

Ministry of Health of Rwanda
USAID/Rwanda

**Report of a Qualitative Assessment of
Family Planning in Rwanda**

May 2002



**Advance Africa
Deliver
Prime II, Rwanda**

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARBEF	Rwandan Association for Family Health
AVEGA	Association of Widows and the Genocide
BCC	Behavior Change Communication
CA	Collaborating Agency
CBD	Community Based Distribution
CAMERWA	Center for Purchase of Essential Drugs for Rwanda
CBO	Community-Based Organization
CESTRAR	Centrale des Syndicats des Travailleurs du Rwanda
CHK	Central Hospital of Kigali
CHR	Centre Hospitalier Regionale
CpoN	Consultation Post Natale
CPN	Consultation Pre-Natale
CSO	Civil Society Organization
D&G	Democracy and Governance
DHS	Demographic and Health Survey
DSS	Data and Statistical Services
EPS	Education Pour la Santé
FOSA	Formation Sanitaire
KFH	King Faycal Hospital
DSS	Direction de Soins de Santé
FHI/IMPACT	Family Health International
FAWE	Forum of African Women Educationalists
FOSA	Formation Sanitaire
FP	Family Planning
GDP	Gross Domestic Product
GOR	Government of Rwanda
GTZ	Gesellschaft für technische Zusammenarbeit
HA	Health Animators
HIV	Human Immunodeficiency Virus
ICTR	International Criminal Tribunal for Rwanda
ICPD	International Conference for Population and Development
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
ILO	International Labor Organization
ISP	Integrated Strategic Plan
IST	Infections Sexuellement Transmissibles
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	John Hopkins University
MCH	Maternal/Child Health
MIS	Management Information System
MIGPROFE	Ministry of Gender and Promotion
MIJSPOC	Ministry of Youth, Sports and Culture

MINEDUC	Ministry of Education
MINIJUST	Ministry of Justice
MINISANTE	Ministry of Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Accounts
ONAPO	Office national de la population
PACFA	Office of the First Lady
PEV	Program Elargir de Vaccination
PSI	Population Services International
PRB	Population Reference Bureau
PLWA	People Living With AIDS
PMA	Paquet Minimum des Activités
PMC	Paquet Minimum des Complémentarités
PMTCT	Prevention of Mother to Child Transmission
PNP	Politique Normes et Procedures
PROFEMME	Pro-Femmes Twese Hamwe
PRSP	Poverty Reduction and Growth Strategy Paper
PSI	Population Social International
RH	Reproductive Health
RPF	Rwandan Patriotic Front
RWF	Rwandan francs
TBA	Traditional Birth Attendant
SIDA	Syndrome d'Immunodépressif Acquérir
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
TRAC	Treatment and Research AIDS Center
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

At the request of the Ministry of Health, USAID Rwanda initiated a qualitative evaluation of family planning in Rwanda with the collaboration of a team composed of The Ministry of Health, USAID/Rwanda, Advance Africa, the DELIVER Project, and PRIME II II/Rwanda. The qualitative evaluation was conducted between January 28 and February 23, 2002. The collaboration of multiple agencies and experts enabled the team to draw upon a wide range of technical resources. The objective established by the Ministry of Health (MOH) and USAID/Rwanda was to identify major barriers and opportunities for delivering family planning information and services in the country. Given the significant decrease in the utilization of modern contraceptives revealed by the 2000 DHS, both USAID/Rwanda and the MOH considered this assessment as a significant step in designing strategies for maximizing resources to improve access and quality of family planning services. Discussions were held with representatives of a number of ministries, institutions, donors, religious and community leaders in Kigali and in six Provinces. The report incorporates diverse perspectives and proposes appropriate strategies from a multi-disciplinary approach to address obstacles and identify opportunities to strengthen family planning services for Rwandans.

The assessment examines barriers concerning use of family planning (FP) services from the perspectives of community leaders, men, women and adolescents in six districts: Gitarama, Kibuye, Byumba, Umutara, Kibungo and Kigali Ville. Reasons for non-use of FP services were linked to both quality and access to services. Furthermore, social, cultural and religious issues influence sexual and reproductive behavior including contraceptive use. Response from the community confirmed results from previous studies, which pointed to genocide as an important factor affecting fertility behavior in Rwanda. Field visits offered the team an opportunity to visit health facilities where family planning, MCH and VCT services were provided. Client exit interviews and discussions with health providers were useful in understanding access, quality and demand regarding family planning services.

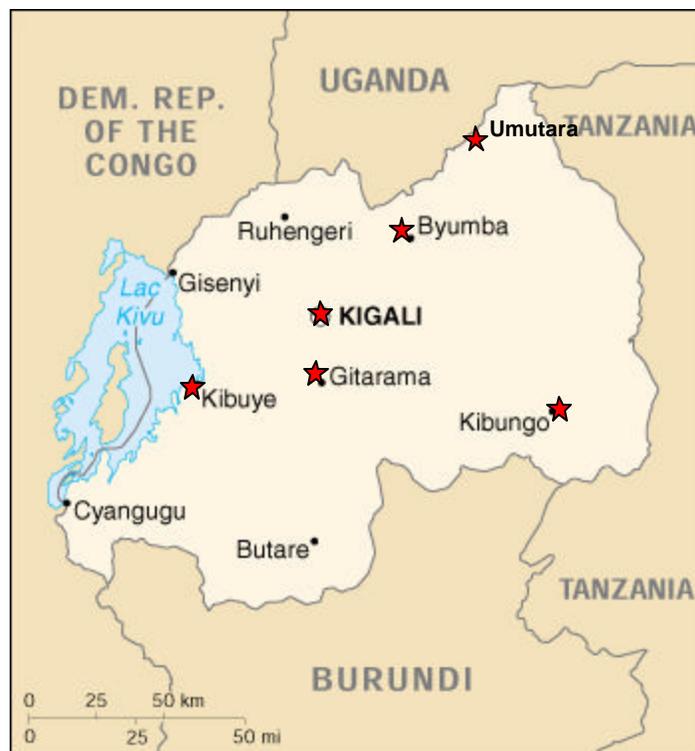
This report synthesizes the qualitative findings and provides the following:

- Reviews specific government policy guidelines, and based on discussions with public sector representatives establishes linkages of family planning programs with relevant policies and programs of the GOR
- Utilizes community perspectives to propose appropriate interventions to improve access and quality of family planning programs in Rwanda;
- Recommends strategies for integrating family planning into existing programs to mutually reinforce each program and improve overall quality of health
- Seeks opportunities for policy and programmatic linkages outside of the health sector
- Recommends strategic advocacy for building consensus to promote family planning programs at different levels and for different groups;
- Defines the potential roles and responsibilities of various stakeholders in the context of civil society

- Identifies special target groups and proposes appropriate interventions to increase access to FP/RH information and services.

Investments in family planning and reproductive health programs have short and long-term benefits. Allocation of resources that meets the needs of underserved, at-risk populations will have an impact on the development of the country **The report can initiate dialogue for building consensus on strategies, stakeholder responsibilities, and a plan of action to mobilize the public and private sector, as well as commit donors to provide resources to implement the interventions.**

Map of Rwanda, 2002
The red represent the sites visited



SECTION ONE

I. Background on Rwanda

Located in the Great Lakes region of Sub-Saharan Africa, Rwanda is the most densely populated country in Africa with over 7.6 million people within 26,300 sq. km¹. The country's rich internal resources have been diminishing partly because of the population burden. Adequate land is a difficult commodity to obtain in this primarily rural (90%), agricultural nation. Since 1994, Rwanda has been struggling to recover from the massive internal civil war and genocide. As one of the poorest nations in the world, Rwanda has an unstable external debt burden of 34% of the Gross National Product.² However, the nation's economy has been improving slowly over the past decade, primarily because of the great influx of foreign aid and special treatment from the international community since the events associated with the genocide. In addition to the struggling economic status, Rwanda's health burden is high, with extremely high mortality levels for women, infants and children under five. Life expectancy is only 39 years old.¹ However, since the 1994 genocide much progress has been made in the economic sector and continuing progress in the nation's health sector.

II. Introduction

Sexuality and fertility are aspects of human behavior with cultural, social and economic implications. Consequently the family planning assessment report team utilizes a broad framework for the interpretation of findings and recommendations regarding family planning services in Rwanda. The methodology for the assessment also took into consideration the following:

- Family planning in the context of the HIV/AIDS epidemic in Rwanda
- The Rwandan genocide and its impact particularly on gender relations, sexual and reproductive behavior in Rwanda
- Analysis of existing policies and programs designed for reconstruction, rehabilitation, democracy and peace and their relevance to family planning programs

To achieve success in promoting family planning programs, it is apparent that a consensus must be reached among all stakeholders concerning both the content and context of policies and programs in family planning. Rwanda has reached a broad based consensus among the population for Peace, Rehabilitation, Reconciliation and Poverty Reduction. The evolution of these policies was participatory and the implementation will be a challenge. These policies and guidelines can reinforce programs such as family

¹ Population Reference Bureau, 2001 World Population Data Sheet

² PHR. *Utilization, Cost, and Financing of District Health Services in Rwanda* Technical Report No. 61, March 2001.

planning. (See **PRSP on Poverty Monitoring Indicators Appendix**) They provide the foundation for partnerships, alliances and collaboration in order to create consensus, awareness and advocacy. Second, the interventions that will be proposed for promoting family planning will also look to sectors outside of health. This will require collaboration among other ministries and civil society to create awareness so services can be rendered to those who need them. . The challenge for meeting the family planning and reproductive health needs of communities in Rwanda is great and requires the mobilization of numerous stakeholders. Existing policy frameworks and programs provide the foundation for an effective implementation of family planning programs.

III. Objectives of the assessment

There were multiple objectives for this assessment:

- Assess the nature, roots and magnitude of existing barriers to using family planning services in Rwanda;
- Provide recommendations about how these barriers can be overcome
- Provide recommendations about how to reconcile unmet need for family planning with resistance to using it as a result of genocide; and
- Recommend how to involve the community in overcoming barriers and supporting family planning

While both USAID and MOH share the above objectives, USAID also has interests in additional outcomes related to their role in supporting the family planning program in Rwanda. The team was asked to suggest recommendations to the following questions:

- How can donor coordination regarding family planning/reproductive health programs be improved?
- What role can USAID play in supporting the family planning program?
- Where should USAID focus its resources?

Furthermore, the Ministry of Health requested that the team focus on answering the following specific questions:

- ✓ Why are Rwandan women not using family planning?
- ✓ At health service delivery points what are the obstacles to providing quality family planning Services
- ✓ What are the possibilities and options for community participation /involvement in FP/motivation and distribution

USAID will use this study and other means to get a comprehensive view of the current status of family planning services, the extent to which the barriers affect use of services, and how best the mission can allocate its resources. The assessment also examines the activities of different donors working in the area of RH and suggests recommendations for improved coordination and collaboration.

The results of the assessment will be used:

- As input to the development and refinement of GOR reproductive health policies
- To help operational policies into strategies for overcoming the barriers to family planning use
- To help USAID and other donors more clearly define a role for itself in supporting family planning/reproductive health program;
- To help develop strategies for involving the communities in family planning programs.

IV. Methodology for the assessment

This section on methodology summarizes team composition, desk review, fieldwork, analysis, participation of stakeholders, report preparation, and the final workshop for discussion of findings and recommendations of the evaluation. Overall the methodology was collaborative, participatory with the Ministry of Health playing a key role in supporting this initiative to initiate the process of reaching a consensus on the major challenges and key recommendations of the evaluation.

A. Team composition

The family planning assessment in Rwanda was a collaborative effort conducted by the Ministry of Health, USAID/Rwanda, Advance Africa, Deliver, and PRIME II. The expertise and experiences that were represented in the team provided an opportunity to examine the different dimensions of the problem. (See **Appendix List of Team Members**)

B. Desk review:

The assessment team first undertook an extensive review of the documentation related to family planning and reproductive health and general documents addressing the current situation in Rwanda. Except for the family planning assessment conducted in Rwanda by ONAPO in 1996 research on family planning is scant. However, The 2000 DHS provides a comprehensive quantitative study of the demographic and health situation in Rwanda. This document is quantitative data on the health and demographic situation in Rwanda. Other documents on HIV/AIDS and gender studies, GOR policy of different sectors provided useful resources. Studies on the impact of the genocide on the health and social welfare infrastructure of the country contributed to understanding issues were raised during the field assessment. Available research on HIV/AIDS helped the team identify at-risk populations to determine where resources can be channeled to address sexually active and vulnerable populations.

