

REPUBLIC OF RWANDA



Ministry of Health
<http://www.moh.gov.rw>
PO.BOX: 84 KIGALI

**NATIONAL FAMILY PLANNING
POLICY
AND ITS FIVE-YEAR STRATEGIES
(2006-2010)**

MARCH 2006

LIST OF USED TERMS /ACRONYMS

ANC	: Antenatal consultation
ARBEF	: Rwandan Association for Family Welfare (<i>Association Rwandaise pour la Bien-Etre de la Famille</i>)
BCC	: Behavior Change Communications
CAMERWA	: Center for Procurement of Essential Medicines in Rwanda (<i>Centrale d'Achat des Medicaments Essentiels de Rwanda</i>)
CDLS	: District AIDS Council (<i>Commission du District de Lutte contre le SIDA</i>)
CNLS	: National AIDS Council (<i>Commission Nationale de Lutte contre le SIDA</i>)
CPLS	: Provincial AIDS Council (<i>Commission Provinciale de Lutte contre le SIDA</i>)
CPA	: Complementary Package of Activities
CPR	: Contraceptive Prevalence Rate
DHS	: Demographic and Health Survey
DSS	: Department of Health Services
HIV	: Human Immunodeficiency Virus
HSSP	: Health Sector Strategy Plan
HIV/AIDS	: Human Immune Deficiency Virus/Acquired Immunodeficiency Syndrome
IEC	: Information-Education-Communication
FARG	: Victims of the Genocide Fund
FP	: Family Planning
FPTWG	: Family Planning Technical Working Group
HIS	: Health Information System
MDGs	: Millennium Development Goals
MIGEPROF	: Ministry of Gender and Promotion of Women
MIJESPOC	: Ministry of Youth, Sports, and Culture
MINADEF	: Ministry of Defense and National Sovereignty
MINALOC	: Ministry of Local Government
MINECOFIN	: Ministry of Finance and Economic Planning
MINEDUC	: Ministry of Education, Science, Technology, and Scientific Research
MINISANTE	: Ministry of Health
MPA	: Minimum Package of Activities
MOH	: Ministry of Health
MTEF	: Medium Term Expenditure Framework
NGO	: Non Governmental Organization
NHA	: National Health Accounts
NRHP	: National Reproductive Health Policy
PAQ	: Partnership for Quality Improvement
PMTCT	: Prevention of Mother-to-Child Transmission
PRSP	: Poverty Reduction Strategy Paper
RAMA	: Rwanda Medical Insurance Agency
SIDA	: Syndrome de l'Immunodéficience Acquis
SPA	: Rwanda Service Provision Assessment
STI	: Sexually Transmitted Infection

TRAC : Treatment and Research AIDS Center
VCT : Voluntary Counseling and Testing

CONTENTS

LIST OF USED TERMS /ACRONYMS.....	2
Contents	4
I. NATIONAL FAMILY PLANNING STRATEGY.....	6
1.1. INTRODUCTION	6
1.2. VISION AND OBJECTIVE OF THIS POLICY.....	6
1.2.1. Vision	6
1.2.2 Objective	6
1.3. <i>CONTEXT OF THE FAMILY PLANNING POLICY</i>	7
1.3.1. Vision 2020.....	7
1.3.2. National Decentralization Policy.....	8
1.3.3. Poverty Reduction Strategy Paper (PRSP).....	8
1.3.4. National Population Policy for Sustainable Development.....	8
1.3.5. National Reproductive Health Policy	9
1.3.6. National Health Policy	9
1. 4. Major elements forming this Policy	10
1.4.1. Focus on Advocacy	11
1.4.2. Mainstream Family Planning Programmes in all health services and increase access to full range of methods	11
1.4.3. Partnerships in administration structures.....	11
1.4.4. Increase Community Mobilization	12
1.4.5. Assure Quality & Formative Supervision in Public and Private Sectors	12
1.4.6. Sustainable Financing in Family Planning.....	13
1.4.7. Evidence-Based Decision Making.....	13
1.5. <i>FANANCING FAMILY PLANNING ACTIVITIES</i>	13
1.6. <i>FAMILY PLANNING POLICY MONITORING AND EVALUATION</i>	14
2. FIVE-YEAR (2006-2010) STRATEGY OF THE FAMILY PLANNING POLICY	14
2.1. Introduction.....	14
2.2 Strengthen and Focus Advocacy	16
2.2.1 Situation analysis	16
2.2.2 Planned activities.....	16
2.2.3. Implementation of Advocacy.....	17
2.3. Reinforce FP Integration and Increase Access to Full Range of Methods	19
2.3.1. Situation analysis.....	19
2.3.2 Planned activities.....	20
2.3.3. Implementation of Family Planning Integration and how Access to Full Range of Methods will be increased	21
2.4 Strengthen Partnerships for Increased Coverage	23
2.4.1 Situation analysis	23
2.4.3 How Partnerships for Increased Coverage will be strengthened	25
2.5 Increase Community Mobilization	28
2.5.1 Situation analysis	28
2.5.2 Planned activities.....	28
2.5.3 How community mobilization will be reinforced	30
2.6 Assure Quality & Formative Supervision in Public and Private Sectors	32
2.6.1 Situation analysis	32
2.6.2 Planned activities.....	33
2.6.3. Implementation of Quality Assurance & Formative Supervision	33
2.7 Develop Sustainable Financing	35
2.7.1 Situation analysis	35
2.7.2 Planned activities.....	36
2.7.3. Implementation of Sustainable Financing	37

2.8. Increase Use of Evidence-Based Decision Making	39
2.8.1 Situation analysis	39
2.8.2. Planned activities	39
2.8.3. Implementation of the Use of Evidence-Based Decision Making.....	40
2.9. INSTITUTIONAL RESPONSIBILITIES REGARDING THE IMPLEMENTATION OF FP STRATEGY.....	41
2.10. FINANCING FAMILY PLANNING ACTIVITIES	42
2.10.1 Contraceptive Commodities.....	42
2.10.2. Service Delivery	44
2.10.3 Essential Support Costs.....	44
2.11. MONITORING AND EVALUATION.....	45

I. NATIONAL FAMILY PLANNING STRATEGY

1.1. INTRODUCTION

The Government of Rwanda is committed to implementing the United Nations Millennium Development Goals (MDG) and the Family Planning strategy contained within this document is oriented toward achieving the target(s) for each of the MDG goals. The indicators and targets specified in the Family Planning strategy are consistent with the attainment of the MDGs in 2015.

It is worth noting that for these goals to be achieved, the collaboration of various sectors is required. For example, the level of education of females has a very positive impact on the use of Family Planning. Thus, the Ministry of education can support the Ministry of Health in its attributions in working towards the attainment of the Millennium Development Goals that our country is committed to achieving.

1.2. VISION AND OBJECTIVE OF THIS POLICY

1.2.1. Vision

The Family Planning Policy is based on the Vision 2020 "...A modern and prosperous Nation, strong and united, worthy and proud of its fundamental values; politically stable, without discrimination among its sons and daughters; and all this in social cohesion and equity."

1.2.2 Objective

The broad objective of this Family Planning Policy is to ensure for Rwanda healthy citizens that are able of working both for themselves and for their nation for its development.

Specific objectives are related to giving birth to a number of children that is within the capacity of each household to support, in such a way that every family and the entire population as a whole will be more productive and then be able to contribute to the sustainable development of our country.

The negative consequences of the absence of Family Planning include the high maternal mortality rate that places Rwanda among the countries with the highest maternal mortality rates in the world, about 1000 per 100.000 live births. In Vision 2020, we should be counting less than 350 women per 100 000 live births.

Another negative consequence that we can mention is the infant mortality rate (86 per 1000 live births) and the child mortality rate (152 per 1000 live births), whereas in the Vision, the infant mortality rate should be less than 25 per 1000 alive births .

Besides, Rwandan families are unable to feed and raise children of the age group we have mentioned above and it is not easy to pay for the education of children in their school age.

Without Family Planning, every year, we would lose hundreds of women and girls dying from illegal abortions performed in dangerous conditions to terminate unwanted pregnancies. At the societal level, unplanned fertility fuels a rate of population growth that is outpacing the economic production, constituting a real hindrance to the achievement of the Vision 2020 to reduce poverty where we hope that all Rwandans will have equal opportunities in a sustainable development.

Another specific objective is to assure a full range of contraceptive methods that are easily accessible throughout the country. This is only possible when a person can freely choose a contraceptive method that is easy for her/him including condoms for either Family Planning or protection against HIV/AIDS.

For the time being, there is no sufficient contraceptive security, thus, only 10% of women of reproductive age are able to choose their contraceptive method. Men seem unconcerned by that issue whereas they are the ones who should take the lead in participating in this activity. 35,6% of women who want to do Family Planning do not manage to find required services. Therefore, the urgent and necessary thing is to increase the coverage of both contraceptives and relevant services.

1.3. CONTEXT OF THE FAMILY PLANNING POLICY

Family Planning Policy and its five-year strategy (2006-2010) which is aimed to achieving sustainable development, has been inspired by the following:

1.3.1. Vision 2020

The Rwanda 2020 vision was developed through a broad-based, participatory consultative process during 2000-2001. The general objective of Vision 2020 is a modern and prosperous Nation, strong and united, worthy and proud of its fundamental values; politically stable, without discrimination among its sons and daughters; and all this in social cohesion and equity. The reconstruction of the Nation and its social capital and its regional and global integration will facilitate and condition sustainable development.

The Vision 2020 is based on the following six pillars:

- 1) The reconstruction of the Nation;
- 2) An efficient State, capable of uniting and mobilizing its population;
- 3) Human Resources development;
- 4) Town and country planning and development of Basic Infrastructures;
- 5) Development of Entrepreneurship and the Private Sector;
- 6) Modernization of Agriculture and Animal Husbandry.

There are also four cross-cutting domains:

- i. Gender Issues;
- ii. Environment protection;
- iii. Science and technologies, including ICT; and
- iv. Regional and international cooperation.

One of the foundations of Vision 2020 is to streamline population growth with the country's economic development and to suppress the main causes of mortality, namely malaria, AIDS and potentially epidemic diseases. Targets related to population growth include: decreasing women's fertility rate, infant mortality rate, maternal mortality rate, and population growth rate.

