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# FOSTERING PUBLIC-PRIVATE PARTNERSHIPS TO IMPROVE ACCESS TO FAMILY PLANNING IN RWANDA

**AUGUST 2010**

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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# EXECUTIVE SUMMARY

The private sector can play an important role in sustaining the success of family planning (FP) in Rwanda. Through public-private partnerships (PPPs), the government can make more efficient use of public resources by targeting and meeting the needs of specific populations and thus help ensure FP services and products will be available to all Rwandans in the long term. This report aims to inform stakeholders working to strengthen family planning through multisectoral partnerships about Rwanda's FP market (clients and providers, as well as products and services) based on analysis conducted by the USAID | Health Policy Initiative, Task Order 1. The project (1) met with key stakeholders and reviewed Rwandan government policies to elucidate the context and environment for private sector involvement in family planning, (2) conducted quantitative analysis to determine the characteristics of Rwanda's FP market, and (3) developed policy options for expanding the private sector's role in delivering FP services.

The review of national policies revealed that Rwanda has a supportive and favorable environment in which to engage private providers in FP service delivery—largely because of key decisionmakers' promotion of greater involvement of the private sector. However, thus far, actual implementation of these policies has been limited and there is no platform to support a multisectoral dialogue. Moreover, the decision of the Ministry of Health to ensure "free contraceptives for all" may constrain private sector growth in the FP market and should therefore be fully considered in terms of its implications for the sustainability of Rwandan family planning over the long term.

To gain a better understanding of Rwanda's FP market and various poverty-related inequities within it, the Health Policy Initiative conducted a secondary analysis of Rwanda's Demographic and Health Surveys (DHS) by disaggregating national wealth quintiles by place of residence. This analysis produced detailed information on Rwanda's FP clients (age, education level, socioeconomic status, place of residence); providers (who they are, what products/services they offer, whom they serve, and their respective roles vis-à-vis the client as well as each another); and products and services. The findings revealed that (1) the urban poor and the rural population (regardless of wealth) have the highest fertility, the lowest contraceptive use, and the greatest unmet need for family planning; (2) there is a strong correlation between relative wealth and use of private sector FP products and services among urban women; and (3) youth and unmarried women are under-served and therefore require greater attention by government and FP providers.

Based on the project's findings, the following actions are recommended to foster PPPs for Rwanda's family planning program: (1) create a coordinating body for PPPs in family planning and reproductive health (RH), (2) develop a PPP strategy; (3) target FP/RH public sector resources more effectively; and (4) explore the feasibility of using social franchising, voucher schemes, mobile clinics, workplace FP programs, and/or expanding health insurance to include private providers—to support these types of partnerships.

# ABBREVIATIONS

| | |
|---|---|
| ARBEF | Association Rwandaise pour le bien-être familial |
| BUFMAR | Bureau des formations médicales agrées du Rwanda |
| CAMERA | Centrale d'achat des médicaments, des équipements et consommables médicaux |
| DHS | Demographic and Health Survey |
| EDPRS | Economic Development and Poverty Reduction Strategy |
| FP | family planning |
| IUD | intrauterine device |
| LA/P | long-acting or permanent |
| MINECOFIN | Ministry of Finance and Economic Development |
| MINISANTE | Ministry of Health |
| MOH | Ministry of Health |
| MOU | Memorandum of Understanding |
| NFPP | National Family Planning Policy |
| NGO | nongovernmental organization |
| NISR | National Institute of Statistics of Rwanda |
| PPP | public-private partnership |
| PTF | Pharmacy Task Force |
| RAMA | Rwandaise d’assurance maladie |
| RH | reproductive health |
| UNFPA | United Nations Population Fund |
| USAID | U.S. Agency for International Development |

# I. INTRODUCTION

In Rwanda, the most densely populated country in sub-Saharan Africa, the average fertility rate is 5.5 children, and almost 40 percent of women want to use contraception but are not doing so (see Table 1).[1] This may be largely attributed to financial and geographic access barriers, as almost two-thirds of the Rwandan population lives in poverty and close to 90 percent resides in rural areas. Not surprisingly, there are acute poverty-related inequities in terms of health status, with those in the higher wealth quintiles having better health outcomes than those in the lower wealth quintiles.

**Table 1. Summary of Rwanda's Key Demographic and Health Indicators**

| | |
|---|---|
| **Fertility Rate**[a]<br>- Current<br>- Desired | <br>5.5 children per woman<br>3.7 children per woman |
| **Contraceptive Prevalence Rate**[a] | All methods: 36.4%<br>Modern methods (oral contraceptives, condoms, IUDs, and sterilization): 27.4% |
| **Total Unmet Need for Family Planning**[b]<br>- For Spacing<br>- For Limiting | 38%<br>*24.5%*<br>*13.4%* |
| **Infant Mortality Rate**[a] | 62 deaths/1,000 live births |
| **Maternal Mortality Ratio**[b] | 750 deaths/1 million live births |
| **Poverty**[c] | 57% living below the poverty line |
| [a] Rwanda Interim DHS (2007–2008)<br>[b] Rwanda DHS (2005)<br>[c] Rwanda State of Environment and Outlook Report | |

In its Vision 2020 (the umbrella program for the country's sector strategies) and Economic Development and Poverty Reduction Strategy (EDPRS) for 2008–2012, Rwanda recognizes the impact of rapid population growth on socioeconomic development and is committed to reducing high rates of fertility through family planning (FP). In addition, the government formulated the National Family Planning Policy (NFPP) (2006–2010) and required all ministries to develop action plans for addressing population issues in their respective sectors. Using a multisectoral approach aimed at improving the quality of and access to family planning, the country is beginning to realize many of its health, education, and economic goals.

Although Rwanda is currently experiencing an upsurge in the use of FP products and services, in 2000, less than 10 percent of women nationwide used contraception. Today, almost one-third of married women are using modern FP methods [e.g., oral contraceptives, injectables, implants, condoms, intrauterine devices (IUDs), and sterilization]. These gains are largely a result of strong political will and initiatives aimed at reducing Rwanda's high rate of unwanted fertility through improved access to high-quality FP services. However, as demand continues to rise and more women enter their reproductive age, ensuring adequate resources are available to meet the needs of the population may prove challenging. Financial sustainability for the FP program may be constrained given that specific program areas within the health sector are already insufficiently funded. According to findings from the Health Sector Strategic Plan (2009–2012), the largest funding gap occurs in the maternal and child health/FP/reproductive health (RH) program areas. In the current environment, with competing health and resource demands, Rwanda must pursue innovative means of financing to ensure the continued development and maintenance of a successful FP program.

[1] Rwandan Ministry of Health, National Institute of Statistics of Rwanda (NISR), and ICF Macro. *Rwanda Demographic and Health Survey 2005.* Calverton, MD: MOH, NISR, and ICF Macro.

The private sector can play an important role in sustaining the success of family planning in Rwanda. By fostering public-private partnerships (PPPs), the government can reduce its burden and help ensure FP products and services are consistently available in the long term. The USAID | Health Policy Initiative, Task Order 1 implemented the PPP assessment from September 2009 to August 2010 to promote public-private dialogue aimed at strengthening family planning through multisectoral partnerships. To better inform the policy discussion, the project (1) met with key stakeholders and reviewed policy documents to elucidate the context and environment for private sector involvement in Rwandan family planning; (2) conducted quantitative analysis to determine the characteristics of the FP market (clients and providers as well as products and services); and (3) developed policy options for expanding the private sector's role in delivering FP services.

The purpose of this report is to present the findings from the Health Policy Initiative's policy review and market analysis to better inform an upcoming policy dialogue on strengthening PPPs in Rwanda.

# II. APPROACH

The process to inform the policy dialogue for PPPs in Rwanda focused on three areas: (1) assessing the policy environment, (2) analyzing the FP market, and (3) developing policy options for PPPs.

## Assessing the Policy Environment

The Health Policy Initiative, in partnership with MINISANTE, met with key partners and stakeholders (see Table 2) to determine opportunities for and barriers to PPPs for family planning. Specifically, the project identified where, if any, public-private sector collaboration already exists for healthcare service delivery and the degree to which various sectors were willing and able to work together to offer FP products and services. In addition, the project reviewed key policy documents and literature and met with private FP providers to explore whether the environment for private sector involvement in family planning is favorable in Rwanda.