C. Participation of stakeholders

Members of the team met with representatives of various ministries, institutions, donors, religious and community leaders first in Kigali. A stakeholders meeting was organized at

the beginning of the assessment where MOH donor representatives and other partners were provided the objectives of the evaluation and feedback was solicited. (See **Appendix for participants of meetings.**)

D. Field work

Fieldwork was conducted between January 28 and February 23, 2002 in six provinces: Gitarama, Kibuye, Byumba, Umutara, Kibungo and Kigali Ville. The work commenced in Kigali with the development of the questionnaire. The team used a series of questions to guide the development of the questionnaires. (See **Appendix for Summary Table of interviews**)

MOH and USAID selected the sites using the following criteria:

- ✓ Low contraceptive prevalence
- ✓ High contraceptive prevalence in comparison to other districts (Kigali Ville)
- ✓ High prevalence of early marriages
- ✓ High prevalence of polygamy
- ✓ Presence of Mutuelles

At each health center the team interviewed separate groups of 8-10 men, women, male adolescents and female adolescents. In addition, the evaluation team interviewed health providers at the center and conducted client exit interviews. (See **Appendix for the calendar of site visits.**)

E Presentation of preliminary findings

Preliminary analysis of the interviews was conducted in Kigali by the whole team. The preliminary findings were presented at the end of the fieldwork to USAID; MOH and partner's organizations at the conclusion of the fieldwork preliminary findings were presented to principal stakeholders. At this meeting the team was able to get feedback on the preliminary findings. (See **Appendix: Participant List**)

F. Analysis and report writing

A draft of the report was prepared for USAID and the MOH was provided for review. The report synthesized data collected in the field, from the desk review and from discussions with various representatives' ministries and donors.

G Workshop for on the findings and recommendations

A workshop was conducted between May 8to May 10, 2002 in Kigali to discuss the findings and recommendations of the evaluation with the following objectives:

1. Reach a consensus on the results of the recommendations
2. Identify interventions for the implementation of recommendations proposed by the evaluation

The workshop was planned to present the major findings, and recommendations of the evaluation. Participants were divided in three working Groups: (1) Civil Society, (2) Service Delivery and (3) Policy Advocacy and Collaboration. The three working groups studied and validated the recommendations. Additionally the feasibility of proposed recommendations to the realities of the country were discussed.

(See appendix for list of participants, Group Work Participants and Guidelines for Group Work)

H. Constraints and Advantages of Methodology:

This assessment was undertaken in only six districts in Rwanda. Sites were not chosen at random, nor were the interviews conducted in a statistically randomized process. In addition, this assessment took an in-depth qualitative approach and did not utilize quantitative methods. Thus, the results cannot be broadly generalized to the whole country. The results however were guided by a wealth of existing data and an in-depth examination of the situation from the viewpoint of Rwandan leaders, health providers, communities and clients. The methodology of the evaluation was also highly participatory and the report reflects the diverse perspectives, opportunities, and challenges facing Rwanda in promoting family planning. With the leadership of the Ministry of Health and USAID/Rwanda, the methodology was designed to enable representatives of ministries, donors, and community leaders to provide tremendous input into both the findings and the recommendations from the beginning of the evaluation process. The final workshop with major stakeholders validated and refined the findings and integrates specific recommendations through deliberations and consensus building.

I. Organization of the findings and recommendations

The findings and recommendations are organized around three basic questions:

- ✓ Why are Rwandan women are not using family planning services
- ✓ What are the obstacles at services delivery points
- ✓ What are the ways for mobilizing community involvement for promoting family planning programs?
- ✓ What are the mechanisms for policy advocacy and collaboration

Each of the questions is followed by a series of recommendations to address the questions. .

J. Finalization of Report

Following the workshop, the team integrated the information from the participants and the working groups, reviewed the recommendations and revised the report. The final report has benefited significantly from the workshop and a consolidated evaluation, which now contains specific recommendations, which are deemed to be practical and useful towards implementation of a family planning program in Rwanda, is presented. The Ministry of Health, which undertook the leadership during this workshop should

have ownership of the results of the assessment vis a vis its mandate in promoting reproductive health.

SECTION II: RESULTS

IV. Why are Rwandan women not using FP services?

Key elements are discussed in response to this question. The principles reasons why women are not using family planning focus on the following:

- ✓ Reasons associated with Poverty
- ✓ Socio-cultural and religious influences
- ✓ Inadequate information, counseling and service on family planning
- ✓ Impact of the Genocide

1. Poverty

In all the sites visited, persons that were interviewed linked high fertility to poverty. All categories of persons interviewed correctly articulated the relationship between low fertility and low mortality. They said the people who have less children experience “less kwashiorkor”, are “more happy” and having the means to educate their children. On the other hand, as shown by the DHS there is a contradiction with this knowledge and the reality, which shows that despite this knowledge poor, women tend to have more children. Part of the reason is that the poor are less educated, have fewer access to family planning information and services. They also have less contact with the health services because of financial constraints.

2. Socio-cultural and religious influences

There was a consensus among women, men, and others that religion influences fertility behavior and contraceptive use. The Catholic Church promotes natural family planning and discourages use of modern contraceptive methods. Religion reinforces traditional Rwandan concepts of “children being gifts from God”. This further reinforces culturally held beliefs against the use of modern contraceptives. Gitarama community leaders said, “*Church worsens the situation by disapproval of the use of family planning.*” Some churches do not even teach FP since, as one respondent said, “*The Bible says that we should produce many children like the sands of the ocean and when you practice family planning you kill creatures of God*”.³ Kibungo community leaders, an all male group noted that “*Churches are not sensitive [to these issues] and churches are ignorant, so how do you expect them to teach.*” In contrast, the Episcopal Church emphasizes family welfare and within this context promotes family planning since the 1980’s. Pentecostals

³ Umutara Discussions with Community Leaders

are perceived as being opposed to modern use of family planning. However, Protestants of other denominations such as Adventists and those who belong to the Assembly of God have no resistance to family planning. The Muslim religion does not prohibit family planning among married couples. .

3. Information and counseling on family planning

Awareness of HIV/AIDS issues was very high among those the team met during the field assessment in Rwanda. On the other hand, information on family planning was considered to be lacking. IEC messages were non-existent to clients who come for other services. According to the respondents, radio programs rarely addressed family planning, whereas HIV/AIDS awareness campaigns are well organized throughout the country. As a result there were misconceptions about the various dimensions of family planning

4. Access to services

The Government of Rwanda has placed health centers in close proximity to the population however, the physical terrain and lack of transport makes it hard for women to travel to health centers for “preventive” and what they consider non-emergency services.

Interviews indicated the workload of women engaged in subsistence farming as a barrier regarding access to services. In particular, women who are heads of households find it even more difficult to complete their work and go to health clinics because services **are not available every day or are closed.**

- [Women] do not have the time to go to the health center to get the services since they have too much fieldwork.
- By the time [women] come back from their fieldwork, they are tired and also the health center is closed.
-Buyumba, Community Leaders

5. Lack of decision-making power of women in the household

In all districts, men are considered to be the primary decision makers related to family size. When support from husbands and partners are not forthcoming, women avoided using contraceptives. Even adolescents felt that “since men are responsible for the family, they should either decide

or be involved in making decisions on the number of children.” An all male group of community leaders from Kibungo said, “*They have had conflicts within the community where the wife went to the health center without the husband’s consent.*” Women today have been given the right to own land. However, customary law which denied women such rights has long been embedded in people’s minds and the justification for the universal

- Husbands are against their wives using FP
- Women do not have much say in the number of children the family should have.
- In Rwandan culture the man should produce as many children as he wants.
- The husband’s family may be against the woman who practices family planning to stop or have fewer children.
- People also still believe that children are gifts from God; hence they want to continue having more children
- If you are seen going for family planning services in the community people criticize you; hence women hide when they are using family planning.
- Women do not want to use family planning because they are afraid that their husbands will go out and see other women.
- Gitarama community leaders

acceptance that men should decide seems to rest on the basic fact that since “men have the resources, they should decide”

6. Patterns in marriages and relationships

The war and genocide left 85,000 child headed households, some of who have grown up or been absorbed into other households. About 120,000 people are in prison awaiting trial for genocide-related crimes, imposing a large economic burden both on the state and on their households. The number of widows and single women as a result of the genocide is significant. According to the DHS in Rwanda “polygamy is not extensive in Rwanda among men the polygamy rate is 7%”. Although polygamy is not extensive, the assessment found informal relationships and multiple partnerships are becoming increasing common as a result of the genocide.

There are a lot of men practicing polygamy. This existed before the war, but since then there has been a significant increase. Even some rich women are seeking men and marrying them. The need for family planning in the polygamous household is critical because there is competition among the women about their number of children. If women do not have a child in two years, the man takes another wife and she may be abandoned.
-Health Animator in Umutara, Tabagwe Health Center

7. Fear of side effects, rumors and its effects on modern family planning use.

Injectibles are the most widely used family planning methods in Rwanda.⁴ In all sites, there were repeated and consistent complaints among men, women, adolescents, and community leaders regarding potential side effects from contraceptives use. The genocide may have increased fears of losing the capacity to produce children. As one respondent put it, she “knew of someone who had a vasectomy prior to the genocide that has now lost all his children. As a result he is alone and cannot father any more children.” Another study confirms side effects as a factor for discontinuation of contraceptive use. Women complain of headaches which lasts during the whole time the women continues to use the contraceptives; weight gain particularly in the feet, prolonged periods, and infertility.⁵

- Complications are serious for women in rural areas with limited access to health care so they abandon use. Health providers are “incompetent” and do not provide the women with adequate explanations.
-*Presbyterian Pastor*
 - Women are complaining about side effects. Normally examinations are performed before providing FP.
-*Assembly of God Pastor*
 - As a mother I think that contraceptives have too many side effects, and therefore I prefer not to use contraceptives.
-*Woman representative of woman’s association*
 - There is a lack of effective training to identify and treat complications of contraceptives.
-*Representative from Education Sector*
- Community leaders in Kibungo February 2002

⁴ DHS 2000 Rwanda

⁵ SWAA Rwanda L’ HHUMURE” Society for Women and AIDS in Africa B.B. 5196 Kigali Rwanda Etude Sur la Santé De la Reproduction des Les Droit de La Femme Rwandaise: Travail Réalise grâce a L’appui technique de John Hopkins Université/Population Communication Services (JHU/PCS) et au soutien financier de L’Agence Américaine pour Développement International (USAID) Kigali 2001. (Information for This data was collected in six Districts: **Gikongoro, Ruhengeri, Nyagatare (in Umutara) Kibuye and Remera and Kigali Ville)**)

Discussions with men, women and even adolescents cited specific complaints from excessive bleeding to decreased breast milk and even “cancer”. The findings of the evaluation confirm that the diminished milk may be the result of inappropriate methods given to lactating women. However it should be noted that rumors of side effects are not scientifically such causing cancer, sterility, the migration of IUD into the cervix, condoms which contain the HIV virus. These types of unfounded rumors contribute to women’s decisions not to use modern family planning methods. Some of the findings from the Deliver assessment confirm that examples such as the reduction of breast milk may have some level of truth since appropriate methods for women who breastfeed may not be available. However, the rumors about side effects are pervasive and contribute to women’s decision not to use modern methods.

8. Difficulty using natural family planning methods

Questions on Natural family planning use were asked to determine the appropriateness of such methods. Since a significant majority of the population is Catholic it was necessary to decide whether natural family planning (NFP) methods introduced in Rwanda prior to the war can be invigorated. The method is considered ideal, natural, without side effects and in line with religious and cultural beliefs. A majority of those interviewed believe that to practice NFP tremendous obstacles have to be surmounted:

- Discipline and self control, particularly where alcohol is involved and men do not participate. This is also cited by other studies done in Rwanda.⁶
- Difficulty of women particularly those who are illiterate in using the calendar method
- The problem of alcohol and practicing the withdrawal method
- Fear of women that their partners would seek other woman if she insists on practicing natural family planning

- Natural family planning methods it should be used by a family which has self discipline and self control and that it is difficult to use and requires a lot of education and requires a compromise between a couple.
 - Community leaders from Buyumba
- Natural family planning methods it is not effective and it is difficult to use. Natural family planning requires education and discipline.
 - All-male group of community leaders from Kibungo

The team was unable to find any organized groups who promoted Natural family planning methods in the country. Those that operated prior to the genocide are currently inactive.

9. Specific problems faced by widows, separated and divorced women

Widows and single women face significant barriers in accessing family planning services in Rwanda. Even in organizations that are established to specifically address their needs, family planning services are prohibited because they are not supposed to be sexually active. However, the reality is that in maternity wards, and VCT centers, there are significant numbers of widows who are

Widows in the community find themselves looking for men to support them for survival. If you are seen going for family planning services in the community people criticize you. Hence women hide when they are using family planning.

- Community leaders

delivering and becoming infected with HIV/AIDS. Health providers in all the districts say widows do not usually come to the health center to talk to the staff about family planning. People ridicule them and they do not have a trusted person to talk to about family planning. Women are reluctant to use services that are clearly identified as family planning services. They face criticism from other women who see them as threats if they openly seek family planning and ostracism from members of their deceased husband's family. Many of these women may also have lost children during the genocide and have not reached their reproductive intentions. Lack of confidentiality is another problem. The needs of women who are single, divorced, widows or whose husbands are in prison are unique since they are not targeted by any of the existing programs.

10. Access, awareness, and support for adolescent reproductive Health Services

Rwanda has legislated the age of marriage to be 21; however, early marriages occur in some communities. To avoid the law, these marriages are not registered since the couple is not at the legal age of marriage. Consequently, they do not use health services, which places them and their children at greater risk of disability and death. There is a great deal of concern in the community regarding adolescent sexuality. Abstinence is viewed as the primary method for avoiding both HIV/AIDS and unwanted pregnancies. The Ministry of Education with assistance from ONAPO has now integrated curriculum on sexuality and reproductive health, which also includes gender. The program is also trying to address out of school youth. Despite the reality that adolescents are at risk of both HIV/AIDS and unwanted pregnancy there is a great deal of resistance for providing services to this group in all the discussions in the sites. During the teams visit to those responsible for education in Education in Buymba and Umutara, these courses have been integrated and teachers are not trained well and therefore it is not easy to discuss issues of sexuality regarding adolescents.