1.3.2. National Decentralization Policy

The National Decentralization Policy and related documents establishes a tiered system of government: 4 Provinces and Kigali City, 30 Districts, 146 Sectors; each district comprises of Sectors, Cellules and Villages.

The Decentralization Policy also empowers the various administrative structures to provide primary health care – including primary health care, dispensaries, maternities, etc; and entrusts them with the power of mobilizing resources for adequate service delivery.

1.3.3. Poverty Reduction Strategy Paper (PRSP)

The PRSP estimates that Rwanda's population will reach over 13 million by 2020, which may undermine the natural resource base and economic development. The PRSP includes Family Planning as a key intervention within the key priority area of *Human resource development and improving the quality of life*. The PRSP also provides several illustrative actions: fertility concerns will be mainstreamed into health information and adult literacy courses in 2020; midwives will be encouraged to provide advice on Family Planning; the Government will ensure the availability of reproductive health services at the district level.

The document identifies key indicators and means for measuring their achievement. These are elaborated in the Medium Term Expenditure Framework (MTEF) and reported on (and modified) in PRSP Annual Progress Reports of 2003.

1.3.4. National Population Policy for Sustainable Development

The National Population Policy for Sustainable Development of 2003 revises and updates an earlier 1990 policy, and takes into account Rwanda's adoption of the resolutions of the International Conference on Population and Development in Cairo, 1994. That Policy presents a multisectoral approach to improving the quality of life of the population.

In addition to reducing the population growth rate, this improvement also focuses on economic growth, food security, health, education, human resource

development, rational management of the environment, and good governance. The 2003 Population Policy presents a number of quantitative targets that are consistent with those presented in Vision 2020 and the PRSP.

1.3.5. National Reproductive Health Policy

The National Reproductive Health Policy of July 2003 was based on a broad, participative process begun with the Gisenyi Round Table in 2000, and further defines policies related specifically to the health sector of the Cairo Conference and the fourth World Conference on Women (Beijing, 1995).

There are six key elements of the NRHP:

- a) Safe motherhood/child health (SM/CH);
- b) Family Planning (FP);
- c) Prevention and treatment of genital infections (STIs/HIV/AIDS);
- d) Adolescent reproductive health (ARH);
- e) Prevention and management of sexual violence; and
- f) Social changes to increase women's decision-making power

For Family Planning, the NRHP establishes an objective of 15% by 2010 for use of modern contraceptive methods among women of childbearing age.

Strategies presented in the NRHP to achieve the 15% objective for modern Family Planning methods include: Carry out advocacy with all potential actors to promote improved awareness of Family Planning and generalized access to Family Planning services for women, men, and youth; integrate Family Planning in Maternal and Child Health Services; develop and implement a social communication and mobilization program; strengthen men's participation.

Other strategies include especially the involvement of various structures and organizations community-based such as religious organizations, NGOs, and associations of women, men, and youth in Family Planning promotion, improvement of Family Planning service providers' skills, making available and reviving Family Planning services in all health facilities (public and private) and building their capacities; establishing a system for monitoring Family Planning activities in all health centers at all levels (community, district, province, national); urging political and administrative authorities about mobilizing the population for the Family Planning issues.

1.3.6. National Health Policy

The National Health Policy outlines the roles of the Central Government, provincial and district structures, and re-emphasizes the norms established by the Ministry of Health 1998 for the Minimum Package of Activities (MPA) and Complementary Package of Activities (CPA) to be provided at Health Center and Hospital levels.

The National Health Policy re-emphasizes the key elements of the NRHP, including Family Planning, as contributing positively to the health status of the family.

The National Health Policy also recognizes that “in terms of the national poverty reduction strategy, actions in the health sector will only have an impact if they are integrated and fundamentally incorporated into the national development program,” and highlights the concept of *partnerships* as a key means of achieving such integration. Partnership strategies include inter-sectoral consultation and collaboration; national, regional, and international cooperation; professional orders and associations; private and conventional non-profit sector; traditional health care sector; and contractualization to reinforce partnerships and increase the responsibility of different actors.

The National Health Policy highlights that the health sector must be financed and urges initiatives that strengthen solidarity such as mutual health insurance schemes (*mutuelles de santé*), prepaid health insurance regimes, and health insurance. Besides this, it establishes the principles of cost recovery and fee-for-service, while assuring establishment of methods of financing for those unable to pay for health services.

1.3.7. The Ministry of Health Decentralization Guidelines

The Ministry of Health Decentralization Guidelines demonstrate how health services have to be provided at the District, Sector and Village levels, where the population accede to health services easily.

The Health Decentralization Norms define the health reference system, the roles and responsibilities of health service providers at each level. The Health Decentralization Norms are based on the implementation of the national decentralization policy, going hand in hand with administrative reform drawing from the Poverty Reduction Strategic Paper (PRSP) and the Medium Term Expenditure Framework (MTEF)

1. 4. Major elements forming this Policy

The major elements forming this policy are:

- Focus on Advocacy;
- Mainstream Family Planning Programmes in all health services and to increase access to full range of methods;
- Partnerships in administration structures;
- Community Mobilization ;
- Assure Quality & Formative Supervision in Public and Private Sectors;
- Sustainable (continuous) Financing in Family Planning;
- Evidence-Based Decision Making.

1.4.1. Focus on Advocacy

The Government of Rwanda encourages and supervises all the administrative structures in advocacy activities regarding Family Planning. It also establishes multi-modal strategies but particularly focusing on Information- Education- Communication as well as on visits to highly-performing Family Planning communities.

1.4.2. Mainstream Family Planning Programmes in all health services and increase access to full range of methods

Since the beginning of 2006, the Government of Rwanda will Establish and maintain routine public-private sector Family Planning dialogue and reporting at the national and District levels; it will also keep on ensuring that Family Planning, VCT, PMTCT and Pre- and Post Natal Care (PNC) are integrated in other services. Besides this, the Government will assure that full range of contraceptive methods are permanently available at all health care levels.

By 2010, the Government of Rwanda will assure that full range of methods are offered, including sterilization, at all Public Hospitals. All health facilities will be empowered to offer consistent referral assistance for Family Planning, in particular, the Government of Rwanda will assure that full range of methods, except sterilization, are offered by at least 50% of Health Centers.

1.4.3. Partnerships in administration structures

Since the beginning of 2006:

The Government of Rwanda will provide more advice and contraceptives through the Ministry of Health. The former is also expected to provide services at all levels and counseling to households willing to do Family Planning and to put at their disposal required contraceptives. In general, the Government of Rwanda is committed to making available essential resources that help private sector practitioners in providing profit-oriented or non-profit oriented Family Planning services. That is why the Government of Rwanda will keep on trying to assure there are no tax or non-tax related barriers to enable private operators to assist the Government of Rwanda in Family Planning.

The Ministry of Education has the duty of producing Family Planning teaching materials at all levels, from nursery, primary, secondary schools, and universities; it also has to design special lessons intended for teachers at all levels.

The Ministry of Local Government in collaboration with local administration structures has the duty of mobilizing the population to adhere to health insurance associations and to go to literacy programmes for those who do not know to read and write; thus better education will help the population to better understand Family Planning programmes.

The Ministry of Gender and Promotion of Women has the duty of determining the role of men and women in Family Planning Family.

The Ministries having Defense, trade, tourism, and security in their attributions are required to mobilize soldiers, police officers, drivers of trucks and lorries with trailers, taxi drivers and motorcyclists, about using condom both for the prevention of the infection of HIV and for Family Planning purposes.

The Ministry having Finance in its attributions shall increase investments in the activities aimed to the reproductive health in general and Family Planning in particular.

The Parliament should strengthen advocacy activities regarding the reproductive health in general and the Family Planning in particular.

The Ministry having Youth in its attributions shall mobilize the Youth about going to the centers that teach people about Family Planning while they are being trained in various crafts and to participate in Anti-AIDS clubs that are present throughout the country.

1.4.4. Increase Community Mobilization

Since the beginning of 2006:

The Government of Rwanda will collaborate with partners to increase Family Planning services that are offered at the community levels and to provide Family Planning contraceptives in health facilities and health centers. That is why, the Government of Rwanda will establish norms and give counseling regarding who prescribes Family Planning methods, as well as who follows up the implementation of those norms.

The Government will increase the integration of Family Planning into various youth centers and clubs. Besides, the Government of Rwanda will assure that men are more involved in Family Planning programmes, increase training for teachers on new Family Planning lessons in nursery, primary, secondary schools and in universities.

Finally, the Government of Rwanda will continue to focus on the education of children but with special emphasis on girls, insisting especially on the reproductive health and keeping on urging parents to understand that their children's lives and education are their prime role.

1.4.5. Assure Quality & Formative Supervision in Public and Private Sectors

Since the beginning of 2007, there will be an assessment and a review of pre-service professional education Family Planning curricula for doctors, nurses, and public health school students, with additional attention to practical application of skills they learnt.

Towards 2010, the Government of Rwanda will assure contraceptive commodities and equipment in all government hospitals. 50% of public Health Centers will be empowered to provide a full range of high quality contraceptive methods; all Rwandan public and private health providers have the knowledge and skills to provide a full range of high quality contraceptive methods, as appropriate to their professional level.

In addition, during that time close to 2010, the Government of Rwanda will assure that Districts provide adequate formative supervision to assure that public and private sector providers in each district are maintaining high quality standards. There will be established an appropriate plan and instructions aimed to decentralize health services to the broadest base possible.

1.4.6. Sustainable Financing in Family Planning

Towards 2007, the Government of Rwanda will develop and put in place a contraceptive pricing policy based on stratified subsidies to assure access to Family Planning for the poor. Thus, during the same year, the Government of Rwanda will Increase health insurance coverage (public or private sector) including the number of about 90% of the population who pay for Family Planning contraceptives and services.

Towards 2010, the Government of Rwanda will implement the Convention of Abuja, Nigeria concerning the allocation of 15% of the national budget to health care services.

1.4.7. Evidence-Based Decision Making

The Government is committed to using evidence-based decision-making in all health care structures.