**Table 2. List of Organizations and Providers Consulted**

| Government | Nongovernmental Organizations |
|---|---|
| Ministry of Health<br>FP Unit<br>Maternal and Child Health Task Force<br>Pharmacy Task Force<br>Ministry of Finance and Economic Planning<br>Population Unit<br>Public-Private Partnerships<br>Development Planning Unit<br>National Parliament Assembly<br>Rwanda Development Board<br>District Health Officials (Kigali, Southern and Western Provinces) | ARBEF<br>BUFMAR<br>CAMERWA<br>Centre Dushishoze<br>Rwanda Pharmacists Association |
| **Providers (for-profit)** | **Partners** |
| Private Pharmacies (Kigali; Southern, Western, and Northern Provinces)<br>Wholesale Pharmacies (Exodus, Abacus)<br>Hospitals/Clinics (Kigali, Southern and Western Provinces)<br>Dispensaries and Drug Shops (Kigali, Southern and Western Provinces) | USAID<br>UNFPA<br>IntraHealth<br>John Snow, Inc./DELIVER Project<br>Management Sciences for Health<br>Population Services International |

## Analyzing the FP Market

An FP market segmentation analysis provides detailed information about (1) FP clients (age, education level, socioeconomic status, place of residence); (2) FP providers (who they are, what products/services they offer, whom they serve, and their respective roles with regard to both the client and each another); and (3) FP products or services demanded and provided in the marketplace. The Demographic and Health Survey (DHS) now routinely includes national wealth quintile data based on this methodology. However, one limitation of using this data is that it can obscure subnational patterns by depicting all urban populations as "wealthier," with greater advantages than rural populations, resulting in the exclusion of urban poor in policy dialogue and resource allocation decisions. To better understand the FP market in Rwanda and to gain more accurate insight into poverty-related inequities within it, the Health Policy Initiative analysis disaggregated national wealth quintiles by place of residence using the 2007 Rwanda DHS.

## Developing Policy Options

As part of its assessment, the project met with key decisionmakers in both the public and private sectors to solicit ideas on how to strengthen multisectoral collaboration for family planning in Rwanda. These discussions, combined with the results from the DHS analysis, helped to inform the development policy options, which in turn served as a basis for a high-level roundtable discussion on how to strengthen PPPs in family planning.

# III. UNDERSTANDING THE POLICY ENVIRONMENT

National policies, laws, and regulations affect the political climate and private market in various ways. A favorable policy environment and open FP market create the potential for strategic collaboration between public and private sectors. Hence, the Health Policy Initiative reviewed policy and legal documents and met with key stakeholders to identify opportunities and barriers for implementing PPPs in family planning and to determine the extent to which policy reform may be needed. This section presents findings from the policy review by major themes that could affect the successful implementation of FP/RH partnership activities.

**Defining the Private Sector**

The private sector comprises anything commercial (for-profit) or charitable (not-for-profit) that falls outside the government's purview. The commercial sector includes private providers (doctors, nurses, midwives); hospitals; clinics; pharmacies; drug shops; labs; manufacturers; and private health insurance companies.

Source: Zellner S, et al. 2006. State of the Private Health Sector Wall Chart. Bethesda, MD: Private Sector – Partnerships-One Project, Abt Associates, Inc.

## National Policies and Strategies Favor Private Sector Growth

Rwanda is highly committed to working with the private sector to help achieve development goals. Rwanda's Vision 2020 recognizes the private sector as one of six main pillars for social and economic development. Country policies prominently feature the private sector as a significant player in initiatives to reduce poverty and improve health services. For example, the National Policy on Condoms (2005) explicitly states that private sector market segments will guide both condom pricing (free versus low and medium cost) and the promotion of condom sources (commercial) and also advocates grouping the population by shared characteristics (epidemiological, demographic, geographic, socioeconomic, religious, psychosocial, etc.). The National Family Planning Policy sets specific targets for contraceptive market share, which is projected to double by 2020 for both nongovernmental organizations (NGOs) and

the commercial sector (see Table 3).[2] These targets are ambitious given that more than 90 percent of the demand for contraceptives is met through donations to the public sector and social marketing programs (see section on "Commodity Security"). At present, there is no clear mechanism or strategy to coordinate efforts for achieving the market share goals set forth in the NFFP. Nonetheless, the above-mentioned policies favor market segmentation, create an enabling environment for PPPs in family planning, and can help expand service coverage among the poor. Therefore, the current focus should be on policy implementation.

**Table 3. Projected Share of Contraceptive Commodity Costs (%)**

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2015 | 2020 |
|---|---|---|---|---|---|---|---|
| Public | 65.5 | 56.6 | 55.2 | 52.5 | 49.7 | 41.0 | 36.5 |
| ARBEF | 9.5 | 10.4 | 10.0 | 10.0 | 10.9 | 11.3 | 11.7 |
| Private (social marketing and commercial) | 25.0 | 33.0 | 34.7 | 37.5 | 39.4 | 47.7 | 51.8 |

## Political Commitment Translates to Action

**Public-private partnerships.** The government of Rwanda is delivering on its commitment to expand the private sector. In early 2010, the Ministry of Finance and Economic Planning (MINECOFIN) created a Public-Private Partnerships Secretariat and developed a PPP Strategy to help guide collaboration across social, economic, and development sectors, further reinforcing the political will and leadership to develop PPPs. The main functions of the PPP Secretariat are to assist line ministries and districts with PPP projects, manage joint ventures between public and private sectors, and mobilize resources for PPP initiatives. The Secretariat also funds proposals aimed at achieving socioeconomic goals through joint ventures. Currently, there is no private sector policy, strategy, or platform to guide PPP in the health sector. However, key representatives from government, nonprofit, and commercial sectors have all expressed interest in creating a mechanism to foster joint dialogue and develop, implement, and monitor a PPP strategy to support FP efforts in Rwanda.

**Financing reforms.** A number of financing reforms—including fiscal decentralization, performance-based health financing, and health insurance schemes—have brought decisionmaking closer to the community level, helped expand healthcare coverage, and improved the quality of health services. In 1999, Rwanda's government health insurance program (*Rwandaise d'Assurance Maladie*, RAMA) was introduced to provide coverage to government employees. To complement insurance schemes such as RAMA and a few private insurance schemes that target the formal sector, community-based health insurance schemes ("mutuelles") that cover rural communities and the informal sector have been introduced to remove financial barriers and promote equitable access to healthcare. Undoubtedly, such measures have contributed to Rwanda's gains in maternal and child healthcare as well as any progress in achieving Millennium Development Goals. However, private providers and clinics do not participate in the government's health insurance schemes (e.g., RAMA).

**Commodity security.** Due to the success of FP programs, Rwanda is taking steps to expand access to safe, affordable contraceptives to meet the growing demand for family planning. In 2005, MINISANTE created the Pharmacy Task Force (PTF), which is largely responsible for the development and implementation of national drug policy, regulation of drug importers and distributors, and oversight of public and private sector pharmacies. As a way of regulating the pharmaceutical sector and improving quality control, MINISANTE implemented a policy limiting pharmacy ownership and management to

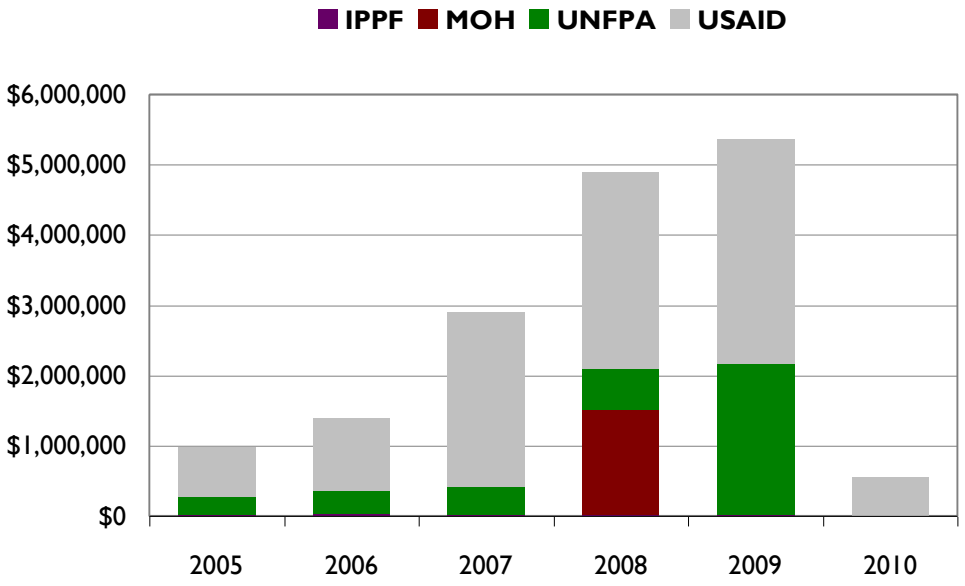
[2] Rwandan Ministry of Health. 2006. *National Family Planning Policy and Its Five-Year Strategies* (2006–2010).

professional pharmacists, which has led to the closure of several pharmacies that do not meet the new requirements.

