. This policy is timely, as Rwanda is embarking on the introduction of community-based provision of FP through community health workers. In addition, the expansion of adolescent sexual and reproductive health programs is a pillar of this policy that will help attract and retain the next generation of FP users. These efforts are anticipated to trigger a paradigm change in the way FP services are provided and accessed in order to contribute towards a healthy and productive Rwanda for all.

Since the MoH is resolute in taking on this issue using evidence-based approaches while providing room for innovation, positive results are anticipated. The MoH will continue to reinforce coordination efforts for the alignment of implementation efforts, thus promoting greater efficiency and effectiveness of the FP program.

MINISTERE DE LA SANTE

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# LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| BCC | Behavioral Change Communication |
| BSHG | Budget Support Harmonization Group |
| CBO | Community-Based Organization |
| CHW | Community Health Worker |
| CPR | Contraceptive Prevalence Rate |
| DPCG | Development Partners Coordination Group |
| DPM | Development Partners Meeting |
| DPR | Development Partners Retreat |
| EDPRS | Economic Development and Poverty Reduction Strategy |
| FBO | Faith-Based Organization |
| FP | Family Planning |
| FPTWG | Family Planning Technical Working Group |
| GoR | Government of Rwanda |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HSSP | Health Sector Strategic Plan |
| HSWG | Health Sector Working Group |
| IEC | Information, Education and Communication |
| IUCD | Intrauterine Contraceptive Device |
| IUD | Intrauterine Device |
| LAPM | Long-acting and Permanent Method |
| MCH | Maternal and Child Health |
| MDG | Millennium Development Goal |
| MIGEPROF | Ministry of Gender and Family Promotion |
| MIJESPOC | Ministry of Youth, Sports and Culture |
| MINALOC | Ministry of Local Government |
| MINECOFIN | Ministry of Finance and Economic Planning |
| MINEDUC | Ministry of Education |
| MoH | Ministry of Health |
| MOU | Memorandum of Understanding |
| MPDD | Medical Procurement and Distribution Division |
| NEPAD | New Partnership for African Development |
| NGO | Non-Governmental Organization |
| PBF | Performance-Based Financing |
| PRSP | Poverty Reduction Strategy Papers |
| PSF | Private Sector Federation |
| RDHS | Rwanda Demographic Health Survey |
| RH | Reproductive Health |
| RIDHS | Rwanda Interim Demographic Health Survey |
| SRH | Sexual Reproductive Health |

| | |
|---|---|
| SRHR | Sexual Reproductive Health and Rights |
| TB | Tuberculosis |
| TFR | Total Fertility Rate |
| TWG | Technical Working Group |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

# 1.0 INTRODUCTION

The Government of Rwanda (GoR) is committed to working to achieve the United Nations Millennium Development Goals (MDGs) and other international commitments. The country has been credited internationally for being poised to achieve many of the MDGs by the year 2015. This policy aims to ensure the maximum contribution of family planning (FP) to Rwanda's achievement of MDGs and overall development.

Over the past decade, Rwanda's FP program has achieved tremendous results, spearheaded by the government's commitment to addressing the country's very high population density (the highest in all of Africa)— that is seen as one of its biggest challenges to sustainable development. The commitment of the country's Ministry of Health (MoH) to implement a successful FP program is reinforced further by a strong understanding that modern contraception contributes to multiple MDGs in important ways.

Rwanda like many other African countries faces rapid population growth with diminishing natural resources. This increasing population is in need of health, education, economic and other services, which, in turn, requires additional resources, personnel and infrastructure to improve its welfare. Accordingly, development efforts in support of the MDGs should not overlook the importance and benefits of slowing population growth. In the same analysis, the Health Policy Initiative concludes that meeting the need for FP not only allows families to space and limit their births when desired; but it can also reduce the costs of meeting multiple MDGs; namely:

- MDG 1: eradication of extreme poverty and hunger;
- MDG 2: achieve universal primary education;
- MDG 3: promote gender equality and empower women;
- MDG 4: reduce child mortality;
- MDG 5: improve maternal health;
- MDG 6: combat HIV/AIDS, malaria and other diseases; and
- MDG 7: ensure environmental sustainability.

Clearly, a successful FP program cuts across sectors and as such contributes to the achievement of multiple MDGs. Thus, the collaboration of multiple sectors is required if this contribution is to be fully realized. The Government's efforts to create mutually beneficial partnerships at the local, national and global levels aimed at moving Rwanda forward on the path to a brighter future highlights a deep-rooted recognition of the equal importance of MDG 8—a global partnership for development.

# 2.0 CONTEXT

## 2.1 Health Sector Analysis

Much progress has been made in Rwanda's health indicators over the past decade, especially in the last six years. The infant mortality rate decreased from 86 per 1,000 live births in 2004 to 50 per 1,000 live births in 2010 and the under-five mortality rate declined from 152 to 76 per 1,000 live births over the same period (Rwanda Demographic Health Survey [RDHS]; 2010). The 2010 RDHS shows a significant reduction in the maternal mortality ratio from 750 per 100,000 live births in 2005 to 476 per 100,000 live births in 2010. If the pace of this decline continues, Rwanda is likely to meet the MDGs related to child and maternal mortality by 2015.

Table 1: Key Rwandan Health Indicators

**Population and Medical Personnel**

- Total population: 10,537,222 (2012 Census)
- Per Capita Utilization of Health Facilities: 0.79 visits per capita (HMIS, 2012) – DHS 2010 reports 1.8 women, 1.5 men.
- Doctors: 1/17,149 inhabitants (Annual Report of the Ministry of Health 2012)
- Nurses: 1/1,296 inhabitants ( Annual Report of the Ministry of Health 2012)

| Key Health Indicators | RDHS 2005 | RDHS 2010 |
|---|---|---|
| Neonatal Mortality (per 1,000 live births) | 37 | 27 |
| Infant Mortality (per 1,000 live births) | 86 | 50 |
| Under 5 Mortality (per 1,000 live births) | 152 | 76 |
| Proportion of stunted children | 51 | 44 |
| Proportion of wasted children | 5 | 3 |
| Proportion of underweight children | 18 | 11 |
| Maternal Mortality (per 100,000 live births) | 750 | 487 |
| Modern Contraceptive Prevalence Rate (CPR) | 10% | 45% |
| Total Fertility Rate | 6.1 | 4.6 |

**HIV and AIDS and Other Epidemics**

- HIV Prevalence: 3% (DHS, 2010)
- TB case detection rate 27% (TRACPlus/WHO 2009)
- Malaria prevalence in children <5: 1.4% (RDHS, 2010)
- Children under five sleeping under LLIN: 70% (RDHS, 2010)

**Rate of Enrolment in Community Based Health Insurance (Rwanda health statists Booklet, 2011 )**

=
2012=96%

Considerable progress has been registered in combating AIDS and malaria: the HIV prevalence, one of the lowest in sub-Saharan Africa, has remained constant, at 3%, between 2005 and 2010. Because so many people have access to antiretroviral therapy, this low prevalence is seen as an indication that there are few new infections. Further, there has been remarkable progress in the decline of malaria prevalence in Rwanda, which has decreased by half since 2007–08; from 2.6% to 1.4% among children age 6–59 months and from 1.4% to 0.7% among women age 15–49 (DHS 2010). However, these two diseases still place a significant burden on the health system, and in 2008 they, along with HIV and AIDS-related opportunistic infections, accounted for 35% of hospital mortality cases (Rwanda Interim Demographic Health Survey [RIDHS]; 2007/2008).

Geographical access to health services has improved with the construction and rehabilitation of new district hospitals and health centers, but approximately 23% of patients still have to walk for more than one hour or more than 5 kilometers to reach the nearest health facility (Health Management Information System [HMIS]; 2009).

