REPUBLIC OF RWANDA

MINISTRY OF HEALTH
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National Reproductive Health Policy

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Preface

The International Conference on Population and Development (ICPD), held in Cairo in 1994, and the International Conference on Women of Beijing (1995),[2] were cornerstones in Reproductive Health throughout the world, and particularly in Rwanda. The government of Rwanda followed with keen interest the evolution of the Reproductive Health (RH) concept, and decided in 1998 to reorganize the Maternal and Child Health/Family Planning Department within the Ministry of Health, and changed it into the present Department of Reproductive Health, with a considerably extended mandate.

Since then, relentless efforts have been made to adapt the contents of RH programs to the new concept as defined in Cairo in 1994. As a result, at the Round Table of Gisenyi in September 2000, the priority areas for RH in Rwanda were determined. The priorities are: **safe motherhood and child health (SM/CH); family planning (FP); prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS; adolescent reproductive health (ARH); prevention and management of sexual violence; and social changes to increase women's decision-making power**.

The demographic and health survey (DHS) conducted in 2000 shows that maternal mortality is unfortunately one of the highest in Africa (1,071 maternal deaths for 100,000 live births), and infant mortality—at about 107 infants under one die per 1,000 live births—is also very high. The DHS indicated that the use of modern methods of family planning was 4%.

Moreover, the Rwandan nation is confronted with the plague of HIV/AIDS and an upsurge of sexual violence against small children, especially young girls. Regarding HIV, we are pleased that, since the Head of State made a plea, there has been renewed awareness and commitment in the fight against this evil among decision-makers. This is the background in which we elaborated and adopted a strategic framework for the next five years, as well as an action plan for the two coming years. Concerning sexual violence, the Ministries that are directly concerned, namely those of Health and Justice, and also the Ministries respectively in charge of Gender, Social Affairs and National Security, have been mobilized to put an end to it within reasonable deadlines.

Needless to say, in order to arrive at concrete actions in RH, mechanisms of collaboration among all stakeholders must be strengthened; therefore, efficient and practical modalities to coordinate interventions must be put in place.

Lastly, even if RH challenges in our country are overwhelming, the resolve to address them is in the minds of all Rwandans committed to work for their own health and the health of their fellow citizens—and for their country's development.

May the national RH policy, that we hereby make public, contribute towards this result. Such is our wish.

We take this opportunity to praise the efforts that the Rwandans have been relentlessly deploying, inspired by their good will, and to thank the countries and various agencies and institutions providing us with their support.

The Minister of Health

Prof. Abel DUSHIMIMANA

Abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal consultation
ARBEF	Rwandan Association for Family Welfare *(Association Rwandaise pour le Bien-Etre Familial)*
ARH	Adolescent reproductive health
BCC	Behavior change communication
BUFMAR	Office of Church-affiliated Health Facilities in Rwanda
CAMERWA	Purchasing Center for Essential Drugs in Rwanda *(Centrale d'Achat des Medicaments Essentiels du Rwanda)*
CDE	Agreement on the Child's Rights
CFI	Composite Fertility Index
CH	Child health
CHK	Centre Hospitalier de Kigali
ICPD	International Conference on Population and Development
CNJ	National Youth Council *(Conseil National de la Jeunesse)*
CNLS	National AIDS Control Commission *(Commission Nationale de Lutte contre le SIDA)*
CPLS	Provincial AIDS Control Commission
DHS	Demographic and Health Survey
DSS	Health Care Directorate
EPI	Expanded Program on Immunization
FHI	Family Health International
FP	Family planning
GDP	Gross domestic product
GNP	Gross national product
GTZ	Deutshe Gesellschaft für Technische Zuzammenarbeit (German cooperation agency)
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information-education-communication
IMPACT	Family Health International's Implementing AIDS Prevention and Care Project
LIME	Integrated Control of Childhood Illnesses
LIPRODHOR	Human Rights Promotion and Defense League of Rwanda
MCH	Maternal and Child Health
MIGEPROFE	Ministry of Gender and Women's Promotion
MIJESPOC	Ministry of Youth, Sports and Culture
MINADEF	Ministry of Defense and National Sovereignty
MINALOC	Ministry of Local Administration, Information and Social Affairs
MINEDUC	Ministry of Education, Science, Technology and Scientific Research
MINIJUST	Ministry of Justice and Institutional Relations
MINISANTE	Ministry of Health
MINPAC	Minimum package of activities
NGO	Non governmental organization
ONAPO	National Population Office *(Office National de la Population)*
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)

PNLS	National AIDS Control Program *(Programme National de Lutte contre le SIDA)*
PoNC	Postnatal consultation
PRIME II	IntraHealth's Project, Improving Primary Providers' Performance in RH
PSI	Population Services International
RH	Reproductive health
SM	Safe motherhood
STI	Sexually transmitted infections
TRAC	Treatment and Researchn AIDS Center
UNAIDS	United Nations AIDS program
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary counseling and testing
WHO	World Health Organization
WHO/AFRO	World Health Organization, Africa Region Office
ZOA	Vluchtelingenzorg (Dutch cooperation agency/NGO)

Introduction

For several decades, the international community has been concerned with issues related to human reproduction in order to make procreation as safe as possible, while at the same time respecting the social and cultural characteristics of each population.

This field has evolved through the years. Some policies related to mother and child health and to family planning (MCH/FP), as developed 10 or 20 years ago, no longer fit within the current vision of an expanded reproductive health concept. Rwanda recognizes this broader RH concept that resulted primarily from the works of the International Conference on Population and Development (ICPD) held in Cairo, in 1994[1].

The Cairo Conference, as well as the fourth World Conference on Women (Beijing, 1995)[2], specifically recommended that reproductive health and sexual rights be considered as fundamental elements of human rights. These texts, along with the agreements on the child's rights and the elimination of all discrimination that were ratified by Rwanda, are unanimous on some basic principles: entitlement to basic rights and liberties, individual emancipation, eradication of poverty, women's rights to participate in public and private decision-making, men's participation in all aspects of family and home life, permission granted to both men and women to develop a society founded on equality and mutual respect, the right to adequate behavior in terms of sexuality and reproduction (including family planning), and health and education for all.

The Cairo Conference defined RH as follows:

> *"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*
>
> *Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems.*
>
> *It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (ICPD, 1994)*

For West and Central Africa, the RH concept was defined during a Regional Forum in Ouagadougou in 1996, when four major elements of RH were identified: child health, women's health, adolescent health, and men's health. Later, workshops held in Bamako and Libreville in 1998, specifically recommended the following components: safe motherhood (SM), prevention of unwanted

pregnancies, control of STIs, including HIV, and other components including the reduction of sexual and marital violence.

In Rwanda, the health policy was refocused in 1995 through the establishment of functional service health districts. The decision to create health districts was based on the need for equity, integration of services, and improved access to services. In 1998, an institutional framework corresponding to the new RH approach was adopted. As a result, the department in charge of Mother and Child Health and Family Planning in the Ministry of Health became the Reproductive Health Division. Finally, in 2000, Rwanda defined the primary components of its new RH policy, which make up this document. These components are safe motherhood/child health (SM/CH), family planning (FP), prevention and treatment of genital infections (STIs/HIV/AIDS), adolescent reproductive health (ARH), prevention and management of sexual violence, and social change to increase women's decision-making power.

Rwanda's national reproductive health policy will serve as a guide for all RH service provision throughout the country. It will be applied in collaboration with organizations and commissions approved or established by the government (such as, for instance, the National AIDS Control Commission and the Commission of Human Rights); through enforcing laws (such as, for instance, those on matrimonial status, donations and successions); by the integration of the gender approach in all aspects; and through decentralization and good governance policies.

The formulation of a National RH Policy became a reality in the year 2000 through a Round Table on Reproductive Health, held in September 2000 at Gisenyi. This round table yielded a report[3] that includes the six RH priority components in Rwanda:

- ***safe motherhood/child health (SM/CH)***
- ***family planning (FP)***
- ***prevention and treatment of genital infections (STIs/HIV/AIDS)***
- ***adolescent reproductive health (ARH)***
- ***prevention and management of sexual violence***
- ***social changes to increase women's decision-making power***

Evidently, the promotion of other RH aspects is not excluded from eventual consideration (women's cancer, sterility, peri-menopause, etc.), but these are not considered as priority components.

