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COMMUNITY-BASED DISTRIBUTION OF INJECTABLE CONTRACEPTIVES IN RWANDA: AN INTERVENTION TO REVERSE RURAL DISADVANTAGE

SEPTEMBER 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

Family planning preferences and fertility patterns in Rwanda are similar to those observed in much of the sub-Saharan region. They are typical of countries at similar levels of socioeconomic development and female education. However, in Rwanda, these patterns and preferences are changing rapidly. In 2000, six years after the genocide of 1994, demand for and use of family planning was extremely low; only 4 percent of married women of reproductive age were using modern contraceptive methods. By 2005, modern contraceptive prevalence grew to 10 percent. Between 2005 and 2007, contraceptive prevalence nearly tripled, with the contraceptive prevalence rate for modern methods at 27 percent. The unmet need for family planning also increased during this period, suggesting that supply failed to meet the increased demand. In 2005, the met need for spacing and limiting was much lower for rural women than for their urban counterparts. Because much of the population resides in rural areas and because the effect of population density is most acutely felt in rural areas, a particular concern is the widening urban-rural disparity in fertility outcomes. To accommodate changes in preference and to address the disparities in outcomes, the government of Rwanda and the Department of Maternal and Child Health initiated a public sector program for the community-based distribution (CBD) of modern methods of family planning, in particular, injectable contraceptives.

Call for Action

“Family planning is priority number one, not just talking about it, but implementing it.”

President Paul Kagame, 2005

This report presents findings on the international and local evidence for making contraceptives, injectable contraceptives in particular, widely available through a CBD approach. During 2009, the USAID | Health Policy Initiative, Task Order 1, completed a literature review, conducted stakeholder interviews, and developed guidelines and a costed implementation plan to support the Rwanda Ministry of Health’s (MOH) 2008 and 2009 decisions to allow specially trained community health workers (CHWs) to provide injectable contraceptives. The project’s work in Rwanda included the following key activities:

- Interviews with 18 organizations consisting of 22 policymakers and key stakeholders at the national level, including members of the Family Planning Technical Working Group (FPTWG), regarding the feasibility of CBD of injectable contraceptives by paraprofessionals and the steps necessary for program implementation
- A presentation to the FPTWG on key findings
- Technical assistance to the Community Health Desk in the Maternal and Child Health (MCH) Department in the MOH to develop draft guidelines and an implementation plan for a CBD pilot in Rwanda
- A three-day stakeholder retreat to finalize program guidelines and a costed implementation plan for the phased-in approach

The findings from the key informant interviews indicated that many stakeholders in Rwanda were enthusiastic about moving forward with a CBD program but had a few, albeit strong, reservations. The stakeholders’ responses were grouped into three categories—government, nongovernmental organization and donor sector, and professional associations—to understand different perceptions of opportunities and challenges that a national CBD program may face in Rwanda.

The key recommendations from stakeholders included the following:

- A comprehensive training plan for CHWs in clinical skills, management of side effects, and waste disposal can be achieved by considering medical training institutions in these processes rather than using implementing partners alone.

- An integrated and updated plan for supervision, supply, and monitoring and evaluation, with clear roles and responsibilities of all those working in community health, is essential to follow up with the CHWs.
- Clear incentive structures and guidelines must be outlined for the CHWs as essential frameworks within the health system.
- The MOH should consider a pilot as the first step of intervention; if this cannot be done, it should adopt a full-scale intervention, with extra care for close monitoring of changes and any arising challenges.

The findings from the policy review indicate that existing policies are consistent with CBD of family planning, including injectable contraceptives. The principal sources of policy guidance include the Vision 2020, the Poverty Reduction Strategy Paper (2008–2012), the Health Sector Strategy Plan II (2008–2012), Human Resources for Health Strategic Plan, the Community Health Policy (2008), Norms and Standards for Community Health Workers, and the 2009 National Population Policy. Beyond policy guidance, interest in reducing the fertility rate is articulated at the highest levels of leadership and is strongly evident within the Ministry of Finance and Parliament through the Rwandan Network of Parliamentarians for Population and Development.

The FPTWG and MOH decided to adopt all recommendations proposed by the Health Policy Initiative’s assessment of the guidelines and implementation planning process that followed the stakeholder assessment. The decision to adopt the entirety of recommendations seems to be the result of having a comprehensive picture from a diversity of stakeholders regarding the feasibility of a CBD program for injectables in Rwanda. The process represents a significant shift in policymaking—from a single MOH directive to a consensus-building initiative to increase the likelihood of sustainable support. These stakeholder interviews represented the first time that professional bodies and clinicians participated in the policymaking process of the FPTWG and represented the first time that their views were solicited in the build-up to a national CBD program. The decision to include professional bodies was based on the project work in Malawi, where opposition from clinicians was the most significant barrier to development and implementation of a national CBD program. It was also based on World Health Organization (WHO) policy guidance on the best-practice process in task shifting, which recognizes the pitfalls in launching initiatives in health delivery without the participation of professional bodies and clinicians (Frehywot, 2010). As a result of soliciting concerns of clinicians and presenting these findings to the FPTWG, the FPTWG decided to include these bodies in the design and larger rollout planning for a national CBD program.

After the Health Policy Initiative’s stakeholder assessment, the FPTWG requested the project’s assistance with developing guidelines for a CBD program for family planning. At the project’s recommendation, the FPTWG also agreed to prepare an implementation plan for the pilot and develop cost estimates for implementation of the pilot program, so that donors and the government alike would agree on and garner the resources needed to roll out the pilot. The CBD guidelines provided direction on the operationalization of the national community-based program for family planning. Stakeholders costed the implementation plan for the pilot. The process of developing policy guidelines in Rwanda for CBD of family planning emerged from the participatory process led by the FPTWG, closely supervised by the Community Health Desk in the MCH Department in the MOH, along with the Family Planning Desk.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARBEF	Association Rwandaise pour le Bien-être Familial
CBD	community-based distribution
CCDFP	Centres Communaux de Développement et de Formation Permanente
CHW	community health worker
CIMCI	Community-based Integrated Management of Childhood Illness
CPR	contraceptive prevalence rate
CYP	couple-years of protection
DHS	Demographic and Health Survey
EDPRS	Economic Development Poverty Reduction Strategy
FHI	Family Health International
FPTWG	Family Planning Technical Working Group
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	human immunodeficiency virus
HSSP	Health Sector Strategic Plan
IDHS	Interim Demographic Health Survey
IPPF	International Planned Parenthood Federation
MCH	maternal and child health
MDG	Millennium Development Goal
MMR	maternal mortality ratio
MOH	Ministry of Health
ONAPO	Office National de la Population
NGO	nongovernmental organization
PBF	performance-based financing
RAPID	Resources for the Awareness of Population Impacts on Development
RDHS	Rwanda Demographic and Health Survey
RSPA	Rwanda Service Provision Assessment
RWF	Rwandan franc
SMC	Senior management committee, Ministry of Health
TFR	total fertility rate
USAID	United States Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

The Rwanda Ministry of Health (MOH) is exploring the option of distributing contraceptives, including injectables, at the community level and is considering different models of service delivery. Possible frameworks to deliver these services include use of auxiliary nurses and community health workers (CHWs), who will be supervised by nurses at the health centers. The MOH recognized that community-based distribution (CBD) programs played a major role in the rapid expansion in contraceptive use, especially among women in rural areas. Guided by the experience of regional countries in use of CHWs to provide injectable contraceptives with significant success, safe service, and high levels of client satisfaction, the MOH wished to explore this mode of delivery. Before its implementation, a CBD assessment was done at the community level and in the health facilities in 20 districts to gather information regarding the applicability of this mode of delivery. Also, the MOH wished to conduct an assessment with policymakers and partners (program implementers) working in the area of family planning to garner their points of view on CBD of family planning services, more particularly injectable contraceptives.

In 2009, at the request of the USAID Mission in Rwanda and the MOH, Maternal and Child Health (MCH) Division, the USAID | Health Policy Initiative, Task Order 1 assessed the stakeholder environment, developed program guidelines, and supported the development of a costed implementation plan for the CBD of contraceptives, specifically injectable contraceptives.

The government of Rwanda identified family planning as a priority in its Economic Development Poverty Reduction Strategy (EDPRS). Rwanda's Health Sector Strategic Plan (HSSP) II is the guiding document for health sector initiatives for the period 2008–2012 and operationalizes the poverty reduction strategy in health in the medium term. As a result of a review of health sector performance in 2007, the HSSP was modified to reflect new priorities. The HSSP II calls for a rapid and sustained increase in the use of modern contraceptive methods from 27 percent of married, reproductive-aged women in 2007 to 50 percent by 2012 in the least ambitious scenario. To meet these goals, the MOH MCH Department was tasked with expanding access to modern methods, particularly injectables, which is the most popular method for current and future intended use in Rwanda (IDHS, 2007–2008).

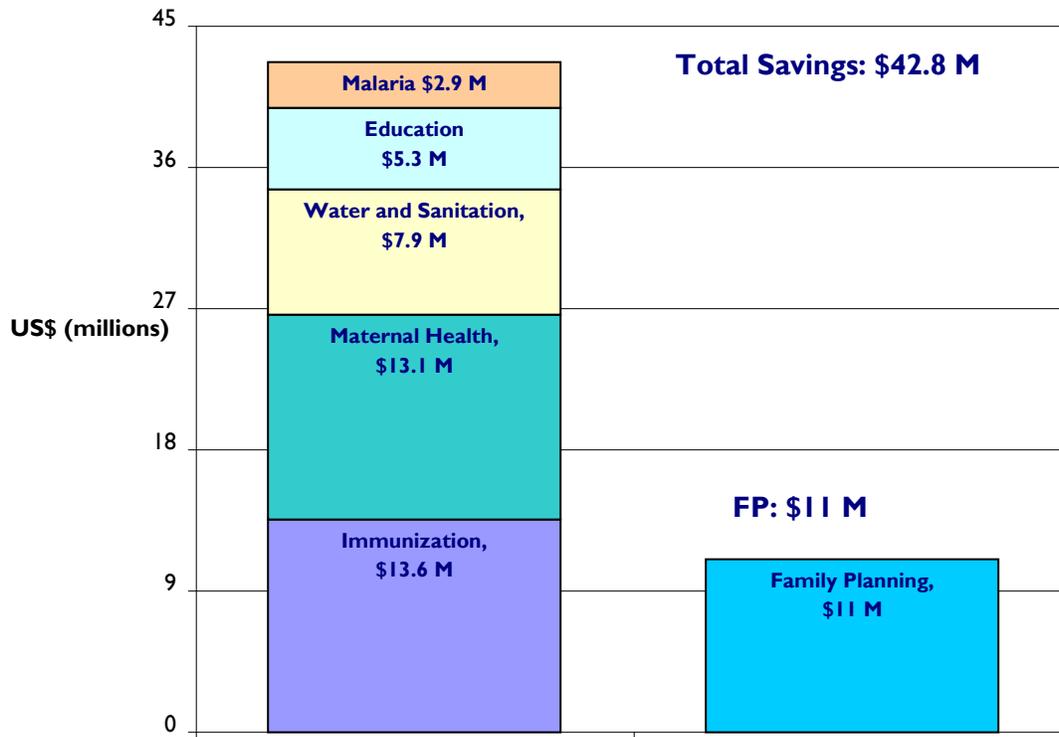
This report summarizes findings and policy dialogue related to developing guidelines and an implementation plan, and the subsequent steps of taking a policy decision to action for CBD of family planning methods. The following sections offer an in-depth understanding of the evidence base for CBD programs in family planning, the history of CBD in Rwanda, current barriers, and opportunities for CBD that enabled the development of national guidelines and an implementation plan to provide injectable contraceptives in Rwanda.