On average, 96% of the population was covered by Community based Insurance in 2012 (HMIS). In addition to mutuelles there are other insurers that include "La Rwandaise d'Assurance Maladie" (RAMA), Military Medical Insurance (MMI) and private insurance, which are commonly reported by households in urban areas, in the city of Kigali and salaried employees in the formal employment sector. The *mutuelles* insurance covers primary care delivered at the health center level; secondary care delivered at the district level via district hospitals and by qualified medical doctors; and tertiary care delivered at the national level via a few specialized, national medical institutions.

The percentage of Government budget for health has also increased from 8.2% in 2005 to 9.1% in 2008, and the annual GoR expenditure for health per person has increased from USD 6 (2005) to USD 11 (2008). In the fiscal year 2009-2010, the % of Government budget allocated to Health was: 10.2%. Nevertheless external support is still needed.

Availability of health care professionals has improved: in 2011 there were 625 doctors and 8,513 nurses/midwives working in Rwanda. Based on 2012 data from the Ministry of Health Human Resources Database (iHRIS), this corresponds to a ratio of 1 doctor per 15,428 inhabitants, 1 midwife per 23,364 inhabitants, and 1 nurse per 1,138 inhabitants. The situation has improved since 2010, particularly for midwives, when the ratio was nearly 66,749 inhabitants per midwife (Annual Report Ministry of Health 2012). Nevertheless, there are still shortages of qualified human resources.

Delivered largely within the public sector health system, the FP program—spearheaded by strong government commitment and the support of development partners—has done exceptionally well. In just five years, the modern contraceptive prevalence rate (CPR) more than quadrupled from 10% in 2005 (Rwanda Demographic and Health Survey [RDHS] 2005) to 45% in 2010 (DHS 2010). The total fertility rate decreased from 6.1 per woman in her lifetime in 2005 (RDHS 2005) to 4.6 children per woman in 2010 (RDHS 2010), underscoring the important role of FP in addressing population growth. Nineteen percent of currently married women have an unmet need for FP (an improvement since 2005, when the figure was 38%): 10% have an unmet need for spacing and 9% have an unmet need for limiting. The total demand for FP among currently married women is 72%, and almost three quarters of that demand (74%) is satisfied. The demand for limiting is slightly higher than the demand for spacing (39% and 34%, respectively; RDHS 2010).

Nevertheless, the RDHS identifies significant barriers to contraceptive use. The most significant barrier has been access to health facilities in Rwanda's hilly terrain where population is dispersed. Twenty-six percent of women mentioned distance to the health facility as a problem for FP use (DHS 2010).

The Community-Based Provision of FP, a recent initiative in Rwanda, was developed in part to address the access issue by mobilizing the country's 45,000 village-based community health workers (CHWs) to:

- increase the use of modern contraceptive methods;

- follow evidence-based practices that support effective contraceptive supply;
- stimulate demand; and
- create a supportive environment.

Over the coming years, the government is committed to implementing this program in all the districts.

Community-Based Provision of FP reflects a fundamental shift in the philosophy of Rwanda's FP programs. The program recently leveraged the existing network of Community Health Workers (CHWs) providing services at the community level. In extensive consultation with its partners, the MoH outlined the program's defining elements on how it will be implemented, including:

- Training. CHWs should gain the required knowledge, skills and attitudes to advocate for and provide high-quality injectable contraceptive services at the community level.
- Integration of injectable FP into the current community-based provision (CBP) package. Injectable contraceptives should be integrated into the current essential CBP package at the community level. Integration not only enhances the sharing of existing infrastructure or facilities and personnel, but also maximizes the management of service delivery, simplifies logistics and harnesses meager resources.
- Service delivery. The implementation program should encourage the use of and ensure availability of injectable contraceptives in the community.
- Monitoring and supervision. Monitoring and supervision of injectable contraceptive services should be strengthened within the existing systems.
- Quality assurance. Through training institutions and professional bodies, injectable contraceptive services should be integrated into quality assurance programs. The performance of CHWs should be promoted and professionalism should be encouraged by the MoH, with the help of professional bodies.
- Logistics management. The MoH and its supporting partners in logistics supply systems should institute a well-run logistics system to ensure supplies are in good condition and delivered in a timely manner. The system should control costs by eliminating overstock, spoilage and proper waste disposal.
- Performance-based financing. The increase in the use of FP services was linked with the supply-side incentives—a strategy that has worked in recent years. It is important that as a CHW's workload increases, he/she is compensated for this time. The majority of stakeholders support compensating CHWs through newly created cooperatives at health centers; the MoH strongly supports this strategy.

This program shall constitute a major innovation if successfully implemented and, therefore, shall be documented. Successes of Rwanda's FP Program shall serve as an important experience regionally and globally. The current remarkable successes already reached in FP set a high bar for achievement elsewhere.

## 2.2 Policy Analysis

The FP Policy and its Five-Year Strategy (2012–2016) build on other important policy documents. It is notable that all of these policy documents contain important references to FP. These include:

### 2.2.1 Vision 2020

Rwanda's leading planning framework is Vision 2020, which is used to guide overall development in Rwanda. Vision 2020 set three goals for Rwanda: 1. Become a middle-income country having halved the percentage of people living in poverty; 2. Raise life expectancy to 66 years; and 3. Reduce its aid dependency level.

"The general objective of Vision 2020 is to build a modern and prosperous nation, strong and united, worthy and proud of its fundamental values; politically stable, without discrimination among its sons and daughters"; and achieving these objectives in social cohesion and equity.

Vision 2020 places emphasis on the harmonization of population growth with the country's economic development and reduction of the main causes of mortality—specifically aiming to reduce the total fertility rate (TFR), decrease infant and maternal mortality, and ultimately reducing population growth. Vision 2020 singles out FP as crucial for reducing birth rates and the prevalence of HIV and AIDS if double protection is used as recommended.

### 2.2.2 Economic Development and Poverty Reduction Strategy 2008–2012

The 2008–2012 Economic Development and Poverty Reduction Strategy (EDPRS) highlights FP as a key intervention, while identifying high population growth as a major challenge. To address this challenge, the EDPRS set its priorities as: strengthening reproductive health (RH) services and FP; ensuring free access to information, education and contraceptive services; and articulating the existing association between poverty and population density.

### 2.2.3 National Population Policy for Sustainable Development 2003

The National Population Policy for Sustainable Development 2003 was produced after revising an earlier 1990 population policy. It takes into account Rwanda's adoption of resolutions of the 1994 International Conference on Population and Development in Cairo. The Policy presents a multi-sectoral approach to improving the population's quality of life.

In addition to reducing the population growth rate, this policy also focuses on economic growth, food security, health, education, human resource development, rational management of the environment and good governance. It presents a number of quantitative targets consistent with those presented in Vision 2020 and the Poverty Reduction Strategy Papers (PRSP).

### 2.2.4 National Health Policy 2004

The National Health Policy outlines the roles of the central government, provincial and district structures and emphasizes the norms established in 1998 for the minimum package of activities, which includes FP, and the complementary package of activities to be provided at the hospital and health center levels. This policy describes the role of FP as contributing positively to the health status of the family. It also highlights the concept of partnerships as a key means of achieving integration, including inter-sectoral integration (of services).

The National Health Policy calls for greater health sector financing and urges initiatives to strengthen solidarity, such as community based health insurance, prepaid health insurance and other health insurances. It establishes the principles of cost recovery and fee for service, while ensuring the establishment of financing methods for those unable to pay.

### 2.2.5 National Reproductive Health Policy 2003

The National Reproductive Health Policy identifies FP as a key priority area and set a rather modest target of achieving 15% modern CPR among women of childbearing age by 2010, up from 4% at that time. The policy outlines key strategies to achieve the set target including:

- improving awareness of FP and access to FP services for women, men and youth using social communication and mobilization programs;
- integrating FP in Safe Motherhood and Child Health services;
- strengthening men's participation through community-based structures, organizations and network
- improving FP service providers' skills utilizing recommended eligibility criteria for contraceptive prescription from the World Health Organization (WHO);
- increasing availability and revival of FP services in all health facilities (public and private);
- establishing a system to monitor FP activities in all health centers at all levels (community, district, province, national); and
- involving political and administrative authorities and community leaders in FP mobilization.