These priorities fit well with the 1994 ICPD recommendations. The Rwandan government, with the support of its partners, will work from the essential RH components mentioned above to identify the needs and objectives that, in turn, will serve to define interventions.

1. Background

This national RH policy has been elaborated and disseminated in a context in which the Rwandan government had adopted its global poverty reduction strategy for sustainable development, national population policy for sustainable development and national health policy. Therefore, this RH policy uses these, and the international policies and agreements ratified by Rwanda, as references.

1.1. Reproductive health indicators in Rwanda and the region

With 322 inhabitants per square kilometer, Rwanda is one of the most densely populated countries in the world. The Composite Fertility Index (CFI) is 5.8; the population is very young—48% of the population is under 15 years of age. Life expectancy is only 41 years, due in large part to the AIDS pandemic.

Maternal and infant morbidity and mortality rates are very high, as shown in the table below, which compares RH in Rwanda to some other countries in the region. Some indicators are clearly unfavorable in Rwanda: GNP, utilization of modern contraceptive methods, HIV prevalence among adults 15 to 49 years old, percentage of births attended by skilled health staff, and, especially, child and maternal mortality.

Indicators	**Benin**	**Burkina Faso**	**Cameroon**	**Côte d'Ivoire**	**Mali**	**Rwanda**
Annual population growth rate	2.9%	3.0%	2.7%	2.0%	3.0%	2.8%*
% population < 15 years	46%	49%	43%	47%	47%	48%*
GNP per inhabitant (in USD)	$980	$970	$1590	$1500	$780	$930
% literacy women/men	25%/57%	14%/34%	70%/82%	39%/55%	34%/49%	58%/68%
Composite fertility Index	6.3	6.8	4.9	5.2	6.8	5.8**
Contraception: all methods/ modern methods	18%/ 7%	12%/ 5%	19%/ 7%	14%/ 7%	8%/ 6%	10%/ 4%*
Maternal mortality /100,000 live births	880	1400	720	1200	630	1071 *
Infant mortality (under one year of age)	85	105	77	95	113	107
% of delivered women who have had at least one antenatal consultation	94%	94%	77%	89%	32%	92%*
% deliveries attended by a health agent	60%	40%	55%	47%	24%	31%*
HIV prevalence among adults (15-49 years)	2.5%	6.4%	11.8%	9.7%	1.7%	11.2%**

* Rwanda, Demographic and Health Survey (DHS), 2000[5]
** UNAIDS, 2000[6]
Data for other countries: "Population Reference Bureau, PRB," 2002

In addition, according to the DHS/Rwanda 2000[5]:

- 16% of newborns weigh less than 2,500 grams;
- The mortality rate among children under 5 is 196 per 1,000 live births;
- Although 92% of pregnant women have at least one antenatal consultation (ANC), the impact of ANC is low because very few women have more than one consultation, and the quality of antenatal consultations leaves much to be desired. Danger signs during pregnancy and delivery are not generally diagnosed and taken in account. Only very few women are attended by a health professional at delivery. There is practically no "postnatal consultation" component in Rwanda;
- FP is poorly known and very little utilized as a birth spacing method.

Regarding three of the priority components for RH in Rwanda, namely adolescent RH, prevention and management of sexual violence, and social changes to increase women's decision-making power, few data are available.

1.2. Economic background

The GNP per inhabitant was 180 USD in 1995[8], following the onslaught of war and genocide in 1994 that devastated the country's economy. This led to inflation, increased dependency on external aid and a considerable debt burden. Nevertheless, a liberalization policy after the war resulted in relative economic growth in the country and by 1999, the GDP per capita had reached 237 USD.

The industrial and information sectors employ 2% of the working population; the service sector employs 7%. National investments remain low and national savings are nearly inexistent, with poverty widely prevailing; 66% of the households were living below the poverty threshold in 1998 (40% in 1995), and 38% of them would be classified as "very poor."[8]

Poverty is mostly rural. The pressure on land is such that, on average, family plots measure less than one hectare—the critical limit below which a family can no longer meet basic food needs. The lands are overexploited and progressively losing their fertility. Poverty—and often desolation—is rampant in rural areas. The social categories that are primarily victimized by poverty are households headed by women (often widows), or by young unemployed or unskilled persons, prisoners, seasonal workers, old people, handicapped persons and children. In many cases, poverty has been aggravated by social isolation and psychological trauma related to the atrocities and human losses experienced in 1994.

1.3 Health issues related to reproductive health

1.3.1 Malaria, HIV/AIDS and other transmissible diseases

The population's health status is a key factor of a country's development. In Rwanda, there is a high prevalence of endemic diseases (primarily transmissible diseases) that contribute to morbidity and mortality: malaria, HIV/AIDS, respiratory tract infections, diarrheal diseases, parasitic diseases, tuberculosis, typhoid, cholera and meningitis. The most harmful of these, of course, is AIDS, due to its multidimensional negative impact on the entire society. It remains incurable and there is no vaccine as of yet. The only solution is prevention.

Malaria and RH are closely related (anemia aggravating obstetrical hemorrhaging, placental malaria, etc,). Malaria must be detected and treated. According to WHO, antenatal consultations should include the promotion of the utilization of impregnated mosquito nets, as well as systematic preventive treatment of pregnant women in endemic areas. Malaria also should be addressed during

postnatal consultations (PoNC) and immunization campaigns. However, this requires increased coverage of ANC and PoNC (the latter of which needs to be organized and offered) and the involvement of trained birth attendants. Iron supplementation to prevent anemia should likewise be generalized.

AIDS is extremely costly for health services and for the nation. In reference hospitals, AIDS patients occupy up to 80% of the beds. In addition to expenses resulting from frequent hospitalizations, there are other associated direct or indirect costs: drugs, patient surveillance, income loss, death of workers, orphans, etc.

1.3.2 Immunization

The Expanded Program on Immunization (EPI) for young children led to a decrease in the number of cases notified for the six targeted illnesses (measles, polio, tetanus, diphtheria, whooping cough and tuberculosis), especially in 1995 and 1997. However, this trend did not continue in subsequent years. Among these diseases, measles remains a major cause for mortality and morbidity. The EPI has implemented new strategies (reinforced routine immunizations, mass public immunization campaigns and social mobilization). According to the 2000 DHS, 98% of children between 12 and 23 months of age had received at least one vaccine, and 76% had received all vaccines. The overall situation is not bad, but should be considerably improved.

1.3.3 Malnutrition

For more than 30 years, malnutrition has been one of the 10 leading causes of mortality in Rwanda. Nutrition surveys conducted between 1976 and 2000 have, unfortunately, not shown any improvement among children and pregnant women. According to the 2000 DHS, among children under 5, 7% suffer from acute malnutrition, 24% are underweight, and 42% are stunted (and 19% severely stunted).

2. Institutional framework for reproductive health

2.1 Policy basis

In ratifying reproductive health international declarations and agreements, Rwanda has committed itself to enforce these, and to ensure coordination, monitoring and evaluation of corresponding activities, as evidenced through:

- Creation of various structures that include RH among their attributions (such as ONAPO, CNLS, TRAC, CNJ, etc.);
- Setting up a national Commission of Children's Rights, including the right to health care (as stipulated under Article 24 of the agreement related to the Children's Rights – CDE, Geneva 1990), and the definition of health policies favorable to the child;
- Creation of committees of youth and women responsible for health, among other issues, at the community level; these committees are elected at the grassroots level by the community. These are present at all levels of the Rwandan Administration;
- Creation of a Ministry in charge of Gender and Women's Promotion (MIGEPROFE), involvement of various other ministries (MIJESPOC, MINALOC, MINEDUC, MINISANTE), and of the private sector, NGOs, cooperating agencies and United Nations agencies.