Towards 2010, the Government of Rwanda will increase integration of private sector real data into routine data collection of the Ministry of Health (HIS).

1.5. FINANCING FAMILY PLANNING ACTIVITIES

The Government will collaborate with national and foreign partners in order to obtain the funds to use in the national Family Planning programme. The Government of Rwanda envisages keeping on supporting private sector health service providers to assure that Family Planning methods are available to all those who need them and in the shortest time possible.

Towards 2020, the Government of Rwanda predicts that private practitioners will be offering at least 60% of Family Planning services.

1.6. FAMILY PLANNING POLICY MONITORING AND EVALUATION

The implementation of the Family Planning Strategy will be integrated into routine data generated through the improved HMIS of the Ministry of Health. The Government will use the data collected in the context of self-assessment done by basic health structures and facilities.

The government will ensure constant assessment of those health facilities that provide data in order to know that the needed data are available and to keep on carrying out research both on the Demographic and Health Survey (DHS) and the problems of the population and the Service Provision Survey (SPA) will be done every five years.

2. FIVE-YEAR (2006-2010) STRATEGY OF THE FAMILY PLANNING POLICY

2.1. Introduction

At the national level, spacing children too closely cannot allow us to have healthy people that are able to contribute to the sustainable development both of their families and the nation as a whole.

In order to achieve the objective for 2015 all Rwandans are required to participate in Family Planning activities, some of which are included in the five year (2006-2010) Family Planning Strategy.

The major indicators in the health sector can be found in the table below:

Table 1: Major indicators in Rwanda in 2005

Economic and contraceptive Prevalence indicators	
Population under the poverty line	51.7%
Population's participation rate in Mutual Health Insurance Schemes	43.0%
Rwandans who use health services in a year	40.0%
Contraceptive Prevalence Rate – Modern Methods	10.0%
Life expectancy	44.5
Annual Population Growth Rate	2.1%
Annual economic growth	6% (estimate)
Rwandan Women's Fertility Rate (average of children a Rwandan woman can have during her life)	6.0
Indicators of epidemic diseases	
HIV prevalence rate	3% (Towns) : 7.3%, countryside : 2.2%)
Malnutrition prevalence rate among children	30.0%
Research-based health indicators	
Prevalence of diseases that can be prevented (by taking appropriate hygienic measures)	80.0%
Percentage of women's deaths that can decrease by 2015 if births are spaced by two years [MBB (Marginal Budgeting for Bottlenecks): estimates]	36.0%

Table 2: Government Objectives for Family Planning 2006-2010

Indicator	Baseline 2000ⁱ	2005ⁱⁱ	2010ⁱⁱ	2020ⁱⁱ
Contraceptive Prevalence Rate – All Methods ⁱⁱ	13.2%	15.1%	26.3%	45.2%
Contraceptive Prevalence Rate – Modern Methods ⁱⁱⁱ	4.3%	10%	18.5%	36.1%
<i>Source of Contraceptives:^{iv}</i>				
<i>Public Sector (including Religious missions)</i>	69.0%	68.0%	44.9%	26.1%
<i>ARBEF</i>	6.5%	7.7%	9.4%	11.2%
<i>Private Sector - Medical/Pharmaceutical</i>	16.1%	23.1%	44.5%	61.5%
<i>Private Sector – Non-Medical (dual-usage condoms)</i>	7.2%	Data not yet available	Data not yet available	Data not yet available
Infant Mortality Rate ^v	107	86	70	25
Maternal Mortality Ratio (deaths per 100,000 live births) ^{vi}	1071	856	700	350
Number of HIV-Positive women counseled on FP ^{vii}	-	113,000	-	-
Number of HIV-Positive women using modern methods	-	146,000	-	-
Women's Total Fertility Rate ^{viii}	5.8	6.1	5.5	4.5
Annual Population Growth Rate ^{ix}	-	2.6	2.3	2.2

The Family Planning Strategies include seven axes:

- Strengthen and Focus Advocacy;

- Reinforce Integration and Increase Access to Full Range of Methods;
- Strengthen Partnerships for Increased Coverage;
- Increase Community Mobilization ;
- Assure Quality & Formative Supervision in Public and Private Sectors;
- Develop Sustainable Financing;
- Increase Use of Evidence-Based Decision Making.

Each of the above axes has special attributions, objectives, and priority interventions in the short term (2005-2006), medium term (2007-2010), and long term (2011-2020) as detailed below.

2.2 Strengthen and Focus Advocacy

2.2.1 Situation analysis

The Government of Rwanda established Policies and strategies on reproductive health in 2003. Up to now there have been very few achievements in part due to a lack of advocacy at all levels of Government and civil society.

At the national level, messages are unfocused and inconsistent, and there is a general lack of information and uneven coordination among political, technical, and administrative leadership. At the district level, some health structures undertake advocacy but it is often health providers talking to other health providers; cross-sectoral advocacy is rare.

At the community level, there are some laudable achievements where community-based outreach workers are advocating effectively for increased use of modern methods. There is no general Family Planning outreach strategy or program nationwide.

2.2.2 Planned activities

The priority interventions for strengthening and focusing advocacy for Family Planning are:

Short-Term (2005-2006)

- Conduct National and District-level Dissemination Workshops of new Family Planning Strategy, including review of new RAPID computer simulation and preliminary work on message development targeted to the different audiences (national leaders, district leaders)
- Mobilize Rwanda Parliamentarians to take leadership in Family Planning advocacy, including visits to high-performing Family Planning families
- Provide training to interested Rwandan journalists and media personnel for improved coverage of Family Planning issues.
- Launch a targeted media campaign to increase public information of Family Planning

Medium Term (2007-2010)

- Refine and expand national media campaign with specific, targeted messages.
- Mobilize Rwanda Association of Local Government Administrators (RALGA) and similar civil society groups to advocate for Family Planning.
- Mobilize health professional associations – Rwanda Medical Association, Nurses Association, and Pharmacists Association – to advocate among their membership for improved IEC and service provision.
- Assure that private health providers are including Family Planning within services offered, as appropriate to the level of the clinic.
- Maintain dialogue with religious leaders on direct relationship between Family Planning and maternal and child morbidity and mortality, and encourage provision of counseling and/or referrals on all methods, and provision of standard days method beads at all sites.

Long-Term (2011-2020)

- Assure that all Districts are including provision for Family Planning services within annual District Plans and Budgets.
- Maintain media coverage and conduct special events to maintain visibility of Government commitment to Family Planning.

2.2.3. Implementation of Advocacy

Strengthening and focusing FP advocacy will be implemented as follows :

Develop and conduct multi-level advocacy strategies at all levels: National, Provincial, District, Sector, Cellule, Village and Rwandan Community, with targeted messages for specific audiences.

Develop and conduct multi-level advocacy strategies at all levels, within the PRSP, for overall health, for gender, for youth, for the military, for faith-based organizations, for the military, for public-private partnerships, etc.

Assure that advocacy strategies are multi-modal, including different information and communications approaches: mobilization of media, mobilization of leaders and other representatives who are role models, information-education-communications (IEC), household visits. The Government has to put more efforts to explain the important role of men in the Family Planning programmes.

The Rwandan leaders have the duty of mobilizing the population about Family Planning activities at all levels of government and civil society. The key challenge is to help leaders move beyond perceived cultural or religious objections and to be willing to take a public stand to promote healthier mothers and children through Family Planning. The objective is to make Family Planning the norm (guidelines), rather than the exception.

The President constantly mentions HIV/AIDS in every public fora or speech, with the objective of mainstreaming the issues; it is hoped that he will also begin to

mention Family Planning more often. There are opportunities with other well-known political-administrative leaders to become “Family Planning Champions.”

The Ministry of Health, as lead executing agency for this Strategy, in collaboration with national and international partners, will continue to pursue a deliberate strategy of working with leaders at the national, district, and local levels to increase their understanding of Family Planning in the national and local setting; to speak out publicly on Family Planning, to demonstrate their commitments into actions, including visiting public and private Family Planning program sites, and to engage in policy dialogue and formulation on issues important to Family Planning.

Table 3: Major Appropriate Advocacy Activities until 2020

Family Planning : Capacity building and focus on advocacy			
Target	Indicator	Verification means	Note
Family Planning advocacy focused on and strengthened	Percentage of people involved in advocacy compared to those expected.	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Activities	Indicator	Verification means	Note
1. 1. Developing advocacy activities 1.2. Conducting advocacy activities 1.3. Conduct advocacy workshops on Family Planning 1.4. Mobilize Rwanda Parliamentarians to take leadership in Family Planning advocacy 1.5. Provide training to Government and private journalists for improved coverage on Family Planning issues. 1.6. Use Government and private media in Family Planning advocacy 1.7. Improving and expanding FP advocacy activities 1.8. Collaborate with different associations in Family Planning advocacy activities 1.9. Supervise public and private services in Family Planning advocacy activities 1.10. Maintain dialogue with religious leaders 1.11. Plan the financing of FP advocacy activities at all levels that provide FP services 1.12. Explain men's role in Family Planning	Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and health facilities.	Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District and health facilities.	More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and health facilities.

2.3. Reinforce FP Integration and Increase Access to Full Range of Methods

2.3.1. Situation analysis

The public sector currently provides about 68% of contraceptives used in Rwanda. Family Planning has been integrated into both the Minimum Package of Activities (MPA) for Health Centers and the Complementary Package of Activities (CPA) at Hospitals in Rwanda since at least 1998. In practice, however, access to such services is highly uneven.

The 2001 Service Provision Assessment (SPA) found that while 71% of sites offered contraceptive pills and/or injections, only 24% offered counseling on natural methods and only 6% of facilities (hospitals) provide permanent methods. However, in 34% of the health facilities that offer Family Planning methods, the services were only available one or two days per week. In addition, only 53% of the facilities had all methods that they offered in stock on the day of the survey.^x

Integration has not provided the increased “point of entry” that was hoped. A 2003 performance needs assessment for Reproductive Health found that access to Family Planning is limited by the lack of integration with other health services at the facility level, with Family Planning introduced at only 28% of post-natal visits and 54% of premarital health counseling sessions.^{xi}

There has also been inadequate integration of Family Planning with HIV/AIDS services. As of mid-2005, prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT) services were available at more than 25% of the 400 existing Ministry of Health (including “authorized”) care facilities. At least 66 health centers supported by the Global Fund for AIDS, Malaria, and Tuberculosis (“Global Fund”) offer “integrated” VCT, PMTCT, management of sexually transmitted infections and opportunistic infections and TB prophylaxis.