To further these strategies, the national RH policy highlights priority interventions needed to achieve the stated target as the following: designing and disseminating appropriate FP messages for mass media (radio, TV, newspapers, etc.), and information, education and communication (IEC)/FP tools (posters, flyers, flipcharts, etc.); raising FP awareness among men during political and administrative meetings; involving community-based associations and organizations of women and youth in FP awareness-raising activities; integrating FP in training curricula at primary, secondary and higher education levels, with the collaboration of the Ministry of Education; training and conducting refresher training of health providers in contraceptive methods and communication/counselling techniques; strengthening logistics for contraceptives and related materials; developing postnatal care, including FP; and strengthening men's participation in FP programs.

### 2.2.6 Strategic Plan to Accelerate Progress towards Reducing Maternal and Neonatal Morbidity and Mortality, 2009–2012

FP is also linked with the Strategic Plan to Accelerate Progress towards Reducing Maternal and Neonatal Morbidity and Mortality, which acknowledges the impressive increase in the use of modern contraceptives in 2008 (27%) compared to 2005 (6.2%). The plan recognizes the achievements of the FP program but also points to areas of improvement at the institutional, organizational and community levels.

At the institutional and organizational levels, the plan highlights key areas as: coordination; sustainable RH funding; capacity of human resources to provide services; access of adolescents to sexual and reproductive health (SRH) services, including FP education; expansion of FP access; and RH services integration. Other areas included: ensuring confidential provision of RH, strengthening partnerships, setting up an effective distribution system and generating scientific evidence about the existing systems.

At the community level, the plan identifies:

- resistance from certain religious groups,
- cultural beliefs,

- limited male involvement,
- fear of side effects,
- misconceptions and lack of youth friendly services as some of the most important barriers.

In light of these barriers, the plan places FP among its top two priorities with a recommendation to reposition FP as an essential strategy in order to achieve the MDGs.

### 2.2.7 Health Sector Strategic Plan July 2012–June 2018

The Health Sector Strategic Plan 20012–2018 (HSSP III) builds on the achievements of HSSP II, which was phased out in 2012. While recognizing gains made under HSSP-II in such areas as financial and geographical access to health services, infant and child health, malaria mortality, HIV prevention and treatment efforts, the HSSP-III acknowledges remaining challenges.
In August 2011, a mid-term external review of HSSP II was completed. Apart from assessing the progress that the MoH had made toward the targets set in 2009, results of this review shall inform development of HSSP III. The review, among others, assessed the FP program progress and made four key recommendations, which are given due consideration in this policy, including:

- Expanding the adolescent RH program nationwide
- Scaling up community-based FP
- Expanding distribution of condoms in the public and private sectors
- Deepening collaboration with the private sector

An extensive situational analysis conducted in the second half of 2011 together with a comprehensive Mid Term Review provided the necessary information on Rwanda's burden of disease and its epidemiological profile to decide on the five overall priorities of HSSP III. The first priority is to Achieve MDGs 1 (nutrition), 4 (child health), 5 (MCH) and 6 (Disease control) by 2015. FP is an important component that enables the achievement of MDG 5.

Total Fertility Rate (TFR) in Rwanda has been consistently reduced over the past ten years and currently stands at 4.6% children per woman. There are regional variations with urban-rural disparities, where rural women have higher fertility rates than urban women.
The use of modern contraceptive methods among married women at the national level has increased from 4 percent in 2000, to 10.3 percent in 2005, to 27.4 percent in 2007. In 2010 the coverage is 45 percent. A dramatic increase in the use of modern contraceptives has been observed between 2005 and 2010, in both urban and rural areas; all provinces have experienced significant increase in the two-year period.

The external family planning assessment (June 2011) reported strong political support for FP and the country's aims to achieve a Contraceptive Prevalence Rate (CPR) of 70% by the end of 2015 and 90% by 2017. The report recommended: (i) increase availability and (ii) improve quality of FP services at all health facilities and communities and to (iii) strengthen decentralized management of services as well as to (iv) increase the budgetary allocation towards contraceptives.

It is clear that significant program challenges remain. Over the next five years, the FP program must devise innovative strategic and operational approaches in order to overcome those challenges.

HSSPII outlines the key FP objectives as:

- To improve family planning within the maternal and child health subsector
- Increase availability and use of FP services (by choice) in public and private sectors
- Increase knowledge, acceptability and use of the full range of FP methods in the community
- Sustainable FP programming and funding mechanisms developed
- Promote and use operation research from national / international FP programs

### 2.2.8 The Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Policy and Its Strategic Plan September 2011

A lack of youth friendly facilities, including characteristics related to the provider, health facility and program design, represents a major obstacle hindering young people from accessing SRH services. The ASRH&R Policy and its Strategic Plan emphasizes the importance of providing information, counseling and access to FP methods to adolescents, as well as availing necessary information and creating referral systems with other health facilities and the community to increase follow-up of adolescent clients.

## 2.3 Family Planning Program Analysis

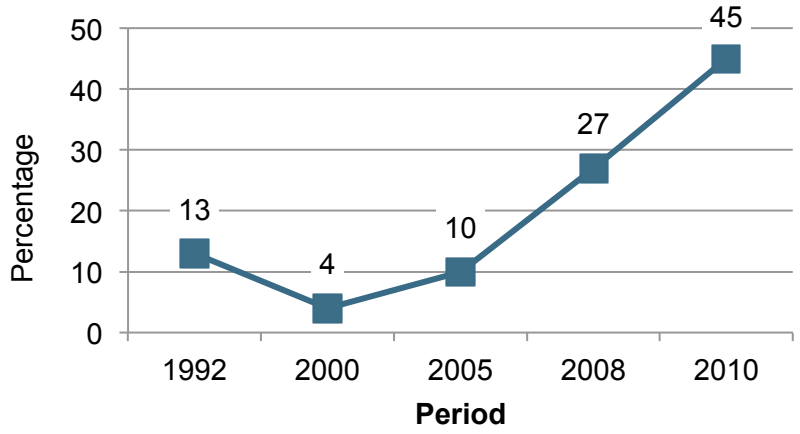
### 2.3.1 Performance

The development of this most current policy was informed by documents with the most recent, accurate and analytical examination of the state of FP in Rwanda. These include the RDHS 2010, plus the results of the Assessment of Rwanda's National FP Policy and its Five-Year Strategies (2005–2010), completed in June 2011. Selected findings from these documents are discussed below.

#### *2.3.1.1 Modern Contraceptive Use*

Rwanda has made dramatic gains in the use of modern contraception. As the results from the RDHS 2010 indicate, use of modern contraceptive methods among married women has increased from a base of just 4% in 2000 to 45% in 2010 (Figure 1).