II. BACKGROUND

Rwanda is a small country, with human capital as its most abundant and potentially most important asset. Its EDPRS for 2008–2012 emphasizes the need for investments in education and health to improve labor productivity. According to the World Bank, these investments are beginning to pay off in terms of achievement of the Millennium Development Goals (MDGs), including MDG2 on universal primary education, MDG3 on gender equality, and MDG6 on HIV/AIDS and malaria. The maternal mortality ratio (MMR) decreased from among the highest in sub-Saharan Africa to 750 maternal deaths per 100,000 live births in 2005. However, this level remains far from the targeted 268 MMR needed for MDG and Vision 2020 achievement. It is in this context of addressing lagging maternal health outcomes that family planning investments are best considered. Closely related to maternal health outcomes are fertility-related

indicators.. The MDG analysis of the costs and benefits of family planning in Rwanda, which was updated in 2008, showed that, overall, for each dollar invested in family planning, Rwanda could save almost US\$4 in other sectors (see Figure 1).

Figure 1. Social Sector Cost Savings from Investments in Family Planning, Rwanda



In addition to maternal health benefits, the EDPRS explicitly recognizes links between increased use and development of family planning and poverty reduction in Rwanda. In response to development and health goals, the EDPRS provided for an ambitious goal of a contraceptive prevalence rate (CPR) of 70 percent by 2012 and a total fertility rate (TFR) of 4.5 children per woman. Rwanda is making impressive strides in increasing contraceptive use. In the past three years, the contraceptive prevalence rate has tripled, from 10 percent of currently married women ages 15–49 years in 2005 to 36 percent in 2007, according to Demographic and Health Surveys (DHS).¹ The increase in CPR occurred after a decade of stagnation immediately after the 1994 genocide. Pregenocide levels of contraceptive use were as high as 21 percent of married women in 1992, according to published surveys and government estimates.

Over the past two decades, the TFR and ideal family size have varied together, with the smallest gap in the year 2000 and the years immediately after the 1994 genocide (see Table 1). Over the past two decades, women preferred to have fewer children—an average of 0.8 to 2.6 fewer children per woman. The disparity persisted in 2007–2008, suggesting that the increase in CPR may represent a real change in fertility desires and norms, rather than simply a recovery to pregenocide levels.

¹ The question in policy circles is whether this is merely a restoration to pre-genocide levels or whether a true shift in preferences and speed of change have occurred.

Table I. Trends in Fertility-related Indicators, 1983–2007

Fertility Indicators	1983	1992	2000	2005	2007
TFR	8.6	6.2	5.8	6.1	5.5
Ideal family size	6	4.2	5	4.5	3.6
CPR (percent)	11	21.2	13.2	17.4	36.4
Modern-method CPR (percent)	1	12.9	4.3	10.3	27.4
Unmet need for family planning (percent)	*	40.4	35.6	38	*

Sources: RDHS 1992, 2000, and 2005 and IDHS 2007; * Data unavailable

Trends in the difference between TFR and wanted fertility rate suggest that there is considerable opportunity for continued increases in CPR and decreases in TFR. However, health providers must address rural-urban disparities in contraceptive use. Since 2000, the gap in achieved and wanted fertility² has widened between rural and urban (see Figure 2) areas. While women in urban areas are moving closer to having the number of children they want, women in rural areas continue to have roughly one more child than is wanted. If urban and rural women both were to have the number of children wanted, the TFR in 2007 would have been 3.6 children per woman, compared with the current level of 5.5. A TFR of 3.6 is even lower than that envisioned by the EDPRS and Vision 2020. A recent analysis of unmet need from the Rwanda DHS (Nyangara et al., 2007) shows that unmet need “differs significantly by rural/urban, partners’ occupation and economic status.” The authors show that, “unlike users, a higher percentage of women with unmet need have never used any family planning method before.” and “like users, women whose partners’ occupation is self-employment in agriculture have the highest unmet need.”

² Wanted fertility is a theoretical concept used to gauge what fertility would be if all unwanted births were prevented.

Figure 2. Rural Disadvantage in Family Planning: The Widening Gap in Achieved versus Wanted Fertility

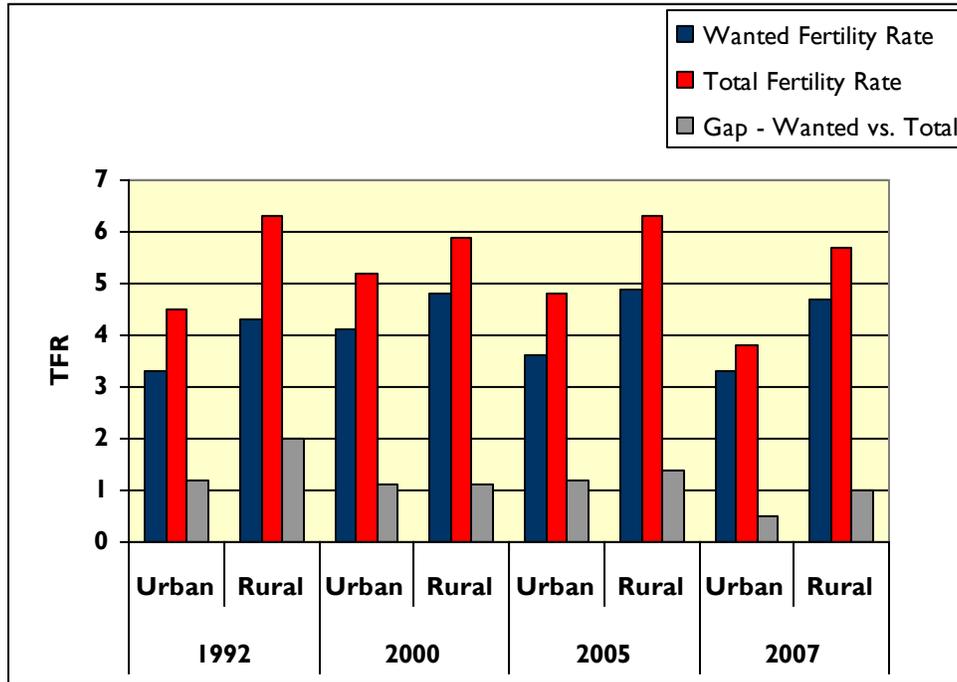
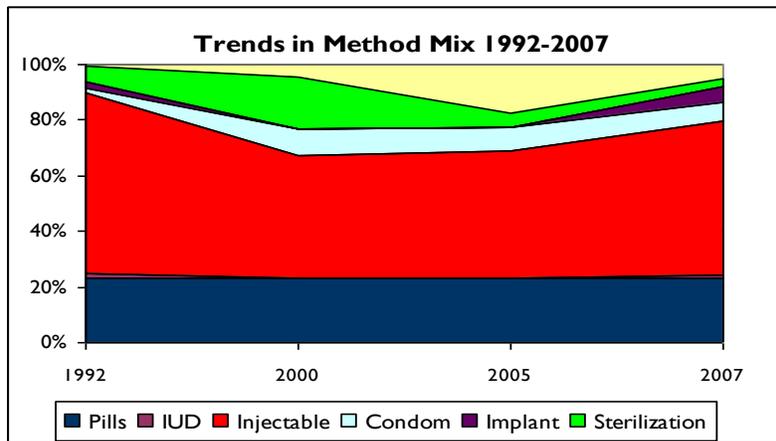


Figure 3 shows the trends in method mix for Rwanda from 1992 through 2007. Particularly striking is that the demand for injectables has remained strong, except for a slight dip after the genocide (2000), and continues to increase and represents the dominant method for family planning in Rwanda.

Figure 3. Trends in Method Mix, 1992–2007



III. OVERVIEW OF COMMUNITY-BASED DISTRIBUTION

Defining Community-Based Distribution

Broadly defined, CBD of family planning is the provision of contraceptives at the community level by nonclinical or paraprofessionals who may be either volunteers or paid staff. Phillips and others (1999) provide the most comprehensive definition in their seminal article on CBD in Africa. In sub-Saharan Africa, CBD of family planning, until recently, only included condoms and pills; however, it has begun to include injectable contraceptives and even implants, a long-acting method, in the method mix. Insertion of IUDs is not currently considered under CBD programs in this region since it requires more clinical knowledge and skills than those of typical CBD providers.

. Community-based family planning reflects a fundamental shift in the philosophy of family planning programs in developing countries. It is a change in the supply of services and the agent of services—from static clinics to door-step delivery in rural communities and from clinicians to trained nonprofessionals with some social standing in a community. Community-based programs include but go beyond the issue of access to services to directly address issues related to client-worker interactions, in making contraceptive use acceptable even among traditional, patriarchal societies. Where community-based programs are thought of simply as improving physical access to commodities—that is, extending the supply chain—they tend to be less successful.³ (See Appendix A for more background on defining community-based family planning services.)