In addition, MINISANTE, through the PTF, is undertaking a new initiative to increase contraceptive availability, particularly for those who cannot afford to pay for private sector services. Since 2009, the PTF has initiated more than 150 Memorandums of Understanding (MOUs) between MINISANTE and private providers, including individual pharmacies and drug shops, to provide private sector contraceptives free of charge (MINISANTE will supply contraceptives to private providers to expand FP distribution channels). Private clinics will continue to charge for FP/RH services but not for the commodity itself. The provision of free contraceptives in both the public and private sectors is expected to help reduce financial and, to some extent, geographic barriers to FP access among clients so as to expand the reach and uptake of modern FP methods. However, some partners and stakeholders have noted that the implementation of the MOUs may cause private providers to offer fewer contraceptive brands, eventually leading to a more limited private sector market for family planning.

Another major challenge for Rwanda in the coming years is ensuring contraceptive security. As mentioned above, more than 90 percent of the contraceptives distributed in Rwanda are donated, with the largest contributions coming from USAID and the United Nations Population Fund (UNFPA). Between 2005 and 2009, donor support for contraceptives grew fivefold over a five-year period[3]—most likely the result of focused efforts to expand family planning (see Figure 1). Due to the success of the FP program, the government should expect a significant increase in funding requirements—not only to meet current and future demand for FP services but also to ensure that public as well as private providers are consistently supplied with high-quality contraceptives. Hence, the implications of implementing the MOUs described above should be carefully considered to ensure resources will be available to sustain the initiative for the long term.

**Figure 1. Contraceptive Distribution (US$)**




[3] "Rwanda—Value of Commodities by Funding Source." Retrieved January 28, 2010, from http://rhi.rhsupplies.org/rhi/shipmentsummary.do.

## Private Sector Reaches Some Under-served Populations

Private providers, including clinics, pharmacies, social marketing programs, and NGOs, are, for the most part, concentrated in urban areas and serve a relatively small proportion of people who are willing to pay, and can afford, family planning. Socio-cultural norms combined with the perceived confidentiality and quality of commercial FP products motivate under-served youth to seek FP services in the private sector. The Rwandan Association for Family Well-being (*Association Rwandaise pour le bien-être familial*, ARBEF), an International Planned Parenthood Federation affiliate, is the largest private provider of family planning. Many of its clients are youth and unmarried women. For a nominal fee, ARBEF provides FP/RH services (for individuals who are unable to pay, services are provided at no charge). Several other private sector providers in Rwanda have reported that (1) most of their FP clients are youth and (2) demand among this group is on the rise, particularly for emergency contraceptives.

Although there are fewer private pharmacies available today versus previous years, a number of private sector providers have expressed strong interest in becoming more involved in expanding FP services. Working in partnership with the government, these providers could help provide specific populations (e.g., youth, unmarried women, and the geographically hard-to-reach) with more accessible FP services. Specific recommendations for these types of partnerships are offered in Section V ("Policy Options"). As economic conditions improve and demand for modern contraception increases, FP clients in Rwanda may be more willing and able to obtain private sector services. While this would help reduce the public sector's burden to provide FP services for all, the viability of the private sector to offer branded contraceptives will depend on the specifications and implementation of the MOU between MINISANTE and private providers. It is likely that fewer contraceptive brands will be available as the private sector may not be able to compete with free FP products offered in both the public and private sector. Table 4 summarizes major findings from the policy assessment.

**Table 4: Summary of Policy Environment**

| | Opportunities | Challenges |
|---|---|---|
| Policies and Strategies | • Favor private sector growth (Vision 2020, EDPRS, Health Sector Strategy, etc.)<br>• "Free contraceptives for all" reduces financial barriers to FP access | • No policy/strategy to coordinate, implement, or monitor private sector participation in health<br>• "Free contraceptives for all" constrains the private sector's ability to offer branded products and requires sustainable public sector funding for contraceptives in the long term |
| Private Sector | • Preferred provider among youth, the unmarried, and the wealthy<br>• Could help government reach FP/RH goals by serving specific population groups (the wealthy, youth, and the under-served) | • Largely concentrated in urban areas<br>• Not affordable to most of the population<br>• Difficult to compete with free contraceptives available in the public sector<br>• Not enrolled in health insurance schemes |
| Private Sector Partnerships in Family Planning | • Health insurance coverage is expanding<br>• Strong willingness and interest among public and private stakeholders to work together to expand family planning<br>• MOU between private providers and MINISANTE will expand access to free contraceptives | • No platform/strategy to guide partnerships<br>• Lack of a PPP coordinating body<br>• Implementation of MOU will diminish incentives for providers to offer branded contraceptives |

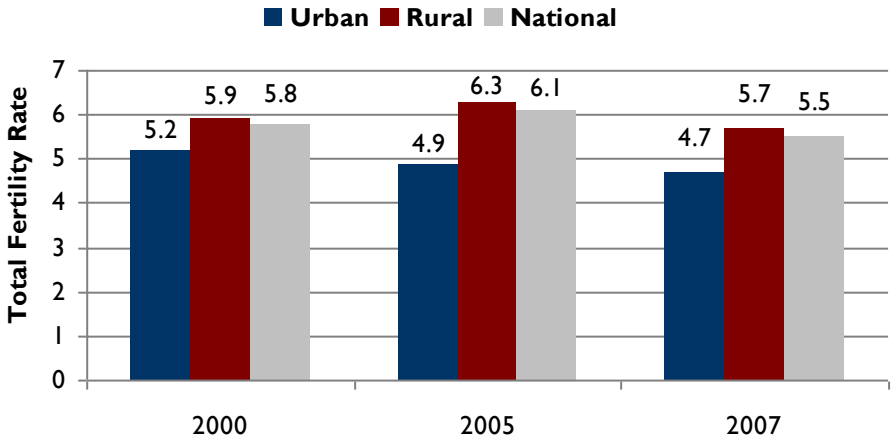
# IV. THE FAMILY PLANNING MARKET

Market segmentation analysis and willingness-to-pay studies can facilitate understanding of the current and past share of each sector in health service delivery. Market segmentation analysis conveys information about public and private sector providers from both demand and supply-side perspectives. Information on current and potential markets[4] can inform the strategic planning process for expanding reach and addressing unmet need for family planning. Given that 82 percent of Rwanda's population lives in rural areas,[5] an analysis that disaggregates the population by urban and rural wealth quintiles may inform future programming as well as various aspects of PPP models, particularly geographic targeting. This section presents trends in family planning, including a deconstruction of Rwanda's client base by various characteristics (place of residence, provider sources, and consumption of health services, among others).[6]

## Fertility

On average, women in Rwanda have approximately six children. Between 2000 and 2007, fertility trends indicated a modest decline overall, but high disparity remained between urban and rural women (see Figure 2). The Health Policy Initiative's disaggregation of national wealth quintiles by place of residence provides a more accurate picture of poverty-related inequity. The analysis reveals a strong correlation between fertility and wealth (for both urban and rural areas, fertility declines as wealth increases). The data further reinforce geographic disparities in Rwanda. For the most part, rural women have much higher rates of fertility compared with urban women—the exception is the wealthiest rural women (ranked in the highest wealth quintile), presented in Figure 3. Note that the fertility rate among the urban poor (who are ranked in the lowest wealth quintile) is much higher than both the national average and the wealthiest rural population segment, which signifies the need to better reach the urban poor.