Figure 1: Changes in Modern Method CPR among Married Women in Rwanda, DHS 1992–2010



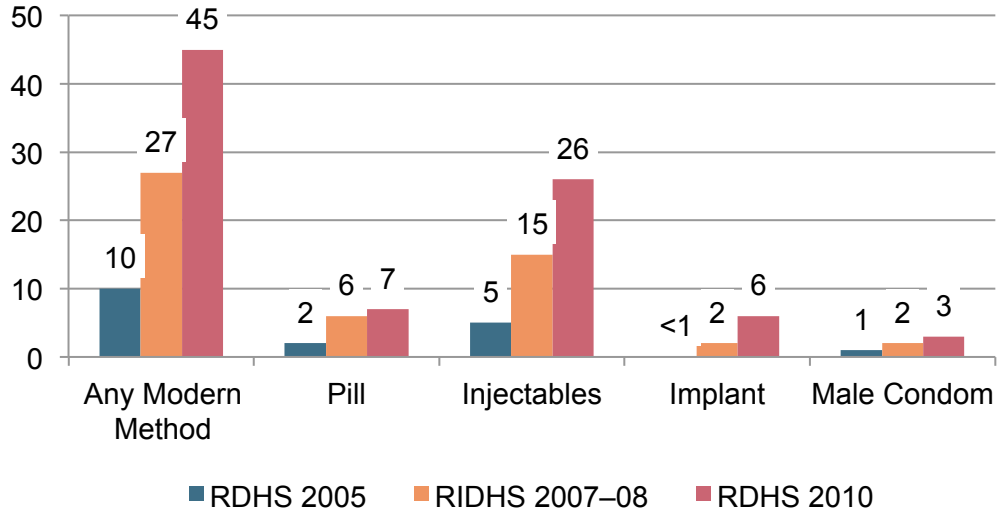

Source: DHSs 1992, 2000, 2005, 2008, 2010

The government, supported by its partners, has focused on FP and made significant investments, which explains the unprecedented tenfold increase in modern FP utilization in the past decade.

### *2.3.1.2 Method Mix*

The RDHS 2010 report also shows that the most commonly used modern methods are injectables (26%), followed by pills (7%) and implants (6%) (Figure 2). An additional 6% of women report using traditional methods.

Figure 2: Modern Contraceptive Mix




Source: RDHS 2010

It is noteworthy that the method mix is dominated by short-acting methods, particularly injectables (26%), but the contribution of pills (7%) and condoms (3%) is also significant. The only long-acting method that contributed significantly was implants, (6%) with female

sterilization and intrauterine devices (IUDs) at less than 1%, tubal ligation at 0.8%. These data indicate that male participation is mainly through the use of condoms. The MoH has been promoting vasectomy as an option for men, and demand for the procedure is increasing.

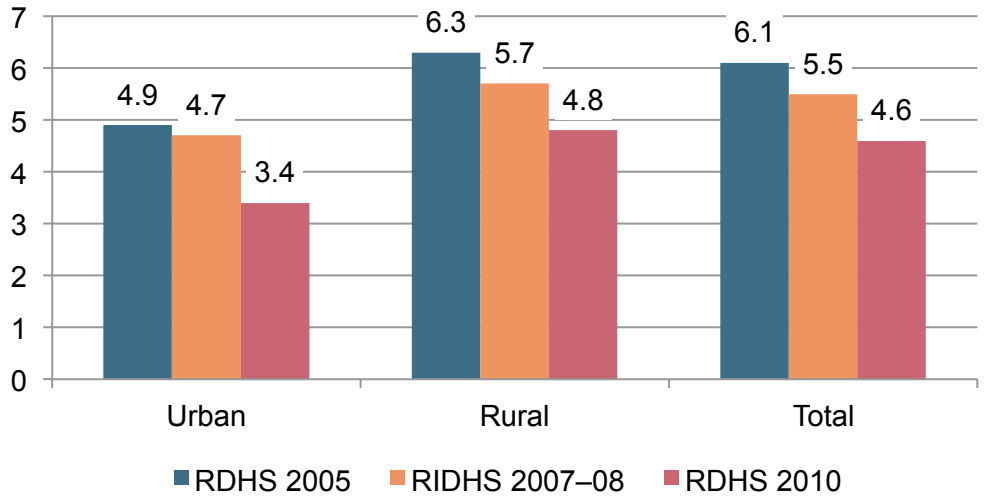
While impressive gains by method are reflected over time, the current method mix does not appear to address women's wide range of fertility preferences. The dependence on short-acting methods, in a setting where the demand is high and unmet need significant, calls for further examination. The RDHS 2010 shows that unmet need for FP is 19%, and is equally split between the need for spacing (10%) and the need for limiting the number of children (9%). For women who want to limit their number of children, long-acting and permanent methods are probably most appropriate. Over-reliance on short-acting methods generally presents higher rates of discontinuation, which potentially results in more unintended pregnancies.

Yet it is clear that Rwandan women are successfully using short-acting methods. This is reflected in the TFR, which decreased overall by 1.5 children per woman. Notably, there were almost equal reductions in urban and rural population (see Figure 3). In addition, CPR is virtually identical in urban (47%) and rural (45%) areas. This is an indication that services are proportionally reaching rural populations.

### *2.3.1.3 Fertility Rates*

Rwanda's efforts to promote FP in order to address its rapidly growing population are clearly having tangible results, reflected in the TFR, which has steadily declined over the years.

Figure 3: Total Fertility Rate of Women; Age 15–49




Source: DHS 2010

#### *2.3.1.3.1 Fertility Trends among Adolescents*

Data from Rwanda's MoH indicate that adolescents and young adults comprise the majority of Rwanda's population. For instance, young adolescents (10–14 years) make up about 17.1%, older adolescents (15–19 years) about 12.4% and young adults 10.7% of the total population,

while another third of the population (32.1%) is under 10 years old (Report on adolescents' health and HIV services in Rwanda, in the context of their human rights; Dr. Binagwaho Agnes: 2009).

Though adolescents (15–19) contribute a smaller proportion to the TFR, adolescent reproductive health services must be given greater attention because of their demographic size and low contraceptive use among those who are married.

Although age-specific fertility rates for three years preceding the survey demonstrate a downward trend, it is notable that the decline in fertility among young adults has been slower (211 children per 1,000 young adults) compared to adolescents (15–19) during the last 15 years (40 children per 1,000 adolescents). This could possibly be because the age of young adults represents a period of marriage and procreation (Report on adolescents' health and HIV services in Rwanda, in the context of their human rights; Dr. Binagwaho Agnes: 2009). Nonetheless, this trend holds enormous promise, especially because it has consistently been decreasing among adolescents and young adults since 1992 as shown in Table 2 below.

Table 2: Trend in Adolescent and Young Adult Fertility

| Age Group | DHS 1992 | DHS 2000 | DHS 2005 | IDHS 2007/2008 | DHS 2010 |
|---|---|---|---|---|---|
| 15–19 | 60 | 52 | 42 | 40 | 41 |
| 20–24 | 227 | 240 | 235 | 211 | 189 |

*Age-specific fertility rates are per 1,000 women (one to 36 months prior to interview).*

Despite the overall decline, Rwanda's TFR remains one of the highest in sub-Saharan Africa and puts immense pressure on the country's already scarce resources. Together, the high fertility rate and population density contribute to development and economic constraints, and depletion of natural resources.

### *2.3.1.4 Birth Spacing*

The 2010 RDHS presents additional information of note regarding postpartum FP, birth spacing and, more importantly, pregnancy desires. Approximately 19% of married Rwandan women of reproductive age have an unmet need for FP. This represents almost equal percentages of unmet need for spacing (9.7%) and unmet need for limiting (9.2%). Despite the notable increases in contraceptive use, according to 2010 RHDS, closely spaced births continue to be fairly common. Of all non-first births, 7.3% were born at an interval of less than 17 months between one birth and another, and 12.6% at an interval of less than 24 months. In these two categories, women became pregnant before 9–14 months postpartum (see Table 3), during the time when women and infants have the maximum amount of contacts with the health system for well-child programs, such as vaccination and growth monitoring.

Table 3: Birth-to-Birth Intervals and Timing of Pregnancy for Births

| Birth-to-Birth Interval | Percentage | Pregnancy Timing |
|---|---|---|
| Less than 17 months | 7.3 | Before 8 months |
| 18–23 months | 12.6 | 9–14 months |
| 24–35 months | 39.2 | 15–26 months |
| 36–47 months | 21.4 | 27–38 months |
| 48–59 months | 9.6 | 39–50 months |
| More than 60 months | 9.9 | After 51 months |
| **Median** | | **Before 23.7 months** |

Overall, about one-half of births in the past five years were conceived well before the recommended interval of 24 months, as reflected by the median pregnancy timing.