Evidence of Impact: CBD of Family Planning, Including Injectables

The effect of CBD is typically measured in terms of changes in knowledge and contraceptive use. Information on the effects of CBD on fertility is limited, but the evidence regarding contraceptive use and knowledge is extensive. A review of available evidence suggests that CBD programs are effective and can be cost-effective and that the CBD agent's profile matters in terms of impact and sustainability, as does and gaining support from the national clinical-medical community for CBD of family planning services. There is also a considerable body of evidence on the CBD of injectables.⁴ For a more detailed discussion on the effects of CBD, see Appendix A.

In the following sections, we discuss Rwanda's particular intersection with CBD programs in family planning prior to the genocide and its more recent revival of this program. We discuss how the current initiative is different from the previous experiment in CBD and describe in detail the process used by the Health Policy Initiative in Rwanda and the outcomes of the project's work there.

³ Unmet need for family planning has less to do with “conventional geographic measures of contraceptive availability—the distance from and time taken to reach services, or the price of contraceptives—than it is to the qualitative and cognitive aspects of services” (Bhushan, 1996).

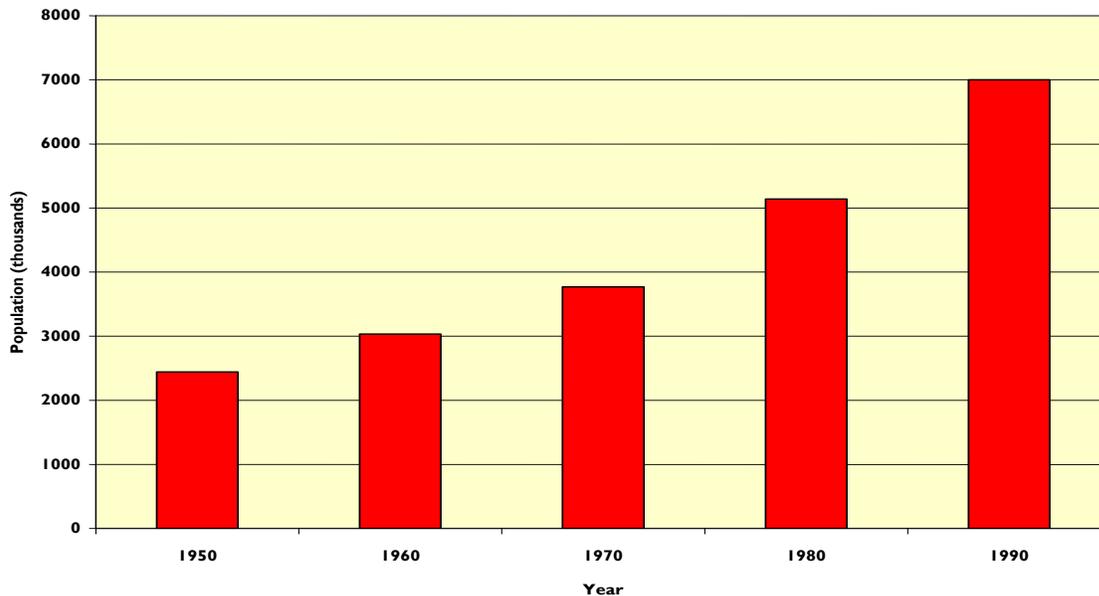
⁴ World Health Organization, U.S. Agency for International Development, Family Health International (FHI). 2009. *Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions From a Technical Consultation*. Research Triangle Park, NC: FHI. Retrieved from <http://www.fhi.org/en/research/projects/progress/gtl/concoba2i.htm>.

IV. RWANDA'S HISTORY OF CBD

Population Policy and the *Abakamgurambaga*

Rwanda's population grew from about 2.4 million people in 1950 to 10.7 million in 2009, based on estimates from the U.S. Census Bureau international database. Data from the first two censuses of 1978 and 1991 and previous surveys under colonial rule suggest that Rwanda's annual rate of population growth increased rapidly for more than three decades—from 2.6 percent in 1952, to 3.6 percent in 1978, and 5.5 percent in 1983. A national fertility survey in 1983 revealed that desired family size remained high (6.3 children per woman); the CPR was negligible—0.9 percent among married women ages 15–49; and in 31 percent of married women, the demand for family planning was unmet. Rwanda's population quadrupled in size between 1950 and 1993 immediately before the genocide (see Figure 4). This increase occurred in the context of extremely limited land resources for agricultural use. Concerns about population density were commonly expressed both before and after independence and led to attempts by successive governments, including colonial authorities, to use strategies that included emigration and resettlement to manage the “population problem” and, later, to a gradual interest in family planning programs (May, 1996).

Figure 4. Mid-Year Population of Rwanda, 1950–1990



Source: U.S. Census Bureau. Retrieved from <http://www.census.gov/ipc/www/idb/country.php>.

Modern contraceptive methods were introduced in Rwanda on a small scale in the 1960s (Solo, 2008), but the delivery of services through the public sector did not occur effectively until 1981, after the establishment of the National Office of Population (Office National de la Population—ONAPO). The ONAPO mission was to articulate and implement a national population policy, with the specific objective of reducing the population growth rate to 2 percent annually, lowering the TFR from 8.5 in 1990 to 4.0 in 2000, and increasing the CPR from 15 percent in 1990 to 48.4 percent by 2000. The impetus in developing these goals came from the first application of a model developed by the Futures Group,⁵

⁵ RAPID Model, 1980.

which was used by ONAPO to understand the links between population and development and to develop projections of population growth and fertility. In 2003, ONAPO was closed and its scope of work was transferred to the MOH, and a population desk was established at the Ministry of Finance.

The ONAPO population policy was first articulated in 1988, with a stated objective of linking to the community or “commune level.” The concrete link between national policy and community family planning services was not established until the mid 1980s, though the practice of delivering health information and services at the community level was routine. Volunteers called *Abakamgurambaga* or “people who awaken the masses” were trained and linked to a network, the Communal Centers for Development and Continuing Education (CCDFP), an organization funded by the Ministry of the Interior and Community Health. The *Abakamgurambaga* worked closely with local commune leaders to organize meetings on development topics.

A Pilot Study of CBD (1988–1989)

In 1988, a pilot program in the Ruhengeri District evaluated the potential impact of a CBD program by using selected *Abakamgurambaga* trained in family planning services. A total of 46 *Abakamgurambaga* were trained to provide condoms and pills and referrals to health centers and secondary health posts for other methods, including injectables. In an operations research study conducted by Columbia University in close collaboration with ONAPO (McNamara et al., 1992), three sites were selected: one where methods that included condoms and pills were used, one where only information was provided, and one that served as the control site. One volunteer was named per 10 households, a high ratio intended to increase the intensity of outreach to couples. The volunteers typically approached women of high parity (4–6 children). The study established that a CBD approach, whereby clients who receive information and referral at the community level make better use of family planning than those who do not receive such support. Overall, the average CPR for all three sites increased from 4.6 percent at baseline in January 1988 to 13.9 percent in May 1989. CPR in the control site increased modestly from 6.8 percent to 7.4 percent in 16 months. The largest increases occurred where volunteers provided information only because the commodities did not include injectables. The main role played by the volunteers was in reducing the social costs of family planning, as measured by the substantial increase in referrals to clinics for medical methods, including injectables. The success of the pilot study was largely attributed to the profile of the agent to the extent that the agents were well known to the community and were from the community in which they worked. The variation in results between groups in the pilot also indicated that the agents worked best where ONAPO and the Ministry of Interior and Community Health worked closely with local leaders to communicate a singularity of purpose.

“The change factor seemed to be the men and women of the rural communities who were known, who were trusted, and who were experienced with communicating the government's message.”
(McNamara et al., 1992)

Scaling Up CBD: From 46 to 17,000 Workers

The success of the pilot led to scaling up of the CBD program throughout Rwanda. From the baseline of 46 *Abakamgurambaga*, a total of 17,000 *Abakamgurambaga* were trained in 1989 by the CCDFP to provide family planning services at the community level. The *Abakamgurambaga* remained members of the CCDFP network and were deployed beginning in 1989. They distributed condoms and pills (after the first cycle was prescribed at the health center) and were assigned targets for new users beginning in 1993. *Abakamgurambaga* did not provide injectables, even though this was the preferred method among users.

Service statistics collected at the health center and by the volunteers at the community level tracked new users and discontinuation by method. In addition, in 1993, ONAPO conducted an evaluation of the

Abakamgurambaga program. Service statistics revealed an initial increase in contraceptive prevalence from 11.8 percent to 14.8 percent; however, this pattern reversed itself and the CPR began to decrease one year into the program, below baseline year levels to as low as 9.9 percent by 1993. Additional small-scale studies showed that discontinuation, especially among recent users, affected the CPR, though the rates for Rwanda were well within the range in sub-Saharan countries. A 1992 survey of clients by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) showed modest levels of concern, relating to insufficient knowledge about contraceptives and poor counseling by health staff. Client concern about side effects of contraceptives and interest in pregnancy were also relevant.

A midterm evaluation, conducted for USAID immediately prior to the genocide of 1994, identified serious misgivings about using *Abakamgurambaga* to provide family planning services at the community level (POPTECH Project, 1994). The *Abakamgurambaga* by design were trained and managed by an organization with close links to the former one-party government. The evaluation report stated that the breakdown of the one-party rule in Rwanda created a “fractioned and fractious” national and community environment and led to mistrust of the newly recruited volunteers and their methods. Community volunteers were no longer seen as neutral in an era of multiparty politics and decentralized authority. In the wake of the genocide, the *Abakamgurambaga* model was discontinued as were the the pilot programs supported by USAID in Rwanda.

The following lessons were learned from the first experience with CBD in Rwanda:

- **Community volunteers must be depoliticized.** The agent profile was the major factor that accounted for the initial good performance and subsequent decreases, as community acceptance of the message and the messengers eroded. The midterm evaluation strongly recommended delinking the volunteers from the network.
- **Clinical supervision is necessary.** The midterm evaluation identified the need for close monitoring and supervision by clinical staff more closely associated with a nongovernmental organization (NGO), such as the National Family Planning Association (Association Rwandaise pour le Bien-être Familial—ARBEF), or clinical staff emerging from the social marketing or private sector instead of a political party or network. Declining performance in terms of new acceptors may have been related to an absence of a relationship between clinical managers in health centers and the CHWs who were being supplied by the centers.
- **Policy and guidelines are necessary.** The midterm evaluation recommended that a future CBD program in Rwanda ensure that “an overall policy ... and strategy be developed” to implement CBD of family planning (POPTECH Project, 1994).