**Figure 2. Trends in Fertility**

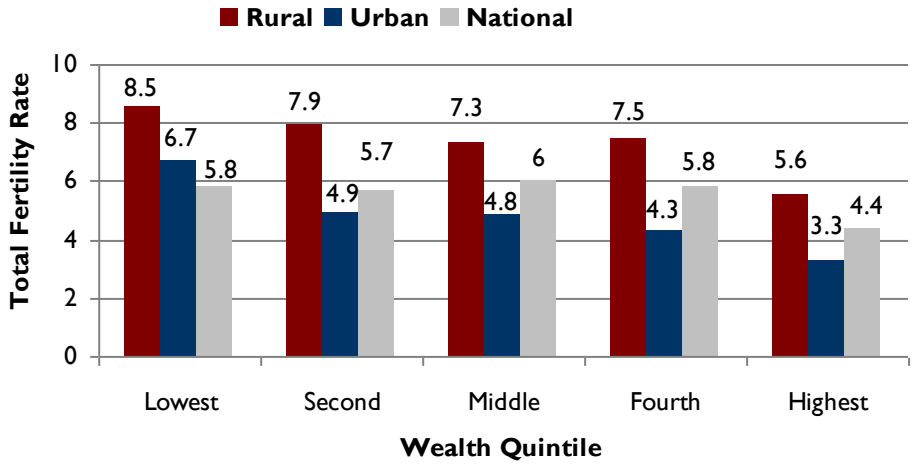



[4] The *FP market* comprises (1) FP/RH services and products (including contraceptive products), (2) consumers, and (3) providers. *Contraceptive methods* include modern FP methods (defined above); traditional methods (e.g., withdrawal and periodic abstinence); and folkloric methods. *Consumers* are defined as women of reproductive age if they use a modern contraceptive method, whereas *likely consumers* are defined as those who use traditional methods or state that they intend to use modern FP methods in future. *Providers* include government, private for-profit (commercial), and not-for-profit (NGO) sources of FP/RH services and products. The manner in which these three components of the FP market fit together has been referred to as the FP *market structure.* Source: Cakir, V., and J. Sine. 1997. *Segmentation in Turkey's Family Planning Market*. Washington, DC: POLICY Project, Futures Group.

[5] Population Reference Bureau. 2009 World Population Sheet.

[6] For further information, refer to Sharma, S., and V. Dayaratna. 2005. "Creating Conditions for Greater Private Sector Participation in Achieving Contraceptive Security." Health Policy 71(3): 347–357.

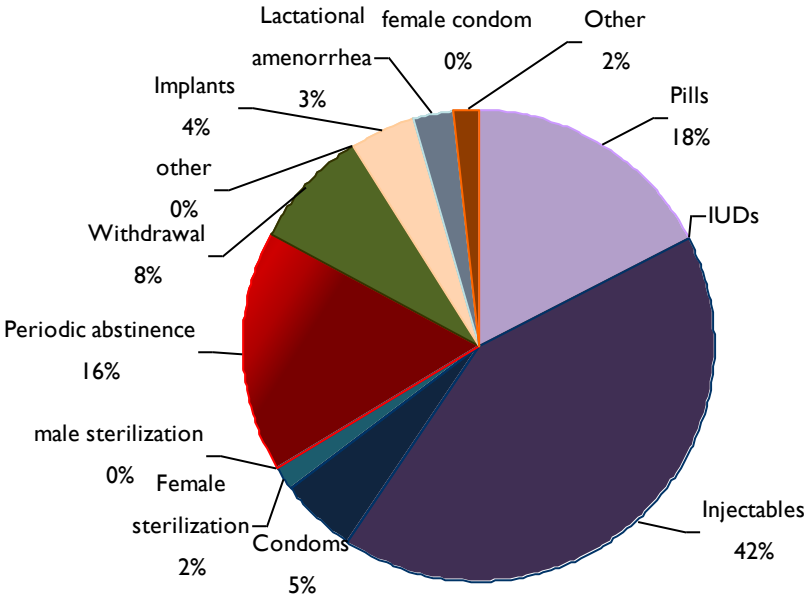
**Figure 3. Fertility by Wealth Quintile**




## Contraceptive Use and Modern Method Mix

Historically, use of modern contraceptive methods has been relatively low in Rwanda. However, based on the most recent DHS, the contraceptive prevalence rate almost tripled between 2005 and 2007, increasing from 10 percent to 27 percent, respectively. Nonetheless, there is still a high reliance on traditional[7] methods, with almost one in four women relying on withdrawal and periodic abstinence for contraception (see Figure 4). These methods are often unreliable and can lead to unwanted pregnancies—an important issue in a country where the average woman wants 3.7 children but has 5.5.[8]

**Figure 4. Family Planning Use, All Methods**

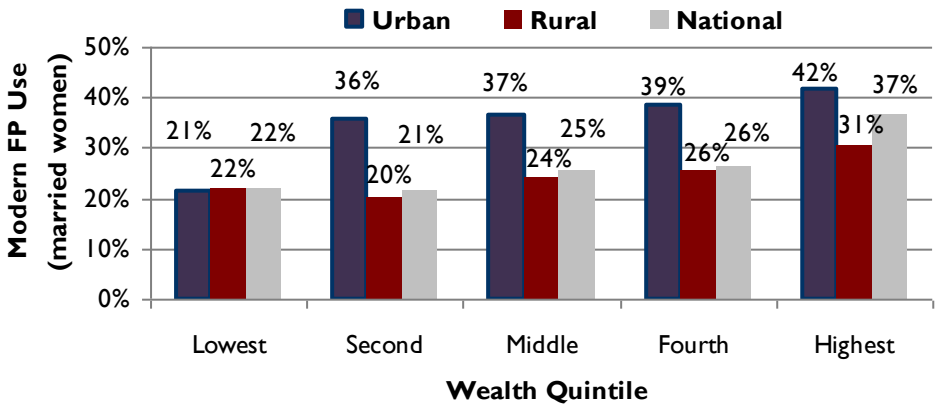



[7] The 2007-08 Rwanda DHS includes withdrawal, periodic abstinence, and folk methods as traditional methods. Use of folk methods was reported at zero.

[8] Rwandan Ministry of Health, National Institute of Statistics of Rwanda (NISR), and ICF Macro. 2009. *Rwanda Interim Demographic and Health Survey 2007–2008.* Calverton, MD: MOH, NISR, and ICF Macro.

As mentioned above, to identify inequities in the use of modern FP methods, national wealth quintile data were disaggregated by place of residence and revealed trends similar to those observed for fertility (see Figure 5). Among urban women, use of modern FP methods increases with wealth, with the wealthiest twice as likely as the poorest to use modern contraceptives (42% versus 22%, respectively). In contrast, the poorest urban and rural women are equally worse off and the least likely to use modern contraceptives. Among rural women, the use of modern FP methods is relatively low across all quintiles, with the highest use (31%) observed in the wealthiest quintile. Again, the wealthiest rural women are better off than the poorest urban women.

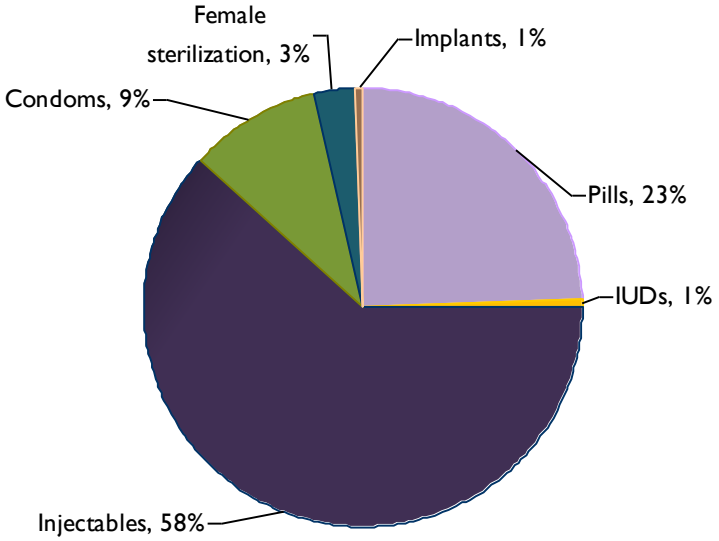
**Figure 5. Modern FP Use by Urban and Rural Wealth Quintiles**




The most popular modern FP methods[9] are injectables (used by 58% of all women), followed by pills (23%) and condoms (9%) (see Figure 6). Together these methods constitute 90 percent of the modern method mix. The heavy reliance on resupply methods (those whose availability depends on a well-functioning supply system) can place greater demands on an already overburdened logistics system. Moreover, these methods may not fully meet FP clients' contraceptive needs. For instance, women who wish to limit childbearing may be better served by long-acting and permanent (LA/P) methods (e.g., IUDs, implants, and female sterilization). However, access to LA/P methods is clinic-based and therefore requires a concerted effort to train FP providers and educate FP clients.