<p>We see many children who are heads of households who marry early to have children; and then the poverty increases and the polygamy increases. Then there are many widows with a critical situation and so there is a need for FP. -Kibungo youth community leaders</p>

11. Perception of family planning as “limitation of births” rather than “spacing of births”

Family planning has become synonymous with the limitation of births rather than an intervention to improve the health of both mothers and children. A woman representative from a women's association said, “The people think that family planning is the limitation of children and women who space children are abandoned by the husbands.” Family planning is considered only as a means to “limit birth”. » As such family planning is an option for women who have reached their reproductive intentions. Other aspects family planning such as child spacing child survival and maternal health does not figure prominently in their understanding of the benefits of family planning. Secondly, family planning as a reproductive rights concern to promote gender equity and the empowerment of women was not incorporated into the message. This was the legacy of ONAPO, which was structured using demographic targets rather than the 1994 International Conference

on Population and Development Framework, which include both the health and reproductive rights dimensions of family planning. .

12. Genocide: Impact of the genocide on sexual and reproductive behavior

A simple answer, which equates genocide with the desire to “replace the dead”, does not capture the complex problems facing Rwandan men and women after the genocide. At the request of the MOH the team examined whether and how the genocide impacted fertility behavior and influenced contraceptive use. Although there was qualitative data and significant anecdotal evidence on whether the genocide is an important factor the evaluation sought further understanding from the field. Undoubtedly, the genocide provides part of the answer for the decrease in contraceptive use in Rwanda; the following summarizes some factors that may have contributed to increased fertility and low contraceptive use as a result of the genocide:

- People want to have more children to replace what they lost.
 - Widows in the community find themselves looking for men to support them for survival
 - Early marriage is prevalent
 - Polygamy, it has become a culture within that areas for husbands to have 3 to 5 wives who have many children.
 - Post genocide has led to a lot of prostitution and those men who do not believe in polygamy are those who will have relationships with prostitution or go to other women and they justify it by saying that they are helping women.
- Community Leaders from Buyumba

- The **cultural and social realities** of people have been transformed by the genocide. These have, reinforced certain aspects of cultural traditions such as polygamy and early marriage. These traditions re-emerge as a result of the loss of significant numbers of adult males.
- The collective social fabric, who created trust and mutual support in communities, has been severely damaged, creating suspicion, tension and conflict. Therefore, community based initiatives such as information on family planning were not there. For example rumors regarding modern family planning methods increased creating distrust and suspicions.
- Survival during and after the genocide took on different meanings for the population. The result was that individuals sought to:
 - “Find a new meaning” in life
 - A reason for “going on”
 - A chance to “replace the dead”
 - An opportunity to “create a family that was lost”
 - “A chance to heal”. For many this meant having a child or having more children. Also, many widows had not achieved their desired number of children.
- The community viewed family planning programs as interventions for the limitation of births rather than the spacing

- There has been a decrease in the use of family planning services since the genocide has brought a lot of problems. The women and the population have lost “the pleasure of life” and the people want to replace the dead. (Woman representing woman’s association)
 - There are a large number of widows who are without children who want to replace their children. (Pastor)
 - Before the war, the government puts its force on PF and after the war there were many other priorities and the government has not made a emphasis on FP. (Pastor)
- Kibungo community leaders

of births. Given the pro-natalist nature of Rwandan society and the reinforcement of church teachings

- Genocide exacerbated the dilemma of youth in Rwanda who were either witnesses or victims of the genocide. Many have taken on adult role of heads of families some are orphans and street children.
- Money is increasingly exchanged for sexual favors especially among the young and the most vulnerable, single, divorced and widowed women. Women without partners are primarily in subsistence farming, have a lack of money to buy basic necessities or labor to perform tasks they cannot do themselves.
- Lost and separated families, widows, single women, orphans, displaced populations all present special needs that need to be addressed by reproductive health programs that helps them not only prevent unwanted pregnancies but also avoid HIV/AIDS.

II. How can the community be involved in promoting Family planning services?

Structures and associations identified within civil society in Rwanda pose challenges and opportunities for involving communities in family planning programs During the evaluation, discussions with community leaders, health animators, religious leaders, women's associations, and health animators provided the basis for identifying the following opportunities and recommendations for community involvement. At the central level, representatives of major religious (Episcopal, Muslim, and Catholic) leaders were interviewed to know their perspectives on how to engage civil society in this process. Experiences of how other countries mobilization of civil society to promote reproductive health and rights also provide valuable lessons. . The final workshop held in Kigali provided input on the specific interventions in the context of Rwandan civil society

1. Women's associations and organizations

Women's organizations specifically those who already offer information on family planning should be supported to provide family planning services to create synergy between women economic and reproductive health status. Prior to the implementation of this recommendation it is important to understand the different types of associations, the range of services they offer, and the possible ways they can contribute towards promoting family planning services. The involvement of civil society in this broad framework of family planning programs includes IEC, counseling, service provision and referrals. Therefore women's associations and organizations depending on their capacity should be carefully evaluated to determine which of these activities they can effectively implement. A brief overview of their potential and the opportunities they offer is described below.

Women's organizations and associations in Rwanda are not a new phenomenon. In 1986, out of 1,457 organizations, almost one third were registered as women's socio economic groups and 143 as women's NGOs (Reseau des Femmes The team encountered representatives of women's council, coordinators of MIGEGROFE, and members of women's associations and groups during the field visit.

The following table reveals the number of women's groups that were in existence by 1999 to demonstrate the significant role they play in the country

Women's groups and associations by 1999

Préfecture	120
Commune	1540
Sector	1160
Cellule	8620

Source: USAID/Rwanda Civil Society in Rwanda Assessment and Options

Women's associations and groups in Rwanda are not a homogenous group and represent advocacy, legal rights, micro-finance, widows groups, and church, professional (ex Media women association) and social welfare associations. They provide a range of services including emergency material assistance, trauma counseling, training, legal assistance, and income-generating activities. Many target vulnerable women such as widows and orphans. Within the context of reproductive health, women's associations have been effectively mobilized to address the HIV/Aids epidemic. As a result of the genocide, prevention of gender-based violence has been a particular concern for them. .

2. Lack of the active involvement of women's association in family planning activities

Despite these tremendous achievements their commitment to improving the economic status of women has not included the provision of family planning services as a critical component for empowering women or improving the reproductive health of women. This clearly has not been a major priority. This is due to the fact that family planning in comparison to the emergency needs facing women after the genocide (such as basic needs of food, shelter, and health problems) facing women following the genocide overshadowed the family planning needs of women.

The **legacy of ONAPO** did not provide a legitimate framework for women's association to continue advocating for family planning within a context that was narrow and did not take into account women's reproductive rights and empowerment and the health aspects of family which includes child spacing. Furthermore, ONAPO under the old structure had lost its credibility and its role as the sole organization, which promoted and delivered family planning services in collaboration with health centers. With the genocide coinciding with the International Conference on Population and Development, which integrated these aspects, the framework for integrating family planning as a legitimate concern for women's organizations did not exist.

3. Potential of women's organization for promoting family planning:

Today with the restructuring of ONAPO, the new orientation of family planning in the context of reproductive health, and the decentralization of the government women's organizations can potentially be effective mechanisms for promoting family planning programs. Organizations of women are based on mutual interest for a common purpose, orientation or need. Women groups and associations have strong structures, with impressive memberships and a recognized need for family planning services. The membership of women's organizations is vast and includes women from all walks of life. However, so far the initiatives that are taken up on reproductive health by women's associations and groups are not coordinated. Therefore the need for training, information and reinvigorating these associations on family planning and reproductive health activities is evident. Secondly, resources to make this a reality do not exist.

The case of AVEGA is an excellent example to demonstrate the need to integrate family planning in women's associations. AVEGA is an association for widows, which operates at the district and cellule level. Even though AVEGA **some health** services to its members, family planning services are strictly prohibited. Widows in AVEGA who become pregnant lose their benefits from the association but not their membership. For example associations, which implement income-generating activities, have been successful in mobilizing women to improve their conditions in life through increasing agricultural productivity and increased income. This model may be applied for mobilizing women to support family planning activities.

- ✓ Identify women's organizations and groups working providing information on reproductive health to women and reinforce messages for family planning
- ❑ Create a network of women's organizations and association in order to help their membership access family planning information from women's association who can be supported to provide family planning services
- ✓ Provide training to members of women's association to provide counseling and referrals for women who need family planning
- ✓ Integrate family planning services in organizations such as AVEGA who provide health services including HIV/Aids prevention and care to include health services
- ✓ Revise the mandate of women's organizations and associations to make family planning a priority
- ✓ Utilize forums that women's associations use to integrate information and IEC on family planning to inform and educate members
- ✓ Establish strong partnership and collaboration with groups working on gender equity at the central, district and community level for advocacy and implementation of family planning programs.
- ✓ Work with organizations such as FAWE on empowerment of young women, expanding their programs of gender sensitivity to schools throughout the country

which will have an impact on family planning awareness through promoting women's decision making.

✓

2. Religious Groups in Rwanda

Unlike other civil society groups that have small memberships and few financial resources, religious institutions in Rwanda encompass mass audiences, which transcend ethnic, class and geographical boundaries. They are involved in social welfare issues that are borne out of fellowship and an interpretation of the doctrine of the both Islam and Christian philosophies of taking care of those religion of "taking care of those who cannot fend for themselves". Therefore in both Islamic and Christian based religious groups the issue of health interventions and communicating and promoting these messages has been very successful.

In Rwanda, more than 50% of the population is members of the Catholic Church, 35% of the population are Protestant and eight to ten percent are Muslim. Currently there is no organized religious opposition to family planning services. In fact the Anglican Church strategic plan document for 2002-2003, which includes family planning. The Episcopal Church has an active group is active with Mothers' Unions throughout the country. On the other hand, organizations such as Mothers Union of the Episcopal Church provide family planning counseling and support service provision. They support family planning but cannot provide services due to lack of human and financial resources. Currently, 320 mothers unions in the country and they can serve as mechanisms for channeling FP information and services.

The team met with representatives of the Catholic, Anglican and Muslim leaders in Kigali to get their perspectives on how to improve reproductive health. In addition Discussion were held discussion with religious leaders of the three major religions at the national and district level with representatives to understand their perspectives and provide recommendations for this report on how to engage them in promoting RH in Rwanda. As indicated in the findings, religion has a strong influence in people's lives. On issues dealing with child health, breastfeeding, violence against women, child spacing and other non-controversial issues these networks have been successful in using religion as a means to mobilize communities. Examples such as mothers' clubs organized by Anglican Church and the Biroyogo Catholic Church HIV/AIDS program are prime examples of what the team witnessed during the assessment.

3. Building Partnership with religious groups for promoting some of the components of reproductive health programs

There is a broad based consensus on the need for family planning building alliances with religious groups based on mutual respect and understanding of religious doctrine. In particular, where religious doctrine supports high fertility it is necessary to build partnerships and convey messages in ways that permit consensus without creating controversy and polarization. The basic elements of this strategy include:

- Promoting spacing of children rather than the limitation of children;
- Promoting the entitlement of health of women rather than the sexual entitlement of women
- Preventing maternal mortality and morbidity
- Promoting safe motherhood
- Preventing HIV/AIDS
- Promoting natural family planning where appropriate

The limitations of religious edicts and interpretations regarding family planning and reproductive rights are still challenges that each religion faces. There is a pastor who says that people think that using family is like killing a child who is to be born. Some churches are preaching the same message and therefore with such controversies, focusing on aspects where there are no controversies may promote healthy sexual behavior.

Challenges in working with religious institutions:

In principle, the Catholic religion does not encourage modern family planning methods, but promotes natural methods for spacing children. However, they acknowledge the difficulty in using traditional methods. It is important to note however, that the opposition to family planning services is not organized in a manner that makes it impossible for women to use FP if quality services were readily available. Involvement in prevention and care of HIV/AIDS has also placed religious institutions at the forefront of those who are struggling to deal with the epidemic. Discussions with community religious organizations made it clear those messages from the churches regarding risk factors and encouraging testing and counseling is already going on.

4. Promoting reproductive health through Catholic health centers and religious influence to delay sexual activity among adolescents

The church advocate abstinence for youth and fidelity for married couples as a way to prevent both HIV/AIDS and unwanted pregnancies. Health Centers, managed by Catholic institutions, do not provide family planning services. Clients are referred to family planning services elsewhere. Sometimes when providers at Catholic health centers are confronted with the reality of women who come and ask for services, services are provided the influence of religion is especially strong among adolescents. A female adolescent in Kibungo said that one should “*Follow the Ten Commandments as Christians have self control, and respect one’s body as the temple of God*”. Part of the message to obey and respect parents is also conveyed by the church. . Therefore, while religion can be an obstacle in promoting use of contraceptive services, it also promotes abstinence, delayed sexual activity, adherence to the legal age of marriage, sanctity of the family, and also against prostitution. This can be an important contribution for safeguarding adolescent health where. However it is not to imply that services for adolescents should not be available.