### 2.3.2 The 2011 FP Program Assessment (2005–2010)

As part of the FP Policy and Strategy development process, an assessment was carried out to document the status of implementation of the 2006–2010 National FP Policy and Five-Year Strategy. An assessment report was compiled based on findings from interviews, field trips and document reviews conducted by local experts, supported by external technical assistance.
The report noted Rwanda's strong political support for FP and the country's aims to achieve a CPR of 70% by the end of 2012 and 90% by 2017, with a reduction in TFR from 5.5 to 4.5 children as the key driving factors. The report highlighted the increased availability and improved quality of FP services through facilities and communities and strengthening of decentralized management of services, as well as progressive increment of budgetary allocation toward contraceptives. The assessment also noted potential areas of improvement, particularly in reporting, which would improve data quality and thus planning.

In this regard, the assessment found that referral hospitals, faith-based organization (FBO) sites and private sites do not always report their FP service data, which leads to erroneous reporting. Catholic sites usually offer and report only natural methods (for example, the Standard Days Method). At these sites, modern FP methods are usually offered through secondary posts. However, secondary posts cannot report through the "mother health centers." Only when the district supervisor collects these data from the secondary post are they then incorporated in the overall district report. Private sector sites report data to the district hospital, but only if there is a memorandum of understanding (MOU) with the MoH, otherwise, their performance is not recorded. In the same context, supervision from district health teams is done sporadically and there is a lack of standardized supervision guidelines and checklists. It is necessary to harmonize the reporting systems across all organizations providing FP services and ensure accurate reporting from all categories of service providers.

In addition, the assessment provided key observations in the areas of contraceptive supply and demand, and analyzed the prevailing environment for the provision of FP services, while also highlighting potential areas for improvement. These assessment observations are outlined in Table 4.

Table 4: Summary of Findings of the FP Assessment 2011

| Supply | Demand | Supportive Environment |
|---|---|---|
| 1. Use of innovative financing schemes such as performance-based finance (PBF) and *mutuelles* helps to motivate staff and equip service sites, but training, particularly for counseling related to side effects needs to continue.<br>2. Use of secondary health posts, involvement of FBOs, nongovernmental organizations (NGOs) and the private sector is growing in the delivery of FP services, but could be expanded.<br>3. There is an expanding community component, but stronger links with clinics are required to ensure that CHWs are not overburdened and to ensure quality.<br>4. Policies have encouraged expansion of long-acting and permanent FP methods, but availability of these methods is still limited despite their high demand.<br>5. FP services in Rwanda have been integrated with a "minimum" package of services, which incorporates FP into elimination of mother-to-child transmission of HIV (EMTCT), antenatal care, well-baby, immunization and other services, but this can be reinforced. | 1. Current mass media efforts are helping to address myths and misconceptions about FP and these need to be continued and better targeted.<br>2. There is also a need to improve interpersonal communication and FP counseling.<br>3. Special programs for men and youth friendly services are lacking and should be developed.<br>4. There is a need for training of health providers on long-acting methods such as implants and vasectomy<br>5. Reinforcing behavioral change communication (BCC) efforts to address rumors and misconceptions, and increase contraceptive demand needs to be a focus. | 1. There is a need for increased collaboration and coordination with FBOs and the private sector and referral levels of the health system.<br>2. There is also a need for continued support for community-based services through innovative work configurations.<br>3. There is a need to harmonize reporting systems for all FP service outlets including public, religious, health posts and private sector providers by using standardized tools, guidelines and checklists.<br>4. There is a need to widely disseminate national FP service standards and guidelines in facilities and orientation of staff on their use.<br>5. There is a lack of standardized tools for supervision or criteria for quality, and a lack of a regular schedule for supervision. |

**Source**: assessment of Rwanda's national family planning policy and its five –year strategies (2005 – 2010)

### *2.3.2.1 Challenges and Opportunities*

As noted in the conclusions and recommendations of the assessment report, significant program challenges remain. It is worthwhile noting that whereas the performance of the FP Program has been exceptional, the progress was not at the expense of programmatic challenges, some of which still remain. Over the next five years, the FP Program must devise innovative strategic and operational approaches in order to overcome those challenges, some of which are outlined below:

- As demand and use of FP services increase, it will become more and more of a challenge to cover the costs of contraception.
- There are still myths, rumors and misperceptions about FP methods and their side effects, requiring efforts to address them with correct information and FP counseling sessions.
- There still exists a gap in SRH education at different levels, including in families and schools, yet these represent a great window of opportunity for children and adolescents to learn about such issues at an early age.
- There still exist socio-cultural and religious influences that affect FP service demand from the population.
- Lack of decision-making power of women about use of FP and insufficient support, participation and sometimes violence from their male partners.
- Perception of FP as "limitation of births" and therefore only appropriate for married people.
- Impact of the genocide (post-genocide desire to replace those lost).

While facing these challenges, the FP Program is also presented with a number of opportunities. For the program to continue to post impressive results, these opportunities will have to be zealously pursued. In this policy, a list of some existing opportunities are outlined, but new ones must be continuously sought out during implementation and new approaches identified. The following are some of the already existing opportunities:

- Rwandan government leaders are very committed to FP as a national health priority at all levels.
- Dynamic Parliamentarians' Network on Population and Development.
- There is sufficient information on FP use and commodities collected through the routine HMIS and other service outlets, such as health posts. Every effort should be made to make use of these data, especially in decision-making about promising initiatives to ascertain their efficiency and effectiveness.
- Strengthening integration of FP in other services such as HIV, MCH, antenatal care, vaccination and other health services by building on current momentum and enhancing accountability presents a huge opportunity for expanding access.
- Government, in close collaboration with development partners, has continued to ensure adequate funding of FP services by contributing to a basket fund and setting up a common and functional procurement system.
- There are numerous supportive policies in place recognizing the importance of FP as a strategy for the country's socioeconomic development and others supporting efforts to eliminate gender-based violence.
- Communities are fully encouraged and engaged to participate, as is evidenced by the wide network of CHWs who provide a range of services including FP in the current pilot districts.

### 2.3.3 Stakeholder Participation

The FP Technical Working Group (FPTWG) is comprised of Rwandan institutions, development partners and NGOs working together to implement FP activities. These include the United States Agency for International Development (USAID) and NGOs it funds; UN agencies (UNFPA, WHO), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Swiss Development Cooperation (SDC), CARE, Association Rwandaise pour le Bien-Etre Familial (ARBEF), Rwandan Parliamentarians' Network on Population and Development (RPRPD), etc. The

members of the FPTWG were very instrumental throughout the process of the development of the FP policy—from the assessment of the last FP policy and strategy to the development of the current policy and related strategic plan.

# 3.0 POLICY FRAMEWORK

## 3.1 Definition, Target Groups and Minimum Package

### 3.1.1 Definition

The WHO definition of FP is that: "It allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy." This policy adopts the above definition for application throughout the process of implementation.

### 3.1.2 Target Group

The target group for this FP policy is principally women of reproductive age (15–49 years) and men (15–59 years). It additionally notes the need to prevent early pregnancies (among adolescent populations) as well as benefits of FP use among most-at-risk populations, such as sex workers, through contraceptives offering dual protection against pregnancy and HIV.

### 3.1.3 The Minimum Family Planning Service Package

This policy prescribes a range of services to be provided under the FP Program as a minimum package, divided as non-clinical (information) and clinical, and is summarized as follows.