[9] For the purpose of this analysis, LAM is excluded from modern FP methods.

**Figure 6. FP Use, Modern Method Mix**




## Sources of Family Planning

Policy and health program reform in Rwanda is rapidly changing the delivery of health services, particularly family planning. In the early 1990s, the public sector was the primary source for FP services, with 98 percent of the market share, and the private sector was nearly nonexistent (see Figure 7). During the mid-to-late 1990s, the FP market began to shift (DHS was not conducted during this period so specific data are not available). By the year 2000, more than one-third of FP clients were receiving FP services from non-public sources. However, trends began to shift again between 2000 and 2007, where private sector market share declined from 18 percent to 8 percent. The public health sector, which consists of government health centers, hospitals, and other public entities, currently dominates the FP market, serving almost 90 percent of all FP clients (see Figure 8.).

A closer look at the source mix and client profiles of each sector reveals more details about FP market

**Figure 7. Trends in FP Market Share**

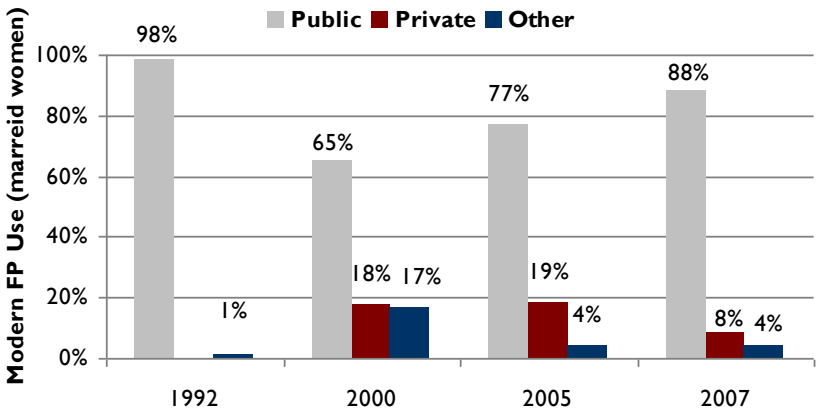
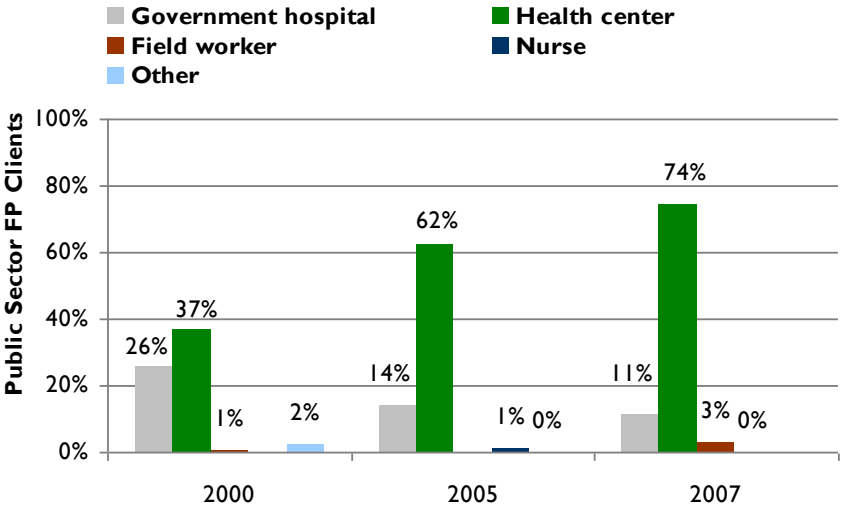


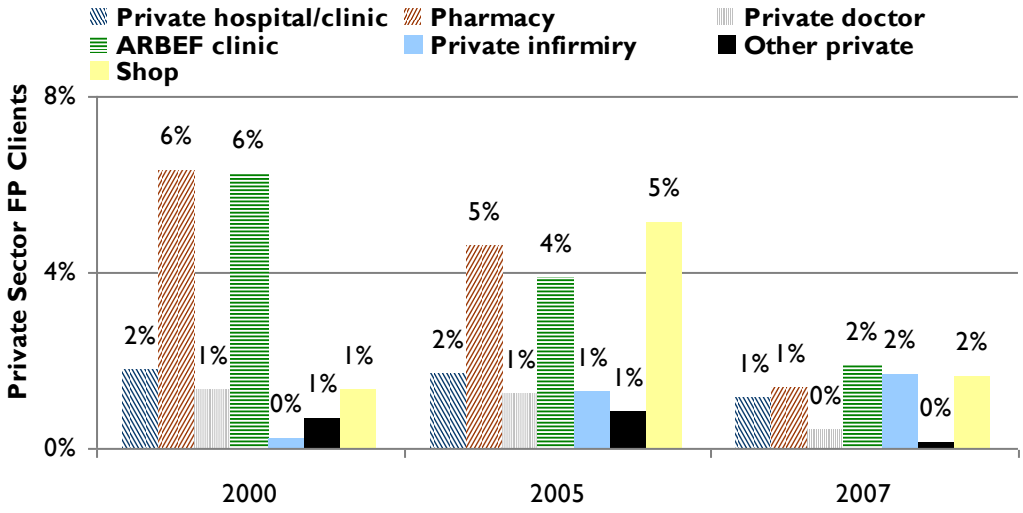

**Figure 8. Trends in Public Sector FP Source Mix**



dynamics. Over the last few years, more public sector clients received FP services from health centers and less received these services from government hospitals. This may indicate improvements in access to and availability of FP services at lower-level public health facilities.

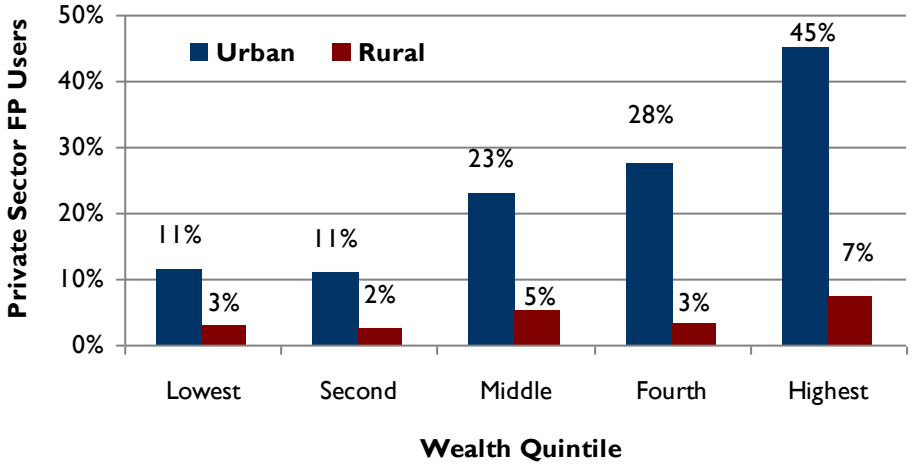
The private sector comprises private hospitals and clinics, private pharmacies, drug shops, and other private medical entities, including the largest private provider, the nonprofit ARBEF. Among private sector sources, ARBEF, drug shops, and private pharmacies have experienced the largest declines in FP market share in relative terms (see Figure 9).