5. **Labor union** can be ideal partners in family planning and reproductive health programs. Rwanda labor unions have organized structures through which information and family planning activities can reach their members and the larger community. CESTRAT (Central Union of Rwandan Workers), which is the Main union body in Rwanda, demonstrates the importance of such groups. The organization provides health and banking services at reduced rates for members in Kigali, Gisenyi, Cyangugi, Kibungo, Butare, Mugambazi-Kigali Rural and Ruhengeri. In addition to its more traditional mission of protection and promoting work rights, CESTRAR has also launched several civil education campaigns on democracy and good governance. The Episcopal Bishop in Kigali informed us that the Taxi Drivers Union approached the church to help them in HIV/AIDS prevention. This indicates the need that employed and self employed males have to be informed.

6. **Increase male involvement**

Since males are the primary decision makers there is need to design interventions to involve males for their support and participation in family planning programs. The report has already addressed the opportunities available in HIV/AIDS programs, which address both males and female to include family planning issues as a way to promote male involvement. The recommendations below provide some of the strategies to that have been proposed and experiences that have been successful in other parts of the world.

a. **Family planning outreach to males:**

Since males have not been traditionally the focus of family planning, programs **provider bias** and the special sexual needs of males can make it difficult for males to seek or access services. Couple counseling increases communication and contraceptive. Male health providers of community-based distributors could provide the best way to reach males and provide counseling on family planning to convince men to support their partners decision to use modern contraception.

b. **Utilizing male association and groups :**

Male associations and groups, male associations such as the military, fishermen unions, cultivators of tea, associations of fathers in churches, associations of youth, association of taxi men mini buses, and mottos all are possible groups where family planning IEC activities and referrals can be provided. The Anglican Bishop of Rwanda indicated for example that the Taxi Drivers Union had requested the church to provide them with information and counseling on HIV/AIDS because many of their members were dying from HIV/AIDS.

c. **Promoting male Involvement through safe motherhood**

Child health:

Male attitudes regarding child health in Rwanda is very positive and should be exploited. A Population council study showed that pregnancy and the antenatal care setting can

provide a window of opportunity to involve men more deeply in the care of their partners and the children. At health centers, post-partum visits by fathers to counsel new mothers with fathers can be successful in preventing closely spaced pregnancies. This is a first step in bringing males in touch with the health service delivery system which may expose them to more information regarding the sexual and reproductive health issues which may in turn provide opportunities to help them understand the benefits of family planning. Other ideas include inviting porters and health care providers of various levels working in the hospital for group IEC family planning sessions as conducted by the health center in Byumba. Similar to many other developing countries, male contact with health providers is limited and therefore any opportunity that brings them to the health center should be used to provide information on family planning.

7. Design Specific Program to Reach Adolescents in general

The need to address the reproductive health of adolescents in Rwanda is critical. There are neither blueprints nor easy solutions to reach this group. However, multiple channels must be used and a wide variety of approaches must be adopted. The draft reproductive health policy of the Ministry identifies the challenges of addressing adolescent reproductive health in Rwanda. Some of the reasons cited include the absence of programs which target adolescents with appropriate services in confidential settings, illiteracy and lack of information, gender preferences and differentials in education, gender based violence among adolescent girls, school drop outs as a result of unwanted pregnancy, poverty in households where adolescents live.

The fact that family planning service provision to adolescents is a controversial issue makes it a challenge to services as an answer for addressing the sexual and reproductive health problems adolescents face. However, youth associations, parent associations, churches and other members of civil society need to address the realities of the increasing numbers of unwanted pregnancies, and HIV/AIDS and design a comprehensive strategy to provide both information and services to adolescents. Lessons learned from other countries in sub-Saharan African countries show that providing information and services does not increase sexuality but provides skills to adolescents to safeguard their health. Youth friendly clinics, peer education, drama, media education and other forms of communication to address ARH should be developed in partnership by all those responsible.

IV. At health service delivery points, what are the obstacles in delivering quality Family Planning services?

The obstacles identified at service delivery points are a synthesis of data collected at six service delivery sites of FOSA, administrative and medical personnel at the provincial level, health animators, traditional birth attendants, and clients. The information was complete at the workshop for the validation of the results.

1. Insufficient human resources and in particular providers of family planning services

There is an overall deficit in medical personnel that is known in Rwanda, which is particularly aggravated as a result of the genocide. Recruitment efforts have been made and this is an important component at the level of program of family planning for the lack of sufficient providers who can offer appropriate Services. The overwork of work on few health care providers who are asked to do multiple tasks were observed a where the only qualified person in Family planning is also performing other emergency health activities such as maternity and that she does not have the time to concentrate on family planning.

2. Inadequate technical staff at the division of reproductive health

In 1998, the division of Maternal and Child Health of the Ministry of Health adopted a new institutional framework and became the Division of Reproductive Health. The Division retained the same level of technical and human resources, in spite of the expected range of components to implement (elaboration of Policies, Norms and procedures of RH, program designing, implementation, monitoring and evaluation). When the team was in the field, the Division had 4 technical staff, but lacked a medical doctor. The staff person from the Ministry of Health who accompanied the team is in charge of contraceptives distribution. During her absence it means that her tasks will suffer and will be disturbed. As a result of her absence, her responsibilities were either added to someone else's or were not covered.

3. Inadequate technical capacity of family planning health care providers:

The Ministry of health has made significant efforts to train with support from WHO and UNFPA but the deployment of trained staff is inadequate. A significant majority of the health care providers that were encountered during the district visits were not adequately trained in family planning service provision, which impacts the quality of information and services, the clients received. The consequences which results from this lack of training are described below:

a. Counseling: Appropriate counseling on family planning methods and potential side effects are not provided to clients as indicated by discussion through

client interviews and group discussions. Health animators were concerned that clients they referred reported that clients that providers did not adequately address side effects nor provide appropriate methods.

b. Adolescent reproductive health: Health providers are not trained to meet the comprehensive reproductive health of adolescents. Health providers have erroneous assumptions and Misconceptions contraceptives, which adolescents can and cannot use. Health providers whom the team encountered in Kibungo believe hormonal methods n affect future fertility and therefore did not provide adolescents with pills or injectables. This is in contradiction to the FP guide form used at the health center, which the Ministry of Health has made available for the center. This form has not contra indication of the unitization of hormonal contraceptives for adolescents. . The health provider did not know (-) or (+) on the form. This was testimony that she was not trained to offer family planning services.

4. Limited method choice

With the exception of Kigali, in all of the districts the only two methods that were available were the pill and the injectables. The implication of lack of method choice for women on her health is grave. In Gitarama, the team encountered to a woman admitted to the hospital for her fourth high-risk pregnancy as a result of hypertension. She had expressed an interest in using family planning earlier. Providers advised her not to take any hormonal method but since IUD was not available at the center. She found herself without her desire carrying with her hypertension, a fourth pregnancy occurred. Method choice is limited in all health centers visited by the team. For example, a client in Tabagwe using a vaginal contraceptive was forced to discontinue use when she could not refill since the center did not have any available. She was offered hormonal contraceptives, which she did not want, and therefore discontinued use the choice of methods is very limited in the centers visited limiting choices women have. The situation is aggravated by the limited competence of health providers for effective referrals of their clients. .

5. FP services are not available daily in each health center

One of the principles embodied in the health policy is that health services must be accessible to ensure continuity of care for clients. For health prevention and promotion such as PF. services should be available all the times at all hours of the week. The team found that some centers are provided only on specific days of the week. Administrators of health centers believe that clients who come for other services need to be addressed first, and those who come for family planning are scheduled for a special day. For women who have to travel long distances to health centers this is an inconvenience.

6. IEC services at service delivery sites are very weak

PFIEC/ activities at the service delivery points are non-existent. Without exception at all the service delivery points the team visited, FP/ IEC materials were not posted in visible places where people were waiting for services, or were being provided with services could see. According to all the health providers interviewed IEC activities on family planning. IEC sessions are rare. In Tabagwe Center in Umutara for example the health center conducted only two sessions on FP/IEC during the last 6 months. The health provider said that women come individually and it is difficult to organize IEC group sessions.

7. Limited collaboration between health centers and health animators and TBAs

a. Health Animators:

The Health Animators programs were established in Rwanda in 1995 with a mission to promote health programs in the community and increase access and utilization of services. The community selects men and women and the committee of the health center guarantees their candidature and provides the criteria for their work. They are literate,

promote sensitization and engage in other health activities such as the distribution of mosquito nets, anti-parasite medications and conduct epidemiological surveillance. Health animators perform awareness activities and provide some services. They are trained and supervised regularly

at the community level by the health centers at the district regional and central levels. Access to health facilities for most Rwandans is not easy for reasons cited earlier. The health animators therefore are in close proximity to the population and know the community intimately. Their understanding of the social and cultural lives of people in the community makes them a valuable asset. Discussions with health animators reveal that they know the size of the community, marriage patterns, and major problems facing the community. Their suggestions are based on the concrete realities they observe daily on the ground. Although the team realizes that health animators provide a valuable resource to improving the health of communities, they identified the following problems:

- The relation between health animators and the health centers is not strong even though health animators even though they continue to provide useful information from the surveys. The information from the surveys includes information on the health of the community.
- Training health animators perceive what they get from the health center as inadequate. For example, at the Kirehe health Center in Kibungo Health animators were trained for one

There is no collaboration on family planning
We have done some surveys of the population, which we provided to the health center, but there was no feedback
There is no motivation and there is not enough time; we also have to do other things to survive.
- Health animators, Kirehe Health Center, Kibungo

The TBA's in Kibuye also provide advice on limitation of children to women who have a lot of children and refer then to the hospital for family planning services. They also provide vaccination information and prenatal information. If the women have the first delivery or more than 5 delivery is referred to the hospital and complicated births also are referred. Many women do not know that family planning is good for them and some husbands do not agree with women's decision to use family planning services. Collaboration with health providers consists of one meeting every three months and usually there is nothing on family planning during these meetings. They were trained a long time ago and they provide some updates when they come to the meeting but only on other issues, which does not include family planning. For the program they are only informed on what they do.

week only in 1997 and they were provided with some manual aids which they utilize anymore

- Health animators do not consider current meetings with the health center and the district medical officer “useful”
- Under the old ONAPO structures incentives to motivate health animators were far more generous. Currently they view their situation in transition and feel that they do not get any benefits from participating in the program even uniforms, cassettes, and without any profits

Currently, there are initiatives in three health districts where health animators are conducting sensitization activities and distribution of pills

b. Traditional birth attendants

The number of deliveries that take place in the home is significant. Traditional birth attendants who are both trained and untrained form a majority of those who serve these populations. TBA's are well known, accepted and selected by the community and already assist in deliveries. They are trained to perform normal deliveries and have rudimentary skills in infection prevention. They conduct some IEC for CPN and refer at risk pregnancies. They do normal deliveries, and provide counseling for pregnant women and new mothers. They operate at the lowest level in the community and therefore are even closer to the community than the health animators. However some are not literate and do not know how to read or write. Some of the trained TBA's have some knowledge and training on family planning and provide some counseling while others do not. Others are also active and have strong linkages with the health center. Monthly meetings, reports and feedback to the health center vary from district to district. The variations are significant. In one district one of the traditional birth attendants complained that she did not receive gloves and that the health center is not interested with their work. The number of traditional birth attendants has decreased from 60 to 10 because of lack of motivation.

At the Kirehe center even though we were not able to meet with them due to calendar problems, the director of the center told us about the successful collaboration the health center had with the traditional birth attendants association. . There are 60 active Tabs who assist in prenatal consultation. They refer approximately 67 women a day. The TBAs sometimes provides family planning counseling and accompany women to FP services. They buy delivery kits and from money they are paid by women who are pregnancy. Women pay 500RWF at their last moth of pregnancy to buy the kit. The traditional birth Association currently manages an account of 230,000Francs. This is an example, which should be studied and replicated to other parts of Rwanda. Such active TBA association can be utilized for family planning sensitization, condom distribution. **However they cannot be used for the distribution of pills.** Their involvement in family planning can be cost effective and sustainable in the long term

8. FP services are not standardized in the country

The Health Activity Standards Document is available at the central level and consists of updated information regarding family planning information. Throughout the field visits, districts neither had a copy nor utilized this information. Family planning forms used for clients were also different. In Kibungo, Byumba, and Gitarama, new revised forms were available. In Kigali, Kabusunzu center, the previous forms used by ONAPO forms were still being utilized. ARBEF continues to use its own forms. Furthermore, 1998 WHO criteria for Family planning are not included in the new form. This situation makes it difficult to standardize the collection and analysis of data for supervision and monitoring of family planning activities.

9. Private Catholics health centers usually do not offer modern FP methods

The majority of Catholic health centers (more than 33 % in the country) are prohibited from providing modern FP methods. However all Catholic centers provide family planning counseling to their clients and provide information on all methods. Both group counseling and individual counseling is provided. The clients then are referred to sites (pharmacies, health centers) to get the appropriate contraceptives. Only natural family planning (NFP) is permitted. NFP is neither well organized nor effectively managed. Women are referred to public centers, and follow up to referrals is not completed. Considering the difficulties women face in using natural family planning, methods some providers offer modern FP services without the formal authorization of the church. In one of the centers FP services centers was organized well. . This example demonstrates that occasionally, it is likely that that Catholic health centers can support modern family planning programs. .