Rwanda's health policy advocates the integration of services as a fundamental organizational principle. (See 2.2, below.) The health center, the system's basic unit, must be multipurpose.

Dispensaries, maternities and nutrition centers that still operate in an isolated manner must become health centers providing the Minimum Package of Activities (MINPAC). District hospitals, which are the first level reference facilities, must provide the package of additional activities.

2.2 Integration of reproductive health services

According to the national health policy, health facilities offer the following integrated RH services:

- antenatal consultations;
- obstetrical care, available at nearly all health facilities (for utilization rates, see 1.2 above);
- family planning, irregularly provided due to insufficient training of clinic staff and inadequate integration of this component in other RH services;
- IEC, destined to promote RH services, which conducted although the number of people reached by messages is poorly documented (the Health Information System, HIS, does not collect these data);
- HIV/AIDS control (which has been improving, though coordination needs strengthening);
- child health, integrated at the level of health facilities, however, not coordinated at the central level (IFID-LIME, immunizations, nutrition), although norms exist[9] to ensure harmonious physical, mental and social development of the child.

In theory, prenuptial and postnatal consultations also are included, but these two services are not systematically offered. Prenuptial consultations provide, although often in a non-integrated manner, HIV and syphilis testing for individuals planning to get married. Although norms exist[9], these activities are not integrated into the HIS. Concerning postnatal consultations, lessons learned from an ongoing pilot experience should allow the practice to be expanded.

Concerning the prevention and control of sexual and domestic violence, efforts are being undertaken jointly by the national police, legal authorities, MIGEPROFE, MINISANTE and NGOs.

Social changes that increase women's decision-making power are essentially the responsibility of the MIGEPROFE. It is obvious that the influence of increasing women's decision-making power on the quality of RH services is potentially very significant.

One activity not yet integrated is school health. However, the norms, objectives and activities were established in 1993.[9]

2.3 Administrative, care and community services involved in RH

These services are found at the three levels of the health system: central, intermediate and peripheral.

At the central level, the RH Division of the Ministry of Health, with its various sections (MCH, FP, Research and Documentation), and three other divisions (nutrition, health education, promotion of health care quality) are under the responsibility of the Directorate of Health Care (DSS).

At the Ministry of Health, other services have RH related activities, including:

- The Division of Integrated Control of Childhood Illnesses (LIME, *Lutte Intégrée contre les Maladies de l'Enfance*): This is under the responsibility of the Directorate of Epidemiology and Public Hygiene, and manages the Expanded Program on Immunization (EPI), and the Program to Control Childhood Illness. Other divisions and programs handle child health in a non-specific

manner, including the National Leprosy and Tuberculosis Control Program, the Division of Mental Health, and the National Malaria Control Program;

- The Treatment and Research AIDS Center (TRAC): This center's responsibilities include the Prevention of Mother-to-Child Transmission, HIV epidemiologic monitoring and coordination of treatment regimes using antiretroviral drugs.

At the intermediate level, health districts are expected to play a coordination role between the central and peripheral levels, and among the decentralized facilities, including district hospitals, health centers and the communities.

At the peripheral level, there are health facilities that provide integrated services according to the MINPAC norms for health centers and those that provide the additional activities package (hospitals), some clinics and private dispensaries, community initiatives, as well as organizations that offer mass education (functional literacy training of MINALOC) which progressively integrate RH into their programs.

2.4 RH program coordination and implementation

Coordination of RH is the responsibility of the MINISANTE. It should be emphasized that there is:
- Insufficient information on the implementation interventions, resulting in redundant efforts and squandered resources;
- Lack of follow-up of accomplishments and of evaluation of results achieved;
- Weaknesses in understanding the responsibilities of each intervening party.

This RH policy should help to improve the currently inadequate information, coordination, monitoring and evaluation of RH. Coordination should involve various actors, listed according to the primary intervention areas:

RH Components	**Responsible**
Safe motherhood and infant health	MINISANTE, MINALOC and MINEDUC
Family planning	MINISANTE, MINEDUC, MINALOC and MIJESPOC
Prevention and treatment of genital infections, STIs/HIV/AIDS	MINISANTE (TRAC), MINEDUC, MIJESPOC, MINALOC, MINADEF and CNLS
Adolescent reproductive health	MINISANTE, MIJESPOC, MINEDUC and MINALOC
Prevention and management of sexual violence	MINISANTE, MINIJUST, MIGEPROFE, MINALOC, MINADEF, MINEDUC
Social changes to increase women's decision power	MIGEPROFE, MINEDUC, MINALOC and MINISANTE

In the short term, the government will establish two coordination units, one under the responsibility of MINISANTE, in charge of coordinating clinical services interventions, and the second, under the responsibility of MINALOC, in charge of coordinating all IEC/behavior change communication (BCC) interventions. For aspects specific to their mandates, MIJESPOC has an IEC section focused on adolescents, and MIGEPROFE has a section responsible for control of sexual violence (in close collaboration with MINIJUST, MINALOC and MINADEF). The National AIDS Control Commission ensures the coordination of HIV/AIDS prevention interventions.

In the long term, there must be a more functional structure to handle global, multi-sector and multidiscipline coordination for all RH interventions in Rwanda. Coordination mechanisms should be attached directly to the ministries involved, or at least been in communication with them.

3. Situational analysis of priority components

3.1 Safe motherhood and child health

3.1.1 Current status

Maternal and child mortality rates in Rwanda are among the highest in the world: 1,071 maternal deaths for 100,000 live births, 107 infant deaths for 1,000 live births, and 196 deaths of children under 5 per 1,000 live births[5]. These deaths for the most part seem due to lack of awareness of the problems, or to late recognition of problems and inadequate care-seeking.

In rural areas, only 31%[5] of births are attended by qualified health care providers and, in general, the capacity to address obstetrical complications is limited. Moreover, coverage by the reference and counter reference system for obstetrical emergencies is not complete.

Concerning postnatal consultations, the Ministry of Health is trying to promote them through pilot initiatives; although they were a component of the 1993 "health center service standards" [9], they are far from being systematically offered and used.

Immunization coverage against the six childhood illnesses is relatively acceptable for the country overall (see 1.4.2).

The national health policy established the list of safe motherhood services that should be made available and integrated in health facilities throughout the country. These include:

- Prenuptial consultations, antenatal consultations, obstetrical care (non urgent and urgent, including post-abortion care), neonatal follow-up and maternal follow-up after delivery. It should be noted that adequate handling of emergencies with community participation for costs and transport is more efficient in decreasing maternal morbidity/mortality than assistance at antenatal consultations (which should nevertheless not be neglected);
- Newborn resuscitation equipment is often nonexistent in health facilities;
- Postnatal consultations, post-partum care at the maternity ward (in the short term) and ambulatory care (in the longer term) are nearly nonexistent;
- There is clearly an insufficiency, compared to norms, in qualified staff (1 nurse per 12,000 inhabitants; 1 to 7 A2-level nurses per health center; 1 doctor for 53,000 inhabitants). Some hospitals have only one doctor, although the minimum theoretical number is four. Furthermore, doctors and nurses are often occupied with administrative tasks, living clinical activities to less competent providers;
- Lastly, there are problems related to supervision, staff instability, and the lack of standards for services/norms and protocols.

3.1.2. Strengths and weaknesses

The ratification by Rwanda of declarations and agreements constitutes an asset for the organization of SM/CH activities. Other assets include the national policy documents in matters of population and development[11], health and RH[2]. Furthermore, Rwanda is enforcing WHO guidelines[15,16].

SM/CH activities are already included in the health facilities' activities package. However, financial, geographic and socio-cultural access to services and the quality of services are problematic. Fortunately, SM/IH interventions receive the support of many public and private organizations, national and international partners, which requires adequate coordination mechanisms.

Community health workers and community birth attendants can play an important role at the community level. These two categories of providers can be, in principle, very useful in improving general RH performance and SM/CH in particular, if they are supervised, given continuous training and motivated. The basic administrative structures at the community level also have a role to play.