National norms and standards exist for PMTCT and VCT. However, a 2004 situation analysis of integration of Family Planning into VCT and PMTCT in Districts found a lack of clear expectations regarding Government intent toward such integration, as well as varying quality of Family Planning messages. The analysis also found minimal emphasis on Family Planning services within health centers dominated by HIV/AIDS testing, care and treatment.^{xii}

In the 2001 SPA, only 53% of the facilities had all methods that they offered in stock on the day of the survey.^{xiii} As of 2004, stock outs were localized in certain districts (10 out of the 38 districts surveyed). Several factors are at play in these locations, primarily the turnover of staff knowledgeable about the re-ordering procedures for contraceptives (defined nationally through standardized information management forms), lack of a mechanism or procedure for transferring skills when trained staff members leave, and continuing need for reinforcing compliance with proper logistics management functions at facility levels.^{xiv}

In 2000, the three operational clinics of Rwandan Association for Family Welfare (ARBEF) were the source of contraceptives for 6.5% of respondents for the 2000 DHS, including 11.8% of women who used pills and 10% of women who used injectables. By 2004, ARBEF had eight operational clinics which provided about 7.7% of contraceptives in Rwanda.^{xv} ARBEF offers the full range of contraceptives except sterilization.

Because ARBEF is focused on reproductive health, integration with other services offered is less of an issue than in public sector facilities. However, given the relatively recent addition of VCT to its menu of services, ARBEF's client base in some facilities has shifted toward HIV testing instead of Family Planning. There is an opportunity to reach more potential clients through strengthening integration of Family Planning messages with VCT throughout the ARBEF system.

The 2000 DHS showed that about 16.1% of women obtained their contraceptives at private facilities other than ARBEF. Pharmacies were the largest source, providing 10.5% of pills, 6% of injectables, and 38.6% of condoms. Private clinics provided 6.3% of sterilization, 6.4% of pills, and fewer than 6.3% of injectables. There are no data as to the private sector's current level of activity in Family Planning.

2.3.2 Planned activities

The priority interventions are:

Short-Term (2005-2006)

- Revise, as appropriate, 1998 Norms and Standards to assure that full range of FP is integrated in MPA (health centers) and CPA (hospitals).
- Revise Family Planning Protocols (*ordinogrammes*) according to WHO criteria.
- Initiate 2006 SPA that includes and disaggregates public and private providers (including ARBEF, clinics, private doctors, pharmacies, private nurses)
- Select initial cohort of approximately 25% of Districts for initial expansion of services, and undertake needs assessment in each District.
- Initiate contraceptive technology update training in "first cohort" each Health District (to include private providers)
- Initiate mini-laparoscopy (mini-lap) training for doctors in 10 "first cohort" districts, and some reference hospitals.
- Provide refresher training/new training to assure improved integration of Family Planning counseling within PMTCT and VCT sites
- Provide refresher training for Pharmacy/Depot managers at Hospitals and Health Centers to incorporate newly introduced methods.
- Provide required infrastructure and equipment to assure that "first cohort" is providing high quality full range of contraceptive methods.

Medium Term (2007-2010)

- Progressively cover remaining 75% of Districts with needs assessment, training, and provision of necessary materials and equipment in at least 10 additional Districts between 2007 and 2010.
- Continue contraceptive technology update training, mini-lap training, Pharmacy/Depot manager training, and counseling training at remaining Districts.
- Continue to reinforce integration of Family Planning with VCT/PMTCT throughout the health system.
- Make use of research data (DHS and others) to develop District-level action plans to expand Family Planning coverage and quality at public and private facilities, as indicated.
- Plan and implement decisions from the survey that will be carried out in 2010.

Long-Term (2011-2020)

- Continue contraceptive technology update and other required trainings at Districts to assure full range of methods are offered.
- Continue to reinforce the integration of Family Planning with VCT/PMTCT nationwide.
- Make use of data from 2010 DHS to develop new District-level action plans (DHS plus, etc.).
- Plan and implement decisions from the survey that will be carried out in 2015. Make use of data from 2015 DHS to develop District-level action plans to expand Family Planning coverage and quality at public and private facilities, as indicated.

2.3.3. Implementation of Family Planning Integration and how Access to Full Range of Methods will be increased

The Family Planning integration and increasing access to a full range of methods will be implemented as follows:

- Assure that full range of methods are offered, including sterilization at all District Hospitals by 2006.
- Assure that full range of methods, except sterilization, is offered by at least 50% of Health Centers while authorized health care facilities offer consistent referral assistance.
- Establish and maintain routine public-private sector Family Planning dialogue and reporting at the national and District levels.
- Increase integration of Family Planning and voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) of HIV and AIDS.

Table 4: Activities of integrating Family Planning and increasing access to a full range of methods.

Family Planning services in health facilities and increasing access to those services			
Expected results	Indicator	Verification means	Note
Improved Family Planning services in health facilities	Percentage of high quality services compared to the number of planned services	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Access to Family Planning services increased.	Percentage of people that obtain high quality Family Planning services, compared to the number of people expected to obtain high quality services	Annual report at each level	
Activities	Indicator	Verification means	Note
1.1. Include full range of methods, including sterilization, in all Hospitals 1.2. Include full range of methods, except sterilization, in all health centers 1.3. Establish and maintain routine Family Planning dialogue in health centers and clinics 1.4. Increase integration of Family Planning and VCT and PMTCT centers 1.5. Revise Norms and Standards 1.6. Revise Family Planning <i>ordinogrammes</i> . 1.7. Initiate SPA in public and private health facilities 1.8. Select Districts in which Family Planning services will be offered 1.9. Provide training on Family Planning 1.10. Provide training to VCT/PMTCT agents in charge of counseling to build their capacities in Family Planning counseling 1.11. Provide Family Planning training for Pharmacy/Dépot managers 1.12. Provide required infrastructure and equipment and capacity to health centers selected to offer high quality full range of contraceptive methods 1.13. Plan necessary equipment to ensure other health facilities and centers are empowered to offer FP services 1.14. Initiate and provide contraceptive technology training 1.15. Strengthen advocacy in VCT and PMTCT centers 1.16. Develop annual Family Planning operational plans 1.17. Implement the Family Planning propositions from five year DHS	Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and health facilities.	Details on those indicators are presented in the annual action plan at every level: Ministry, Province, and District and health facilities.	More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and health facilities.

Note:

- The contraceptives considered are those available in the public sector

- The qualifications of personnel necessary to sell oral contraceptives and injectables in the pharmacies are to be determined by the standards of MINISANTE.
- The qualifications of the personnel necessary in the health facilities to deliver these services is also to be defined by the standards of MINISANTE

2.4 Strengthen Partnerships for Increased Coverage

2.4.1 Situation analysis

Table 2 in section 2.1 above shows that Rwanda is achieving its Family Planning objectives through a number of strategic partnerships within the public sector; with the not-for-profit and for-profit private sector ; and with the international donor community.

As stated above, the public sector provided about 68% of contraceptives in Rwanda in 2005. Within the public sector, the 2001 SPA found that 40% of Rwanda's primary and secondary health facilities (dispensaries, health posts, health centers) were operated by NGOs, most of which were faith-based organizations (FBOs) and religious missions. These are valued partners with the Government and are integrated into Rwanda's public health system as *authorized health care facilities*.

The majority of these facilities do not offer Family Planning services as a matter of faith. The Government maintains a dialogue with these partners and encourages them to incorporate at least Family Planning counseling and referrals where possible. The Government also pursues a strategy of establishing secondary public sector posts to assure that Family Planning services are available within all health networks in the country.

The Rwandan Association for Family Well-Being, ARBEF, operated eight clinics at the end of 2004, and was the source of about 40% of all contraceptives provided in Rwanda in 2004. ARBEF is opening another clinic in 2005, and will continue to expand as client demand and donor support so indicate.

As mentioned above, the ARBEF clinics provide a full range of contraceptive methods (except sterilization) as well as VCT. Several of the ARBEF clinics are located in public health networks operated by FBOs that do not offer Family Planning, providing good complementarity within the public health network. ARBEF operates on a partially-subsidized level, charging modest fees for all services it offers.

The Government values its partnership with ARBEF and will strengthen collaboration and dialogue in future years.

The 2001 SPA documented 329 private commercial medical facilities in Rwanda, excluding pharmacies, which the Assessment did not record. The 2000 DHS

documented that the private facilities was the source of modern contraceptives for 4.6% of respondents, with an additional 11.5% utilizing pharmacies as their most recent source.

Since 1999, the private sector has grown considerably, with 2 and 3 private doctors and/or nurses believed to be practicing as private practitioners. MINISANTE had registered 365 private pharmacies throughout the country as of mid-2005, of which 22 large and 17 medium (*depots*) were operated by trained pharmacists, and the rest (*comptoirs pharmaceutiques*) by nurses or other personnel.^{xvi} Although the large clinics and pharmacies still tend to be found in Kigali, Gisenyi, and other large cities, the small "*comptoirs pharmaceutiques*" are found throughout the country.

The Government also values its partnership with international donors that provide support for Family Planning in Rwanda. The Rwanda National Health Accounts (NHA) 2002 documents per capita health expenditures of US\$ 8.62, with 42% contributed by the private sector (including households), 33% by the donor community, and 25% by the public sector.

Those accounts note a shift in allocation of financing with respect to HIV/AIDS and reproductive health, with donors accounting for 75% of all HIV-related expenditures, and 80% of expenditures for reproductive health.^{xvii}

2.4.2. Planned activities

The activities for strengthening partnerships for increased FP coverage are:

Short-Term (2005-2006)

- In all health facilities and health centers: Integrate Family Planning in VCT and health services, and provide refresher training in counseling for all medical staff on counseling.
- Private Sector
 - Undertake rapid assessment of private provision of Family Planning
 - Initiate collaboration with private sector representatives and professional associations at the national and decentralized levels to formulate and apply private sector norms, standards, and quality assurance/supervision systems.
 - Initiate systems to incorporate ARBEF service delivery data into national Health Management Information System (HMIS).
 - Collaborate with relevant partners to identify means to incorporate new Family Planning social marketing data into national HMIS.
- Donors: Develop mission statement, objectives, and Workplan for Family Planning Working Group.
- Initiate 2006 Service Provision Assessment (SPA) that includes and disaggregates public and private providers (including ARBEF, clinics, private doctors, pharmacies, private nurses, and "*comptoir pharmaceutiques*").