Table 5: Package of Family Planning Services

| Non-Clinical (or Information) Services | Clinical Services |
|---|---|
| 1. Pre-conception advice and fertility awareness information<br>2. Confidential advice about contraception<br>3. Unplanned pregnancy advice<br>4. Postabortion counseling<br>5. Female sterilization counseling<br>6. Vasectomy counseling<br>7. Confidential advice about sexually transmitted infections | 1. Contraceptive pills<br>2. Injections<br>3. Condoms<br>4. Emergency contraception<br>5. Free pregnancy tests<br>6. Fitting and checking of coils (IUCDs); implant insertion or removal<br>7. Lactational Amenorrhea Method<br>8. Standard Days Method<br>9. Permanent methods for male and female sterilization |

## 3.2 Goal and Objectives

This policy's goal is to increase the use of FP by Rwandan women of reproductive age group (15–49 years) and increase their male counterparts' involvement in FP programs. To this end, the policy's general objective is to increase modern contraceptive use among women in union to 70% by 2016, through a programmatic framework supporting sustainable service quality, normative demand and an enabling environment.

## 3.4 Policy Objectives

The policy details the steps and priorities that will ensure timely and effective implementation of the National FP Policy and thus facilitate efforts to meet its goal. The specific objectives of this policy are:

1. Support sustainable FP service delivery systems in both the public and private sectors. (Supply)
2. Increase the correct knowledge, acceptability and use of the full range of FP methods and services in the community. (Demand)
3. Strengthen and sustain a supportive environment for comprehensive FP programs. (Environment)
4. Identify and apply innovations to support effective practices in FP.

This Policy draws inspiration and lessons from the performance of Rwanda's rapidly growing FP program. More importantly, it fully considers the priorities highlighted in the current policy and outlines key strategic interventions across its four objectives to address those priorities. The seven priorities identified by stakeholders include:

1. Ensure sufficient focus and expansion of adolescent sexual and reproductive health (ASRH) programs and ensure that they are provided in a youth-friendly manner;
2. Continue to put in place the fundamentals of CBP and scale it up nationwide;
3. Expand distribution of condoms in the public and private sectors;
4. Deepen collaboration with the private sector to provide FP services;
5. Increase access to long-acting and permanent FP methods;
6. Ensure greater integration of FP services with MCH activities, such as immunization, nutrition, well-baby care, fistula care, postabortion care, postpartum, etc., and promote provider-initiated FP counseling; and
7. Promote greater male participation in FP programs.

## 3.5 Guiding Principles

In pursuit of these policy objectives, the MoH shall adhere to the following values and principles in order to fulfill the above stated mission:

1. This Policy shall reinforce the GoR's commitment to addressing challenges related to population growth as one of its priority areas for ensuring sustainable development.
2. Women and men shall freely decide on the number, spacing and timing of their children and have access to the information and means to exercise these choices.
3. Women and men shall demand and have access to quality FP services not only as a service, but as a fundamental human right.
4. Women and men shall have access to the widest possible range of safe and effective FP methods and participate fully in defining the FP services they need.
5. FP activities shall be non-discriminatory and available to all.
6. The MoH shall actively work toward improving the quality of care in FP and RH programs by (but not limited to):
   - Providing the same range of RH and FP services to all clients;
   - Involving communities in planning programs appropriate to their needs;
   - Increasing the choice of FP methods available;

- Improving the skills and competence of FP service providers;
- Providing accurate information and confidential counseling to clients;
- Providing follow-up advice and services to clients;
- Ensuring affordable, acceptable and accessible services; and
- Making the prevention of unwanted pregnancies and high-risk pregnancies the highest priority, with every attempt being made to minimize unsafe abortions.

## 3.6 Key Interventions

### 3.6.1 Sustainable FP Service Delivery Systems in Public and Private Sectors (Supply)

The first policy objective is to support sustainable FP service delivery systems in both the public and private sectors. In pursuit of the above policy objective, the MoH shall:

- Build capacity of service providers in FP at all levels of the health system (public, community, private and NGOs): The MoH, in collaboration with its partners, shall reinforce the capacity of providers through pre-service and in-service training, mentoring and will replicate new FP approaches.
- Ensure commodity availability at all levels (public, community, private, NGOs): Rwanda's current procurement process of FP products is well-structured and inclusive of all partners involved in the provision of FP services. The MoH and its partners shall: conduct regular quantification and supply chain analysis; establish a system to collect dependable logistics data by deploying appropriate technologies (software); and conduct training of health facility personnel on logistics to ensure uninterrupted supply of FP products. In addition, the MoH shall increase budget allocation to FP and RH services to ensure a stable and equitable long-term financing and management of FP products.
- Ensure a sustainable reporting, monitoring and evaluation system at all levels of FP program: Rwanda HMIS, *District Health Information System,* also known as DHIS II, is currently well-integrated and allows for integrated reporting. The Ministry aims to continue to build its staff capacity to use data for decision making. This policy calls on managers at different levels to use FP data for planning and decision making. In addition, the MoH shall create mechanisms to capture information from the private sector and create linkages at all levels to ensure efficient and effective use of collected data.
- Ensure integration of FP in other services at all levels and that they are provided in a youth friendly manner: As part of a concerted effort to ensure birth control options are available, FP shall be further integrated with a wide range of other health services, including FP counseling and provision integration with HIV services, maternal health services, and community outreach and CBP. To promote the use of FP programs among adolescents, youth friendly conditions will be created within the health facilities. FP services shall be extended to youth friendly centers, in collaboration with the Ministry of Youth and Sports and Culture and with the Ministry of Education, which will promote FP education throughout the education hierarchy.
- Ensure appropriate infrastructure and adequate equipment to address FP: The MoH shall continue to ensure that all services are provided in a proper and dignified environment by ensuring that infrastructure required for providing FP services is set up or renovated and that requisite equipment is procured.

### 3.6.2 Knowledge, Acceptability and Use of FP Methods and Services (Demand)

Myths and misconceptions about FP continue to be a challenge to FP programs in many developing nations. The mistaken belief that contraception causes cancer or infertility, misconceptions about return to fertility after contraceptive use and misunderstanding pregnancy risk,[1] especially in the postpartum period represent some of the most important issues. The second policy objective is to increase the correct knowledge, acceptability and use of the full range of FP methods and services in the community. In pursuit of the above policy objective, the MoH shall:

- Implement interventions aimed at correcting major myths and misconceptions about FP through mass media and interpersonal communication: The MoH will identify strategies to address myths and misconceptions that are barriers to FP uptake and devise effective communicate strategies to correct and address them. The MoH shall also monitor and evaluate the effectiveness of identified strategies.
- Devise strategies that promote positive attitudes among community members about the use of contraception by youth (including adolescents): These include beliefs that contraception is meant for married people and interpreting as promiscuous adolescents and young unmarried adults seeking FP services[2] among others. The MoH will promote a safe and supportive environment for improved adolescent health and FP use among youth through sustained advocacy to cabinet and legislators. In order to ensure informed engagement with these government entities, the Ministry shall gather scientific evidence about the need for specific laws related to sexuality and adolescent RH. Further, the MoH will work to sensitize communities to change their attitudes toward FP use by unmarried young people.
- Increase adolescents' knowledge and promote informed uptake of FP services: The MoH will promote knowledge of FP among young people and adolescents through sustained education programs and youth friendly services and centers to ensure that young people are able to make informed decisions about available FP options and the benefits they present. The MoH will implement strategies aimed at improving adolescents' knowledge of FP, reinforcing parent-child communication and sexuality education (in and out of schools) to ensure that youth at all levels have useful knowledge about FP and sexual reproductive health and rights (SRHR).
- Reinforce CHWs effectiveness in informing and mobilizing the communities: The MoH will leverage the extensive CHW network to ensure that they are sensitized and have necessary FP skills and will provide them with tools to assist in communicating about FP.
- Ensure that men are constructively engaged: The MoH shall identify and address causes and concerns related to the lack of involvement by males in FP (some information exists within Rwanda Men's Resource Centre, which aims for a "peaceful society where women and men share roles and responsibilities of raising families and governing society in equality and respect) and will implement appropriate strategies to promote male involvement in SRH/FP.