**Figure 9. Trends in Private Sector FP Source Mix**




It is important to note that while the share of the private sector market declined, the overall FP market increased fivefold between 2000 and 2007, and most of that increase was in the public sector. Not surprising, among urban women, private sector use increases with wealth, with large disparities between the lowest and highest wealth quintiles. This correlation is not observed for rural women, among whom private sector use is relatively low across all wealth quintiles (see Figure 10).

**Figure 10. Private Sector FP Use by Redistributed Wealth Quintile**



## Unmet Need for Family Planning[10]

Women who wish to space or limit births but are not using contraception are classified as having an unmet need for family planning. Thirty-eight percent of women in Rwanda have an unmet need for family planning—of which 25 percent prefer to space and 13 percent want to limit the number of births. Analysis of unmet need using disaggregated by wealth quintiles reveals patterns of poverty-related inequities similar to those observed for other key FP indicators. Once again, among urban women, health indicators improve as wealth increases. Unmet need was twice as high among the lowest quintile compared with the wealthiest quintile (43% versus 22%, respectively) (see Figure 11). However, an interesting finding emerges when rural women are examined. Although unmet need is high—more than 35 percent across all wealth quintiles—rural women are relatively better off than the bottom two quintiles in urban areas (see Figure 12). The data suggest that urban poor are far more disadvantaged compared with all other urban and rural women when it comes to having an unmet need for family planning.

Worth noting is that the level of unmet need may be higher than what is captured in the DHS because, by definition, unmet need does not include women who are (1) using traditional family planning methods or (2) unmarried and sexually active. In Rwanda, both the 25 percent of women who use traditional methods (and are thus likely at risk for unwanted pregnancy) and unmarried sexually active women (a group that is almost twice as large as that for married respondents in the 2007 DHS) are excluded from unmet need calculations. Hence, there are a large proportion of women with an unmet need for family planning above and beyond current estimations. Moreover, traditional method users are likely consumers of modern family planning methods. If Rwanda is to achieve its current FP/RH goals, the women who fall into these two categories must be reached with FP services.

**Figure 11. Unmet Need for Family Planning among Urban Women**

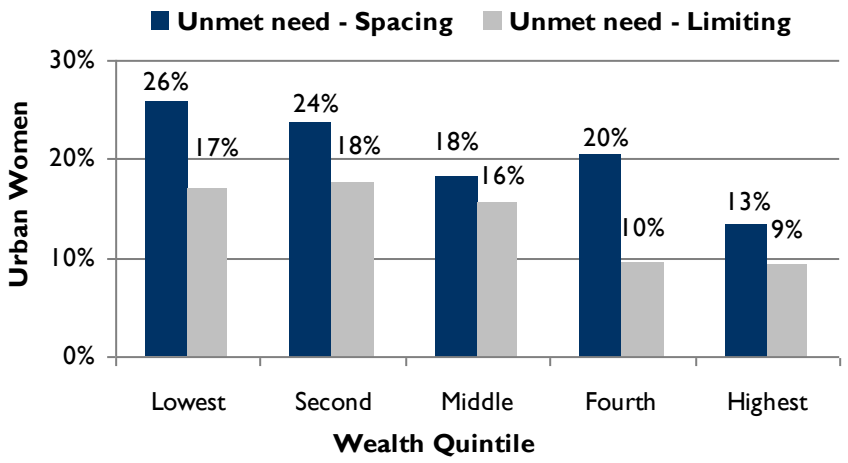
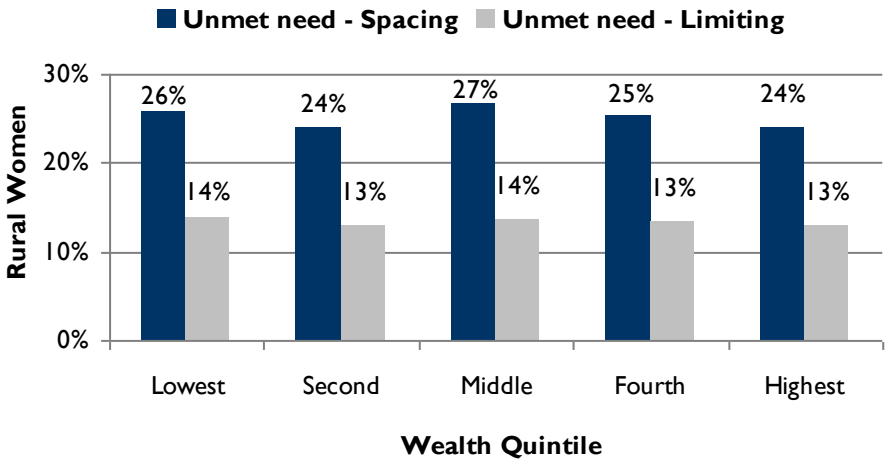



**Figure 12. Unmet Need for Family Planning among Rural Women**




[10] The information presented in this section is based on the 2005 DHS (the 2007 Rwanda Interim DHS did not include data on unmet need).

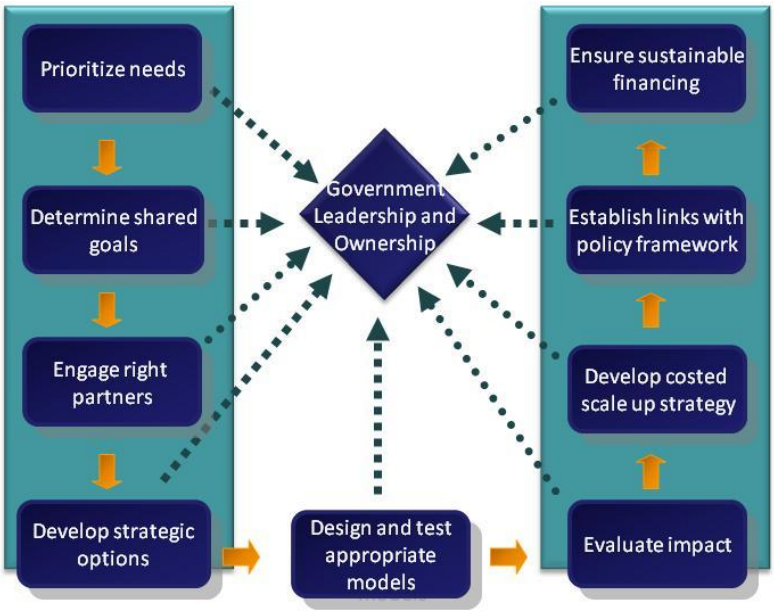
# V. POLICY OPTIONS

The following policy options were developed based on global experience and input solicited from MINISANTE, MINECOFIN, partner organizations, implementing agencies, and private providers and institutions, including NGOs; and are designed to promote discussion for an upcoming roundtable among public-private sector stakeholders.

## Create a Coordinating Body for FP/RH PPPs

A committee or coordinating body for FP/RH PPPs could serve as a platform for sharing information, formulating policies/strategies, monitoring their implementation, and liaising with the PPP Secretariat within MINECOFIN. Through strong government leadership, the PPP coordinating committee could implement a systematic process, as highlighted in Diagram 1, for identifying and creating PPP models most appropriate for the Rwandan context.

**Diagram 1. A Systematic Process for Building PPP Models[11]**




## Develop a Strategy for FP/RH PPPs

An FP/RH strategy for PPPs could help guide the working relationship between the various sectors involved in FP service provision. This type of strategy could present the feasibility of different models and specify the potential roles for various sectors—public, commercial, and NGO. Through the use of a joint strategy, resources could be used more effectively to expand and scale up Rwanda's FP services and make them more sustainable in the long term. See Box 1 for key questions to consider when drafting a targeting strategy.

[11] Sharma, S. 2010. "Creating Conditions for Greater Private Sector Participation." PowerPoint presentation given at "Policy Pays Off: Building Foundations for Sustainable Health Programs," National Press Club, February 2010.