10. Private sector and national NGOs involvement in FP is limited

The participation of the private sector (private doctors) in family planning is weak. With the exception of Kigali the team did not examine any private FP services. The two private clinics in Byumba and Kibungo did not provide FP services. They simply referred women to the public health center. In Kigali, the only private clinic visited offered FP services, but expressed for adequate IEC materials training on family planning updates. The team did not come across many non-governmental organizations involved in FP service delivery with the exception of ARBEF's two centers in Kigali. One of the two ARBEF clinics offer integrated RH services with VCT services and prenatal care with the other center providing services to adolescents and young people. Many national NGOs are involved in IEC/RH, which includes FP. ARBEF also has initiated CBD programs in three sites that are successful. The team was not able to see these programs but reviewed the service statistics from reports they offer family planning services through community based distribution system.

11. The integration of family planning activities such as maternal and child health services

The support for vaccination and immunization programs in Rwanda is very high. There is no ambiguity concerning the benefits of the program to the welfare of both the mother and the child. The question related to uncovering the reasons for support for child survival programs and the apparent lack of support for family planning programs. The community articulated this in numerous ways. (See Box Above)

- Vaccination is a straightforward service because they can see the results and the program is structured;
 - They can make the association between vaccinations and the welfare of the child immediately;
 - They understand the end result and know the consequences of not participating in vaccination;
 - There is no stigma or rebuke from the community;
 - The women go to the health center because they see a direct relationship between pregnancy with no problems and safe deliveries.
- Gitarama Community Leaders

The community strongly believes in the benefits of child survival programs and actively participates to make it successful. . In particular, women make an effort to ensure that their children are vaccinated and protected from childhood diseases. In Kibungo community leaders gave another reason why vaccination programs was supported. They said that women are supposed to show their vaccination certificate; therefore vaccination is essentially viewed as “an order”. Additionally, vaccination campaigns by the government motivate and encourage people. This was confirmed by discussions with women who think vaccination is mandatory and without their vaccination certificate they would not be treated well by health providers.

The percentage of women who received vaccinations in the districts that were visited ranged from a low of 63% in Umutara to a high of 84% in Kigali Ville. During this time, family planning counseling can be provided for women who come to the centers for their vaccination. The Generally women who have secondary education are more likely to come for pre-natal vaccinations and the more children women have the less likely they receive their vaccination increasing their own risk and that of their children. The percentage of women receiving vaccinations decreases to 41.8 % when they have 6 or more children. The vaccination coverage rate for women where site visits were conducted starts from 63% in Umutara to 84% in Kigali Ville. Vaccination is a great opportunity for counseling women on family planning when they are at the health services for this service.

IV. At service delivery points how do you improve quality, availability and access to services?

1. Increase the capacity of human resources

Given the complex issues in reproductive health, adequate technical staff to monitor coordinate and harmonize activities between the central and district level is a prerequisite for achieving the objectives. Within the RH division adequate staff to focus on family planning would be beneficial. With the reorganization of ONAPO, the MOH will have a strong partner in supporting the coordination of selected activities including research and evaluation. Nevertheless, the technical capacity of MOH in the RH division must be reinforced. . Furthermore the overall health sector needs to need to recruit, train and motivate personnel with better salaries, and distinguish them with promotions

2. Strengthening the capacity of health care providers at different levels through training

It is a priority to improve the knowledge and technical aptitude of health providers in family planning to obtain a vision on the principles of FP and adopting a uniform familiarity and adherence to policy, norms and procedures by all FP health providers at the different levels of the health centers Currently, internationally defined guidelines exist to train family planning providers and evaluate their performance. These norms and procedures should be adapted to the local needs in the PNP and form the basis for supervising, monitoring and evaluating FP programs.

a. Pre-service training:

In the course of pre service training it is necessary to retrain the educators at schools of health to introduce family planning in the training at the schools of medicine and the family of medicine. Sites must be identified, for practical experience and training on method choice must be provided at the different sites. Distance education can also be part of the training strategy.

b. In -service training:

In FP must be standardized in all medical schools and updated curricula based on the existing model developed in West Africa for Francophone countries by JHPIEGO should be incorporated The training approach should be based on the Performance Based Improvement utilized by INTRA/Prime II) Training in counseling clinical FP service provision should be also provided for nurses and midwives who provide antenatal services. A system for continuous family planning training at all different levels should be established. Identify and equip sites for practical training, and introduce training in at the site for apprenticeship and distance education and training.

c. Motivation:

Providers must be motivated by better salaries career promotions study tours exchange of experiences and honor and acknowledgement of their work and

3. Expand the community based distribution program in Rwanda

Due to time and logistic constraints, visits to ARBEF CBD programs were not carried out. Nonetheless, the success and achievements of CBD programs in other sub-Saharan African countries leads the team to consider that family planning services through outreach services can achieve the following: 1) decrease the workload of health providers at health centers; 2) utilize health centers as referral points for first time users and complications associated with contraceptive use; 3) make FP services more available and accessible every day; 4) strengthen the capacity of providers to offer an integrated package of SR services;. Ongoing initiatives implemented by ARBEF and PSI on community-based distribution should be evaluated for measuring effectiveness and quality. A national approach on CBD should be developed and implemented.

4. Implement the recommendations of the DELIVER contraceptive and logistics assessment

A major component of the current assessment included the assessment of the contraceptive logistics system.⁷ The MOH recognizes the necessity to strengthen the contraceptive and logistics system. Discussions with the representative of the First Lady's Office underscored the need to improve quality of services including availability of method choice prior to promoting family planning in the country. Strengthening the contraceptive and logistics system would have a tremendous impact on decreasing rumors, complaints of real and perceived problems associated with contraceptive use. Therefore, recommendations that are proposed by the **DELIVER** team representative should first be addressed to ensure that contraceptive supply and security are adequately met to improve quality of existing services. .

5. Strengthen the role of health animators and traditional birth attendants

The role and responsibilities of health animators' and traditional birth attendants and their with the community and the health center should be clarified. The following should be implemented:

- Integrate IEC activities during home visits and popular meetings organized at the community level
- Distribute condoms
- Ensure that re supply of pills for female clients who have already prescriptions from the health center
- Restock contraceptive supplies from the health center
- Utilize lists to monitor individuals using family planning services
- Monitor clients using contraceptives from their homes
- Refer clients to the health center for first time consultation and in cases where clients complain of side effects

⁷ See complete report from DELIVER Team Member, Marilyn Noguera.

To ensure that Health Animators provide quality of services the following recommendations are proposed:

- Provide information which is appropriate to their level mission
- Provide appropriate IEC materials and contraceptive supplies
- Ensure that monitoring and supervision of their activities, reports and meetings in and reports and reunions are integrated in FOSA (Formation Sanitaire)
- Reinforce their motivation through a system for the recuperation of fees from products they provide and seek ways to honor and distinguish their contribution

During the field visit, a significant number of health animators we encountered in the field were men. This apparently is the result of a significant number of women who have dropped out of the program. It would be important to increase the number of women health animators to reach women.

The experience in many countries in sub-Saharan Africa shows that TBAs who have the trust of women and are the major source of information on sexual and reproductive health can be a valuable resource if they are properly trained, monitored and supervised by the modern health services.

Similarly to what has been proposed for Health Animators the following is proposed for TBA's

- ✓ Provide information adapted to their level and mission
- ✓ Provide adequate IEC materials and condom supplies
- ✓ Provide monitoring and supervision of their activities through reports and meeting in FOSA
- ✓ Reinforce their motivation through the recuperation of fees from the sale of products and seek ways to honor and distinguish their contributions.

Additionally undertake activities of awareness for individual counseling on the importance of family planning programs at their meeting, they can distribute condoms and refer clients to the health center.

The both categories of such personnel it is important to:

- ✓ Provide clear written guidelines to those responsible for FOSA the roles of the trainers, supervisors in family planning and the descriptions of their work and responsibilities.
- ✓ Provide appropriate training to ensure that these responsibilities are carried out (i.e. conduct planning meetings, ensure monitoring, continue training)
- ✓ Involve district health personnel in reinforcing such collaboration

Discussion with TBAs in Kibuye showed that TBAs were supportive of family planning. Even though they look at family planning in the context of safe motherhood they are interested in learning more about family planning particularly as it relates to helping women address the side effects. They are supportive of family planning for those who have reached their desired number of children. Again family planning as an intervention for child spacing was not mentioned however, they did say that it is related to improving the health and welfare of the mother.

6. Strengthen the role of NGOs, the private sector and religious health centers

Integrated clinics, such as those that implemented by ARBEF in Kigali and other regions of Rwanda can be a model, even if clients pay more. The availability of methods encourages client demand. The association of private sector providers should be encouraged to coordinate their activities with the MOH to find more effective ways to expand FP services in commercial private clinics beyond Kigali. A special advocacy should be conducted with the help of the National Council for the Prevention of HIV/AIDS for the application of the National Reproductive Health Policy into their centers. Referrals centers where clients go after counseling from Catholic health centers to get contraceptives should be strengthened.

7. Integration of family planning with existing health activities

As part of this assessment the team looked for opportunities where family planning activities can be integrated. Recommendations are based on the feasibility of the integration and the potential for synergy.

a. Integration of family planning in other services included in the Minimum Package of Activities (PMA) of health services and the Minimum Package of Complementary Services at Referral Hospitals.

In the description of PMA and PMC, family planning is already included. However, health providers do not take opportunities at each occasion to either talk about family planning or include it in their services. The information activities and orientation of the training of health providers provides them with skills on CPN, CpoN, PEV, CN and nutritional rehabilitation. Family planning services should be offered every day in the health centers. To ensure confidentiality a separate room for consultations can take place must be provided. General consultations in the health center and hospitals in the districts and gynecological consultations for clients referred patients is the first contact clients have which are occasions for introducing family planning services. The clients can be open to listening to the information if the health provider is trained in family planning. There is need to increase the personnel which can complement existing ones at the hospitals and health centers in the district to offer family planning services for long term contraceptives such as the insertion of IUD.

b. Integration of family planning and HIV/AIDS Activities

HIV/AIDS activities in Rwanda are present throughout the country. Many health centers, organizations and associations undertake prevention messages, testing and counseling centers, as well as educational programs. These programs touch a large segment of the population and address youth, women, and men in both rural and urban areas. In particular demand for VCT is high and these centers provide an opportunity for integration of family planning messages and services as a critical component of the services for both HIV positive and negative clients. It can be cost effective and reach populations who are sexually active and at risk of both HIV/AIDS and unwanted pregnancies.

An important finding by the team found in this assessment is the need for integrating VCT services with family planning services. The recommendation is based on the fact that populations who come to VCT centers are also at risk of unwanted pregnancies because they engaged in unprotected sexual activities. MTCT services are also a good opportunity to link with family planning services because the HIV positive women need to be protected against unwanted pregnancy.

Benefits of integrated services to HIV/AIDS activities

- Specific groups such as **widows and unmarried** women who have higher HIV rates and present a significant number among those who are being tested at VCT sites are not reached by traditional family planning messages can be reached.
- Male involvement in family planning programs should be a critical focus since decision-making regarding fertility still remains primarily in the hands of males. Therefore, reaching males through VCT centers would provide an excellent way through which to promote male involvement in family planning.
- All the women who are HIV/positive need counseling and services on family planning if they chose to prevent pregnancy. This is particularly important for those who are not in close proximity to health care system or providers.
- Time spent at VCT sites by clients provide health providers opportunities to integrate individual or group IEC, services, and referrals the same day. Opportunities for accomplishing this were clear during site visits
- Common themes such as male involvement and gender-based violence can be integrated within the context of women's rights for both HIV/AIDS and family planning issues strengthening both messages. HIV/AIDS and VCT data shows gender-based violence that includes sexual violence to be an important factor to consider for women who come for counseling.
- Costs associated with integration of family planning services will be lower since the basic infrastructure and system for VCT is already established. Burdening other health programs which have limited financial and human resources may limit the effectiveness of counseling and family planning services provision.
- HIV/AIDS counselors can benefit from the support of family planning providers or the services associated with such programs. This will undoubtedly help them address the sexual and reproductive health concerns of their clients. In particular, since many of the clients are those coming as part of pre-marital⁸ requirements, this provides an opportunity for counseling couples who are starting their life together regarding their reproductive intentions
- Where **MTCT** is part of the HIV/AIDS programs pregnancy prevention may be an important service provided to mothers who choose not to become pregnant after delivery.
- Youth reproductive health services are not available in the country; youth go to VCT centers for testing. This provides an excellent opportunity to counsel youth on family planning methods whether they test positive or negative.

V. Policy advocacy and coordination

⁸ The team found that that churches advised, counseled and sometimes even required couples to get tested prior to marriages. Testing prior to marriage is becoming more and more accepted and among some people is perceived to be a mandatory requirement.

A. Advocacy

How do you promote advocacy to ensure that family planning becomes a priority among policy makers and opinion leaders at all levels

1. Findings:

During the development of the reproductive health policy in Rwanda, family planning was identified as one element of the six priority components. The present evaluation reveals that the immediate preoccupation of opinion leaders and policy makers at the central, provincial and district level following the genocide was on other priorities they were confronted with and responsible for. Consequently, family planning was not considered a major concern. Neither program managers, nor religious groups and other associations at the central level had other major health concerns such as HIV/AIDS, vaccination and malaria. Primarily at the district and provincial level where site visits were conducted team encountered health program managers who felt that they neither had the time nor the initiative to pay particular attention to family planning since it was not priority at the moment.