### 3.6.3 Supportive Socio-Cultural, Political and Resource Environment (Environment)

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[1] ASSESSMENT OF RWANDA'S NATIONAL FP POLICY AND ITS FIVE-YEAR STRATEGIC PLAN
[2] RAPID ASSESSMENT OF SEXUAL REPRODUCTIVE HEALTH PROGRAMS, SERVICES AND POLICY ISSUES IN
[2] RAPID ASSESSMENT OF SEXUAL REPRODUCTIVE HEALTH PROGRAMS, SERVICES AND POLICY ISSUES IN
RWANDA; 2011

- Maintain political commitment from the central to the community level: The MoH shall continue to support and provide for implementation of FP initiatives at all levels of the health care system and advocate for FP mainstreaming in other sectors. Additionally, the MoH shall update or develop and disseminate FP protocols, tools, norms and standards and ensure FP coordination at all levels.
- Develop and implement BCC strategies: The government will work to reduce socio-cultural barriers to FP and increase ASRH access with involvement of all stakeholders (including FBOs, community-based organizations [CBOs], student and youth associations, and other social network initiatives).
- Devise and implement sustainable FP funding mechanisms: The government will continue to increase budget allocations to FP and RH programs even though reliance on external support for FP programs will continue over the next few years. In addition, the MoH will continue to support PBF of FP and explore means for financing FP through community health insurance schemes.
- Promote FP service delivery and financing in the private sector: The MoH shall facilitate private sector participation in the provision of FP services in the future. In the short-term, the Ministry of Health shall facilitate expansion and integration of FP in private sector activities (acting as service outlets availing FP products to the private sector for free distribution). In the medium- and long-term, the private sector shall be encouraged to take a more active role in social marketing and selling of FP products as a business.

### 3.6.4 Innovations, Generated within outside of Rwanda (Innovations)

The fourth policy objective is to seek out and apply innovations, which are generated within and outside of Rwanda, in order to support effective practices in FP. In pursuit of the above policy objective, the MoH will:

- Short–term:
  - Share lessons learned from Rwanda's FP experience in at least two international settings per year.
- Medium–term:
  - Over five years, design, implement and document at least three innovations in long-acting and permanent method service delivery.
  - In coordination with the Adolescent Sexual Reproductive Health (ASRH) policy and strategy, design, implement and document at least two innovations.
- Long–term:
  - Document the evolution of Rwanda's FP program and publish in peer-reviewed journals.
  - Track and document the effect of sharing lessons learned from Rwanda's FP program on program performance in other African countries.

Within this framework, cross-cutting themes include: 1) supporting adolescent sexual and reproductive health; 2) accelerating FP integration within maternal, newborn and child health; 3) positioning long-acting and permanent contraceptive methods; 4) supporting stronger FP service delivery in the private sector; 5) promoting women's independence and decision-making in contraceptive use; and 6) addressing gender equality and mitigating gender-based violence and violence against women.

# 4.0 INSTITUTIONAL FRAMEWORK AND IMPLEMENTATION

## 4.1 Implementation

Overall, the MoH is responsible for the coordination and implementation of the country's health activities and programs and will be the primary implementer of the FP Policy and Strategic Plan through the Family Planning Desk of its MCH division.

## 4.2 Specific Roles and Responsibility of the MoH

As the leading institution responsible for implementation of this Policy, the MoH will:

- Ensure periodic review of the programs of ministries, departments, agencies and engagements with NGOs and other institutions involved in the implementation of the FP Policy and Strategic Plan.
- Advocate, promote and coordinate the operationalization of the policy and strategic plan at both national and sub-national levels.
- Advocate for policies that facilitate FP programs and services at the national, district, sector, cell and village levels.
- Advocate for women's empowerment in FP decision-making and implement mechanisms to expand male involvement in FP.
- Advise the GoR on resource mobilization for FP services and monitor their utilization to support the implementation of the FP Policy and Strategic Plan.
- Build the capacity of providers to ensure that the services they provide conform to the standards and quality of care set out in the MoH's FP protocols.
- Facilitate and support operations research on FP, document best practices and disseminate results.
- Strengthen linkages with other ministries and departments, development partners, NGOs and the private sector involved in FP programming.
- Spearhead the implementation of the FP strategic plan to ensure realization of the goals of the FP Policy.
- Develop standards for care and services in the provision of FP at the community level through the CBP program.

## 4.3 The Collective Role of Partners of the MoH

The need to harness the shared roles and responsibilities of all stakeholders will be critical in the realization of the goals of this Policy. The MoH will ensure that complementarities of the roles and responsibilities of all ministries and agencies, development partners, religious organizations and faith-based institutions, research institutions, CBOs and NGOs are identified in line with their mandates. Linkages will be further strengthened to ensure joint formulation, implementation, monitoring and evaluation of FP programs.

## 4.4 Financing and Advocacy

The MoH will identify funding for the implementation of this plan. In the short-term, FP programs will continue to rely on donor support. However, in the medium- and long-term, more sustainable financing mechanisms will need to be considered. In addition to increasing budget allocations for FP programs, the government will have to explore other funding sources such as

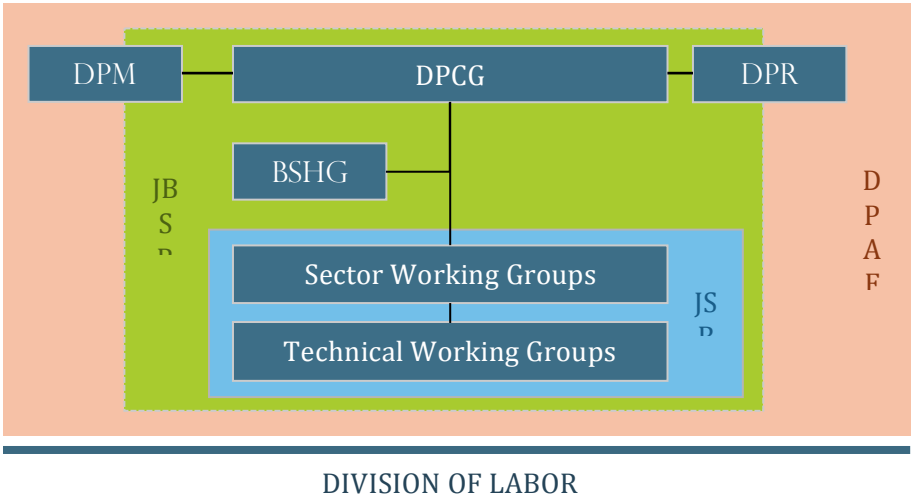
insurance coverage of FP services, expansion of FP in the private sector and continued PBF of FP interventions, as well as coverage of FP by the national health insurance systems.

The MoH will continue to advocate with other GoR ministries and agencies, including but not limited to the Rwandan Parliamentarians' Network on Population and Development (RPRPD), the Ministry of Finance, Ministry of Local Government (MINALOC) and Ministry of Gender and Family Promotion (MIGEPROF), for resource allocation for policy interventions. It will also advocate with other partners, such as international agencies, to mobilize external resources and to help build the system by providing technical support. Advocacy should also involve NGOs and FBOs that can implement elements of the FP policy using their own resources. To further advocacy efforts, effective partnerships with different organizations in accordance to their comparative advantage should be developed and managed efficiently.

## 4.5 Coordination

Development partner coordination in Rwanda is highly organized and is inclusive of all partners (bilateral and multilateral donors, international and local NGOs, private sector). As shown in the diagram below, the key entities include the: Development Partners Coordination Group (DPCG), Budget Support Harmonization Group (BSHG), sector working groups and technical working groups (TWGs).

Figure 5: Rwanda's Donor Coordination Hierarchy




The DPCG, chaired by the Ministry of Finance, is the country's highest-level coordinating body and oversees the entire aid coordination system. The DPCG coordinates an annual Development Partners Meeting (DPM) and Development Partners Retreat (DPR) for dialogue between the GoR and its development partners. The BSHG is a TWG of the DPCG that coordinates budget support. The sector working groups are technical entities for GoR line ministries and their respective donors to coordinate and discuss programs and projects within a given sector. TWGs serve as key entities for technical experts to review and discuss program planning and implementation.