The weaknesses are, unfortunately, quite numerous:

- Prenuptial consultations, practically nonexistent;

- Low utilization rate of SM/CH services, due to ignorance of risk factors and warning signs, as well as the use of incompetent providers (healers, untrained traditional birth attendants, etc.). For instance, only one woman out of 10 benefits from the four recommended antenatal consultations[4,5], and there is insufficient IEC on risk factors and warning signs (lack of IEC tools, lack of coaching of providers). The majority of deliveries are performed at home without any assistance from competent providers;

- The reference and counter reference system is generally weak, between the community and health centers as well as between the health centers and hospitals. Maintenance of ambulances and recovery of related costs pose major problems;

- The capacity for addressing obstetrical emergencies is low in most health facilities. This factor explains, in large part, the high maternal and infant morbidity and mortality rates.

3.2 Family planning

3.2.1 Current status

As explained in the introduction, birth planning is a fundamental human right. Moreover, FP and birth spacing (in Rwanda, 24% of births occur within less than two-year intervals)[5] are strategies that can improve the health status of the population. They can contribute to the reduction of maternal and infant mortality and morbidity[5], and unwanted pregnancies that can result in induced abortions or the neglect of unwanted children. (The complications of induced abortions, especially serious when they are performed in poor conditions, cause 15% of maternal deaths.)

In absolute figures, a decrease in the number of unwanted pregnancies evidently decreases the number of maternal deaths.

In Rwanda, indicators for birth planning are still unsatisfactory considering the high unmet demand. The birth rate (45‰) and the composite fertility index (CFI) are very high. Although the overall knowledge level of contraceptive methods is very high among the interviewed woman (95% know at least one birth control method)[5], FP services utilization is still very low (4% of women in couples for modern methods)[5]. This constitutes a definite decline, considering that the corresponding figure was 13% in 1992[12]. Contraceptive prevalence varies greatly depending on the place of residence and

level of education, but the potential demand exists everywhere: 36% of women in couples have unsatisfied FP- related needs[5].

Exclusive breastfeeding is practiced for three months by 90% of mothers, and prolonged breastfeeding is the rule. This practice should, therefore, be strongly encouraged as it is very favorable to birth spacing. However, the risk of HIV transmission through breastfeeding poses a problem for 10% to 13% of the mothers.

Regarding contraceptive supply, the public sector represents the main source, supplying 69% of contraceptives; 23% of female contraceptive users are supplied through private medical sources, and 7% from non-medical private sources (kiosks, shops, friends, relatives and other sources).

3.2.2 Strengths and weaknesses

The strengths on which FP-related policy can be built include:

- Existence of a national population policy for sustainable development;
- High level of knowledge of contraceptive methods among the population;
- Increasing number of health facilities providing modern contraceptive methods;
- Efforts made to restructure contraceptives logistics in Rwanda;
- Studies already conducted on FP that have provided a better understanding of the problems.

The weaknesses include very low current utilization of FP services, low quality of FP services, considerable shortage of staff trained in FP, frequent stock-outs of FP materials and equipment, negative influence of certain socio-cultural factors (including the lack of capacity of women to make decisions), poor geographic accessibility to services in certain zones of the country, and financial constraints of potential clients. Lastly, family planning remains a component insufficiently integrated in other reproductive health services.

In general, decision makers and opinions leaders are not fully involved in promoting and supporting family planning, which is a fundamental right, and an efficient way to decrease the high level of maternal mortality in Rwanda. There is, in fact, a notable difference between the rhetoric of providers and decision makers, relatively little motivated about FP, and the needs of the men and women interviewed[5], of whom 50% are seeking FP services and who desire, on average, 4.8 children, whereas the composite fertility index is 5.8.

3.3. Prevention and treatment of genital infections (STIs/HIV/AIDS)

3.3.1 Current status

For STIs, prevention is key. For testing and treatment, the syndromic approach is a must. Very few laboratories are available at the moment. In theory, prevention, testing and treatment are integrated services. These services must be offered at every encounter with clients, especially in the framework of integrated reproductive health. For instance, syphilis testing is to be included in the "ANC package." For treatment, the list of essential drugs includes the necessary STI antibiotics.

The HIV/AIDS pandemic certainly did not spare Rwanda, where, according to a UNAIDS report released in June 2000[6], sero-prevalence among the general population of 15-49 years is 11.2%, which is very high. Nor did it spare the children: 4.1% of 12-14 year old are seropositive. Although sero-prevalence has decreased in urban areas from 17% in 1986 to 11% in 1997, in rural areas, to the

contrary, it has increased during the same period from 1.3% to 10.8%. This situation is related, no doubt, to ignorance, poverty, traditional behaviors and migrations.

Among pregnant women, the HIV seropositivity rate is alarming and steadily growing. According to a sentinel survey, this rate has gone from 2% to 8% in rural areas, and from 8% to 13% in semi-urban areas between 1991 and 1996.

Antiretroviral drugs utilized to slow down or stop the progress of the disease remain financially inaccessible. Also, before resulting almost inevitably in death, AIDS has a strongly negative physical, psychological, economic and social impact, not only on the affected individual but also on his close circle of relations, and on the entire nation. Objectively, if financial considerations are emphasized, hospitalization costs and medication expenses, among others, must be addressed.

3.3.2 Strengths and weaknesses

The positive aspects of the framework of STI/HIV/AIDS control in Rwanda at the level of the government include a firm political will. There are currently two structures involved: the National Treatment and Research AIDS Center (TRAC) and the National AIDS Control Commission (CNLS).

The TRAC is responsible for medical and research aspects of HIV/AIDS. It is in charge of IEC/Voluntary Counseling and Testing (VCT). The restructuring of the National AIDS Control Program (PNLS) into the TRAC was performed together with the decentralization of its activities at the health facilities level (adding VCT to prevention of mother-to-child-transmission, PMTCT). The CNLS is in charge of designing a national HIV/AIDS control policy, advocacy, social mobilization, mobilization of resources, decentralization (establishment of provincial AIDS control commissions, or CPLS) and coordination of multi-sectoral interventions.

Some weaknesses remain: the TRAC does not yet have the necessary means to efficiently carry out all of its responsibilities. Voluntary testing structures, and reference as well as treatment facilities, are still insufficient. There is still little case management for patients at medical, psycho-social and economic levels. Access to antiretroviral drugs remains restricted to a minority, and up-to-date and reliable data are lacking. Activities to increase awareness are still insufficient, concerning the CNLS and the CPLS.

Fortunately, partnerships between the government and other actors such as United Nations organizations, NGOs and international donors (bilateral cooperation agencies) for HIV/AIDS prevention and control are being noticed.

Among the obstacles, one should also mention insufficient numbers of qualified staff, geographic inaccessibility in some areas of the country, financial inaccessibility, obstacles related to Rwandan social and cultural constructs and the inadequate decision-making power of Rwandan women (who cannot impose condom utilization on their male partners).

3.4 Adolescent reproductive health

3.4.1 Current status

Young people and adolescents represent a particularly large group in Rwanda. Youth between 10 and 35 years old (the official definition used in Rwanda) represent 49% of the population of

8,162,715 inhabitants (according to the general population and housing census conducted in 2002). Adolescents between 10 and 19 years old make up 28% of the population, and those between 10 and 24 years old, 35%. Youth are a particularly vulnerable group. During the years following the 1994 genocide and war, the proportion of children and adolescents in difficult situations increased drastically, and included street children, AIDS orphans, and adolescent heads of family.

According to the partial data available, youths and adolescents are exposed to multiple RH-related problems. A total of 25% of adolescents are sexually active before the age of 18. The 2000 DHS revealed that 7% of adolescent girls between 15 and 19 years old are pregnant or already mothers. For HIV/AIDS, a 1997 study on sero-prevalence indicated that the levels were very high among 12 to 14 year-old youth (4.2%), as well as among those between 15 and 18 years old (6.5%) and those between 20 and 25 years old (13.6%).