V. REDISCOVERING CBD IN 2009

A Changed Landscape for CBD in Rwanda

Between 1989 and 2009, the need for CBD of family planning did not change; however, the leadership and environment for implementation became more favorable. CBD of condoms began following the genocide on a small scale through ARBEF. In 2005, Population Services International began working in family planning and introduced CBD of condoms and pills and social marketing of condoms, pills, and injectable contraceptives. There is limited and contradictory information on the extent of CBD programs and methods offered outside the public sector, but according to MOH sources, the scale of such programs is limited.

Strengthening the policy environment and diversifying the policy instruments

Current health investments in Rwanda are guided by the EDPRS for Rwanda 2008–2012, which offers coherence to government planning. Population growth is a dominant theme in the poverty reduction strategy, and slowing the rate of population growth through family planning is one of the four priorities identified in the plan. Indicators and targets for population growth and fertility rates are tracked under the MDG for environment and maternal health, which increases the visibility and focus of family planning in the policy arena. In 2008, the EDPRS identified the fertility rate as seriously off track in terms of progress toward Vision 2020 goals. This concern regarding high levels of fertility is reinforced in the HSSP for 2008–2012. The HSSP II was revised to reflect three strategic priorities of which family planning is described as a “top priority” to receive greater attention and funds from the health sector. The HSSP II calls for a focus on increasing the accessibility and quality of family planning services. From a baseline prevalence of 27 percent modern-method use in 2008, the plan anticipates that, by 2012, modern-method prevalence must grow to 57 percent in the least ambitious scenario and to as much as 72 percent in the scenario expected to meet EDPRS targets in 2012.

"We've been to the bottom. We know what it's like to be a country that is in ashes and now we're able to spring back with a reason and determination to say, 'we're going to make this work, we're going to succeed.'"

Patrick Nyirishema, Director of Rwanda's Information Technology Authority

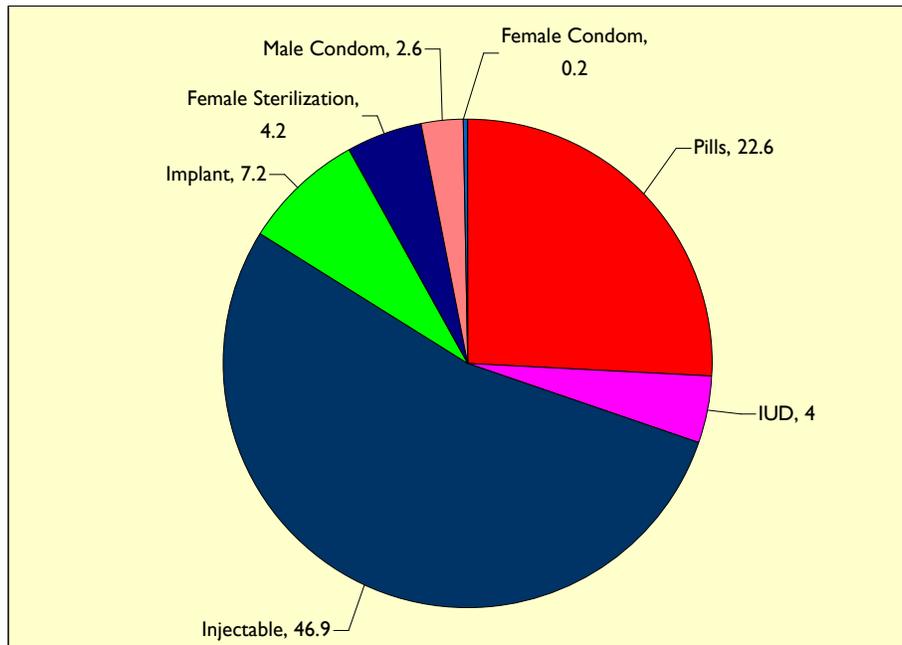
The Community Health Policy developed in 2008 is the governing policy document for community health initiatives in Rwanda. According to the policy, the role of community health is to increase access and health-seeking behavior so that services “go beyond the self-selected population that shows up at the health centres.” There is an explicit understanding that the MDG goals cannot be met without reaching out at the community level. Family planning services are framed in the context of reducing maternal morbidity and mortality and offer information about child spacing and modern methods of contraception. In addition, CHWs are permitted to distribute condoms and pills. The community health policy draws on the National Reproductive Health Policy developed in 2003 and the Family Planning Policy developed in 2005.

Bringing preferred methods to the community method mix

To implement the ambitious targets of the HSSP, the MCH Department of the MOH began to explore integrating some family planning services with current services provided by the CHWs. Guided by the experience of other regional countries using CHWs to provide injectable contraceptives, with success in providing service safely and with high levels of client satisfaction, the MOH wished to explore this mode of service delivery. Stakeholders in the FPTWG understood that any expansion of services must include injectables if a CBD approach were to be successful. This position was based on the popularity of injectable contraceptives. Trends in injectable use suggested an upward trend, with 2000 remaining as the anomaly year. The dominance of injectables is also seen in method preference among current nonusers who intend to use in the future (see Figure 5). Women overwhelmingly prefer injectables. This not surprising, given the large unmet need for spacing within rural communities where information and incentives for smaller families have been expanding in recent years.⁶

⁶ See for instance: Rwanda Development Gateway article, “Government to launch nationwide family planning program, 2007.”

Figure 5. Preferred Method of Contraception for Future Use, 2007



Source: Ministry of Health et al., 2009.

In June 2008, the FPTWG decided to obtain firsthand knowledge of the safety and effectiveness of CBD of injectables. Family planning stakeholders, including the MOH, family planning and community health desk coordinators, United Nations Population Fund representatives, and other FPTWG members, participated in a one-week study tour in Uganda, organized by Family Health International (FHI). During the July 2008 tour, the participants reviewed training materials, protocols, checklists used by CHWs, logistics, and injection safety procedures. Following the tour, the study team conducted a week-long retreat, presented their findings to the larger FPTWG and the MOH Senior Management Committee (SMC). The study team recommended that Rwanda go forward with CBD of injectables, closely following the program in Uganda, with some changes. Possible frameworks to deliver these services included use of auxiliary nurses and CHWs, who would be supervised by nurses at the health centers. In July 2008, the SMC of the MOH made the groundbreaking decision to move forward with a plan to increase access to injectable contraceptives through CBD of family planning services.

Using performance-based financing and health insurance

The MOH Annual Report for 2008 identified the CBD of injectable contraceptives as a key initiative for 2009. The report recognized that government initiatives in performance-based financing (PBF) and community health insurance, the existence of a family planning policy and strategy (2006–2010) and the community health policy (2008), and the work of the FPTWG created a strong, enabling environment for CBD of family planning. The PBF program, which provides financing to districts and health centers through an assessment of results, specifically includes family planning indicators. The program consists of a performance-based contract signed by local administrative authorities and is a mechanism that rewards output. The indicator to measure progress in family planning is the number of new users of family planning. According to the MOH 2008 annual report, the average number of new users per health facility grew from about 18 in 2006, when PBF was started, to 60 by 2008. In 2009, the MOH expanded PBF to the community level to provide an incentive for CHWs to produce and improve results. Community PBF does not reward individual CHWs but rather provides financial support to cooperatives established by the CHWs to develop alternative sources of income. The nascent scheme requires

considerable input in terms of management, training, and assessment. Community health insurance (Mutuelles de santé) is another important enabling factor for expanding use of family planning because it covers basic health services for enrollees and charges a modest copayment for long-acting and permanent methods. Enrollment in community health insurance has grown from 3 percent of the population in 2003, when the insurance was first introduced, to 85 percent in 2008; adding in coverage through private insurance, 91 percent of the population is covered.

Performance-based financing and health insurance at the community level are important tools added since CBD was first introduced in Rwanda. The institutional arrangements necessary to support health-seeking behavior and reward health provision are being developed. These mechanisms help move the system beyond training of health providers, which, although necessary, is insufficient to keep trained providers in the community offering services oriented toward achieving the MDGs. Few previous CBD programs have made these kinds of institutional investments prior to introducing family planning services. The decision to include injectable contraceptives in the CBD program is an important recognition of the need to consider a woman's preference. Programs unable to show a difference between provision of family planning through CBD and provision through static clinics have not included injectable contraceptives.

The SMC made the decision to go forward using the existing cadre of CHWs and requested an assessment of site readiness to prepare. The site readiness assessment was funded by USAID through FHI and was implemented by the MOH. It is in this context that the Health Policy Initiative was first invited to join the FPTWG in Rwanda and provide technical assistance to the MOH regarding national guidelines and policy development alongside the planned field assessment. The MOH also prepared a scope of work and plan for a national site-readiness assessment for the policy and guideline development process. The MCH Department of the MOH intended that a national program for CBD of family planning would be implemented and that guidelines would be developed using a comprehensive field assessment as essential first steps. The initial plans were to complete the assessment by December 2008. Despite the strong interest of the MCH Department, several factors—including the elections and change in the health minister, limited family planning personnel at the national level, and delays in obtaining ethics approval—led to the postponement of the national MOH site-readiness assessment. The assessment was finally conducted in July 2009, six months after initially planned, and findings were presented to the FPTWG in August 2009. The following section provides a brief overview of the MOH site-readiness assessment.

Ministry of Health Site-Readiness Assessment Findings

The purpose of the the MCH Department's field assessment was to provide (1) a snapshot of community and provider perceptions regarding the provision of injectable methods by CHWs (known as binomes)⁷ and (2) to assess the readiness of facilities to manage a CBD program and the current provision of family planning services of the facilities. The assessment used a combination of quantitative and qualitative methods.

The research team assessed site readiness through a survey of providers regarding their views on the CBD of injectables and other methods. In each of the four provinces of Rwanda, two districts were selected randomly. The research team interviewed district managers, doctors at hospitals, health center heads, and family planning managers at health centers in the two districts selected.

⁷ Community health is one of the 10 principles of the Rwandan government national rural health care framework and a cornerstone of the work of Inshuti Mu Buzima (Partners in Health). In early 2008, each *umudugudu* (village) in Rwanda elected two binomes, or community health workers. The binomes visit each household in their village monthly and serve as the communities' connection to the health system.