In the health sector, the Health Sector Working Group (HSWG) is the main coordinating body and is co-chaired by the MoH and a rotating lead development partner. In 2010, the MoH organized TWGs into a consolidated list of seven overall groups, with approximately 30 sub-

groups. Each group and sub-group has an official from the GoR as a chair and a development partner as a co-chair.

The coordinating entity for the FP program is the FPTWG, which coordinates and provides leadership related to policy implementation and strategic orientation. Once every month, the group meets to bring together government and partners supporting the FP program. The group is chaired by the head of the FP desk and the co-chair rotates among development partner members. For elaboration of the current policy, the FPTWG nominated nine of its members to keep in constant liaison with the consultant and to provide all the requisite support. Over the coming five years, this mechanism will be strengthened and expanded to include other relevant institutions. The group shall develop an annual national FP plan of action and ensure that it is jointly executed. This group shall continue to be the FP coordination body at the national level.

Establishment of the Joint Action Development Forums at the district level is inspired by the central-level development partner coordination mechanism, but still needs to be strengthened. Lessons drawn from successful central-level coordination approaches need to be extended to the district and community levels where interventions, including those of FP, actually take place. At the district level, coordination will be done by the district authority in charge of health with clear guidance and support from the central level.

## 4.6 Monitoring and Evaluation Framework

Monitoring and evaluation (M&E) of the process and the outcomes of the respective strategic plan implementation are critical to informing the MoH of progress being made. Additionally, it identifies gaps, and allows adaptation and innovation during the implementation phase.

This policy's M&E framework is aligned with the MoH's M&E mechanisms (principally the HMIS). The M&E plan (see Annex 5.2) outlines key strategies that will be implemented from 2012–2016, with a proposed mid-term evaluation in 2013.

### 4.6.1 Definition of Indicators

During the development of the FP Policy and Strategic Plan, core indicators, including end-term targets for monitoring and evaluating the impact of FP programs and services, have been developed. This is important as it innately ensures the appropriate and optimum use of available resources and provides a knowledge base for evidence-based programming, including cost-effectiveness for each key intervention.

The M&E plan outlines how the indicators will be measured including the responsible institution, the frequency of data collection and the frequency of analysis.

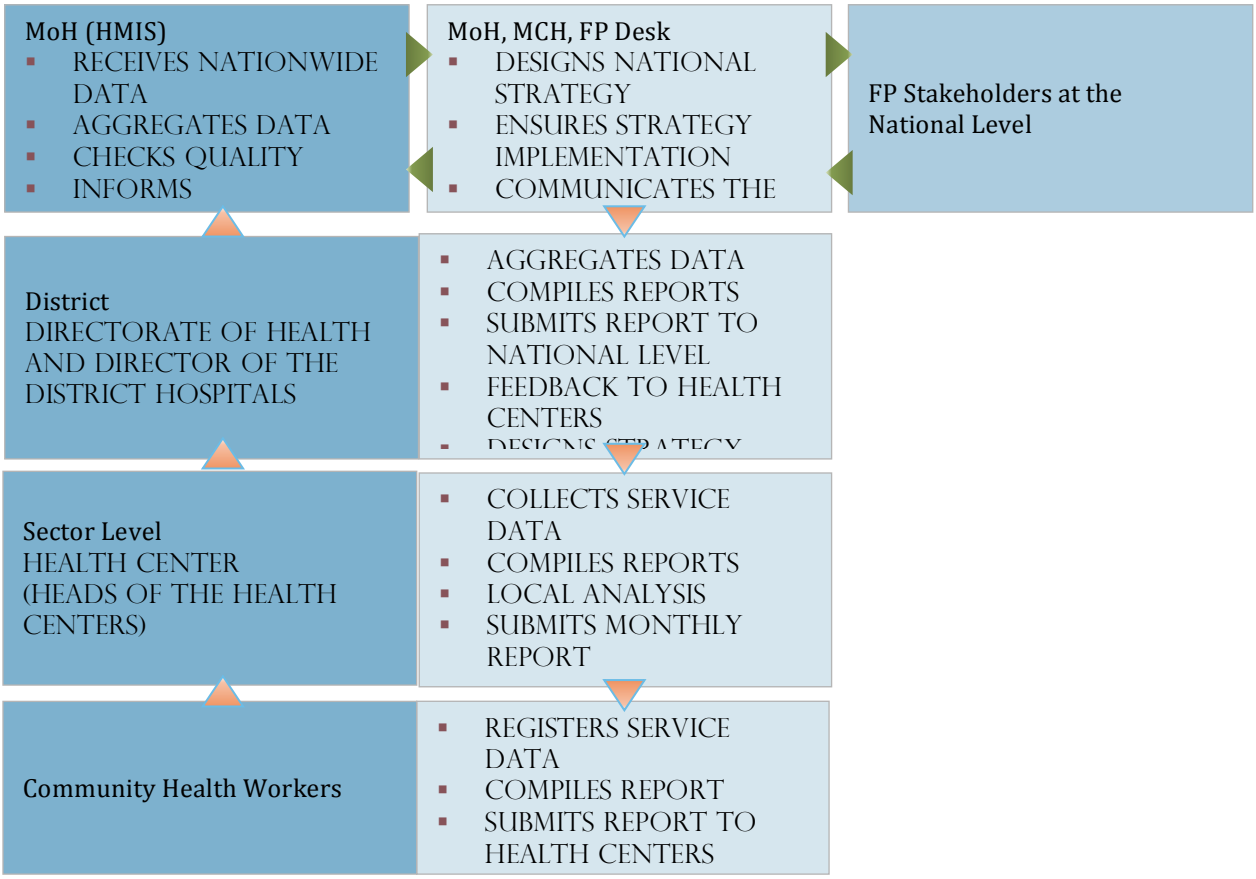
### 4.6.2 Monitoring, Data Collection and Use

Monitoring this policy's strategic plan will rely greatly on routine data generated through the reporting systems of the HMIS and Consumables and the Medical Procurement and Distribution Division (MPDD). To allow for concerted efforts, joint operational annual plans will be developed by the FPTWG, in collaboration with partners, as has been the practice and which will be strengthened. District Health Directorates and District Hospitals will be consulted during planning in a participatory planning process to ensure that district's needs are reflected in the strategic plan. Implementation of such a plan will be evaluated twice a year.

It is worthwhile noting that the FPTWG will undertake periodic review of key FP data sources and reports to ensure that needed information is being obtained. Integrated quarterly formative supervision of health facilities by MoH officials will continue to be a reliable means of verification of the reported information.

Data flow is from health centers to the central level via district hospitals. Health centers and communities will utilize existing standard reporting templates and submit their data to the district hospitals. Districts in turn will receive, aggregate and analyze collected data to assess performance of individual health centers and provide feedback. District hospitals will then submit aggregated data to the central level, where nationwide aggregation and performance analysis takes place and feedback will be sent to district hospitals. At each level, data will be analyzed, interpreted and used to inform decision making and planning. The conceptual model below shows the relationship between different levels, how data from one level reaches another, the role of each level and how feedback is relayed from the higher to the lower level.

Figure 6: Data Flow from One Level to Another




This policy and the respective strategic plan have been developed with 2015 in mind as a landmark year whereby countries will evaluate progress toward MDGs. In terms of program impact, therefore, it is anticipated that carrying out an impact evaluation by conducting the RDHS in 2015 will provide information on higher-level indicators (which cannot be obtained through routine monitoring), including maternal mortality, infant and child mortality and morbidity, contraceptive prevalence rate, proportion of use of each method (modern, traditional), and source of supply (public or private sectors).

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