Inadequate access to RH services exposes adolescent girls to unwanted pregnancies and, as a result, dropping out of school, unsafe abortion, sexually transmitted infections, maternal and/or child death, newborn abandonment, infanticide and many kinds of physical and psychological violence.

However, updated and more in-depth studies would be useful to better document adolescent RH related problems.

Adolescent reproductive health (ARH) services are only now beginning to be offered in the public and private sectors (private offices, NGOs, etc.). The first ARH service centers were established in 1998 under the sponsorship of the Ministry of Youth, Sports and Cultural. Presently, seven centers are working throughout the country. However, most of them limit their services to IEC. The same ministry established a National Youth Council (NYC), which operates, even at the decentralized level, and has developed and implemented a plan for HIV/AIDS control among youth.

TRAC offers HIV counseling and testing services to the entire population, including the youth. Some NGOs and projects participate actively in ARH by establishing youth centers and carrying out training and awareness-raising activities.

The Ministry of Education, Science, Technology and Scientific Research (MINEDUC) is conducting a program for HIV/AIDS control called the IEC/STI/AIDS School Program that has contributed, among other things, to raising awareness on STIs/HIV/AIDS among school officials (inspectors and directors of primary and secondary schools), pupils during vacation camps and pedagogic facilitators. It also supported the production of teaching aids (training guides, school manuals, various reference documents) and IEC materials (posters, video-cassettes), and to the creation of anti-AIDS clubs in the schools.

3.4.2 Strengths and weaknesses

The fairly late average age for first sexual relations (20 years), first marriage (21 years), and first birth (22 years), compared to elsewhere in sub-Saharan Africa, is a favorable factor for women's reproductive health in Rwanda[5]. Another favorable factor is the long average period of post-partum amenorrhea (14 months, on average)[5] . These behaviors should be encouraged.

There is obvious political will in favor of adolescent reproductive health in Rwanda. This will has been shown, among other things, through the First Lady's commitment (through an initiative to establish a multidiscipline center for youth), the establishment of the National Youth Council (NYC) and other structures for youth, and through the existence in some ministries of a division in charge

of ARH. In addition, resources have been mobilized to support the prevention of STIs/HIV/AIDS among youth.

Other assets to ARH in Rwanda are the anti-AIDS clubs in the schools and the national strategic plan for STI/HIV/AIDS control.

The weaknesses of ARH interventions include insufficient specific data on ARH, lack of integration of ARH services within health facilities, absence of clinical ARH services in most of the working youth centers and insufficient technical skills of RH providers.

Social and cultural considerations still favor boys' school attendance to the detriment of that of girls. As a result, illiteracy rate is 42% among women and 32% among men[5].

In addition, there is insufficient coordination of IEC/ARH activities.

3.5 Prevention and management of sexual violence

3.5.1 Current status

Sexual violence is defined as any act by a person using force, intimidation or tricks (as in the case of rape of little girls) to impose unwanted sexual relations on another person. This can be rape, conjugal violence, forced marriage, commercial sex, etc. These acts, whether performed within the family, in the community or in the workplace result in negative consequences for the victims' physical, mental and social health, and prevent them from enjoying their rights and liberties.

In Rwanda, sexual and domestic violence constitute a major public health problem. Their prevention and management are included in the RH priority components. One study shows that in Rwanda, sexual violence against women and children is, unfortunately, on the rise.[14]

In addition to the problem of rape, the problem of prostitution and pandering must be addressed. This includes sexual exploitation of little girls placed in houses of prostitution and the problem of "*guterura*," i.e., abducting young girls for forced marriage.

Sexual violence was used as a weapon of war during the 1994 massacres and genocide, and many persons suffer from physical and moral damage. In transit and refugees camps, women and young girls suffered rape and forced temporary unions. Sexual and domestic violence result in severe consequences, included psychological trauma that may be manifested by self-repulsion. This can lead to prostitution, depression and even suicide. The impact of violence can include physiological damage (torn perinea, fractures of members, etc.) that could result even in death, as well as STIs causing sterility, HIV/AIDS, unwanted pregnancies and births and illegal abortions.

Observation of sexual violence has revealed causes such as the rumor that men can be protected against STI/HIV infection by raping little girls, or that such relations would cure these affections (according to advice given by certain witchdoctors—who must be taken to court). No excuse is acceptable.

Further in-depth studies at the national level are necessary. However, one can already cite among the factors conducive to violence: women's disadvantaged situation, despite efforts deployed to improve it; indifference or fatalism of the community towards sexual and conjugal violence; victims' persistence in refusing to disclose the act, considered shameful by the society; low levels of

education and illiteracy of a large part of the population, which lives in ignorance of its rights and duties.

3.5.2 Strengths and weaknesses

Nationwide advocacy against sexual and domestic violence is beginning to occur, and there is a strong commitment on the part of political leaders. Political will has been demonstrated by, among other things, the adoption and revision of laws against sexual and domestic violence, initiation of studies devoted to these issues and progressive establishment of centers to care for the victims. The government is on the war path against sexual and domestic violence and awareness of the communities is progressively being raised—and they are engaging in the same fight. However, because this issue is considered relatively new, there is not currently sufficient data on the prevention and management of sexual and domestic violence.

3.6 Social changes to increase women's decision-making power

3.6.1 Current status

In Rwanda, decisions related to RH are made in the family by the husband (only 43% of the couples discuss FP)[5]. However, the community also exerts pressure on women to have many children, and preferably boys. In addition to these cultural aspects, there still exist discriminating laws, even if a recently enacted law on inheritance was favorable to the females.

Unwanted pregnancies result in girls dropping out of school. This occurs as early as the second part of primary school, with increasing numbers through the last university study cycle.

The nonexistence of prenuptial and postnatal consultations, which could provide an opportunity to allow women and/or couples to decide on their reproductive future, and during which counseling on sexual and domestic violence could be offered, is a hindrance couples' harmonious development, and more particularly that of women.

3.6.2 Strengths and weaknesses

Women's decision-making power is considered an important issue in Rwanda, as evidenced by the existence of a ministry in charge of gender and the promotion of women, an increase in the number of women in positions of responsibility, increased representation of women in basic administrative structures, existence of organizational structures of women at all administrative levels in the country, the enactment of a law on inheritance favorable to women, the existence of a law on the management of married couples' assets (common or separate status of assets), the creation of associations for the defense of women's rights, support to income-generating projects for women's associations, etc.

There is strong political will in favor of women's promotion, and the Rwandan society seems overall favorable to this change.

However, there is reluctance to change on the part of some of the population, for instance among the poor, who often have limited access to information, and therefore to new ideas. Literacy remains higher among men (68% versus 58% for women). A male child is favored in terms of education, the girl sometimes must endure forced or precocious marriage, and informal polygamy hampers women's harmonious development. Moreover, although legal provisions exist, the enforcement of

compulsory enrollment for all children in primary schools and decisions on free education at this level has yet to happen.

It should also be noted that guidelines have not yet been given to health facilities on the integration of the component "social change to increase women's decision-making power" in service and protocol standards.

4. Reproductive health goal, objectives and strategic plan

The goal of the RH policy is to contribute to improved reproductive health, in order to enable efficient participation from all groups of the population in the social and economic development of their country.

The general objective is to reduce maternal and child morbidity and mortality.

The specific objectives of the overall national RH policy are:

- Improve access to and quality of care;
- Improve the functioning of the system for collecting and analyzing data (health information system, HIS);
- Promote equality and equity between men and women, and their involvement in improving RH in their families and the society; and
- Promote access to RH services for adolescents and youth.

For the six priority components, the RH policy presents, below, specific objectives and priority strategies and interventions. The priority interventions are proposed for a two-year period, and progress indicators are included in an appendix.

4.1 Safe motherhood and child health

4.1.1 Specific objectives

The national RH policy sets the objectives for prevention, integrated management and data collection for monitoring.