International cooperation for family planning promotion was also weak as a result of the genocide. The immediate concerns of reconciliation, reintegration of displaced populations, HIV/AIDS epidemic, and prevention of malaria control, and vaccination were emergency issues. All those that interviewed during the assessment agreed that the moment has now arrived for family planning to become a national priority for health. An additional problem is that Family planning is perceived as an exclusive responsibility of the Ministry of Health. Despite the fact that the personnel and the infrastructure of the Ministry of Health cannot address the various dimensions of family planning, the perception is that family planning is the exclusive domain of the Ministry of Health. For example the integration of family planning into existing policies and programs designed to promote gender equity and empowerment can be a foundation for advocacy of family planning programs. Reproductive Rights and Women's Empowerment is a vehicle to promote reproductive health and has been endorsed by the International Conference on Population and Development Conference in Cairo (ICPD) in 1994. Structures to promote gender equity and women's social empowerment are well established and have governmental commitment. After the genocide communities were mobilized to promote peace and reconciliation, as well as to legislate equality of women. The process has rendered them a dynamic force in Rwandan society. Collaboration and linkages of the family planning agenda with the women's empowerment struggle in Rwanda is a critical step to create legitimacy, awareness and relevance.

Lack of priority given to family planning has also translated into the allocation of resources, which is limited both by the government and both the government and other

partners. Therefore, without the priority given to this program, fewer resources are allocated for the implementation of family planning programs.

2. Recommendations

a. Overall advocacy strategy of the Ministry of Health:

The ministry of health should initiate a advocacy plan which should be followed by all national and international partners, as well as policy makers and opinion leaders at all levels to consider family planning as a national priority and take appropriate actions in favor of family planning promotion.

It is critical to establish in comprehensive manner to involve opinion leaders and policy makers at the central, provincial and central level. To provide an example,

At the **central level** the President and the Secretariat of the First lady, Parliamentarians and members of the government, leaders of the major religions, the presidents of private enterprises, union representatives, women and youth associations, national presidents of different councils and commissions etc.

At the **provincial level** prefects and provincial representatives of the decentralized structures of government, priests, ministers and Muslim leaders, representatives of NGO

At the **district level** representatives of decentralized community based structures etc.

b. Preparation of justification and instruments for advocacy

. It is necessary to provide those responsible with all the information, which will help effectively implement effective advocacy activities

- Copies of the document of the Reproductive health policy
- The synthesis of the results of this evaluation, the demographic and health survey, and the situation analysis of family planning and other studies that are judged to be useful and easy to understand for a large audience

The process for the organization of the advocacy is to ensure that all the opinion leaders and decision makers assume their specific roles and responsibilities at national provincial and central level regarding the promotion of family planning.

At the **central level**, a national symposium on Family planning should be held for the adoption of the policy on reproductive Health. This national symposium should be presided by the highest authorities of the country, for launching of the policy to all those responsible to introduce in their speeches and their actions elements of promotion of Family planning as a basis for information they receive from the Minister of Health.

At the **provincial and district level**, it is necessary to follow up and organize workshops for the dissemination of the reproductive health policy. During these workshops the focus should be on the importance that has been accorded to family planning as a health interventions for children, women and that of the whole family. Participants should then be able to incorporate these messages in their speeches, sermons and forums in their communities

At the **international level**, it is recommended that funds be solicited specially from UNFPA, which is the agency with the mandate for mobilizing funds for issues regarding reproductive health. UNFPA should help Rwanda seek funding for increasing family planning interest among international programs.

c. Identification of target groups for advocacy

1. Findings

- ✓ The population is aware that these groups are vulnerable and need family planning services.
- ✓ This particular population and the health providers stigmatize this population when they seek family planning services
- ✓ There are unwanted pregnancies in this group and this confirms their need for family planning services. In Kibuye, a midwife confirmed that one third of the women who had delivered were widows who did not want to become pregnant
- ✓ The lack of confidentiality in family planning services is a particular problem confronting this group
- ✓ For adolescent integrate family planning information and services in recreation programs
- ✓

2. Recommendation

Develop an advocacy Strategy for vulnerable groups: Develop a strategy of advocacy and IEC targeting vulnerable groups (consequences of the genocide such as widows, single women, women with husbands in prison, and women who are victims of violence and adolescents)

d. Recommendations for resource mobilization

It is also recommended that a process for the mobilization of additional resources be established to promote family planning programs

- a) The comprehensive and quantitative assessment of necessary resources, the results of the situation analysis conducted by ONAPO, other situation analysis and recommendations from the current evaluation
- b) The identification of internal resources that can be mobilized. For example the national budget in particular regarding funding from Poverty Reduction

Strategy and Debt Relief Resources, and the contribution from community health committees and the private and commercial sector.

c) The mobilization of internal resources, which can be secured from private sector family planning service provision.

d) Establishment of measures to provide incentives for the private sector to alleviate the public sector

Organizing a roundtable a of donors as a last resort to seek complementary funding for family planning activities

All development sectors have to be actively involved in the implementation of this program

e. Recommendations Developing PNP/PF

Accelerate the development of PNP/PF utilizing the documents of other countries (Burkina Faso, Benin, Togo) to adapt to the realities of Rwanda and integrate important elements to address the needs of the following

- Vulnerable groups and issues of the genocide
- Adolescents
- Multi-sectoral aspects
- Obstetric and neonatal emergencies (SONU) and Post Abortion Care (PAC)
- Link all sectors in the validation of the PNP (RHP) document

Following the national symposium, ensure that all sectors integrate specific activities on family planning in their plan of action

f. Cost recovery for family planning services

1. Findings

During the team visits, the policy of providing free family planning services is not uniformly applied. Visits to health centers for complications and side effects of contraceptive methods were not free. However, it was noted that there were different views on whether cost recovery from family planning should be part of the policy. However, potential clients who may already not be convinced of the benefits of family planning may find fees an obstacle particularly those who live in rural areas. The perception of quality for some clients on free services is another problem. Free services are considered of inferior quality than those than those where fees are charged.

- ✓ The incentive fees provide which motivates health agents to provide family planning services to clients.
- ✓ The difficulties in sustaining family planning programs without some mechanism for cost recover as provided by the current policy

2. Recommendations

Because of the complexity of the problem, financial contribution by the population for cost recovery should be postponed for a year or two. Until then the status quo of the policy to provide free contraceptive services should be maintained.

- ✓ Conduct in depth studies of cost recovery for family planning services
- ✓ Identify all initiatives such as ARBEF's clinic, the health center at Kabusunzu, the ARBEF CBD program and the PSI social marketing program, and private clinics
- ✓ Conduct a study on the acceptability and the capacity of clients to pay for family planning services

B. Collaboration/Coordination

1. Findings

At the international level, the support for family planning programs has diminished since the genocide in favor of other priorities, such as national reconciliation, reintegration of displaced populations, the HIV/Aids epidemic, malaria prevention, and vaccination programs. All the representatives of donors the team met believed that family planning should now become a national health priority. Current interest in this evaluation, which the ministry has spearheaded, demonstrates that donors are interested in increasing their involvement in family planning activities. However, the coordination of these activities weak despite the fact that the first meeting on reproductive health took places December 2001.

Currently, coordination is weak due to the following reasons:

- The absence of written directives regarding coordination
- Insufficient knowledge of the quality and number of interventions
- The absence of a unit to coordinate activities and lack of competent personnel to monitor evaluate family planning programs with clear descriptions of tasks
- Inadequate preparation for sporadic meetings, often without clear objectives. Such meeting arrangement is not well organized and invitations to participants arrive late to participants.

During the field assessment the team found reproductive health initiatives were not effectively coordinated. For example the PSI, CBD initiative in Kibungo and the ARBEF initiative were doing the similar activities without any collaboration. Another example is that ARBEF is training community-based distributors while there exist health animators currently who could have been trained as CBD's. Another aspect of collaboration that donors who are working in areas such as gender, HIV/Aids, civil society, Democracy and Governance do not seek ways to work in collaboration with family planning programs effectively.

2. Recommendation

The coordination of interventions in family planning Rwanda must be reorganized. There are excellent models that can inspire such reorganization such as UNAIDS, UNDAF or thematic groups such as the one for vaccination. The coordination model used in Togo consists of a meeting every six months of all implementers. The objective of the meeting is to analyze their reports at the end of the year and consolidate their current plan of action. The second meeting, which takes place in the middle of the year, is to ensure monitoring and implementation planned activities. In addition, plans for the following year are prepared

a. Strategies for improving coordination

A document, which provides guidelines for coordination, should outline the following:

- ✓ Objectives of coordination
- ✓ Roles and responsibilities
- ✓ Timetable for meetings
- ✓ Level of coordination (central, province, et district)
- ✓ Implement a formal system of coordination which defines for example at each level at least one meeting per six months implementers of reproductive health and family planning
- ✓ Implement an appropriate unit of supervision evaluation and coordination of activities and intervention at the DSR

C. Overall recommendations for the Ministry of Health

The **Ministry of Health** should take the leadership role or assign donors the responsibility on behalf of the Ministry to establish a task force to coordinate activities related to family planning and reproductive health to achieve the following objectives:

- Identify programmatic priority areas in family planning and reproductive health among donors in order to establish a consensus for the allocation of resources;
- Create a forum for the exchange of ideas and experiences among donors and their grantees for resource mobilization to develop FP program activities, for example:
 - To identify best practices for expansion or replication
 - To organize a coordination mechanism for family planning in Rwanda similar to that organized by UNAIDS, UNDAF and other countries with specific health teams such as vaccination.
 - Produce a formal document which can defines the objectives, roles and responsibilities and levels of coordination (central provincial and district level).
 - To identify programs for collaboration and partnership in different districts where donors are working to avoid replication of activities
 - To help donors understand and support the decentralized structures and guide them in working through these channels in a more coherent manner
- Hold joint training sessions and workshops to minimize time spent by health service providers for in-service training;

- Plan joint research and assessment activities in order to understand the obstacles regarding family planning and reproductive health programs in the country;
- Help establish agreed upon standard indicators to measure the success of different interventions to improve the access and quality of family planning services; and

Facilitate linkages between donors and civil society in order to strengthen the involvement of communities in promoting family planning and reproductive health services

D. The role of USAID and allocation of its resources

The assessment team believes that USAID can play a **key role** in supporting family planning programs in Rwanda for the following in the following ways:

- a. Support capacity development in training, logistics, distribution, project management, and research;
- b. Support part of contraceptive procurement, distribution and management
- c. Support part of procurement of equipment and supplies for the health centers
- d. Provide technical assistance in program design and implementation and IEC/BCC strategy development;
- e. Develop integrated FP activities with USAID programs like HIV/AIDS and food security

The team suggests that USAID resources be allocated based on the following principles:

- Build on existing programs and activities to implement programs that are cost effective and promise results that communities can see in the short term. This is a priority that will have implications for the mission's ability to work with various stakeholders and determine how population and family planning programs can become part of their agenda.
- Strengthen the capacity of the MOH to coordinate, monitor and evaluate family planning activities must be strengthened and supported. While integration of family planning with other reproductive health is beneficial, it is critical to ensure that such integration does not marginalize either programs
- Strengthen the MIS systems both at the Central and the District level to collect data for monitoring and evaluating programs; and
- Support the development of BCC strategies for different target groups with the participation of different stakeholder in order to create awareness and support for family planning programs.

The team cautions that although resources are a major component for the success of making family planning programs, it is vital to ensure that resources are allocated toward activities that are most likely to yield results. Priorities should be determined in collaboration with the MOH and other stakeholders, particularly those who are most likely to be implementers. Such collaborative decision-making is key for success.

Stakeholders must develop consensus on priorities, recommend strategies, develop action plans, and agree upon roles and responsibilities. Such consensus will guide the mission towards a realistic plan for allocating resources for family planning and reproductive health programs in Rwanda.

VI. Conclusion: Summary of Major Findings and Recommendations

The team utilized a broad conceptual framework for the interpretation of findings and recommendations regarding family planning services in Rwanda. Given the objectives of the assessment and sources from where data was collected, the team hopes that the findings and recommendations reflect the wide range of stakeholder perspectives. When family planning is presented within the broader context of reproductive health and rights, opportunities for creating a dialogue as well as integrating it to existing policies and programs currently being implemented within the context of PSRD, health, gender, education, and youth policy become effective. Additionally, family planning must also take into consideration the following two factors:

- Family planning in the context of the HIV/AIDS epidemic in Rwanda
- The Rwandan genocide and its impact particularly on gender relations, sexual and reproductive behavior in Rwanda

The foundation for a strategy to promote family planning in Rwanda must also be in the context of the principles established by the Ministry of Health and the priorities identified by the Reproductive Health Division i.e. safe motherhood, prevention of unwanted pregnancy, access to contraceptive services, prevention and care of HIV/AIDS, and addressing the issues of sexual violence.