Medium-Term (2007-2010)

- In health facilities and health centers: Maintain routine contraceptive technology update training and counseling refresher courses for all medical personnel in Medical facilities and VCT sites.
- Private Sector: Progressively incorporate new private sector practitioners into District Health networks, and assure application of national norms, standards, quality assurance/supervision by private providers.
- ARBEF: Maintain relationship with ARBEF; where possible, increase complementarity between ARBEF and FBO services in the public health system.
- Complete 2006 SPA. Make use of data from 2005 DHS and 2006 SPA to develop District-level action plans to expand Family Planning coverage and quality at public and private facilities, as indicated.
- Undertake a situational analysis of the use of contractualization in the current health system, and develop recommendations for more strategic use.

NOTE:

The term “contractualization” is used here to refer to the use of formal contracts or conventions to guide relations between two or more partners working toward the same objectives. There are existing contracts (conventions) between the Government and the religious missions who operate 40% of Rwanda’s public health facilities, and there are contracts between the Government and a number of international NGOs who provide Family Planning in Rwanda. The term “contractualization” is not limited to “the contractual approach” that provides incentives payments to health providers in some donor-supported projects; it also applies to public health facilities.

Long-Term (2011-2020)

- Maintain public-private partnerships throughout all health networks nationwide.
- Increase use of contractualization as key tool for service management.

2.4.3 How Partnerships for Increased Coverage will be strengthened

Partnerships for increased coverage will be strengthened in the following way:

- Maintain dialogue with religious missions and FBOs and encourage them to provide at least counseling and referrals for Family Planning, if they chose not to provide actual contraceptive methods.
- Initiate and integrate Family Planning counseling services throughout the whole medical system, including integration of Family Planning in VCT offices.
- Establish and maintain routine public-private sector Family Planning dialogue; norms, standards, and quality assurance/supervision and reporting at the national and District levels
- Strengthen the Family Planning Technical Working Group, and expand it to include private medical sector representation.
- Increase use of contractualization to strengthen partnerships where appropriate.

The Government values its partnership with Rwanda’s private medical facilities and pharmacies and will encourage them to increase provision of appropriate Family Planning commodities and services in future years.

There is strong potential to mobilize these partners for both full commercial services, in cooperation with health insurance agencies, and for partially subsidized (social marketing) contraceptive services and sales in the short- and medium-term.

The Government will significantly increase its collaboration with private sector representatives and Rwanda's health professional association to strengthen these important partnerships.

The Government collaborates with donors in numerous fora, including the Health Cluster Group and a newly formed Family Planning Working Group.

While the donor contribution is highly valued, the Government recognizes the need to work with other partners to identify means to reduce its reliance on donors over the medium- and long-term.

The Government recognizes that contractualization is a useful tool to strengthen partnerships. The Government will explore use of contractualization between and among partners as a means of recording expectations, relative contributions, and roles and responsibilities of different partners in the implementation of Rwanda's Family Planning Program.^{xviii}

Family Planning Partnership for increased coverage of Family Planning services			
Expected results	Indicator	Verification means	Note
Access to High quality Family Planning services increased	Percentage of high quality Family Planning services compared to planned services	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Activities	Indicator	Verification means	Note
<p>1.1. Maintain dialogue with religious leaders</p> <p>1.2. Integrate Family Planning counseling throughout the entire advocacy system in general</p> <p>1.3. Integrate Family Planning counseling in VCT and PMTCT centres</p> <p>1.4. Maintain public-private sector Family Planning dialogue</p> <p>1.5. Develop norms, standards, reporting requirements</p> <p>1.6. Provide Family Planning reports at the district and national levels</p> <p>1.7. Expand Family Planning Technical Working Group (FPTWG) to include private medical sector representation.</p> <p>1.8. Use of Family Planning contractualization where appropriate.</p> <p>1.9. Identify FP contraceptive needs throughout the country</p> <p>1.10. Initiate collaboration with private sector representatives and professional associations at the national and District levels for quality assurance.</p> <p>1.11. Incorporate ARBEF service delivery data into national Health Management Information System</p> <p>1.12. Collect and update Family Planning data in the Health Management Information System (HMIS)</p> <p>1.13. Develop Family Planning attributions, objectives, action plans in collaboration with relevant partners</p> <p>1.14. Carry out Family Planning SPA at the national level</p> <p>1.15. Train new medical staff in Family Planning</p> <p>1.16. Maintain partnership between the Government and ARBEF regarding Family Planning matters.</p> <p>1.17. Develop operational action plans based on research data</p> <p>1.18. Analyzing Family Planning Contractualization for quality assurance</p> <p>1.19. Maintain Family Planning partnerships at all levels</p> <p>1.20. Promote "Contractualization" regarding Family Planning.</p>	<p>Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and health facilities.</p>	<p>Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District and health facilities.</p>	<p>More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and health facilities.</p>

2.5 Increase Community Mobilization

2.5.1 Situation analysis

Information, education, and communications efforts for Family Planning in Rwanda benefit from the existence of one common language – Kinyarwanda. Besides, the Rwandans have established a well-organized system of newly elected local government structures from Nyumbakumi (10 households), Cells, Sectors to Districts. Each local government level has a Community Development Committee (CDC) and a social affairs representative, both of which provide important leadership of the community.

There is also a host of civil society organizations, both religious and secular, on which to build. The public health system includes several thousand community outreach workers to provide IEC and, in limited areas, to distribute Family Planning commodities. Numerous NGOs and community based organizations collaborate with elected leaders and public health facilities to support these outreach workers in a variety of ways.

IEC materials produced by MINISANTE are supplemented by materials created by these partners to help mobilize the populations and provide them with data. Due to all these efforts, the 2000 DHS found about 90% of the population are aware of Family Planning methods.

However, despite the widespread knowledge, misinformation and rumors still persist and uptake rates remain low, particularly in rural areas. There is no coordination of IEC efforts and sharing of “best practices” across programs is rare.

Relatively modest efforts at community-based services/distribution (CBS/D) (in Butare and Kibogora) are showing good rates of success with condoms and pills.

2.5.2 Planned activities

The planned activities to increase community mobilization for Family Planning are:

Short-Term (2005-2006)

- Enhance IEC for FP
- Review existing IEC/BCC materials; develop new Family Planning messages for schools at all levels from the nursery to university.
- Produce visual materials with new messages for use in Health Center reception rooms.
- Produce appropriate teaching materials for community-based IEC.
- Train journalists and develop media campaign targeted to rural communities.
- Carry out mass media campaign targeting information to rural areas - radio, cassettes, etc.- focus in 10 "first cohort" districts.

- Provide health outreach workers (*animateurs, animatrices*) with refresher training: introduce new IEC messages & materials and strengthen skills in outreach.
- Develop and expand community-based services and distribution (CBS/D) of contraceptives:
 - Conduct CDS/D Strategy workshop - agree on method and modality: establish norms - who prescribes, what follow-up is required? what are the eligibility criteria for CBS/D agents?
 - Train CBS/D agents in new norms, standards, reporting requirements, and resupply.
 - Develop and nurture new Supervision arrangements of CBS/D agents
 - Mobilize parents to make them understand that their children's lives and education are their prime role.
- Youth:
 - With MIJESPOC, increase the integration of Family Planning into youth centers and clubs
 - With MINEDUC, undertake rapid assessment of impact and/or use of 2002 Family Planning curriculum and develop recommendations for focused Teacher Training and production of complementary materials
 - Develop various lessons for different levels of education, from the nursery to university.
 - Focus on children's education but with special focus on girls, insisting on the reproductive health.
- Men As Partners (MAP)
 - Identify and list men's associations at the Sector level - football, choral, dancers, coops, religious groups, etc. that are targeted to Family Planning.
 - Undertake selection and training of two men per District in "Men's Reproductive Health" - select men from among Community Development Committees (CDCs) or other leadership fora
 - Use trained men as key informants to help develop IEC for MAP, and longer term strategy.
 - Explain to men the important role they have regarding Family Planning.

Medium-Term (2007-2010)

- Progressively cover remaining 75% of Districts at rate of about 25% (10 Districts) per year from 2007 to 2010 with enhanced IEC, CBS/D, Youth, and MAP activities.
- Develop and conduct enhanced Teacher Training for presented Family Planning curriculum.

Long-Term (2011-2020)

- Expand CBS/D to the extent possible for re-supply, in accordance with National Contraceptive Pricing Policy (ref. 4.6, Sustainable Financing, below)

2.5.3 How community mobilization will be reinforced

Community mobilization will be reinforced in the following way:

Expand community-based Family Planning services and distribution of contraceptive commodities to relieve pressure on health facilities,

Increase knowledge and change attitudes about modern contraception, particularly among youth and to increase men's active roles in reproductive health and Family Planning;

Opposition to Family Planning by some religious groups create information and service delivery barriers. Such barriers must be creatively addressed through dialogue and establishment of alternative IEC and service delivery venues, e.g. secondary health posts, contracts with private clinics;

Numerous NGOs collaborate with Health District supervisors to make sure those norms are respected.

Such area-specific programs in addition to the distribution of preventive therapy in the national malaria program suggest that CBS/D of Family Planning services and commodities merits increased investment in the near future. There is a rather urgent need to establish national norms and guidelines on authorities for prescription and follow-up, and on selection of outreach agents, to assure consumer safety but most agree that it is an idea whose time has come in Rwanda.

Regarding potential consumers of IEC and CBS/D, women of reproductive age have formed the key target group to date. It is absolutely necessary to increase the involvement of Rwanda's in-school and out-of-school youth, who comprise 60% of the total population under 20 years of age.