- For prevention, the objectives are to:

- Reduce maternal mortality from 1071/100,000 to 700/100,000 by 2010;
- Reduce infant mortality from 107/1,000 to 70/1,000 by 2010;
- Reduce mortality among children under 5 from 196/1,000 to 100/1,000 by 2010;
- Increase the proportion of children under 5 taken in a timely manner to health facilities in case of illness and for case management of diarrhea, fever, respiratory infections and malnutrition (IEC for parents on warning signs and training of staff in integrated management of childhood illness); at least 80% of children under 5 will receive adequate treatment of diarrhea by 2010 (according to 2000 DHS, currently only 58%).

- For case management, improve the quality of services offered by SM/CH providers, particularly to manage pregnancies, and to offer obstetrical, postpartum, neonatal and pediatric care.

- For data collection and monitoring, strengthen the health information system (HIS) and establish a functional follow-up system for SM/CH (monitoring system at the health facility level).

4.1.2 Strategies

- For prevention, the national RH policy emphasizes the following strategies:

- Regular training, refresher training and supportive supervision for health care providers;
- Coaching of traditional birth attendants for home deliveries, training them to recognize pregnancy- and delivery-related risk factors;
- Supplying delivery kits to traditional birth attendants;
- Preventive child health care activities integrated in health facilities. Growth and nutrition monitoring of 0- to 5-year-old children must be provided in all health centers, and nutritional rehabilitation therapy is included in the additional activities package for most district hospitals;
- Active participation of families and communities in SM/CH promotion;
- IEC at various levels (during health talks, counseling and at the community level) on prenuptial and antenatal consultations, risk factors (pregnancy and delivery), warning/danger signs, the importance of postnatal follow-up and immunizations, and certain situations which require care beyond the capacity of traditional birth attendants;
- Strengthening nutrition services in health facilities;
- Providing IEC materials to health facilities and community health workers;
- Utilization of community networks (traditional birth attendants, local authorities and elected parties).

- For case management, the following strategies will be implemented:

- Identify traditional birth attendants and train them to recognize antenatal and obstetrical risk factors and warning signs, and make timely references;
- Organize collaboration between health centers and traditional birth attendants;
- Provide refresher training in SM/CH to community health workers;
- Strengthen community participation (health solidarity funds, transport of parturients, management of health facilities, nutritional monitoring) ;
- Equip health centers and ensure adequate staffing;
- Provide in-service training for management issues;
- Make available and accessible basic materials and drugs;
- Design and disseminate service standards, protocols, flowcharts, service guides, etc.
- Generalize the use of partographs

- For follow-up, strategies are to:

- Design and disseminate the tools for supportive training, including follow-up of the trained providers;
- Organize supervision at all levels, including the private sector; schedule and involve supervisors coming from reference hospitals to supervise district hospitals, and district hospital teams in supervising providers in the health centers, and systematize feedback;
- Refine SM/CH indicators and corresponding data collection tools (registers, health cards).

4.1.3 Priority interventions

- Ensure follow-up of future mothers from the beginning of their pregnancy and of the child until it is more or less autonomous;
- Set up an adequate monitoring system for pregnancy and delivery, for the postpartum and post-abortum periods;
- Strengthen IEC on the benefits of delivery in a health center;
- Provide proper management of obstetrical emergencies and childhood illnesses.

4.2 Family Planning

4.2.1 Specific objectives

For family planning, the RH policy has set a specific objective to increase to at least 15% (up from the present figure of 4%[5]) by 2010, the utilization rate of modern contraceptive methods among women of childbearing age.

4.2.2 Strategies

The strategies corresponding to this objective are to:

- Conduct advocacy with all potential actors to promote improved awareness of FP and generalized access to FP services for women, men and youth;
- Integrate FP in SM/CH services;
- Develop and implement a social communication and mobilization program;
- Strengthen men's participation;
- Involve various community-based structures and organizations such as religious organizations, NGOs and associations of women, men and youth in FP promotion;
- Improve FP service providers' skills;
- Promote the utilization of eligibility criteria recommended by WHO[13] for contraceptive prescription;
- Make available and revive FP services in all health facilities (public and private);
- Establish a system for monitoring FP activities in all health centers at all levels (community, district, province, national);
- Involve political and administrative authorities and community leaders in FP mobilization.

4.2.3 Priority interventions

To achieve the above objectives, the national RH policy emphasizes the following interventions:

- Design and dissemination of appropriate FP messages for mass media (radio, TV, newspapers, etc.), and IEC/FP tools (posters, flyers, flipcharts, etc.);
- FP awareness raising among men during political and administrative meetings;
- Involvement of community-based associations and organizations of women and youth in FP awareness-raising activities;
- Integration of FP in training curricula at primary, secondary and higher education levels, with the collaboration of MINEDUC;
- Training and refresher training of providers in contraceptive technology and communication/counseling techniques;
- Strengthening logistics for contraceptives and related materials;
- Development of postnatal care, including FP;
- Strengthening men's participation in FP programs;

- FP awareness raising in the schools;
- Revision of the FP training curriculum in nursing schools;
- Improving the quality of services.

4.3 Prevention and treatment of genital infections (STIs/HIV/AIDS)

4.3.1 Specific objectives

- For prevention and detection, objectives are to:

– Reduce STI incidence and prevalence rates;
– Reduce HIV incidence rates among various population sub-groups;
– Provide psychological and social support to people living with HIV/AIDS and to their families.

- For case management, specific objectives are to:

- Provide adequate STI diagnosis and treatment;
- Promote voluntary HIV counseling and testing;
- Improve performance in detection and case management;
- Increase the survival rates of children born to HIV+ mothers;
- Give proper treatment to all patients suffering from opportunistic infections.

- For data collection and management, the policy emphasizes monthly reports, field visits and targeted surveys.

4.3.2 Strategies

- For prevention, the national RH policy advocates:

- Promotion of the use of male and female condoms;
- Strengthening IEC/BCC in order to increase the proportion of people (adults, youth > 10 years) accessing quality information related to STIs/HIV/AIDS;
- In-service training for providers to improve performance in case management of STI/HIV/AIDS;
- Integration of the PMTCT program, including promotion of appropriate nutrition and treatment of concomitant illnesses and infections;
- Making available drugs for the treatment of AIDS opportunistic infections;
- Design of and support for income-generating projects for associations of persons living with HIV/AIDS;
- Involvement of the entire Rwandan society in HIV/AIDS control (health centers, churches, public administration, army, prisons, truck drivers, sex workers, migrant temporary workers, etc.);
- Training of facilitators for these various groups;
- Training of community extension workers;
- Literacy and control of ignorance and poverty;
- Dissemination of testimonials by persons living with HIV/AIDS;
- Expansion of PMTCT activities.

- For detection and management of STI and HIV cases, the RH policy advocates:

- Increasing the number of qualified personnel and testing centers to improve geographic access;
- Strengthening IEC/BCC in order to persuade people to use voluntary testing services;
- Strengthening mechanisms for medical treatment of HIV-infected persons, by improving drug access and promoting home care.

4.3.3 Priority interventions

Interventions include:

- Strengthening coordination structures of all STI/HIV/AIDS interventions;
- Advocacy and IEC/BCC, mostly on behalf of youth;
- Training in counseling and rapid HIV testing techniques;
- Extension of the PMTCT program;
- Obtaining antiretroviral treatments and making them widely available.

4.4 Adolescent reproductive health

4.4.1 Specific objectives

Although in Rwanda, youth and adolescents are considered those from 10 to 35 years old, this RH policy is specifically directed to adolescents and youth of 10 to 24 years (including young domestic employees and street children). Three specific objectives are put forth:

- Substantially increase levels of knowledge among youth and adolescents of reproductive and sexual health;
- Encourage adolescents to adopt positive behaviors in RH, particularly in order to reduce STI incidence and HIV prevalence rates as well as the number of unwanted pregnancies;
- Increase the utilization of ARH clinical services in public and private health facilities.