**Box 1. Key Considerations for Designing a Targeting Strategy**

1. **What is the objective of public sector targeting efforts?**
   - Which communities need to be reached and at what level (e.g., district, village, household, or individual)?
   - Who are the poor, vulnerable, or other under-served populations and how can they be identified? If focusing on the poor, how many should be reached? (Urban poor often have higher absolute numbers than rural poor and are easier to reach.)
2. **Where are the poor and where are the services?**
   - Are the urban poor concentrated in specific areas?
   - Are services available (in terms of physical access, hours of operation, etc.) in rural, geographically hard-to-reach areas?
3. **What are the barriers to access among under-served populations?**
   - Are services physically accessible?
   - Are services affordable?
   - Are services youth-friendly?
4. **Which type of targeting strategy should be implemented? (*Note*: The four categories are not mutually exclusive.)**
   - Geographic (e.g., eligibility for free services based on residence in a particular area)
     - Urban or rural?
     - State or regional?
     - Districts or communities?
   - Individual (e.g., those with certain characteristics or status or identifiable through some other mechanism can opt in to a specific FP program)
   - Categorical (e.g., those with certain social characteristics in terms of age, ethnicity, family status, etc. can receive certain services)

## Target Public Sector Resources More Effectively to Reach Under-served Groups

Through PPPs, the government can make more efficient use of public resources by strengthening and expanding FP programs to reach the underserved. In turn, the private sector can seize opportunities for growth by developing niche FP markets. Market segmentation data help to identify inequities in health coverage and thus determine where to target resources and expand service reach. In Rwanda, this type of analysis underscored the need for greater attention to the urban poor and the rural population. Discussions with providers highlighted the importance of focusing on youth, given the barriers they face when seeking FP/RH services. In the PPP strategy development process, policymakers need to determine the most appropriate approach to targeting under-served populations. Answering the questions shown in Box 1[12] can help focus program resources and efforts more effectively.

## Explore and Build on Successful FP/RH PPPs

When market conditions are favorable, the private sector often has the incentives and resources for rapid scale-up and delivery of high-quality health services. Global experience shows that various types of partnerships with the private sector are effective in reaching poor and geographically hard-to-reach populations. These PPP mechanisms are listed below.

[12] Adapted from USAID | Measure Evaluation. 2008. *Addressing Poverty: A Guide for Considering Poverty-related and Other Inequities in Health.*

**Social franchising.** In social franchising, a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (the franchisees) to conduct business in a prescribed manner in a certain place over a specified period. The role of the franchiser is to build capacity and train providers, develop vendors and procure commodities at competitive prices, regulate quality assurance systems, and market the network. Three components need to be in place for a social franchise to function: a business format, a brand, and quality assurance.[13] Social franchising offers numerous possibilities for public-private partnerships:

- The public sector, in collaboration with the private sector, would be responsible for incorporating important elements of the social franchising into existing policies (e.g., pricing, quality assurance standards, monitoring, etc.).
- The franchiser could help develop selected public health facilities/posts and "upgrade" them into the branded network.
- The franchiser could develop existing private clinics/pharmacies and "upgrade" them into the branded network.
- The public sector could provide training to network providers in quality standards, policies, referral systems, and information sharing.
- Community health workers, including community-based distributers, can also be included in the social franchising network
- The public sector should have a vital role in monitoring quality of services by setting guidelines and conducting audits for social franchising units.
- The social franchising model would need to ensure linkages/referrals to the existing public health system.

**Table 5. Various Social Franchising Networks in Africa[14]**

| Country | Franchising Networks for FP/RH |
|---|---|
| Kenya (AMUA) | 144 clinics in rural and peri-rural areas |
| Ethiopia (Blue Star) | 107 franchises in rural and peri-rural areas |
| Ghana (Blue Star) | 102 clinics in urban and peri-urban areas |
| Malawi (Blue Star) | 59 clinics in rural and urban areas |
| Cameroon (ProFam) | 25 clinics in urban areas |
| Congo (Confiance) | 78 general FP clinics and 277 partner clinic pharmacies in urban and rural areas |
| Madagascar (Top Reseau) | 155 clinics in urban and rural areas |
| Mali (ProFam) | 33 clinics in urban areas |

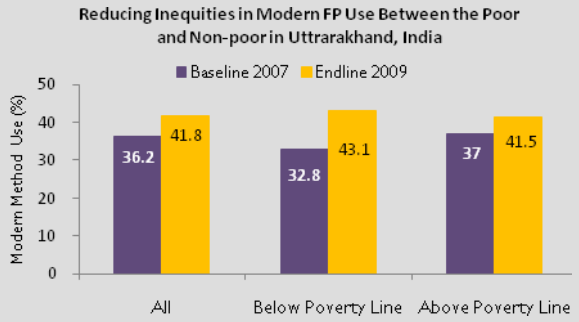
[13] Annigeri, V., L. Prosser, J. Reynolds, and R. Roy. 2004. *An Assessment of Public-Private Partnership Opportunities in India.* PopTech.
[14] Sharma, S. 2010. "Creating Conditions for Greater Private Sector Participation." PowerPoint presentation given at "Policy Pays Off: Building Foundations for Sustainable Health Programs," National Press Club, February 2010.

**Voucher scheme.** A voucher scheme is a demand-side financing mechanism that can reduce RH inequities by enabling access to services while empowering the poor to choose their own providers. Specifically, voucher schemes have proven to be an excellent means of (1) providing private sector services at deep discount rates; (2) expanding cost-effective services, despite understaffing at government facilities; (3) relieving pressure on government in certain areas; (4) enabling clients to save money; and (5) providing poor clients with services that would not be received otherwise. A voucher scheme designed to reach the poor in two of India's poorest states helped reduce inequities in FP services (see Box 2). Rwanda could implement this type of scheme to provide the urban poor with access to free FP services in the private sector.

**Mobile clinics.** Mobile clinics offer a wide range of possibilities to expand health services, including FP, in remote and rural areas. One model of a mobile clinic that uses a PPP could involve having the private sector provide capital investments while operational costs are shared between both sectors. A fixed date and delivery point for health services can establish credibility among clients. Moreover, creating referral linkages with state public health facilities can improve service delivery. An innovative partnership using mobile clinics can help reduce geographic access barriers by bringing services closer to Rwanda's largely rural population.

**Box 2. PPPs in Action**
**Voucher Scheme Reduces FP Inequities in One of India's Poorest States**

India tested and scaled up various types of **voucher scheme** models to provide affordable reproductive and child healthcare services to poor families in the states of Uttar Pradesh, Uttarakhand, and Jharkhand. Under this scheme, families can redeem the vouchers at any of the selected accredited private hospitals in exchange for free RH services, including prenatal care, childbirth, postnatal care, and FP services. The hospitals, in turn, can submit the vouchers to the government for reimbursement. The successful implementation of the vouchers scheme pilots in Uttarakhand resulted in reduced inequities (see figure below). The model was subsequently scaled up to provide coverage to more than 5.36 million people.




Source: Karra, M., S. Sharma, and M. Vargas. 2009. *Fostering Public-Private Partnerships to Reduce Health Inequities in Peru*. Washington, DC: Futures Group International, USAID | Health Policy Initiative, Task Order 1.

**Other.** There are several other models for PPPs, such as expanding health insurance coverage to include private providers. Rwanda may want to consider this option (at present, RAMA only provides coverage for services rendered in public health facilities). Expanding insurance to cover the private sector could help reduce the burden on public health facilities, as some clients may shift to the private sector. Another option is the establishment of FP programs in the workplace. Given that Rwanda is experiencing private sector growth in various industries, this may provide a good opportunity to reach more FP clients. Employees with access to health services at their workplace are likely to experience better health outcomes and less absenteeism. Rwanda's Private Sector Federation, an umbrella organization comprising 23 business associations, has expressed interest in collaborating with the government to pilot programs offering FP/RH services (and other health services) in the workplace. These options should be explored.

# VI. STUDY LIMITATIONS

Rwandan stakeholders reviewed an earlier version of this report and suggested expanding the analysis to address issues not covered here. Due to limited funding and data availability, this activity was narrow in scope and focused on overarching policy issues affecting private sector participation in family planning provision for Rwanda. The limitations of this analysis, many of which respond directly to feedback from key stakeholders in Rwanda, include the following:

**Site visits.** Private sector site visits were limited to three districts in Kigali province and four districts outside of Kigali (Southern, Western, Northern provinces). Few, if any, private FP providers exist in Rwanda's more remote districts; hence, districts were selected based on where more private providers would be available.