The recent (2002) introduction of reproductive health and Family Planning curricula in school curriculum is an excellent beginning, but teachers need more training in the content and pedagogical methods and could benefit from production of complementary teaching materials.

Urban and rural youth are an increasing proportion of clients at VCT centers, particularly in urban areas. The use of VCT centers that target youth for Family Planning will be pursued, along with increased emphasis on provision of Family Planning services at Youth Centers, Anti-AIDS Clubs, sports clubs, and other venues.

A second key underserved target group is men. Health outreach workers who undertake household visits are increasingly targeting couples in Family Planning counseling, but there remains a large gap in men's knowledge of reproductive health in general and Family Planning in particular.

Men comprise the majority of the leadership in the political, economic, religious, and social spheres at the national, regional, and community level. Experience

elsewhere suggests that fuller participation of men in decisions and actions related to reproductive health, at the individual, family and community level, leads to increased knowledge and use of improved practices by men, women, and children.

IEC interventions targeted at men would cover basic reproductive health functions of males and females, human sexuality, concepts of consensual and forced sexual relations, conjugal relations, domestic violence, parenting, Family Planning methods, STI/HIV/AIDS prevention, and issues related to aging of men and women. Men are found in different sub-groups: singles, married, military, urban, rural ; they will be targeted with different messages and media.

Table 6: Increasing community mobilization

Family Planning: Increasing community mobilization			
Target	Indicator	Verification means	Note
Increased community mobilization	Percentage of FP centers where outreach capacity has been increased compared to what had been planned.	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Activities	Indicator	Verification means	Note
1.1. Expanding community based Family Planning services 1.2. Train Youth on Family Planning activities 1.3. Developing visual teaching materials 1.4. Developing IEC materials 1.5. Train journalists and prepare community mobilization using journalists. 1.6. Initiating media-based community mobilization 1.7. Train outreach agents in IEC 1.8. Conduct CDS/D Strategy workshops 1.9. Train CBS/D agents in new norms, standards 1.10. Develop and nurture supervision arrangements for service agents 1.11. Collaborate with MINEDUC to undertake rapid assessment the use of Family Planning curriculum 1.12. Identify and list men's associations targeted to Family Planning. 1.13. Develop messages targeted to all education levels 1.14. 1.15. focus on children/girls' education 1.16. Mobilize parents to understand their prime role in their children's lives and education.	Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and health facilities.	Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District and health facilities.	More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and health facilities.

2.6 Assure Quality & Formative Supervision in Public and Private Sectors

2.6.1 Situation analysis

The quality of services, the training of health care providers, and the level of supervision remain significant barriers to service delivery. Although the 2001 SPA found that 93% of facilities offer FP counseling and examinations in privacy, only 37% of facilities had infection prevention items in the service area where Family Planning examinations were carried out.^{xi}

Similarly, only 10% of facilities had written guidelines or protocols for Family Planning service delivery that were visible. Health Service Providers have not been clearly informed about expectations regarding Family Planning and they lack job aids or specific job description that could help with understanding.^{xx} Less than 10% of providers reported that they had received in-service training in either technical or counseling skills for Family Planning and only 22% of providers state that they were ever trained in Family Planning.^{xxi}

As a result, many providers express that they lack confidence in discussing Family Planning messages and there are rarely discussions about various Family Planning methods beyond what is available at that facility.^{xxii} Relatively few health networks or facilities routinely undertake internal performance evaluations or assessments such as Client-Oriented-Provider-Efficient (COPE) or Partnership for Quality Improvement (PAQ) and thus have no routine way to identify problems or successes to supervisors.

Rwanda established Family Planning Norms in 1998, and the latter need updating and improvement. Although the Health Decentralization Strategy was issued in 2003, the Family Planning Norms were not revised to reflect new authorities at the Health Center level, and only District Hospitals are currently authorized to provide Long-Term and Permanent Methods (LTPM).

Additionally, the criteria for eligibility for contraception established by WHO are not widely known. It would be better to incorporate them into a revision of MINISANTE Family Planning protocols. District Supervisors generally use a simple checklist approach to supervision which does not reinforce skills or application of such norms, and formative supervision is largely unknown.

The shortage of human resources is also a key constraint. Out of 402 medical doctors practicing in Rwanda, only 6 work in Health centers with the rest evenly divided between the public and private sectors (198 in public sector above Health Center level, 198 in private sector). The 2001 SPA found that only about 40% of public health structures met established norms for staffing.

There are only 8 Obstetricians/Gynecologists and only about 125 trained midwives serving 1.2 million Rwandan women in the reproductive age.

Even when available, most health personnel have minimal competencies in Family Planning. The teaching of contraceptive technology is marginal in most pre-service professional education programs in Rwanda, with doctors and nurses receiving only 6 to 10 hours of theoretical training and little practical experience.

2.6.2 Planned activities

The priority activities for assuring quality & formative supervision in the public and private sectors are:

Short-Term (2005-2006)

Quality assurance:

- The Quality Assurance activities for 2006 are identical to those for Increasing Integration and Full range of Methods in 4.2.2 above. This is due to the urgent need to begin to meet the high demand of the population with improved services.
- Other quality assurance measures – pre-service professional education, revised supervision guidelines – will be initiated in the medium-term.
- Develop standardized formative supervision tool – pre-test, revise, re-test, finalize – and disseminate in 10 “first cohort” Districts, including private sector providers.

Medium-Term (2007-2010)

- All items for the Long Term in 4.2.2 above, along with:
- Progressively cover remaining 75% of Districts with formative supervision.
- Review and revise pre-service professional education Family Planning curricula for doctors, nurses, and public health school students, with additional attention to practical application of skills.

Long-Term (2011-2020)

- Periodically review norms and protocols to assure adherence to international norms and protocols.
- Continue contraceptive technology update training, mini-lap training, Pharmacy/Dépot manager training, and counseling training on regular basis.
- Continue to strengthen formative supervision.

2.6.3. Implementation of Quality Assurance & Formative Supervision

Quality Assurance & Formative Supervision in Public and Private Sectors can be done as follows:

Assure that government hospitals provide all contraceptive commodities and equipment and that Health Centers provide at least 50% of full range of high quality contraceptive methods while authorized health care facilities offer adequate referral assistance.

Assure that all Rwandan public and private health providers have the knowledge and skills to offer a full range of high quality contraceptive methods, as appropriate to their professional level.

Assure that Districts administer adequate formative supervision to assure that public and private sector providers in each district are maintaining high quality standards.

Maintain a supportive policy and regulatory environment that promotes progressive devolution of service provision to the broadest base possible.

Attention has to be focused on Long term or Permanent Methods (LTPM) to significantly increase national contraceptive prevalence rate, and the use of newer technologies. For example, mini-laparoscopy for female sterilization is a technology used throughout Africa that requires only local anesthesia and is easier on the woman and less expensive than classical tubal ligation. The introduction of mini-lap would enable more doctors to perform more female sterilizations for less costs.

Table 7 : Quality Assurance & Formative Supervision

Family Planning: Quality Assurance & Formative Supervision			
Target	Indicator	Verification means	Note
1. High quality services offered	Percentage of high quality FP centres compared to the centres that had been foreseen.	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
2. Permanent Supervision	% of Public or private centers supervised/compared to those foreseen.	Annual report at each level	
Activities	Indicator	Verification means	Note
1.1. Develop and establish a policy aimed to increase expand Family Planning coverage 1.2. Integrate Family Planning in various services 1.3. Review and revise pre-service professional education Family Planning curricula for doctors, nurses, and public health school students 1.4. Maintain Pharmacy managers' update training on Mini-Laparoscopy 1.5. Maintain routine training 2.1. Supervise all hospitals and health centers regarding Family Planning 2.2. Encourage FBOs to provide at least counseling and referrals for Family Planning services if they do not provide them 2.3. Assess qualifications and skills necessary to deliver quality Family Planning services 2.4. Assure that Districts conduct formative supervision regarding Family Planning 2.5. Develop standardized formative supervision tool and disseminate it in 10 Districts forming the 'first cohort'. 2.6. Continue to strengthen formative supervision.	Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and Health Facilities	Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District and Health Facilities	More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and Health Facilities

2.7 Develop Sustainable Financing

2.7.1 Situation analysis

The 2002 Rwanda National Health Accounts (NHA) show that in 2002 the Government of Rwanda allocated about US\$ 70.1 million, or 4% of its total expenditures, on the health sector.

Those accounts show that per capita health expenditures of US\$ 8.62, with 42% contributed by the private sector (including households), 33% by the donor community, and 25% by the public sector. The NHA note a shift in allocation of financing with respect to HIV/AIDS and reproductive health, with donors accounting for 75% of all HIV-related expenditures, and 80% of expenditures for reproductive health.

The NHA further documents that “While households are not the largest financiers of these sub-sectors, they do finance over half of all curative expenditures for these key intervention areas. The public sector is responsible for just 8% of expenditures for both HIV/AIDS and reproductive health.”

There is still significant burden on households to pay for FP and RH services. As a result of social marketing and fees for services at health facilities, Rwandan households pay for approximately 12% of Reproductive Health expenses nationwide, or about 253 FRW per year. Spending on injectables and oral contraceptives are about equally born by donors and households.^{xxiii} This cost is a significant potential barrier, especially for the poorest Rwandans.

Although there is less concrete evidence about access to reproductive health care, data suggests that the patterns are similar. According to the 2000 DHS, people who are well-off are much more likely to use FP, whereas the poorest people have almost no access.^{xxiv} In addition, poor people are less likely to be educated and have access to Family Planning information, as well as a general lack of access to health services as a result of financial constraints.^{xxv}

In recent years, the Government introduced and strengthened a number of programs to increase access to health services, including Family Planning. Currently, public health facilities provide Family Planning services for “free,” i.e., at no charge to the client.

This policy overlooks the fact that the facility must still incur a certain cost to provide the service, in terms of staff time for reception and counseling and modest materials. Indeed, even the “free” contraceptive commodities provided through the CAMERWA network must be transported to the health center, stored, and looked after. A preliminary estimate of expenses incurred by a health center in providing such “free” services is about US\$ 7,000 per year. If all hospitals (37) and about 60% of the health centers (180) provide full services, this would mean a cost of US\$ 1.7 million/year for the public health system.