In the same two districts of the four provinces, the perception of 320 community members, men and women and of 320 CHWs were obtained through a series of focus group discussions. The survey instrument established that managers at the district, hospital, and health center levels had strong reservations about a CBD program.

The study found that 75 percent of 33 district and health center managers and *titulaires* (facility directors) who were interviewed did not support CBD of injectables. Only slightly more than half (55%) of the 20 family planning providers at the health facility level interviewed supported the idea of CHWs' providing injectables. Further probing suggested that managers and physicians were primarily concerned about the level of training and capacity of CHWs and broadly supported the need to expand access to clients at the community level. Community members were most concerned about the education of CHWs, the cleanliness of CHWs, and ability of CHWs to properly store and dispose of syringes and manage the side effects from injections. Supervisors in the health system were most concerned about training, equipment, incentives, and work burden in the proposed CBD program. Based on the focus group discussions, CHWs said they were ready to provide injectables and to focus on counseling and information.

Important reasons for contraceptive nonuse included religious affiliation and male opposition to family planning. However, spousal agreement/disagreement was not probed. The focus groups and survey suggested that much work was necessary to invest in training and management of CHWs to gain public trust and support from both the community and the health providers to run a CBD program for family planning. The field assessment revealed that most CHWs were trained in family planning communication, that two-thirds completed primary school, and most were married and employed in agricultural work. Supervision and reporting structures seemed strong: 96 percent of the CHWs reported regularly and most supervision was conducted by the local health center staff.

The field assessment also provided important information about the pockets of low demand for family planning that seemed to stem from opposition based on religious views. However, this study was not designed to evaluate in any detail the reasons for nonuse and factors that lead couples to regulate fertility. One factor that might affect family planning access is the proportion of facilities managed by the Catholic Church in Rwanda. According to the assessment, 40 percent of the health facilities visited were run by the Catholic Church and were not amenable to providing family planning services. Although the government is making a concerted effort to place secondary health posts near such facilities, it is important to determine whether these health posts could manage and resupply the CHWs.

In August 2009, the MOH site-readiness assessment findings were presented to the FPTWG by the MOH consultants. Although data were extensive, it was difficult to interpret some findings to build national guidelines and an implementation plan for CBD. The Health Policy Initiative recommended the following process in keeping with WHO guidance on task-shifting endeavors:

- Solicit the views of national-level stakeholders, particularly on the issue of policy, guidelines, key barriers, and implementation.
- Interview and include professional bodies who will be responsible for providing the training and whose support is important to build a broad coalition for CBD. One of the lessons learned in Rwandan history of CBD is the need to involve a good cross-section of the stakeholders so that the program generates public trust and sustainable results. Until this time, professional associations of physicians and nurses were not aware of the proposed plan for task shifting and were not part of the FPTWG. The FPTWG agreed to include professional bodies in the process; their participation seemed particularly important given the recent changes in government health management.
- Develop guidelines to address the decision to implement CBD of family planning.

- Develop a costed action plan to implement CBD of injectables. It is in keeping with the general findings of CBD programs globally and the specific history of CBD in Rwanda that the Health Policy Initiative focused its investments in the key areas of process and policy instruments.

The following sections detail the process followed by the project in Rwanda after the August 2009 decision to expand family planning services, including injectables, to the community level.

Health Policy Initiative and the Key Stakeholder Assessment

The FPTWG, led by the head of the MCH Department, prepared a list of stakeholders. A subcommittee worked closely with the Health Policy Initiative to design a brief questionnaire to gather qualitative data from these stakeholders. A total of 21 stakeholders from 18 organizations were identified for key informant interviews and 21 were interviewed. The interviewees included the members of the FPTWG, heads of professional clinical associations, and members of training institutions. The composition of the stakeholder group was, in part, dictated by the membership of the FPTWG but was also chosen to solicit the views of organizations that would provide services and technical assistance, as well as those that would be responsible for training and supervision of CHWs. See Appendix B for a complete list of stakeholders interviewed.

The objectives of the national stakeholder consultations were developed with the Community Health Desk that would be responsible for implementation of the CBD of injectables in Rwanda. The main objectives were to

- Ascertain stakeholder views on initiatives by the MOH to include injectable contraceptives in the minimum package of services at the community level;
- Understand stakeholder perception of challenges if CBD of injectables were implemented; and
- Propose solutions to these challenges to successfully implement CBD of the injectables.

Findings

As expected, of the stakeholders interviewed, those representing the government, MOH, and implementing partners, including international and local NGOs, were more supportive of the inclusion of CBD of injectable contraceptives in the minimum package for the CHWs. Of the stakeholders interviewed, all stakeholders representing the government and donors, were fully supportive of the CBD of injectables, whereas implementing partners, whether international or local NGOs, were mostly neutral on this issue—with over half of the NGO stakeholders reporting that more must be understood regarding how well CHWs would be trained and whether there was demand for these services in very rural areas. Only two NGO representatives expressed support for the initiative, whereas all professional medical and nursing stakeholders/clinicians were opposed to the initiative to launch CBD of injectables. The clinicians who were interviewed expressed some reservations because of concern that CHWs lack the skills to provide services and the basic knowledge to manage side effects and waste disposal. Although the representatives of medical professional groups acknowledged the access problems associated with injectables, they did not think that CHWs were ready to administer any form of injectable. Governmental and NGO representatives were confident that these challenges could be managed but that plans must be in place to address training, supervision, logistics, and advocacy with health managers and clinicians who would supervise CHWs.

All stakeholders agreed on the importance of training CHWs on clinical skills and knowledge, ensuring regular resupply, and providing effective supervision. They also wanted to be sure that women understood the common side effects. As a medical professional stated, “It does not matter whether it is the CHW or any other care provider that administers the injectables in the community. What matters is the willingness

of the beneficiaries to take the product administered and the capacity of the provider to ensure safety of the injectables.”

The majority of donors and NGO representatives were in favor of doing a pilot test on CBD of injectables because this would be the first intervention of its kind at the community level. They noted that it would provide enough time to study and address the challenges and provide a fair estimate of the cost to roll out the intervention, thereby minimizing implementation errors and inefficiencies overall. One stakeholder observed that “A pilot is necessary for any new intervention of such magnitude as CBD of injectables because this gives monitors (this time, MOH) ample time to observe and measure the output while studying the challenges on a smaller scale than if it was on a bigger scale.” Another stakeholder observed that “It might not be easy to estimate the cost of the CBD intervention on large scale than if it was done on small scale as a pilot.” Table 2 summarizes the main opportunities and challenges identified by stakeholders according to distinct themes developed by the Community Health Desk.

Table 2. Stakeholder Opinions on Current Opportunities and Challenges

Themes	Opportunities	Challenges
Political commitment and status of human resources for health	Willingness of all stakeholders to increase most wanted family planning methods and also support task-shifting efforts. Most professional bodies accept current strategies to address human resource shortages.	Inappropriate training for CHW to administer injectables Questionable knowledge of CHWs
The role of CHWs in providing family planning services	CHWs are already supplying various CBD family planning services. CHWs are already present. Stakeholders support supply through CHWs.	Weak supply system between health center and community
Budgeting and incentives for CHWs to provide family planning services	MOH and stakeholder suggest a willingness to provide incentives to CHWs through cooperatives and PBF to deliver family planning services.	Dependence on partners for funding and lack of sustainability plan
Guidelines and supervision for CBD of injectables	MOH is dedicated to developing guidelines for injectable contraceptives and integrated supervision of CHWs.	Absence of injectable contraceptive guidelines and supervision protocols for CHWs

Specific findings

Preparation at community level

Almost all (20 of 21) of the national key stakeholders strongly supported increasing access to popular family planning methods such as injectables. However, the majority think that the inadequate clinical skills of the CHW constitute a major barrier. This contrasts with the field assessment findings in which less than half the health managers and supervisors at district and health centers believed that CHWs can administer CBD of injectables because of their level of education and knowledge. Also, the number of facilities actually providing family planning services in Rwanda is limited because about two in five health facilities are faith based. These facilities provide good health services, but many do not offer injectable contraceptives. The government has been placing secondary health posts adjacent to facilities run by faith-based organizations. These health posts must take on supervisory roles when CHWs begin to provide injectables. The stakeholders who were interviewed recommended community preparedness as an

initial step, including advocacy and sensitization of local authorities, opinion leaders (e.g., religious, teachers, local judges). The MOH field assessment found that a minority of CHWs believe that men are reluctant to accept injectables. Because half the CHWs are men, the MOH should capitalize on this to ensure that more men are trained in basic skills to change their mindset.⁸

Training

The training component was cited as most challenging to implement CBD of injectables. The majority of national stakeholders, especially representatives of medical professional groups, was concerned about the level of training and quality of services that CHWs could offer. The stakeholders stated that both theoretical and clinical training are essential. Stakeholders recommended that the training curriculum be integrated with the regular in-service essential health package training for all CHWs. The training modules must include supportive supervision and monitoring by the instructors.

Curriculum components should include the following:

- A comprehensive training module on family planning counseling and injectable administration, with practical experience under an experienced supervisor
- Community health management to develop a tracking system of supplies and logistics reporting and to coordinate and plan with communities to build capacity
- Training of CHWs (about 3 weeks) to provide injectables at the community level

Because community assessment of CHWs showed that about four in five CHWs have a basic knowledge of injectables (effectiveness of injectables compared with that of pills, periodicity of injections, and side effects), stakeholders emphasized that continued in-service training was vital to the scale up and success of CBD of injectables.

Supervision

CHWs are supervised by staff from the health centers. According to focus group members and national stakeholders, even though community supervision protocols are available, these protocols are seldom followed. The community assessment found that 1 in 10 CHWs had not been supervised during the previous year, whereas 2 in 5 CHWs said that they had been supervised for two major health programs. The national stakeholder assessment also revealed significant inefficiencies in CHW supervision because of staffing shortages and means to conduct community supervision. The addition of CBD of injectables to the existing package would mean a greater workload, which could affect CHW performance. The majority of stakeholders stated that integrated supervision should be emphasized. Nurses from the health centers are mandated to supervise CHWs in their catchment zone. With the plan to add injectables to the existing package, it is crucial that additional staff and logistical support be required to ensure that supervision is effective. Currently, the Community Health Desk of the MOH has placed two people at each health center to supervise CHWs; however, these are not nurses and may only be able to provide administrative supervision.