**Unmet need.** While the DHS has shown a dramatic increase in modern contraceptive use between 2005 and 2007, this analysis was not able to capture shifts in unmet need over the same time period. Specifically, to compare socio-economic inequities in urban versus rural areas, 2005 data on unmet were used to calculate wealth quintiles by geographic area.

**Youth and unmarried women.** In-depth market analysis for youth or unmarried women was not conducted. Once DHS data were disaggregated, each market segment yielded a small sample size—insignificant to draw conclusions from. Issues raised about this population group came from discussions with key stakeholders and FP providers who emphasized that youth and unmarried women represent a large proportion of clients who encounter barriers when seeking FP services.

**Barriers to FP use.** One main objective of this analysis was to identify policy barriers to private sector involvement in family planning. However, barriers related to the demand and uptake of family planning—socio-cultural, financial, physical access, and service delivery barriers—were not included in the scope of this activity but are important factors to address when considering how to expand use of and reduce unmet need for family planning.[15]

**Religious institutions.** The primary purpose of the PPP roundtable was to promote dialogue among key decisionmakers and current providers of family planning (all sectors), thus religious institutions[16] were not included. As the policy process moves forward to strengthen public-private partnerships, advocates and key decisonmakers should consider how to constructively engage religious leaders and institutions in future policy dialogue on family planning.

# VII. PROMOTING DIALOGUE ON PUBLIC-PRIVATE PARTNERSHIPS

In August 2010, Health Policy Initiative, in collaboration with the Ministry of Health (MOH, known as "MINISANTE"), organized a roundtable discussion on public-private partnerships in family planning; this was the first time a multisectoral dialogue on this issue was held in Rwanda. The purpose of the meeting was to discuss findings from the policy and market segmentation analyses and help public and private sector FP providers and key decisionmakers understand the potential for public-private

[15] Family Health International, in collaboration with the Ministry of Health, recently conducted a study to specifically identify barriers to family planning use in Rwanda. Study results were not available at the time this report was written, but findings will be disseminated September 2010.

[16] A number of health facilities in Rwanda are managed by religious institutions—most often the Catholic Church. These facilities do not provide family planning.

partnerships to help expand family planning in Rwanda. Participants were given a draft report of the PPP analysis in advance of the meeting.
Approximately 20 participants across various sectors attended the meeting. A list of organizations represented at the roundtable is provided in Table 6.

**Table 6. Organizations Represented in PPP Roundtable**

| Government | Projects/Partners |
|---|---|
| Maternal and Child Health Unit, Ministry of Health<br>Pharmacy Task Force, Ministry of Health<br>Population Desk, Ministry of Finance and Economic Planning<br>National Parliament Assembly<br>Rwanda Development Board | USAID<br>World Health Organization<br>CSDI-Community<br>DELIVER Project<br>EngenderHealth<br>Family Health International<br>HU/Roads Project<br>IntraHealth<br>Millennium Villages Project |
| **Private Sector (Non-profit and Commercial)** | |
| ARBEF<br>ARPHA<br>Kimironko Health Center<br>Population Services International<br>Private Sector Federation | |

The Health Policy Initiative facilitated a discussion on the major findings from the policy and market segmentation analysis and presented various PPP models from other developing countries that have proven successful for expanding access to family planning. Participants were then divided into three groups to (1) identify major challenges to FP in Rwanda, (2) identify opportunities for improving the uptake of family planning, (3) propose specific actions for how PPP could be strengthened to expand FP, and (4) suggest specific next steps for PPP within the next year.

Across all breakout groups, socio-cultural issues and religious beliefs were identified as key barriers to the uptake of family planning. However, political reforms, including decentralization, and a favorable policy environment for expanding private sector involvement in Rwanda were highlighted as opportunities for strengthening public-private partnerships. A major outcome of the roundtable discussion was consensus on next steps to move the PPP process forward. The Ministry of Health will provide guidance and leadership to ensure the following actions are taken:

- MOH and partners help establish a national PPP coordinating body for family planning
- FP Technical Working Group creates a terms of reference to guide the agenda and activities of the PPP coordinating body
- PPP coordinating body develops an action plan for a public-private partnership in family planning
- MOH, with input from other stakeholders, revisit the Memorandum of Understanding to understand how implementation will impact private sector involvement in FP and revise the MOU accordingly
- MOH integrates PPP actions into the next FP Strategic Plan (process for development underway)
- PPP coordinating body liaises with and seeks guidance from the PPP Secretariat and FP Technical Working Group

# VIII. CONCLUSION

PPPs can help create healthy competition, achieve economies of scale, maximize the use of current capacity, extend service delivery networks, target the poor, and mobilize additional resources. Designing

and implementing effective PPPs is an evidence-based systematic process of prioritizing needs, determining shared goals, engaging appropriate partners, developing strategic options, designing and testing appropriate models, evaluating impact, developing costed scale-up strategies, establishing links with the policy framework, and ensuring sustainable financing.

Rwanda's policy environment favors the creation and strengthening of PPPs in family planning. Supportive policies are in place and there is willingness among stakeholders to promote better collaboration and more strategic involvement of the private sector in the FP/RH arena. However, actual implementation of these policies and a platform to support multisectoral dialogue are still lacking.

There is no doubt that Rwanda's commitment to family planning has led to remarkable achievements in key FP/RH indicators—most notably a tripling of modern contraceptive use since 2005. Meeting the demand of current and future users of family planning remains a challenge. A high level of unmet need and heavy reliance on traditional FP methods are also important issues. In addition, socioeconomic inequities and barriers to FP access among the poor need to be addressed and should be a central goal of FP policies and strategies.

Table 7 summarizes the major themes that emerged from the Health Policy Initiative analysis and lists policy and programming questions that could help guide decisionmaking, particularly for the next phase of the NFPP. While the implementation of various PPP models may not resolve all of the above-mentioned issues, the policy options and key actions to be taken through the MOH could help pave the way for a more robust, multisectoral FP program in Rwanda.

**Table 7. Summary of Policy Issues and Considerations for Future FP Programming**

| Policy Issue | Considerations for Policymakers |
|---|---|
| **Policy**<br>"Free contraceptives for all" | • To what degree will private sector branded products be able to compete with free, publically funded contraceptives?<br>• Will public sector funding keep pace with the growing demand for contraceptives in the near and long term?<br>• What are the long-term implications of implementing the MOUs on free contraceptives in terms of the sustainability of family planning? Will free contraceptives constrain the private sector's ability to provide branded contraceptives in future? |
| **Method Mix**<br>Heavy reliance on resupply methods and traditional methods | • What can be done to encourage FP clients to shift from traditional to modern contraceptive methods?<br>• Why is there such heavy reliance on resupply methods (which represent 90% of the method mix)?<br>  o Are women able to use their contraceptive method of choice?<br>  o Are clinical methods readily available for clients who want them?<br>  o To what degree does provider bias toward certain methods exist?<br>  o Is there a need for more information, education, and communication activities? If so, among which client populations and provider groups? |
| **Contraceptive Use and Unmet Need**<br>High disparity among urban women and between geographic areas | • How can the urban poor, who have the highest unmet need and the lowest use of modern FP methods, be identified and reached more efficiently with FP/RH services?<br>• How can FP services be expanded and scaled up to improve geographic reach to rural women?<br>• What kind of PPP mechanisms can be implemented to reach specific under-served populations? |
| **Source Mix**<br>The overall FP market is growing but the private sector share (now < 10%) is decreasing | • What is the role of the private sector (commercial and NGO)?<br>• As the FP market grows, can public sector providers keep pace? If so, will are there adequate resources (human and financial) to sustain family planning in the long term?<br>• Should the commercial sector continue to charge clients who are willing and able to pay so that government resources can be efficiently targeted to reach under-served populations?<br>• How can NGOs be better supported in their efforts to expand and scale up services to help the public sector reach the under-served? |
| **Other Under-served Populations**<br>Youth and unmarried women | • Due to their desire for confidentiality and anonymity, youth often seek private sector services but may not be able to afford them. How can the public and private sector collaborate to expand and scale up youth-friendly services?<br>• How can youth be better reached with information, education, and communication activities and FP services to reduce the need for "emergency" contraceptive methods? |

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