Coverage by public institutions that provide or guarantee services includes: 155,400 by the Rwanda Medical Insurance Agency (RAMA); 283,000 by the Fund of the Genocide Victims (FARG); 113,770 by *Gacaca*; 107,000 by the penitentiary system (i.e., the prisoners); and about 100,000 by the military. Coverage by private insurance schemes includes the growing movement of 'mutual health schemes' (*mutuelles*), now estimated to cover over 2 million people; and private commercial health insurance, which covers about 200,000.^{xxvi}

2.7.2 Planned activities

The priority activities for developing sustainable financing for Family Planning in Rwanda are:

Short-Term (2005-2006)

- Initiate detailed survey of current contraceptive pricing in Rwanda, to include public sector facilities (civil and military), private providers (ARBEF, clinics, doctors, nurses, pharmacies), and non-medical distributors, where such exist.
- List and analyze current insurance coverage of Family Planning in Rwanda, to include prices paid for goods and services by RAMA, FARG, *Gacaca*, Penitentiaries, the Military, *mutuelles*, and commercial insurers.
- Maintain dialogue with private sector professional associations to assure there are no barriers to private involvement in FP activities.
- Strengthen donor partnerships and increase to the extent possible subsidized (ARBEF, social marketing) provision of contraceptive commodities and services.

Medium-Term (2007-2010)

- Develop and put in place a contraceptive pricing policy based on stratified subsidies to assure access to Family Planning for the poor.
- The policy should be developed based on careful study and extensive dialogue with private health providers and insurers. An illustrative targeted stratification would be:
 - Private insurance/RAMA for about 20% of the public sector employees
 - Stratified subsidies – ARBEF, social marketing through private clinics and pharmacies and community-based distribution plans – for the middle class people (about 40%)
 - Modest payment – by *mutuelles* – for the poorest 20%
 - "Safety Net" for indigents, as determined by District Committees through Ubudehe scheme.
- Assure adequate and appropriate national supervision of all health insurance schemes, to protect consumers.
- Continue to conduct regular National Health Accounts with analysis of Family Planning.
- Assist public health center Health Committees to improve efficiency and capacity.

Long-Term (2011-2020)

- Assure adequate and appropriate national supervision of all health insurance schemes, to protect consumers.
- Continue to conduct regular National Health Accounts with analysis of Family Planning.
- Assist public health center Health Committees to improve efficiency, capacity and good management.

2.7.3. Implementation of Sustainable Financing

Developing Sustainable Financing and how this will be put into practice:

- Meet Abuja commitment of 15% of the national budget spent on health care by 2010.
- Maintain dialogue with private sector practitioners to assure there are no barriers (tax or non-tax) to private involvement in FP activities.
- Develop and put in place a contraceptive pricing policy based on stratified subsidies to assure access to Family Planning for the poor.
- Increase health insurance coverage (public or private sector) that includes payment for Family Planning contraceptives and services to at least 50% of the population by 2020.

It is clear enough that the Government of Rwanda cannot continue to carry such costs over the long term. As part of its strategy to increase access to all health services, the Government is promoting enrollment of all Rwandans in health insurance associations. According to a research carried out by the School of Public Health of the National University of Rwanda, as of the end of 2004, 37.8% of the population was enrolled in such associations.

RAMA, the military, *mutuelles*, and private health insurance all provide reimbursement for Family Planning services, and will serve as strong partners to the Government as it seeks to improve financial access in the medium and long term.

Table 8 : Sustainable Financing

Family Planning Sustainable Financing			
Target	Indicator	Verification means	Note
Sustainable Family Planning	% of funds compared to what has been planned	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Activities	Indicator	Verification means	Note
<p>1.1. Meet Abuja (Nigeria) commitments by 2010</p> <p>1.2. Maintain dialogue with the private sector to assure there are no barriers to private involvement in Family Planning</p> <p>1.3. Develop and put in place a contraceptive pricing policy based on stratified subsidies to assure access to Family Planning for the poor.</p> <p>1.4. Increase health insurance coverage</p> <p>1.5. Carry out a survey of current contraceptive pricing in Rwanda</p> <p>1.6. Identify and analyze current insurance coverage of Family Planning, to include prices paid for goods and services by RAMA, FARG, <i>Gacaca</i>, Penitentiaries, <i>mutuelles</i>, etc.</p> <p>1.7. Strengthen donor partnerships and increase subsidized provision of services to the extent possible.</p> <p>1.8. Assure adequate and appropriate national supervision of all health insurance schemes, to protect consumers.</p>	<p>Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District, and Health Facilities</p>	<p>Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District, and Health Facilities</p>	<p>More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District, and Health Facilities</p>

2.8. Increase Use of Evidence-Based Decision Making

2.8.1 Situation analysis

Since 2000, Rwanda has carried out several high quality surveys and studies that provide a host of highly reliable quantitative information on the use of health services in general (the 2000 DHS and 2002 SPA); income and expenditure patterns (the *Enquête Intégrale sur les Conditions de Vie*, or EICV and a Multi-Indicator Cluster Study, or MICS II); and health finance (the NHA and numerous studies on *mutuelles* conducted by the School of Public Health with other partners)

There are also a number of smaller surveys carried out through the National University in collaboration with donors. This Family Planning Strategy relies heavily on all that has been revealed by the above-mentioned studies and surveys.

Besides this, the Ministry of Health maintains a Health Management Information System (HMIS) which provides data on the use of services. HMIS data are generally of uneven quality and the HIS itself is not comprehensive and does not include data from ARBEF and the private sector.

2.8.2. Planned activities

Activities planned to increase the Use of Evidence-Based Decision Making are:

Short-Term (2005-2006)

- Collaborate with private sector representatives to determine modes of integrating private sector data into public HIS
- Collaborate with private sector representatives (including ARBEF) to incorporate private sector contraceptive commodity data into CAMERWA contraceptive commodity forecasting.
- Complete and analyze 2005 DHS, revise Family Planning projections based on new data.
- Cooperate with broader Health Cluster in the dissemination of new DHS data, and hold separate Family Planning Technical Working Group workshop to disseminate and discuss implications of 2005 DHS Family Planning data
- Initiate 2006 Service Provision Assessment (SPA) that includes and disaggregates public and private providers (including ARBEF, clinics, private doctors, pharmacies, private nurses, and "*comptoir pharmaceutiques*")

Medium-Term (2007-2010)

- Continue to strengthen HIS and CAMERWA systems; and to consider reports from ARBEF and the private sector
- Undertake periodic National Health Accounts.
- Complete 2006 SPA. Make use of data from 2005 DHS and 2006 SPA to develop District-level action plans to expand Family Planning coverage and quality at public and private facilities, as indicated.

- Plan and undertake 2010 DHS and SPA.

Long-Term (2011-2020)

- Make use of data from 2010 DHS and SPA to develop new National and District-level action plans.
- Plan and undertake 2015 DHS and SPA. Make use of data from 2015 DHS and SPA to develop new action plans to expand Family Planning coverage and quality at public and private facilities, as indicated.

2.8.3. Implementation of the Use of Evidence-Based Decision Making

Increase the use of reliable quantitative and qualitative data by decision makers at all levels of the system.

Increase the integration of private sector data into routine data collection and reporting tools of MINISANTE (HIS).

Within the broader health sector framework, MINISANTE intends to invest significant time and resources to improve the HMIS in the long term so that real-time data on services can be used to inform decision-making.

In spite of useful studies and the HIS, there is still an enormous gap in knowledge among Family Planning partners of the status of the current program, its successes, problems, etc. The 2004 informal creation of a Family Planning Working Group, and its mid - 2005 formalization into the Family Planning Technical Working Group, is expected to facilitate such information sharing in the near future. The Ministry of Health will continue to look for opportunities to bring public, private, and international donor partners together to foster information sharing so that future planning can indeed become evidence-based.

What has been said above provides recommendations for the introduction and use of self-evaluation tools such as COPE or PAQ to inform decision-making at the district, facility, and community level. The use of COPE, PAQ, or similar self-evaluation methods is expected to greatly enhance "ownership" and direction of these critical levels of the health system in the short-, medium-, and long-term.

Table 9: Evidence-based decision-making

Family Planning: Evidence-based decision-making			
Target	Indicator	Verification means	Note
Decisions are evidence-based	% of decisions made based on evidence compared to all decisions made in general.	Annual report at each level	Each level must have a well designed activity plan that is agreed by all those who will be involved in that activity.
Activities	Indicator	Verification means	Note
1.1. Promoting the Use of Evidence-Based Decision Making 1.2. Introducing, analyzing and using Family Planning data for all decision-makers. 1.3. Spreading new Family Planning data to all decision-makers. 1.4. Carry out 2006 SPA 1.5. Strengthen HIS and CAMERWA systems in using evidence based FP data 1.6. Undertake periodic Family Planning related data 1.7. Make use of research data to develop new FP action plans. 1.8. Use ICT to make public new research FP data.	Details on those indicators are presented in the annual plan table at each level: Ministry, Province, District and health facilities.	Details on those indicators are presented in the annual action plan at each level: Ministry, Province, District and health facilities.	More detailed notes are displayed in the annual plan table at each level: Ministry, Province, District and health facilities.

2.9. INSTITUTIONAL RESPONSIBILITIES REGARDING THE IMPLEMENTATION OF FP STRATEGY

The lead agency to carry out the Family Planning Program is the Ministry of Health. In the beginning of 2005, the Ministry of Health restructured staff positions and is now in the process of re-aligning them to new positions, and establishing new roles and responsibilities. During 2006, the Ministry of Health plans to revise its human resource norms for the decentralized levels and to revise job descriptions to meet the new norms. The new human resource norms will increase attention to supervision in the health system.

The Ministry of Health will continue to work closely with the National Parliament and the executive Cabinet for national policy guidance and supervision. MINISANTE will maintain partnership with ministries that provide Family Planning services, namely MINADEF, MIJESPOC, MINEDUC, and MIGEPROF. Likewise, MINISANTE will maintain close consultation and collaboration with MINALOC, MINECOFIN, and MIFOTRA as part of the implementation of the PRSP and the National Health Decentralization Policy.