Policy and guidelines

The CHWs have been accepted and supported by the MOH and have been formally taught existing operational policies and/or regulations. Nearly all of the national stakeholders said Rwanda has a supportive policy environment for the CBD of injectables. However, no formal policy guidelines clearly outline roles and responsibilities of all those who will be involved in the CBD of injectables. Therefore,

⁸ Multivariate analysis of unmet need in Rwanda showed that “social and cultural factors (mainly religious prohibition and husband opposition) are the main reasons about 26 percent of women have an unmet need for family planning. Therefore, programs in this country should consider involving religious leaders and men in the family planning programming decisions” (Nyangara et al., 2007).

counseling and injectable contraceptive services must be integrated into existing essential CBD health packages and training institutions must be involved in the policy development processes.

Logistics and waste management

Most stakeholders interviewed, especially those supporting MOH in the supply of family planning commodities, confirmed the existence of a well-established supply system for medicines and sundries from the central medical stores (CAMERWA) to the district level, which ensures a constant supply (no stockouts). However, there is a supply gap between health centers and the community level. Likewise, the procurement of injectable contraceptives will require more diligence in monitoring and forecasting to prevent stockouts. Therefore, forecasting projections should be changed to consider CHW injectable contraceptive needs in procurement. In addition, advance planning is necessary for supplies to distant and more remote areas.

Monitoring and evaluation

Because CBD of injectables is a new initiative, monitoring and supervision will be critical and should be strengthened within the existing systems. For efficiency gains, stakeholders (implementers and the MOH) think that an integrated support supervision and a monitoring and evaluation plan, with clear roles and responsibilities of all of those intervening in community health, are essential to follow up with CHW newly assigned activities.

New product versus existing product (Depo-Provera)

A new formulation of medroxyprogesterone acetate (Depo-Provera), known as Depo SubQ, that can be injected subcutaneously (rather than intramuscularly) is about to come on the market in some African countries.⁹ It has the same effectiveness and safety as Depo-Provera but is more user-friendly for CBD workers. The research team was interested in knowing whether stakeholders had heard of this product and had a favorable opinion of it. Most stakeholders said that if the product were approved by the MOH and the Rwandan drug authority, they would support its use because the CHWs could easily administer the product, women could easily inject themselves subcutaneously, waste management would be easier, and the method would be applicable to the Rwandan community settings.

Overall Recommendations

The following overall recommendations were made:

- A comprehensive training plan is crucial for clinical skills, management of side effects, and waste disposal. This can be achieved by considering outsourcing support from medical training institutions.
- An integrated support supervision, supply, and monitoring and evaluation plan, with clear roles and responsibilities of all those intervening in community are essential to follow up with the CHWs.
- Clear incentive structures and a legal framework should be outlined for the CHWs because they are key personnel working within the health system.
- The MOH should consider a pilot test as the first step of the intervention or a phased-in system.

⁹ The “uniject” design uses a plastic blister filled with the required dose of a vaccine or medication for one injection. The device requires little or no training; health workers push in the cap to activate it, insert the needle, and squeeze the blister. A one-way valve expels the vaccine or drug and prevents uptake of other contents, reducing the risk for transmission of infection. Because the device is prefilled with a single dose of medication, it reduces the need for multidose vials (a source of vaccine waste) and simplifies storage. The dosage provides three months of protection.

- District health providers and faith-based health facilities should be considered in all processes of the roll out of the new injectable contraceptive.
- The MOH should develop a strategy to sensitize people at all levels (health facilities and community) about the injectable contraceptive and emphasize differentiating of real side effects from rumors.

Follow Up

After the CBD assessments, the MOH invited key family planning partners through the FPTWG to discuss how to move forward based on the assessment conclusion and recommendations. The MOH/Community Health Desk planned to commence training of the CHWs in December 2009. Before training started, a subcommittee of the FPTWG was formed to do the following:

- Implement training and development of a costed action plan;
- Prepare guidelines; and
- Obtain approval of guidelines and a costed plan from the MOH.

The subcommittee technical working group agreed to plan a retreat outside Kigali, facilitated by the Health Policy Initiative, to concentrate on producing these deliverables.

VI. GUIDELINES AND IMPLEMENTATION PLAN FOR CBD OF INJECTABLE CONTRACEPTIVES

In October 2009, the subcommittee of the FPTWG attended a three-day retreat to finalize guidelines regarding CBD of injectables and prepare an implementation plan for Phase 1 of the CBD program. See Appendix C for the terms of reference and list of members of the sub-TWG. The Health Policy Initiative, in collaboration with the Community Health Desk, organized the retreat. The 13 participants had expertise in CBD implementation, including logistics, training, supervision and monitoring, and funding. Clinicians from one district in which the CBD pilot was expected to occur were invited to provide guidance regarding the particular clinical issues that would help frame the guidelines. The head of the Nurse/Midwives Association also attended. In this way, a broad cross-section of policymakers, implementing partners, and clinical bodies were represented to develop guidelines for the CBD program in Rwanda.

The following major themes were described in the CBD guidelines developed at the retreat. Box 1 highlights the key guidelines developed with the Health Policy Initiative's technical assistance.

- **Training.** CHWs should gain the required knowledge, skills, and attitudes to advocate for and provide desired quality injectable contraceptive at the community level.
- **Integration of injectable family planning into the current CBD package.** Injectable contraceptives should be integrated into the current essential CBD package at the community level. Integration not only enhances the sharing of existing infrastructure or facilities and personnel, but also maximizes the management of service delivery, simplifies logistics, and harnesses meager resources.
- **Service delivery.** The implementation program should encourage the use of and ensure availability of injectable contraceptives in the community.
- **Monitoring and supervision.** Monitoring and supervision of injectable contraceptive services should be strengthened within the existing systems.

- **Quality assurance.** Through training institutions and professional bodies, injectable contraceptive services should be integrated into quality assurance programs. The performance of CHWs should be promoted and professionalism should be encouraged by the MOH, with the help of professional bodies.
- **Logistics management.** The partners supporting the MOH in logistics supply systems should institute a well-run logistics system that ensures supplies are in good condition and delivered in a timely manner. The system should control costs by eliminating overstock and spoilage and ensuring proper waste disposal.
- **Performance-based financing.** The increase in the use of family planning services was linked with the supply-side incentives—a strategy that has worked in recent years. It is important that, as a CHW workload increases, labor days are compensated. The majority of stakeholders support compensating CHWs through newly created cooperatives at health centers; the MOH strongly supports this strategy.

Box 1. Highlights of the National Guidelines on CBD of Family Planning

- CHWs can provide condoms, pills, cycle beads, and injectables.
- Only trained CHWs providing CIMCI can provide injectables.
- Clients will receive their first injectable at the health center from the family planning nurse; subsequent injectables may be provided by the trained CHW.
- CHWs of both genders may provide injectables.
- Training regarding safe injectable practices will be conducted for 3 days, after the standard training on family planning.
- District trainers will conduct training in conjunction with the National Clinical Training Institute.
- CHWs will receive a CBD family planning kit for activities to cover commodities, safe disposal, and record keeping.
- CHWs will be replaced during their routine monthly visit to the health center.
- CHWs will receive monthly supervision by the community health supervisors of the health center.
- CHWs will receive incentives through the community PBF program that supports the community cooperative, and the main family planning indicator will be the number of new users.

After the retreat, the Health Policy Initiative provided technical assistance to the Community Health Desk to identify appropriate sites for the pilot. The plan was to identify a “typical rural district” that had low contraceptive prevalence and poor geographic access to health centers plus an urban site to understand the range of implementation issues to be assessed prior to a national rollout. Based on discussions with the MCH Coordinator and further review of the 2007 Rwanda Service Provision Assessment (SPA), 2007 Rwanda DHS findings, and service statistics, one urban site and two rural sites—Gatsibo, Rusizi, and Kicukiro—were selected. Some of the indicators included the availability of trained district staff to supervise CHWs, average distance to the closest health facility, terrain, distribution of Catholic/faith-based health centers in the district, and demographic and socioeconomic characteristics of the district.

In November 2009, the subcommittee of the FPTWG approved the pilot implementation of the national CBD of family planning program in the three districts: Gatsibo, Rusizi, and Kicukiro. The committee submitted a final version of the program guidelines to the MCH Coordinator. The MOH approved the guidelines, marking the first step in implementing the CBD program in Rwanda. The second step was to develop an implementation plan for the pilot, which would be then used as a model for scaling up the

CBD program in Rwanda. At the recommendation of the Health Policy Initiative, the subcommittee of the FPTWG continued to meet throughout November to identify the key elements for implementation (see Table 3 for the costed elements for two of the three districts).

Table 3. Costed Implementation Plan for CBD in Two Districts in Rwanda

Key Activities to Be Implemented	Amount RWF (million)
Component 1: Advocacy and sensitization Mobilize communities on the importance of the CBD strategy for family planning products, including injectable contraceptives by CHWs	10.8
Component 2: Training Conduct training of CHWs in two districts on CBD of family, including injectables	6.0
Component 3: Logistics, supply chain and waste management Design logistics and supply chain between CHWs and health centers Ensure safe, secure storage of commodities and avoid infection through proper waste disposal at the community level	10.5
Component 4: Service delivery Develop a referral mechanism/procedure between health centers and communities	TBD by MOH
Develop a checklist for CBD of injectables for CHWs	4.0
Component 5: Supervision and quality assurance Develop supervision protocols and ensure availability of means to conduct effective supervision at the community level	21.0
Component 6: Incentives and motivation Development of a plan to address retention and performance on family planning at the community level Sensitization of community leaders and health center staff on indicators relating to family planning	TBD by MOH
Component 7: Monitoring and evaluation Development of a monitoring and evaluation plan to evaluate the performance of CBD in two districts Data collection and data analysis and reporting	TBD by MOH
Total of 7 Components consisting of 43 separate activities (excluding costs of 4, 6, and 7)	52.3 RWF

Source: MOH Rwanda. Implementation plan for the community-based distribution of family planning methods, December 2010.