To achieve success in promoting family planning programs, a consensus has to be reached among all stakeholders on both the content and context of policies and programs. Rwanda has also built a broad based policy consensus for Peace, Rehabilitation, Reconciliation and Poverty Reduction. These policies provide a basis for strengthening programs such as family planning since they serve as guidelines for how Rwanda views its future development. Given the realities of global changes in the orientation of family planning programs since ICPD, multi sectoral partnerships, alliances and collaboration will need to be established for the reduction of fertility. Changes in sexual and reproductive behavior also have to ultimately come from individuals. Change community norms will necessitate collaboration with civil society. The changes in policy at the central level are only the first step in the process of involving the community to accept family planning as an integral component of both health and development for the country.

The 2000 DHS indicates that modern use of family planning in Rwanda has decreased from 12% to 4% since 1992. As demonstrated in the report, the reasons for the decrease are complex and therefore the recommendations will not be simple. Increasing the rates of utilization will require interventions, which impact not only the health aspects of family planning but also the socio-cultural, behavioral and religious context, which guide people's decisions in matters related to sexuality and reproductive health decisions.

The opportunities for promoting family planning activities in Rwanda are encouraging. The following opportunities were identified by the through the assessment:

1. It is estimated that more than a **third of women in union 36%** have an unmet need for family planning if that need were satisfied; contraceptive prevalence would reach 49% among women in union. The total potential demand for family planning would primarily be for spacing births (31%) Today only slightly more than a quarter of the total potential demand is satisfied. **(2000 DHS)**
2. There is a strong donor commitment to allocate resources to strengthen family planning and reproductive health programs. ^{9[1]} Discussions among donors indicated their interest in allocating resources, but helping coordinate their activities in order to maximize the impact they have in the country will be important. The experience from other countries in Sub-Saharan Africa demonstrates the need to jointly plan with donors to ensure that activities are not redundant but coordinated.
3. High population growth and high fertility is recognized as major obstacles to poverty reduction in the country, particularly because of the high-density population density and available resources. . This is reflected in all major policy documents, as well as discussions with policy makers. However, the demographic argument for promoting family planning programs among the population does not address individual reproductive intentions, are the cornerstone of fertility decision-making. Linking individual use of family planning services to improved quality of life is more palatable, less controversial and non political than the demographic argument which may have political undertones.
4. There is a strong **commitment by the government of Rwanda** to promote gender equality as indicated by legislative reform in inheritance rights for women, affirmative action in political representation, institution of legal age of marriage and the prevention of violence against women.
5. **The Ministry of Health** is committed to promoting quality reproductive health programs in the context of safe motherhood, child survival through integrated services and improved quality and access. Through its special division of RH, the Ministry of Health is taking the leadership role in defining its agenda in strengthening the quality and access to RH services.
6. **ONAPO** is reorienting its activities and will play an integral role in promoting quality through conducting assessments in quality, research activities and supporting the work of MOH. Rather than working parallel to the MOH it will work in tandem with the MOH. This new role will help in defining a new vision for IEC, partnership and collaboration.

^{9[1]} A world bank population and health project will be extended for an additional five years beginning 2002, UNFPA is committing 7 million dollars for support in three core areas: reproductive health, population and development strategies, and advocacy. This is also complemented by UNDAF goals and strategies elaborated for the areas of HIV/AIDS and reproductive health. USAID's support for this assessment also indicates support for future activities in the area of family planning and reproductive health.

7. **Public sector interest** in FP has a broad base support beyond the Ministry of Health in the Ministries of Gender, Education, and youth. These ministries have activities on women, youth, HIV/AIDS and provide tremendous opportunities for integration.

8. **The Decentralization policy** of the government will facilitate the process of implementing population policy, reproductive health policy and programs all levels of government. Decentralization promotes broader participation giving ownership to local communities. The framework for decentralization allows a multi-sectoral approach, which can help integrate population activities across other sectors at the district level.

9. The proliferation of civil society associations and groups that have emerged to address the needs of vulnerable populations as a result of the genocide are now continuing their work towards reconciliation, peace, reconstruction and economic development. These are mechanisms for advocacy because issues related to fertility; population and contraception require dialogue for creating a transparent process.

10. At the local level there was a **high level of awareness** regarding the benefits to family planning for health and welfare of mothers and children as well as the economic burdens of having too many children. Both individuals and community leaders were concerned about adolescent reproductive health and maternal and child welfare and the health risks of having closely spaced pregnancies and too many children.

The challenges facing Rwanda are also immense.

- Adolescents who constitute more than 40% of the population in the country require special attention to address their sexual and RH. Given that both rural and urban youth face similar risks Rwanda has to target adolescents in the whole country with life options, which can decrease the risk death and disability due to risky sexual behavior. This is complicated by the fact that parents and religious groups are faced with the dilemma of prohibiting condoms despite the knowledge that adolescents are becoming sexually active at younger ages.
- The impact of the genocide will be experience not only by this generation but also perhaps for the next generation of youth whose livelihood and security has been threatened. Widows, orphans, households headed by orphans, and those coming of age and their families will require programs to address disrupted social relations. Policy makers will need to recognize these dynamics and be sensitive in formulating and designing programs.
- As a result of HIV/AIDS epidemic, resources are shrinking. The burden on the health care system and families who are bearing the brunt of caring for HIV patient is enormous. Family planning may be marginalized by donors and by health care providers unless there is an increased emphasis on the value it adds to improved quality of life even for those who are at risk of HIV/AIDS.

- Because of the tremendous needs, the GOR and the MOH are faced with activities that are not coordinated. However in the aggregate they fit within the multiple objectives established by different sectors. Without a coherent strategic plan, which each Ministry can monitor and evaluate, it will be difficult to determine whether these interventions are effective.

In conclusion, the team believes that findings and recommendations in the report is a first step towards establishing a coordinated strategy for promoting family planning activities in Rwanda. This calls for the collaboration of major stakeholders to pool their technical, financial and human resources. Lessons learned from other countries demonstrate that population and family planning programs are crosscutting. Therefore all sectors will find different aspects in the program, which they can integrate and implement. With appropriate coordination and planning, and the involvement of stakeholders for shared responsibilities and lessons learned from other countries the potential for success is improved.

APPENDIX I POVERTY MONITORING INDICATORS (PRSD)

A. Poverty monitoring Indicators indicators, with targets

B. Performance

For 2005, 2010 and 2015

1. Outcome Indicators (Gender-Disaggregated wherever possible)

Health/Nutrition

- *Life Expectancy
- *Infant Mortality Rate
- *Under 5 Mortality Rate
- *Maternal Mortality Ratio
- Malnutrition
- Vaccine cover
- Births attended by qualified personnel
- *Rate of contraceptive use
- HIV/AIDS Incidence
- Rate of use of health services
- Rate of satisfaction

Control population growth	Reduce the population growth rate from 3.2% to 2.5 % in 2010	Demographic and health survey, every five years
Control fertility rate	Reduce the total fertility rate from 6% to 4% by 2010	Demographic and health survey, every five years
Reduce maternal mortality	Reduce the maternal mortality rate from 810/100.000 to 202/100.000 by 2015 Make reproductive health services available to all	Demographic and health survey, every five years
Reduce infant and child mortality	Reduce infant mortality rate from 107 to 35/1000 by 2015. Reduce child mortality	Demographic and health survey, every five years

Source: Poverty Reduction Strategy Rwanda, 2000.

Appendix II: Team Members

Ministry of Health	
USAID/Rwanda	Dr. Elizabeth Dbrant Health and Population Officer USAID, Rwanda
Advance Africa/Washington	Dr. Kambatibe Nbanda, West Africa Regional Director clinical Kwame Asieudu, HIV/AIDs technical Advisor Belkis Giorgis, Gender adn Adolescent Technical Advisor
Deliver/Washington	
Prime II/Rwanda	Christine Coonery, Director PrimeII Dr. Sostene

Appendix III: Summary Table of Interviews
Rwanda Assessment: Field Visits

District	Adolescents		Women	Men	Widows and single women	Community Leaders		Clients	TBA	Health Animators ***	Health providers
	M	F				M	F				
Gitarama <i>Kabgayi Hospital*</i>	10	9	10	10	12	2	5	6	7	3	7
Kibuye, <i>Kibuye Hospital</i>	9	9	8	14	5	5	1	5	5	24	3
Byumba <i>Bungwe Health Center**</i>	10	8	8	11	6	9	6	11	6	21	5
Umutara, <i>Tabagwe Health Center</i>	6	7	8	8	*	4	1	7	N A	7	2
Kibungo, <i>Kirehe Health Center</i>	8	6	8	7	6	5	NA	4	N A	5	8
Kigali Ville, <i>Kabusunzu Health Center</i>	7	6	8	6	3	3	2	2		2	2

*Catholic ** Anglican

***The majority of Health Animators the team encountered in the field were male. However, the high attrition of female health animators rather than preference for male health animators is the reason for this.

Appendix IV. Calendar for Assessments in Rwanda

January/ February 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<u>27</u>	<u>28</u> Arrival of Kampatibe, Belkis and Kwame Arrival times to be sent to Beth.	<u>29</u> Briefing w/ USAID, MOH and INTRAH/PRIME for logistics	<u>30</u> Team mtg. to refine SOW, questionnaires, assessment tools. This will include Dr. Vianney and Mr. Mugenzi. (see notes below)	<u>31</u> Stakeholders mtg.: MOH, USAID, CAs, UNFPA, UNICEF, etc.	<u>1</u> Meetings MOH: Group and individual (see list attached)	<u>2</u> Desk and logistics review
<u>3</u>	<u>4</u> Arrival Marilyn Noguera Appointments: CAs (see attached list)	<u>5</u> Appointments: (see list attached)	<u>6</u> Appointments: (see list attached)	<u>7</u> Visits/ field work (Rural)	<u>8</u> Visits/ field work (Rural)	<u>9</u> Site Visits/ field work (Rural)
<u>10</u>	<u>11</u> Kigali- Visits/ field work (Urban Site)	<u>12</u> Kigali- Visits/ field work (Urban Site)	<u>13</u> Visits/ field work (Rural)	<u>14</u> Visits/ field work (Rural)	<u>15</u> Visits/ field work (Rural)	<u>16</u> Report Preparation
<u>17</u>	<u>18</u> Appointments TBD * This day is reserved for any appts. not covered earlier or found necessary or follow-up meetings.	<u>19</u> Analysis of Report	<u>20</u> Prepare power point of findings	<u>21</u> USAID debriefing	<u>22</u> Stakeholders debriefing	<u>23</u> DEPART

Stakeholders Meeting	Meetings: MOH	Appointments: CAs and other donors	Appointments: Others (public/private)	Field Visits:	Stakeholders debriefing
<p>Objectives of the Stakeholders Meeting will be to introduce Advance Africa and its team, the objectives and outcomes of the assessment as outlined in scope of work, and to identify major priorities in FP/RH from participants. Advance Africa will prepare a power point presentation of the above. Advance Africa recommends the meeting to be one day.</p>	<p>1- General meeting with relevant staff identified at MOH. <i>(all)</i></p> <p>2- Dr. Joseph Byangandondera, <i>(Dr. Kampatibe, Kwame Asiedu)</i></p> <p>3- Dr. Gaspard, <i>(Kwame Asiedu)</i></p> <p>4- Melanie Mukantagara, <i>(Dr. Belkis Giorgis)</i></p> <p>5- Alexis Rnzindaza, Susan Mukabanda Dr. Claude Sekabaraga, <i>(Dr. Kampatibe)</i></p>	<p>1- Impact/ CARE/ UNAIDS <i>(Kwame)</i></p> <p>2- PSI <i>(Marilyn Nuguera)</i></p> <p>3- UNFPA <i>(Belkis and Marilyn)</i></p> <p>4- Intrah/ PRIME <i>(Belkis)</i></p> <p>5- WHO/ UNICEF <i>(Kampatibe)</i></p> <p>6- ARBF/ ONAPO/ <i>(all)</i></p> <p>7-GTZ <i>(Kampatibe)</i></p> <p>8-World Bank <i>(Kwame)</i></p>	<p>1- Joan Mutamba <i>(Belkis)</i></p> <p>2-David Nyashiya <i>(Belkis, Kwame)</i></p> <p>3- Dr. Bandura <i>(all)</i></p> <p>4- Religious leaders <i>(all)</i></p> <p>5-Women's Groups <i>(Belkis) *</i></p> <p>6- PROFEMMA <i>(Belkis)</i></p> <p>7- John Rutayisire <i>(Belkis)</i></p>	<p>1- For rural sites selected, we require more information on health posts and level of services provided to develop instruments.</p> <p>2- Other information on districts which will help assessments.</p>	<p>1- Organize a meeting for stakeholders of original meeting for discussion of preliminary findings.</p>
<p>USAID presentation of objectives of assessment, logistics for meeting and inviting participants, participant lists to include those identified by the mission in the contact list. Contact person to introduce Advance Africa team.</p>	<p>MOH appointments to be made for 2 hrs with group, and 1 hr. each for individuals.</p> <p>Normal working hours will be followed.</p>	<p>CA appointments to be made for 2 hrs each.</p> <p>Normal working hours will be followed.</p>	<p>Appointments to be made for 2 hrs.</p> <p>Normal working hours will be followed.</p>	<p>Identify other ways of meeting with the communities in their areas</p>	<p>Debriefing will be planned for half a day.</p>

Appendix V- Meeting with Stakeholders

Date: January 30, 2001

Site: ONOPO

Objectives of the Meeting was to introduce the Advance Africa team which will be conducting the family planning assessment in Rwanda, and provide an orientation regarding the best methodology of the family planning assessment to solicit feedback from key partners regarding family planning issues in Rwanda.