MINISANTE will also normalize its relationship with RALGA and other local government fora; professional associations such as the Rwanda Medical Association, the Association of Private Physicians, the Rwanda Nurses Association, the Association of Pharmacists; and other civil society groups.

Within the PRSP, MINISANTE will implement the Health Sector Strategy Plan (HSSP), which provides for three focal points for direction and consultation for this Family Planning Strategy:

Ministry of Health Cabinet

Its Members: Minister of Health; Minister of State for HIV/AIDS; Secretary General of MINISANTE, Directors and Coordinators

Its Chairperson: Minister of Health

Attributions: Makes top management decisions; Endorses HSCG proposals; Guides policy and strategy development.

Health Sector Technical Working Group

Its members: Secretary General of MINISANTE and Directors; MINECOFIN; Donors; key NGOs; Global Fund Country Coordinating Mechanism representative; HIV/AIDS Sector Cluster Group representative; others by invitation.

Its Chairperson: Secretary General of MINISANTE

Attributions: Policy development; aid coordination; project monitoring and review; make recommendations to MINISANTE Cabinet.

Family Planning Technical Working Group

Its Members MINISANTE representatives, donors, other stakeholders active in Family Planning

Its Chairperson: rotating among members

Attributions: To be specified during 2006

During 2006, the Family Planning Technical Working Group (FPTWG) will determine whether to expand membership to representatives of the private sector, or whether to establish other regular consultative fora with private sector representatives where they can present their opinions.

2.10. FINANCING FAMILY PLANNING ACTIVITIES

The estimated costs of the Family Planning Program can be roughly divided into three categories: 1) Contraceptive Commodities; 2) Routine Service Delivery; 3) Essential Support Costs for advocacy, partnerships, community mobilization, and quality improvement/formative supervision. Each of these categories is briefly discussed in the following paragraphs.

2.10.1 Contraceptive Commodities

The expenses that will be incurred for all contraceptive commodities – mini-lap kits, implants, IUD, injectables, pills, condoms, and standard days method beads (SDM beads) -- to achieve the contraceptive prevalence rates are summarized in Table 10. The costs represent the commodities as received in Kigali.

The total expenditures on commodities for the first five years of the Policy (2006-2010) amount to \$ 4.75 million. As shown in Table 10, during this first five year period the relative share of public sector expenditures is expected to decrease from 65.6% to 49.7% in 2010, with ARBEF and the private sector shares (including partially subsidized socially marketed commodities) are expected to increase accordingly.

The private sector share would exceed that of the public sector by 2015, and by 2020 the combined ARBEF and private sector share would be more than 60% of commodities.

Table 10 Estimated Contraceptive Commodity Costs, by Sub-Sector, 2006-2010 (USD)

	2006	2007	2008	2009	2010	2015	2020
Total FP Commodity Costs (\$USD)	545,370	708,763	901,707	1,135,368	1,453,770	2,921,659	4,594,196
Share of Costs for each side							
<i>Public & authorized health care facilities</i>	65.6%	56.6%	55.2%	52.5%	49.7%	41.0%	36.5%
<i>ARBEF:</i>	9.5%	10.4%	10.0%	10.0%	10.9%	11.3%	11.7%
<i>Private (social marketing plus commercial)</i>	25.0%	33.0%	34.7%	37.5%	39.4%	47.7%	51.8%

Note It is clear that the share of commodity costs of each side differs from the FP share that will be used by each side. It can be noticed that the public sector will be more active than the private sector in the provision of LTPM, which are generally more expensive. On the other hand, the private sector will be much more active in the promotion of low cost condoms, pills, and injectables.

2.10.2. Service Delivery

Rwandan households and donors currently cover most of the costs of Family Planning service delivery. Donors and NGO partners cover all of the costs of contraceptive commodities mentioned above, and provide significant technical and financial assistance used in social outreach.

With the exception of salaries paid to civil service professionals and some very modest operating costs at the central and local administration levels, Rwandan households cover the vast majority the costs of actual service delivery through the public sector, ARBEF, and private sector delivery systems. As mentioned above, a preliminary estimate of the cost of providing such “free” services according to current MINISANTE norms is about US\$ 7,000 per year, or over US\$ 3 million/year for the over 400 facilities of the public health system alone

It is worth highlighting that such service delivery costs do not include the costs of pre-service training, quality assurance or supervision. These costs are partially included in “essential support costs,” below. These will be included in to the services costs through more detailed studies and analyses at a later date.

As summarized in the above-presented summary, at the present time few public health facilities provide Family Planning services according to the norms of the Ministry of Health, so this cost is presently lower. However, according to this Family Planning Strategy, all government hospitals and at least 60% of MINISANTE health centers would be providing a full range of services while authorized health care facilities provide referral assistance, the costs would be at least \$ 1.7 million/year for basic service delivery in the public sector.

If current MINISANTE pricing policies remain in effect, these costs would be borne by Rwandan households who pay for services at public sector health centers - although they would not pay for the Family Planning services themselves, because the health center would incur the cost, they would need to be cross-subsidized from other services.

Costs in the private sector vary significantly and merit considerably more research. However, it can safely be assumed that ARBEF and private sector costs would be at least equal to, if not greater than, the public sector costs each year.

2.10.3 Essential Support Costs

The essential support costs for advocacy, partnerships, community mobilization, and quality improvement/formative supervision efforts essential to increasing the integration, range, and use of Family Planning services in Rwanda are estimated at between US\$ 2 million and US\$ 5 million per year. A preliminary one-year implementation plan for 2006 will require US\$ 3 million. These costs would be subject to discussion and revision by members of the Family Planning Technical

Working Group during July and August of each year, as the Government prepares its annual budget.

2.11. MONITORING AND EVALUATION

The current implementation of the Family Planning Strategy will use routine data generated through the improved HIS and CAMERWA reporting systems. Health Facilities and communities will utilize COPE, PAQ, or similar methods as a key means of self-assessment on a regular basis. The Family Planning Technical Working Group will undertake periodic review of these key data sources to assure that information needed is being obtained.

In the short- and medium-term, particular interest will be focused on the rate of expansion of LTPM to all Districts, the rate of sales of partially subsidized/socially marketing pills and injectables, and the rate of uptake from the expanded community-based services/distribution programs. These data will inform decision-makers as to the relative impact of different investment strategies.

In terms of program impact, carrying out DHS and SPA every five years (2005/06, 2010, 2015) will provide a host of information on higher level indicators, including maternal mortality, infant and child mortality and morbidity, contraceptive prevalence rate, proportion of use of each method (modern, traditional), source of supply (public or private sectors).

ⁱ Baseline Data for all indicators are from Rwanda Demographic and Health Survey 2000 and 2005, except for except for the Population Growth Rate, which is from the 2002 Rwandan Census data, and the % of Health Facilities Providing Family Planning according to National Norms, which is from the 2001 Rwanda Service Providers Assessment.

ⁱⁱ The CPR projections were developed based on DHS 2000 + DHS 2005 data for 2000, actual contraceptive commodity data for 2004, projected increases in dual-usage condoms beginning in 2006

ⁱⁱⁱ The CPR projections were developed based on DHS 2000, actual contraceptive commodity data for 2004, projected increases in dual-usage condoms beginning in 2006

^{iv} The CPR projections were developed based on DHS 2000, actual contraceptive commodity data for 2004, projected increases in dual-usage condoms beginning in 2006

^v National Reproductive Health Policy, July 2003. Note that the NRHP targets for infant mortality for 2010 of 70 is slightly lower than those in Vision 2020, demonstrating accelerated progress. The 2020 target is taken from the Rwanda's Millennium Development Challenge goals.

^{vi} National Reproductive Health Policy, July 2003. Note that the NRHP targets for 2010 of 700 and for 2020 of 350 are slightly higher than the Vision 2020 targets of 600 and 200, respectively. The adjustment was made to conform to Rwanda's Millennium Development Challenge goals.

^{vii} HIV-positive Women Counseled, Treated: TRAC, 2004 data.

^{viii} Total Fertility Rate: The baseline of 5.8 is from the 2000 Demographic and Health Survey. The targets for 2010 and 2020 are from Vision 2020. The data for 2010 and 2020 are from Vision 2020.

^{ix} Population Growth Rate: The baseline for 2002 is from the reanalysis of the 2002 Rwandan Census. The targets for 2010 and 2020 are from Vision 2020.

^x Minister of Health "Rwanda Service Provision Assessment Survey, 2001; June 2003; p. 67-78.

-
- xi Perle Combray, Constance Newman, Mariama Barry and Sosthène Bucyana; "Performance Needs Assessment for Reproductive Health Providers in Rwanda; PRIME II, Technical Report #43; October, 2003; p. 11-13.
- xii Basile Tambashe, Laura Voltero; "Integrating Family Planning into PMTCT Services: Situation Analysis Results for Byumba and Kigoma Rwanda"; PRIME II; March 2004; p. ii.
- xiii Rwanda Ministry of Health: "Rwanda Service Provision Assessment Survey, 2001; June 2003; p. 67-78.
- xiv DELIVER Project, 2005. Health Facility Assessment 2004. Not published.
- xv Pro-Femmes, 2004 ARBEF Annual Report.
- xvi Data from MINISANTE Department of Pharmacies, May 2005.
- xvii DRAFT Rwanda National Health Accounts 2002, February 2005.
- xviii The Government of Rwanda introduced the use of contractualization in its 2004 draft Health Sector Policy.
- xix Service Provision Assessment; p. 74.
- xx Integrating Family Planning into PMTCT Services, p. 30.
- xxi "Performance Needs Assessment for Reproductive Health Providers in Rwanda; PRIME II, Technical Report #43; October, 2003; p. 21. The Service Provision Assessment cites that 9% of providers received in-service training on counseling methods and 6% received training on technical aspects. (p. 77)
- xxii Integrating Family Planning into PMTCT Services, p. 30-31.
- xxiii Integrating Family Planning into PMTCT Services, p. 53..
- xxiv Impact of Prepayment Pilot (October 2001); p. 63.
- xxv Qualitative Assessment in Family Planning; p. 9.
- xxvi Dr. Laurent Musango, Director of the School of Public Health, June 2005.