The MCH Department approved the final version of the costed implementation plan (FPTWG, MOH, Republic of Rwanda, unpublished document) for the pilot, or Phase 1, of the CBD program in November 2009. The MCH Community Health Desk will use the guidelines and implementation plan to move the national rollout of CBD after the pilot phase, which was scheduled to begin January 2010 and end by March 2010. However, despite the commitment at the national level, the planned implementation of the pilot has not yet started. The MCH Department continues to see this work as a priority and has scheduled training to begin August 2010, after the presidential elections (Dr. Fidel Ngabo, MCH Coordinator, MOH Rwanda, personal communication, July 17, 2010).

VII. CONCLUSION

Building on programs of Rwanda distributing oral contraceptives and condoms, the MOH decided to add provision of injectable contraceptives to the duties of CHWs. Setting the recent CBD experience apart are the following:

- The studied investments in policy instruments, including program guidelines, health insurance, and performance incentives;
- The inclusion of a diverse stakeholder mix to sustain support for the program; and
- The focus on a diverse method mix, including the most popular method of injectables, which provides clients with options for which they clearly express demand.

The national level stakeholder assessment provided a forum for the voices of medical professional groups that will be responsible for the clinical management of CBD workers. The assessment also galvanized a growing consensus among FPTWG members that the most cost-effective approach would be to phase in a CBD program. This was an important change in the plans being made for CBD in Rwanda.

The outcome of the project's work in Rwanda was a costed plan for the implementation of CBD in three districts in Rwanda, which required donors and partners to identify both the activities and associated costs to successfully implement such a program. This is an important result that has consequences for resource mobilization for the national scale-up of CBD. If continued investments are made to the community-based performance financing and training of CHWs, this program should go a long way toward reversing the rural disadvantage in family planning in Rwanda.

Lessons Learned

CBD of family planning when undertaken to reduce unmet need where there are high social and opportunity costs for using family planning requires the following key elements:

- Innovative demonstrations of success on a small scale, or as a pilot for national stakeholders
- Strong policy environment including development of policies and guidelines for safe distribution of methods
- Evaluating the role of economic and opportunity costs for women with an unmet need
- Performance structures that support quality performance of providers and supervisors
- Supervision systems that ensure availability of commodities
- Method mix that is in demand among the target population
- Involvement of diverse stakeholders including professional bodies and clinicians in the development of policies and guidelines
- CBD agents whose profile is trusted in the communities they serve

APPENDIX A. OVERVIEW OF CBD

Defining CBD

Broadly defined, CBD of family planning is the provision of contraceptives at the community level by nonclinical or paraprofessionals who may volunteer or be paid staff. Phillips and others (1999) provide the most comprehensive definition in their seminal article on CBD in Africa. In sub-Saharan Africa, CBD of family planning only included condoms and pills but has begun to include injectable contraceptives and even implants, a long-acting method, in the method mix.

Community-based distribution should be thought of as a subset of community-based family planning services. Community-based family planning reflects a fundamental shift in the philosophy of family planning programs in developing countries. It is a change in the supply of services and the agent of services: from static clinics to door-step delivery in rural communities, and from clinicians to trained nonprofessionals with some social standing in a community. Community-based programs include but go beyond the issue of access to services, to directly address issues related to client-worker interactions, in making contraceptive use acceptable even among traditional, patriarchal societies. Where community-based programs are thought of simply as improving physical access to commodities—that is, extending the supply chain—they tend to be less successful.¹⁰ Where such programs are careful about the “who,” as well as “what” is supplied at the local level, evidence suggests that the approach moves latent demand to effective demand for family planning in areas of low use, and significant social constraints against use.

The change in approach to family planning programs began in the 1960s in Thailand, through the use of female midwives in lieu of doctors providing services in rural communities. Changes in programming in other Asian countries and in Latin America followed in the early 1970s, galvanized by the policy statements from the International Planned Parenthood Federation on the need to consider nonphysician-led family planning in developing countries. However, the first evidence-based program was the Matlab project in Bangladesh (1977–1984), which revolutionized thinking about the role of family planning programs in demographic change. The Matlab project showed that community-based programs can increase contraceptive prevalence significantly and can be cost-effective when measured in terms of births averted. The success of the project led to its being scaled up within the public sector throughout Bangladesh.

Why a Community-Based Approach to Family Planning?

Community-based family planning services were introduced largely to address low levels of contraceptive use among women with latent demand or an unmet need for family planning in areas in which there are high social and opportunity costs for women using contraception. Similar to all other family planning programs, CBD programs evolved out of three imperatives: demographic trends, health, and human rights (Seltzer, 2002). However, it is the demographic rationale that has largely dominated CBD initiation. Projects such as Matlab in Bangladesh and Navrango in Ghana were undertaken to show that family planning programs can bring about demographic change even in areas where socioeconomic factors are unfavorable. The projects were able to show their affect through dramatic increases in contraceptive prevalence in these areas.

¹⁰This is because unmet need for family planning has less to do with “conventional geographic measures of contraceptive availability—the distance from and time taken to reach services, or the price of contraceptives—than it is to the qualitative and cognitive aspects of services.” (*Unmet need*. Working Paper No. 4. Baltimore, Johns Hopkins University School of Public Health, Center for Communication Programs, November 1997.)

Subsequent projects in Asia and sub-Saharan Africa used the results of these projects to argue for scale-up within the public sector and for similar methods in other countries. International donors and national governments alike were strongly influenced by Malthusian theories of population growth and economic welfare. There was some concern that investments in development projects would be wasted by growing populations of the poor in the same regions. Early CBD programs were premised on the theory that a supply-side approach could work to reduce high fertility among the rural poor. The CBD programs that moved information and supplies and choice to communities could tap into an anticipated latent and substantial demand for family planning in rural communities. This was in opposition to some economist expectations that demand for family planning follows socioeconomic development and, therefore, supply-side approaches were premature. Programs initiated primarily in Asia and Southeast Asia, including those in South Korea, Thailand, Indonesia, Bangladesh, India, and Pakistan, were based on the demographic rationale.

Similar concerns regarding demographic explosion dominated early discussions favoring family planning in Latin America (Oakley and Rodriguez, 2005), but health concerns were particularly appealing in countries in which a strong Catholic ethos made family planning and its access more suitable through the safe motherhood model. A combination of strong demand for fertility regulation, along with burgeoning private and nonprofit sector ensured that family planning services were available in most of Latin America beginning in the 1970s. Community-based distribution was a strategy developed, particularly by national family planning associations such as ProFamilia in Colombia, to serve “hard-to-reach” populations, including urban poor and indigenous populations in Bolivia, Colombia, Guatemala, and Peru. In Latin America and the Caribbean, political and religious movements influenced the role of the government and public sector in family planning.

Human rights concerns that coalesced in the International Conference on Population and Development in Cairo in 1994 may have meant a temporary setback to family planning programs in favor of a more comprehensive approach to women’s health and preferences (Pelon, 1999). But for CBD in particular, the language of human rights has evolved into the most persuasive argument for expanding services. It was what enabled CBD programs to move from information-only programs to ones in which pills (a previously prescription-only method) could be dispensed. Family planning programs today use the argument of unmet need, an issue of women’s rights, to call for rapid expansion of services in areas where most women in developing countries live—rural and remote from health facilities. Because most public and private sector programs do not serve these populations well, the CBD approach continues to be a popular solution.

Evidence of Impact

The impact of CBD is typically measured in terms of changes in knowledge and contraceptive use. With the exception of the Matlab and Navrango projects, data on changes in fertility are seldom available for CBD programs. Table A1 provides a summary of the CBD programs in Asia and Africa that provide some of the well-known evidence on the effectiveness and impact of community-based family planning.

The literature on CBD of family planning is extensive and largely dominated by programmatic efforts in Asia and Latin America, with more recent (1980–1990), nascent programs in sub-Saharan Africa, with the exception of the long-running programs in Ghana and Zimbabwe. The review suggests the following:

- CBD programs are effective. They have increased knowledge and use, often resulting in dramatic increases in CPR. They have shown that the community-based approach can successfully tap into latent demand and reduce the social and opportunity costs of using family planning. Most programs implemented in Africa have been too small and fragmented to show demographic impact.

- CBD programs can be cost-effective. The Matlab project was the first to show that the CBD approach was cost-effective when measured by the cost of births averted (Simmons et al., 1991) It did not measure cost savings from improved reproductive health and reduced mortality rate and therefore may be seen as an underestimate of its effectiveness. Based on the findings from the project, the program was expanded to the public sector in Bangladesh. CBD programs could be more cost-effective in sub-Saharan countries, in which the baseline CPR is low and the expansion from rural areas can be substantial.
- The agent's profile matters in terms of impact and sustainability. Community trust in the agents and the nature of client-agent interactions have an effect on outcomes. The importance of selection of CBD agents is borne out in studies in rural Bangladesh, northern Ghana, Mali, Kenya, and Peru.
- Gaining support from the clinical-medical community to CBD is essential (WHO, 2005). Where programs are implemented at the national level, involving the medical community to develop policy, guidelines, and systems for supervision is useful for program implementation and sustainability.

Community-Based Distribution of Injectables

Community-based distribution of injectables is not new. Since 1970, projects in Asia have shown the safety and efficacy of having nonclinicians providing this service. What is relatively new is its introduction in sub-Saharan Africa. The evidence on the safety and effectiveness of the CBD of injectable contraceptives was recently reviewed in a high-level technical consultation sponsored by the World Health Organization (WHO), the United States Agency for International Development (USAID), and Family Health International (FHI) June 2009 in Geneva, Switzerland.

Objectives of the consultation included the following:

- Review systematically the evidence and programmatic experience on interventions designed to expand access to/provision of contraceptive injectables, focusing on non-clinic-based services and programs
- Reach conclusions on issues for which evidence is consistent and strong; for which evidence is mixed; and for which evidence is marginal or entirely lacking and, therefore, requires additional research
- Document discussions and conclusions of the consultation, including policy and program implications, and to disseminate these widely

The consultation brought together 30 experts in CBD of family planning. Based on an extensive scientific review, the consultation concluded that “community-based provision of progestin-only injectable contraceptives by appropriately trained CHWs is safe, effective, and acceptable” (WHO et al., 2009). This conclusion could have far reaching effects in countries in sub-Saharan Africa that have been reluctant to task-shift hormonal contraceptives, particularly injectables to nonclinical providers.