Three key questions:

- Why are Rwandan women not using family planning services
- At health service delivery points, what are the obstacles to providing quality family planning services?

What are the possibilities/options for community participation/involvement in family planning motivation and distribution?

Participants

Belkis Giorgis	Advance Africa
Kwame Asiedu	Advance Africa
Elizabeth Dabrant	USAID
Kristin Cooney	Prime II Kigali
Mugenzi Jean Nejo	Ministry of Health Div.
Dr. Jeanne Kabagema	World Health Organization
Dr. Mbominibuka	Care International
Murara Jerome	Ministry of Health, Plan Division
Umunyana Nyankesha Elanie	Ministry of Health TRAC Tel

Appendix VI. Technical Working Group to Develop Questionnaires

Date: February 1, 2001

Site: USAID

Objective: To Refine Questionnaires to be administered in the field

Participants

Belkis Giorgis	Advance Africa
Kristin Cooney	Prime II Kigali
Bueyana Sosthere	Prime II Kigali
Ntagungira Adrienne	ONAPO Kigali
N. Gwiza Danielle	Prime II Kigali
Sempabwa Emile	Prime II Kigali
Nyirasafalo Dahrose	Prime II Kigali
Mukakabanda Suhomme	Ministry of Health
Dabame Elizabeth	USAID
Sifa Seraphina	ONAPO
Kwame Asiedu	Advance Africa
Kompatibe	Advance Africa
Elizabeth Bryant	USAID

Appendix VII Questionnaires

LEADERS COMMUNAUTAIRES

1. QUE PENSEZ-VOUS DE L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE ACTUELLEMENT?
2. D'APRES VOUS QUELS SONT LES 4 FACTEURS PRINCIPAUX QUI INFLUENCENT L'UTILISATION DES SERVICES DE PF?
3. SELON VOUS POURQUOI LES FEMMES DE VOTRE ZONE UTILISENT PLUS LES SERVICES DE CPN ET DE VACCINATION QUE LES SERVICE DE PF?
4. QUE PENSEZ -VOUS DE LA CONTRIBUTION DES HOMMES DANS L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?
5. QUE PENSEZ-VOUS DE L'UTILISATION DES SERVICES DE PF PAR LES JEUNES?
6. QUELLE EST SELON VOUS L'INFLUENCE DES CONFESSIONS RELIGIEUSES SUR L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?
7. QUELS SONT SELON VOUS LES AVANTAGES DE L'UTILISATION DES SERVICES DE PF DANS VOTRE COMMUNAUTE?
8. QUE PENSEZ -VOUS DE LA RELATION ENTRE L'UTILISATION DES METHODES DE PF ET LA LUTTE CONTRE LES IST/VIH/SIDA?

(INTRODUCTION EXPLICATIVE DE PF NATURELLE EN ANNEXE)

9. QUELLE EST VOTRE OPINION SUR L'UTILISATION DES METHODES NATURELLES DANS VOTRE COMMUNAUTE?
10. QUELLE EST VOTRE OPINION SUR L'UTILISATION DES SERVICES DE PF PAR LES VEUVES ET LES FEMMES SEULES?
11. COMMENT PERCEVEZ VOUS L'UTILISATION DES SERVICES DE PF EN RAPPORT AVEC L'ADHESION AUX MUTUELLES DE SANTE DANS VOTRE ZONE ?
12. QUELLES SONT VOS PROPOSITIONS POUR AMELIORER L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?

QUESTIONNAIRE 2

GROUPE D'HOMMES

11. QUE PENSEZ VOUS DE L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE ACTUELLEMENT?
12. D'APRES VOUS QUELS SONT LES 3 OU 4 FACTEURS PRINCIPAUX QUI INFLUENCENT L'UTILISATION DES SERVICES PF?
13. SELON VOUS POURQUOI LES FEMMES DE VOTRE ZONE UTILISENT PLUS LES SERVICES DE CPN ET DE VACCINATION QUE LES SERVICE DE PF?
14. QUE PENSEZ VOUS DE VOTRE CONTRIBUTION DANS L'UTILISATION LES SERVICES DANS VOTRE COMMUNAUTE?
15. SELON VOUS, QUI DEVRAIT PRENDRE LA DECISION SUR L'UTILISATION DES SERVICES DE PF DANS LA FAMILLE?
16. QUE PENSEZ VOUS DE L'UTILISATION DES SERVICES DE PF PAR LES JEUNES?
17. QUELLE EST SELON VOUS L'INFLUENCE DES CONFESSIONS RELIGIEUSES SUR L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?
18. QUELS SONT SELON VOUS LES AVANTAGES DE L'UTILISATION DES SERVICES DE FP DANS VOTRE COMMUNAUTE?
19. QUE PENSEZ-VOUS DE LA RELATION ENTRE L'UTILISATION DES METHODES DE PF ET LA LUTTE CONTRE LES IST/VIH/SIDA?
20. POURQUOI D'APRES LA PLUPART DES HOMMES N'UTILISENT PAS LE CONDOM DANS LEUR COUPLE COMME METHODE DE PF?

(INTRODUCTION EXPLICATIVE DE LA PF NATURELLE)

21. QUELLES EST VOTRE OPINION SUR L'UTILISATION DES METHODES NATURELLES DANS VOTRE COMMUNAUTE?
22. QUELLE EST VOTRE OPINION SUR L'UTILISATION DES SERVICES DE FP PAR LES VEUVES ET LES FEMMES SEULES?
23. QUELLES SONT VOS PROPOSITIONS POUR AMELIORER L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?

QUESTIONNAIRE 3

GROUPE FEMMES

24. QUE PENSEZ VOUS DE L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE ACTUELLEMENT?
25. D'APRES VOUS QUELS SONT LES 3 OU 4 FACTEURS PRINCIPAUX QUI INFLUENCENT L'UTILISATION DES SERVICES PF?
26. SELON VOUS POURQUOI LES FEMMES UTILISENT PLUS LES SERVICES DE CPN ET DE VACCINATION QUE LES SERVICE DE PF?
27. QUE PENSEZ VOUS DE LA CONTRIBUTION DES HOMMES DANS L'UTILISATION DES SERVICES PF DANS VOTRE ZONE?
28. QUE PENSEZ VOUS DE L'UTILISATION DES SERVICES PF PAR LES JEUNES?
29. SELON VOUS QUI DEVRAIT PRENDRE LA DECISION SUR L'UTILISATION DES SERVICES DE PF DANS LA FAMILLE?
30. QUELLE EST SELON VOUS L'INFLUENCE DES CONFESSIONS RELIGIEUSES SUR L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?
31. QUELS SONT SELON VOUS LES AVANTAGES DE L'UTILISATION DES SERVICES DE FP POUR VOUS ?
32. QUE PENSEZ -VOUS DE LA RELATION ENTRE L'UTILISATION DES METHODES DE PF ET LA LUTTE CONTRE LES IST/VIH/SIDA?

(INTRODUCTION EXPLICATIVE DE PF NATURELLE)

33. QUELLE EST VOTRE OPINION SUR L'UTILISATION DES METHODES NATURELLES DE PF?
34. QUELLE EST VOTRE OPINION SUR L'UTILISATION DES SERVICES DE PF PAR LES VEUVES ET FEMMES SEULES.
35. QUELLES SONT SELON VOUS LES DIFFICULTES POUR UNE VEUVE OU UNE FEMME SEULE A AVOIR ACCES AUX SERVICES DE PF?
36. QUELLES SONT VOS PROPOSITIONS POUR AMELIORER L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE?

QUESTIONNAIRE 4

GROUPES ADOLESCENS ET ADOLESCENTES

37. QUE PENSEZ-VOUS DE L'UTILISATION DES SERVICES PF PAR LES JEUNES ?
38. QUE PENSEZ VOUS DE VOTRE CONTRIBUTION DANS L'UTILISATION DE SERVICES DE PF DANS VOTRE ZONE?
39. QUELLE EST SELON VOUS L'INFLUENCE DES CONFESSIONS RELIGIEUSES SUR L'UTILISATION DES SERVICES DE PF PAR LES JEUNES?
40. QUELS SONT SELON VOUS LES AVANTAGES DE L'UTILISATION DES SERVICES POUR VOUS LES JEUNES?
41. QUE PENSEZ -VOUS DE LA RELATION ENTRE L'UTILISATION DES METHODES DE PF ET LA LUTTE CONTRE LES IST/VIH/SIDA?
42. SELON VOUS DANS UNE FAMILLE QUI DEVRAIT PRENDRE LA DECISION SUR L'UTILISATION DES SRVICES DE PF ?
43. QUELLES SONT VOS PROPOSITIONS POUR AMELIORER L'UTILISATION DES SERVICES DE PF PAR LES JEUNES DANS VOTRE ZONE?

ANNEXE : Note explicative sur la PF naturelle (à utiliser pour expliquer au groupes avant de poser la question 9).

Les méthodes de planifications naturelles sont celles qui conseillent l'abstinence pendant les périodes reconnues par la science comme fécondes :

1. La méthode de la température
2. La méthode de la glaire cervicale
3. La méthode du calcul des jours de fécondité à l'aide du collier de perles

Ici, il ne s'agit pas des méthodes traditionnelles que sont la séparation des couples pendant des années, le port des fétiches protecteurs ou l'utilisation des plantes dont l'efficacité n'est pas démontrée par la science.

QUESTIONNAIRE 5

QUESTIONNAIRE FOR CLIENTS

1. POURQUOI ETES-VOUS VENUE AU CENTRE DE SANTE? POUR LES CLIENTES AUTRE QUE PF?
2. PENDANT VOTRE COSULTATION VOUS A -T -ON PARLE DE LA PF?
3. QUE CONNAISSEZ VOUS DE LA PF?
4. COMMENTS AVEZ VOUS ETE INFORMEE SUR LA PF?
5. SELON VOUS PAR QUEL MOYEN SOUHAITEREZ VOUS AVOIR DES INFORMATION SUR LA PF?
6. **INSTRUCTIONS: SI CLIENT DE PF**
 - A. AVEC L'AIDE DE QUI AVEZ VOUS PRIS LA DECISION D'UTILISER LES SERVICES DE PF? POUVEZ-VOUS NOUS DIRE
 - B. QUELLES SONT VOS IIMPRESSIONS SUR LE SERVICE QUE VOUS AVEZ RECU

INSTRUCTIONS: SI NON-CLIENT DE PF

- C. SI VOU DEVRAIS UTILSER LES SERVICES DE PF DANS VOTRE FAMILLE QUI VOUS AIDERAIT A PRENDRE LA DECISION
 - D. SI VOUS AVIEZ BESOIN DE SER VICE DE PF COMMENT SOUHAITERIEZ -VOUS ETRE AIDEE?
7. QUELLES DIFFICULTES AVEZ RENCONTRE POURS OBTENIR LE SERVICE DE PF OU AUTRE?

QUESTIONNAIRE 6

PRESTATAIRES DE SERVICES

1. QUELLE EST SELON VOUS LA SITUATION ACTUELLE SUR L'UTILISATION DES SERVICES DE PF DANS VOTRE ZONE DE RAYONNEMENT?
2. QUELLES SONT LES DIFFICULTES QUE VOUS RENCONTREZ DANS L'OFFRE DES SERVICES DE PF ?
3. QUELS SONT LES CHANGEMENTS QUE VOUS OBSERVEZ DEPUIS 1994 EN MATIERE DE PF ?
4. POURQUOI SELON VOUS LES SERVICES DE PF SONT SOUS UTILISES DANS VOTRE ZONE DE RAYONNEMENT ?
5. SELON VOUS COMMENT PEUT ETRE AMELIOREE L'UTILISATION DES SERVICES DE PF ?
6. QUE PENSEZ-VOUS DE L'UTILIZATION DES SERVICES :
 - PAR LES ADOLESCENTS
 - PAR LES HOMMES
 - PAR LES VEUVES ET LES FEMMES SEULES
7. COMMENT COLLABOREZ-VOUS AVEC LES ANIMATEURS DE SANTE ET LES ACCOUCHEUSES ET LES ACCOUCHEURS TRADITIONELS DE VOTRE ZONE EN MATIERE DE PF ?

A. PRIVE : QUESTIONS ADDITIONNELLES]

1. QUELLE EST VOTRE PARTICIPATION DANS L'ELABORATION ET LA MISE EN ŒUVRE DU PROGRAM NATIONAL DE PF ?

B. PRESTATAIRES COMMUNATAIRE

2. QUELLE EST NOTRE IMPLICATION DANS L'OFFRE DE SERVICES DE PF ?

3. QUELLES DIFFICULTES RECONTREZ-VOUS DANS L'OFFRE DES SERVICES DE PF ?

4. COMMENT COLLABOREZ-VOUS AVEC LES PRESTAIRES DES FORMATIONS SANITAIRES EN MATIERE DE PF ?

5. QUE PENSEZ-VOUS QU'ON PEUT FAIRE POUR AMELIORER L'UTILISATION DES SERVICES DE PF DANS NOTRE COMMUNAUTE?

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