4.4.2 Strategies

- The primary ARH strategies are to:

- Integrate ARH education in the teaching curricula of primary, secondary and higher education, and in organizational structures (associations, anti-AIDS clubs, etc.) and youth training centers, as well as popular education facilities;
- Strengthen and expand upon existing facilities which meet ARH needs;
- Increase, in each province, the number of sites providing voluntary counseling and testing services that are adapted to adolescents;
- Increase the proportion of health facilities providing clinical reproductive and sexual health services to adolescents, including distribution of condoms and contraceptives, STI testing and treatment and management of unwanted pregnancies;
- Integrate ARH services (IEC and clinical services) in all health facilities;
- Strengthen providers' technical skills in ARH;
- Strengthen advocacy on behalf of ARH with authorities and community leaders;
- Strengthen the system of community health insurances (*mutuelles de santé*) in the communities in order to improve financial access to care for adolescents and young people;
- Establish a database in the area of ARH;
- Establish at the level of MIJESPOC coordination mechanisms for IEC/BCC interventions in ARH.

4.4.3 Priority interventions

Interventions include:

- Design and dissemination of a national policy of ARH and IEC/BCC for RH, integrating ARH;
- Elaboration and dissemination of ARH service standards;
- Organizing ARH providers training;
- Supply youth centers, health facilities and other youth structures with materials and equipment needed for ARH service provision;
- Organizing supportive supervision of providers in ARH;
- Revision and dissemination of school programs integrating ARH;
- Determining priority research areas for ARH;
- Support to local initiatives through community health insurances *(mutuelles de santé*) (and allow youth to access them), support to youth/adolescent associations, and to specific groups (such as young domestic employees and street children) in order to improve their economic situation (small loans, income-generating projects);
- Establishment by the MIJESPOC of a coordination committee for IEC/BCC in ARH and operationalization of this committee.

4.5 Prevention and management of sexual violence

4.5.1 Specific objectives

In order to prevent and eradicate sexual and domestic violence, and offer care to the victims, the national RH policy has set the objective of reducing cases of violence within households and the community through community involvement.

4.5.2 Strategies

Designated by the 1994 ICPD as an area requiring attention, and declared a "public health priority" in 1999 by UNFPA, the prevention and management of sexual and domestic violence find their rationale in the fact that no society should tolerate them, and their causes must be fought and consequences must be addressed. To this end, the national RH policy advocates the following strategies:

- Design a protocol to address sexual and domestic violence. This protocol, prepared by the Ministry of Health in collaboration with the Police Department and the entities in charge of justice, including the Ministry of Gender and Women's Promotion, will ensure coordination and broad dissemination among all the actors;
- Integrate interventions on behalf of victims of violence in the services package offered at the health center, particularly by providing the victims with rehabilitation and support services, including guaranteed confidential counseling and adequate care in the area of mental health services;
- Establish a national advocacy program with authorities at all levels of the administrative and political apparatus;
- Establish mechanisms for the prevention of sexual and domestic violence, in collaboration with the involved ministries (MINISANTE, MINIJUST, Ministry in charge of Security and National Police), United Nations agencies, NGOs and other associations;
- Mobilize communities in campaigns condemning violence against women and young girls;

- Enforce the law against perpetrators of such violence, including violence in time of war;
- Improve the capacity of providers and supervisors providing aid to victims;
- Establish a follow-up system for sexual and domestic violence;
- Raise the awareness of communities and law enforcement agents in caring for victims of sexual and domestic violence;
- Elaborate and operationalize coordination mechanisms of the actors.

4.5.3 Priority interventions

Interventions include:

- Elaborate and disseminate a protocol for caring for victims of sexual and domestic violence;
- Integrate care of victims of sexual violence in MINPAC and the complementary activities package (at the hospital level);
- Conduct awareness-raising campaigns for the community and its leaders;
- Enforce the law against perpetrators of sexual and domestic violence;
- Strengthen providers' skills in prevention and management of sexual and domestic violence.

4.6 Social changes to increase women's decision-making power

4.6.1 Specific objectives

In order to raise the education level of girls, and their capacity to make autonomous decisions, the national RH policy has set the following objectives:

- Ensure that all pupils of both sexes complete at least primary school;
- Decrease illiteracy rates among women and men;
- Beyond primary school, decrease school and academic drop-out rates among girls.

4.6.2 Strategies

In order to achieve these objectives, the most important strategies are the following:

- Implement the international agreements ratified by the Rwandan government concerning the promotion of women;
- Elaborate, pass and enforce laws on equality between men and women;
- Suppress laws that discriminate against women;
- Give special attention to the girl child in matters of education for all, particularly through support to the "Education for all Children" fund at the level of the provinces and administrative districts;
- Promote equality between men and women;
- Conduct advocacy and awareness-raising activities to change attitudes of both men and women at the community level;
- Promote access to quality RH services respecting women's decision-making power;
- Promote close collaboration among MINISANTE, MIGEPROFE and partners;
- Ensure that the law on property rights be enforced in order to allow women to benefit from their rights.

4.6.3 Priority interventions

The RH policy promotes the following actions:

- Provide gender education to men and women of all ages;
- Pass laws promoting women's emancipation;
- Improve women's economic power, including within the household, allow them with greater autonomy.

5. Resource mobilization

Human, financial, and material resources, as well as infrastructure, will be examined, each in turn. The implementation, monitoring and evaluation of the RH policy obviously require adequate mobilization of resources.

5.1 Human resources

Health care staffing has always been insufficient, qualitatively as well as quantitatively, even prior to the 1994 war and genocide. The situation worsened with these events. Despite recent efforts, norms on staffing levels are far from being met, and the personnel are not always distributed equitably. Most hospitals have only one or two doctors, instead of four, which is the recommended minimum. Many health centers have only one or two nurses. Supervision reports have shown that clinical doctors in hospitals (who may serve at the same time as the director) and health center nurses (who serve also as the clinic manager) are often occupied with administrative responsibilities and, therefore, must leave the technical work to less-qualified providers.

Presently, the National University of Rwanda (UNR) trains, on average, 30 doctors annually, and nursing schools train about 220 nurses per year.

Until the staffing norms can be met, the following alternative strategies will be enforced:
- Raise community awareness (including traditional birth attendants, community health workers, women's organizations and associations) in initiatives for the local (community) management of some RH services;
- Advocate private practitioners and NGOs to integrate services related to the various RH components in their activities;
- Establish incentive mechanisms to motivate health personnel to stay at their posts;
- Progressively introduce a contracting approach in health facilities in order to improve providers' performance levels;
- Elaborate and disseminate ministerial instructions guiding authorized procedures for each personnel category and those that can be delegated to a lower level, including community actors like community health workers, traditional birth attendants, etc.

5.2 Financial resources

In RH, financial resources come primarily from external sources (cooperative agencies, United Nations agencies, NGOs). The government's contribution essentially covers salaries, purchases of materials, and supplying and maintaining locales and equipment. However, the funds available are insufficient, resulting in a need for financial contribution from the patients, difficulties in the health facilities, movements from the public sector towards the private by certain practitioners, and a decrease in preventive medical services.

In order to remedy these negative consequences, the government will do the following:
- Plan for a budget line devoted to RH in the health budget, in order to guarantee the sustainability of results obtained in this area;
- Strengthen, through advocacy, the mobilization of financial resources on behalf of RH and for support to community health insurances (*mutuelles*) by international cooperation organizations.

5.3 Materials and infrastructures

Rwanda's health map shows uneven distribution of health infrastructures; urban centers are privileged to the detriment of the rural zones. Moreover, certain infrastructures do not function at full capacity or provide only insufficient quality of care, due to lack of or insufficient materials and/or qualified personnel, as indicated earlier.

Some health facilities do not have consultation rooms, delivery rooms, toilets or running water. The majority of them have no telephone or radio. Hospital ambulances are not always functional. Basic equipment, materials and products are often lacking: sphygmomanometers, thermometers, speculums, obstetrical suction cups, contraceptives, etc.

As a result, there is a national low level of utilization of these services. In order to remedy this situation, the government will, in addition to supporting interventions to improve staffing, will:

- Manage and maintain in working order the available medical equipment (including ambulances and radio systems);
- Mobilize financial resources to ensure equipment and materials needed for RH services;
- Promote the recommended strategies in poorly served areas;
- Revitalize community-based distribution of contraceptives and condoms, and social marketing strategies;
- Support community initiatives such community associations to acquire and manage materials for improved transport and transfer of patients presenting obstetrical emergencies.