Table AI. Illustrative CBD Programs in Asia

Program/Location	Purpose	Type of Approach	Effect on Contraception Prevalence Rate (CPR) and Fertility	Cost-Benefit
<p>Bangladesh</p> <p>Matlab (1977)</p>	<p>To measure latent demand for family planning among rural women</p>	<p>Quasi experimental: Two regions: intervention and control. In intervention area, door-step delivery using well-trained community women to counsel, inform, and provide injectables, pills, and condoms</p>	<p>In 1977, at the beginning of the project, contraceptive prevalence in project areas was 10%; increased within a year to 25% and to 69% by 1998. In the comparison areas, CPR also increased but only to 48% in 1998. The difference in CPR in that period had a significant effect on TFR, which differed by one child within 2 years of the project.</p>	<p>Measured in terms of births averted and costs. The project has yielded about 6,914 births averted from 1978-1985. The estimated cost per birth prevented ranges from \$150-\$220, which does not include savings because of improved health of the mother.</p>
<p>Thailand</p> <p>Ministry of Public Health (1969)</p>	<p>To determine whether nonphysicians, in particular trained auxiliary midwives, could provide oral contraception safely and effectively</p>	<p>Trained auxiliary midwives prescribed oral contraceptives in four rural provinces without a physician examination. They were provided with a simple checklist to rule out contraindications. The four provinces were compared with 13 control provinces to evaluate differences in user and continuation rates for pills.</p>	<p>6 months after initiation; fourfold increase in pill users and a higher proportion of pill users in the study areas compared with the control areas. No increase in occurrence of side effects; continuation rates were higher for midwives than for physicians. One year after initiation, Ministry of Public Health recommended that 3,000 nurse midwives nationwide could prescribe the pill without physician oversight.</p>	<p>Not measured</p>

Table A2. Illustrative CBD Programs in Africa

Program/Location	Purpose	Type of Approach	Impact on Contraceptive Prevalence Rate (CPR) and Fertility	Cost-Benefit
<p>Ghana</p> <p>Navrango (1984)</p>	<p>To assess the effect of community health and family planning programs on fertility and mortality rates</p>	<p>Quasi experimental – Evaluated the independent and combined effects of a nurse-outreach and traditional social organization of outreach on contraceptive knowledge, use, and fertility. Four areas in the Kassena-Nankana District were studied. Three years after exposure to the traditional outreach only, nurse-outreach only and combined methods were compared with the control area, which relied on static clinic-based family planning</p>	<p>The stand-alone approaches – nurse-outreach and zurugelu/traditional both are more effective than static clinics in increasing knowledge, but these effects decreased over time. Nurse-outreach only method was most effective in altering fertility desires among women. The combined strategy had a significant effect on increasing CPR but of too small a magnitude to affect fertility. The combined strategy decreased TFR by one birth in 3 years compared to 0.3 births in the comparison area. Contraceptive use had limited effect on fertility decreases, whereas age of marriage and postpartum abstinence had a significant effect on fertility decreases.</p>	<p>Not assessed</p>
<p>Mali</p> <p>Rural, southern Mali – five subdistricts</p>	<p>To test whether integration of a CBD model into an existing primary care health system can increase contraceptive prevalence</p>	<p>Quasi experimental design measuring program effect on family planning KAP. Male and female CBD agents trained and supervised by the NGO managing primary care system. Two subdistricts received education only on family planning through home visits and group talks, two subdistricts community-based family planning promoters sold condoms and spermicides; in one subdistrict no education or methods were provided (control)</p>	<p>Contraceptive knowledge increased in all three groups; largest increase in the CBD group. Use by women increased significantly in all groups, with largest increase in CBD group, followed by control group. Spousal communication in CBD and education groups increased significantly, particularly among those without primary schooling.</p>	<p>Not measured</p>
<p>Kenya</p> <p>Assessment of community-based family planning programs in Kenya</p>	<p>To assess the effectiveness of different CBD models in providing information and service and their cost-effectiveness</p>	<p>Assessed 7 of 20 CBD models operating in Kenya and compared performance against each other and static clinics</p>	<p>Did not assess effect on CPR. Showed that “regardless of program type or location, CBD agents see, more revisit than new clients” and only refer a small proportion for clinical methods. Found that “the agents located in the area with a higher CPR performed better than agents from the same program in sites with a lower CPR agent.” Incentives in the form of salaries could improve performance of CBD agents even when demand for family planning is low.</p>	<p>Measured cost-effectiveness by cost per client met and cost per CYP generated. No firm conclusion on cost-effectiveness per client met; costs ranged from \$1.3 to \$1.9 million cost per CYP generated was similar for urban and rural programs.</p>

APPENDIX B. STAKEHOLDERS CONSULTED ON CBD

Organization	Contact Person	Position	Telephone
GOR/MOH			
1. Maternal Health	Dr. Agnes Binagwaho	Permanent Secr.	(consulted, did not interview)
2. MOH (MCH task force)	Dr. Fidel Ngoba	Head of task force	0788304750
3. Rwanda Medical Council	Dr. Ruhirwa Rudoviko	Legal advice	0788409984
4. Rwanda Medical Association	Dr. Cathy Kantengwa	President	
5. Nursing Council	Ms. Murebwayire		078 852 2277
6. School of Public Health	Prof. Kakoma	Director	0788738085
7. Kigali Health Institute	Dr. Ndushabandi Desire	Rector	
8. FP/HIV/AIDS integration	Dr. Eugene Mwinura RWABUNEZA	FP Desk. Head	0788357338
9. University Teaching Hospitals (CHUK)	Dr. Hategekimana Theobald		
Civil society organizations (CSOs)			
10. ARBEF	Dr. Nyabyenda	Head	
Stakeholders supporting community initiatives			
1. FHI	Dr. Anacet Nzabimpa	Family Planning/HIV focal point	
2. USAID	Soukey Traoré	Health Advisor	0788304781
3. DELIVER Project	Aoau Diarra Dr. Jovith Ndahinyuka	Country Director and Technical Advisor	0788304505 (Jovith)
4. Management Sciences for Health (MSH)	Dr. Kantengwa Kathy	Country Director	
5. Intrahealth (Twubukane)	Laura Hoemoke Nyirangendo Jean Marie		
6. IntraHealth Capacity	Dr. Twahirwa William	Deputy chief of party	0788308870
7. EIP (Concern, IRC)	Rose Luz	Chief of Party	
8. PSI	Emery Nkurunziza	FP/RH HoD	0788307957
Donors			
1. German Technical Cooperation (GTZ)	Célestin Karamira	GTZ Technical Assistant	0788304288
2. CARE International	Jaime Stewart	Health and OVC Sector Coordinator	0788306081
3. UNFPA	Ms. Daphrosa Nyirasafali	RH National Program Officer	(250) 583003

APPENDIX C. TERMS OF REFERENCE FOR FAMILY PLANNING SUB-TWG

The MOH is implementing various community health interventions, all geared at improving health outcomes among the Rwandan population. Community-based distribution (CBD) of family planning products by CHWs is one of the key strategies to be started, with an aim of increasing the uptake of family planning services. Community-based distribution of contraceptive pills, cycle beads, and condoms by the CHWs is embedded in the national community health policy and the family planning policy. A rapid assessment on the feasibility of implementing CBD of Depo-Provera by CHWs, among other family planning products, has been done. Assessment reports highlight some of the many benefits of CBD of Depo-Provera, but also some key issues to be addressed prior to or during implementation of such an intervention. It is imperative that a well-elaborated CBD implementation guide be developed. Against this background, the FPTWG requested the sub-TWG, composed of 13 members from various development partners led by the MOH, to create a draft CBD implementation guide, which will undergo a wider stakeholder consultative discussion for fine tuning and approval.

The FP/SubTWG includes the following members:

Name	Department	Telephone
George Gahenda	Community Health Desk/MOH	0788612640
Eugene Rwabuneza	MCH/MOH	0788357338
Mary Murebwayire	Nursing/MOH	0788522277
Anastase Nzeyimana	FHI	
Daphrose Nyirasafari	UNFPA	0788430454
Theoneste Urayeneza	Johns Hopkins University	
Jovith Ndahinyuka	USAID/Deliver Project	0788304505
Sophia Nyirangendo	Intrahealth/TWUBAKANE	
Jennifer Wesson	FHI	
James Humuza	Futures Group	
Health center nurse	Gihundwe Hospital	
Supervisor for HCs	Gihundwe Hospital	
Celestin Karamira	GTZ	

Mandate of FP/Sub-TWG

- Review findings from the CBD assessment and create a summary report.
- Review and submit a summary of findings from the CBD to Dr. Fidel Ngabo.
- Review literature on CBD of family planning products with a bias on Depo-Provera elsewhere in the world; to consider countries such as Seychelles, Madagascar, Kenya, and Uganda.
- Organize and hold a workshop to discuss contents of the CBD of family planning products implementation guide (to be held outside Kigali).

- Prepare the first draft of the CBD of family planning products, including Depo-Provera implementation guide (write-up) based on workshop recommendations.
- Organize a two-day work meeting to finalize the draft CBD implementation guide and prepare a presentation for the FPTWG.
- Present and submit the draft CBD of DMPA implementation guide to the FPTWG.

Consultations

The Sub-TWG is free to consult any resource persons about CBD of family planning products.

Reporting Mechanisms

The Sub-TWG will update the FPTWG during its monthly meetings. A draft CBD implementation guide will be presented to the FPTWG.

Activity	Period							
	Sept 22-28, 2009	Oct 1-2, 2009	Oct 5-8, 2009	Oct 14-16, 2009	Oct 19-21, 2009	Oct 22, 2009	Oct 23, 2009	Oct 27, 2009
Review findings of CBD assessment	ALL							
Submit final report on CBD assessment to Dr. Fidele NGABO		George, Jennifer, Priya						
Review literature on CBD of family planning product implementation	ALL	ALL						
Create draft of the CBD of family planning products guide plus action plan			James, Priya					
Three-day workshop on content of the CBD of family planning products implementation guide (preferably at Kabgayi/St. Andre)				ALL				
Write up of first draft of the CBD implementation guide				James/Jennifer	James/Jennifer			
Work meeting to finalize draft CBD of family planning products implementation guide (outside the city center, e.g., Rebero)					ALL			
Present draft CBD implementation guide to FPTWG						James/George		
Integrate comments from FPTWG into the draft document							James/George	
FPTWG to organize a wider stakeholder consultative meeting on the draft CBD implementation guide								Fidele

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