6. Monitoring and evaluation

Implementation of the national RH policy should include efficient monitoring and evaluation systems with mechanisms for regular feedback, at central as well as decentralized levels, in order to ensure that the objectives are met, and to ensure transparency and efficiency in the management of resources allocated to RH.

At the central level, the following actions will be undertaken by the Ministry of Health:

- Establish within the Directorate of Planning a technical structure (an inter-sectoral committee) in charge of ensuring the monitoring and evaluation of implementation of the National RH Policy. This structure will be given the means to function, including financial means (which could be obtained from the various RH projects), and it will be institutionalized by guidelines from MINISANTE that will describe its terms of reference;
- Elaborate a national three-year RH plan that will include district-level and provincial plans, and provide quarterly feedback to the provinces and partners on the data collected through the HIS;

- Organize quarterly meetings of the RH/HIV/AIDS technical group (task force UNDAF) for the coordination of RH interventions;
- Organize an annual coordination and review meeting for RH interventions and, every other year, an evaluation of the implementation of the national RH policy. The results will serve for updating the three-year plan;
- Elaborate and disseminate at all levels supervision tools for RH activities. Supervision should be conducted quarterly at the central level and monthly at the decentralized level;
- Elaborate a monitoring and evaluation plan for the implementation of the national RH policy.

At the decentralized level (provinces and administrative districts), the following actions will be taken:

- Set up a coordination and monitoring/evaluation structure for the implementation of the national RH policy. This structure will be composed of RH actors, including representatives of community providers of RH (including traditional birth attendants and community health workers);
- Ensure quarterly feedback on accomplishments in RH (including RH actors);
- Ensure monthly supervision of RH interventions at the peripheral level.

In ensuring efficiency, this system will be institutionalized through the development and establishment of an internal and self-regulating monitoring and evaluation mechanism.

Conclusion

The Rwandan government identified its RH priorities at the Gisenyi Round Table on reproductive health, held in September 2000, and many efforts have since been made to familiarize the various actors with the priority components of RH for Rwanda in order to better orient interventions and achieve the rational use of resources.

It goes without saying that the choice of the priority components does not diminish the importance of other RH components defined by the Cairo ICPD in 1994, particularly early diagnosis of feminine cancers, post-abortion care and treatment of sterility. Priority selection is foremost an approach that enables us to concentrate efforts and resources, which are always limited, on a certain number of areas to maximize the efficiency and the efficacy of interventions.

In the area of safe motherhood and child health, which is considered as one of the traditional RH components, many activities are being implemented at the level of the health centers; however, considerable efforts must be made, especially considering the maternal mortality rate, which is still one of the highest in sub-Saharan Africa.

Regarding family planning, another traditional component, it is indispensable to revitalize the program in order to increase access to quality services for birth spacing or limitation, according to needs, and to guarantee reproductive rights.

Concerning genital infections (STIs/HIV/AIDS), efforts have been made and are still being made, especially concerning HIV/AIDS. Since the Head of State made HIV/AIDS control a national priority, national authorities have been multiplying their efforts, but the country still has a long way to go.

The new components—adolescent reproductive health, prevention and management of sexual violence and social changes to increase women's decision-making power—will be integrated in the MINPAC and in the complementary activities package of all the health facilities, including private facilities. During a national day held in April 2002, awareness was raised on the magnitude of sexual violence in Rwanda; there is hope that the necessary mechanisms will be established soon at various levels to ward off this plague.

Lastly, when the internal mechanisms will be put in place and coordination responsibilities have been clearly defined, the implementation of this policy should, without failing, yield results. There is, therefore, hope that implementation of this national RH policy will greatly contribute to improving the quality of life of all Rwandans—women, men and children.

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Appendices

Appendix 1: Indicators and measuring tools according to RH priority components

RH components	Indicators and measuring tools
Safe motherhood and child health (SM/CH)	- maternal mortality rate - level of management of deliveries by skilled staff - % of health facilities complying with standards to address specific pathologies in SM/CH - % of health facilities providing specific SM/CH consultations (e.g.: ANC) - % of correctly addressed obstetrical emergencies - number of women attending the four recommended ANC visits - % of exclusive breastfeeding for three months - rate of immunization coverage of children - rate of consultation coverage of children - rate of infant/child mortality under 1 and under 5
Family planning	- CFI - birth rate - % of births with more than 2-year intervals (spacing) - knowledge of contraceptive methods - utilization rate of modern FP methods - % of women in couples with unmet contraceptive needs - % of health facilities providing modern FP methods - range of methods provided (in health facilities and at CAMERWA) - number of staff members trained in FP in health facilities - number of FP awareness-raising sessions in the schools - number of FP awareness-raising sessions in the communities
Prevention and treatment of genital infections (STIs/HIV/AIDS)	- HIV sero-prevalence (adults, children, youths) in urban and rural areas; among carriers of STIs - prevalence of the various STIs - utilization rate of condoms - proportion of adults and youths who received quality information on STIs/HIV/AIDS - average survival time of children born from HIV-positive mothers - availability of drugs to treat opportunistic infections (AIDS) - % of persons voluntarily tested for HIV - number of anti-AIDS clubs - % of health facilities performing HIV testing - occupation rate of beds by AIDS patients in the hospitals and health centers
Adolescent reproductive health	- % of 15-19 year old adolescents pregnant or mothers - HIV sero-prevalence among 12-14 year olds (and/or 15-18 ; 15-19 ; 20-25) - average age at first sexual relations, at first marriage, at first birth - illiteracy rate among women and men - % of adolescents who adopt positive RH behaviors - % of health facilities providing HIV/AIDS voluntary testing and counseling adapted to adolescents - % of health facilities providing clinical RH services adapted to adolescents
Prevention and management of sexual violence	- number of cases of sexual violence - number of providers trained to help victims - number of cases handled by health facilities
Social changes to increase women's decision-making power	- % of pupils of both sexes completing primary school - illiteracy rate among women and men - academic and school drop-out rates among boys and girls - utilization rate of RH services where women make their own decisions - CFI - annual income per inhabitant
All components	- maternal and infant/child mortality rate - number of trainings and refresher trainings - number of supervisions - production and dissemination of standards and protocols - number of trained persons/inhabitants - number of program management tools produced and disseminated by type

Appendix 2: Fundamental principles of reproductive health recommended by WHO/AFRO

WHO/AFRO recommends that Member Countries refer to the following fundamental principles when elaborating their reproductive health policies.

- Strategy implemented by the country itself
- Gender-specific programs
- Efficient partnerships among all actors, including those from the private and informal sectors
- Respect of ethics and cultural sensitivity
- Access to all RH services at all stages of life, and particularly for adolescents
- Equity and equitable distribution of resources, particularly in rural areas (90% of the Rwandan population is rural)
- Participation of the population in the management of health care facilities (management committees of health facilities, health solidarity funds)
- Addressing of the needy and the poor through solidarity mechanisms
- Integrated services (see 2.2) for rationale resource utilization: providing preventive, promotional and curative activities in the same place, with the same team. Integrate the new RH components. Promote evidence-based medicine, i.e. scientifically recognized and proven by international medical bodies (e.g. WHO, academies, Cochrane principles)
- Decentralization, which brings services closer to the population, strengthens the basic levels, and allows RH care to be offered at the most operational level, within the community, with the central and intermediary levels serving as support
- Poverty reduction: the priority RH components fit in the national poverty reduction program. Women are priority targets to increase their decision-making power, particularly in RH matters.
- Participation of men and women: men's participation is currently insufficient. At the various levels, adequate gender relations should be established to improve responsible parenthood and RH decisions. Men should learn how to improve their role in the prevention of maternal morbidity and mortality, FP utilization, STI control, including HIV/AIDS, prevention of sexual and conjugal violence, and behavior change to support women's decision-making power.