ASSESSMENT OF RWANDA'S NATIONAL FAMILY PLANNING POLICY AND ITS FIVE –YEAR STRATEGIES (2005 – 2010)

June 2011

"…a modern, strong and united nation, proud of its fundamental values, politically stable, and without discrimination amongst its citizens."
--Rwanda Vision 2020

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MCHIP Maternal and Child Health Integrated Program

THE respond PROJECT

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ABBREVIATIONS

ANC:	Antenatal care
ARBEF:	Association Rwandaise Pour le Bien-Etre Familial
BCC:	Behavior change communications
CAMERWA:	Center for Procurement of Essential Medicines in Rwanda (*Centrale d'Achaat des Medicaments Essentiels de Rwanda)*
CBD:	Community-based distribution
CBP:	Community-based provision
CHW:	Community health worker
CPR:	Contraceptive prevalence rate
DHS:	Demographic and Health Survey
EDPRS:	Economic Development and Poverty Reduction Strategy
FBO:	Faith-based organization
FP:	Family planning
GOR:	Government of Rwanda
HMIS:	Health management information system
IEC:	Information, education and communication
IMCI:	Integrated management of child illness
KfW:	Kreditanstalt für Wiederaufbau**,** a German government owned development bank
LA/PMs:	Long-acting and permanent methods
LOE:	Level of effort
MC:	Male circumcision
MCHIP:	Maternal and Child Health Integrated Program
MDGs:	Millennium Development Goals
MOH:	Ministry of Health *(MINISANTE)*
MOU:	Memorandum of Understanding
NFPTWG:	National Family Planning Technical Working Group
NGO:	Non-governmental organization
PAQ:	Partnership for Quality Improvement
PBF:	Performance-based Financing
PMTCT:	Preventing Mother to Child Transmission
PRSP:	Poverty Reduction Strategy Paper
PSI:	Population Services International
RALGA:	Rwandan Association of Local Government Authorities
RF:	Results Framework
SDM:	Standard Days Method
SPA:	Service Provision Assessment
TA:	Technical assistance
TFR:	Total Fertility Rate
WRA:	White Ribbon Alliance

EXECUTIVE SUMMARY

The purpose of this Assessment Report is to document the status of implementation and impact of Rwanda's existing National Family Planning Policy and its Five-Year Strategies (2006-2010), identify current needs, challenges and opportunities and inform the development of an updated policy/strategy for 2011-2015. The Assessment is "Phase 1" of a new family planning (FP) policy development process and reflects Rwanda's rapid progress in providing a broad range of quality, voluntary (FP) services to women and men who wish to choose their family size. This Assessment Report is based on a series of preparatory meetings, interviews, field trips and document reviews conducted by Rwandan experts, with technical assistance financed by USAID through EngenderHealth. The team of Rwandan public health experts was supported through the USAID MCHIP project.

Rwanda's strong political and policy support for FP is essential to keeping up the country's aims to achieve a contraceptive prevalence rate (CPR) of 70% by 2012 and 90% by 2017 (Government Programme 2010-2017), with a reduction in total fertility rate (TFR) from 5.5 to 4.5 children (2020 Vision). The Demographic and Health Survey (DHS) that is underway will provide updated data that will enable the GOR to revise or confirm its goals based on the latest evidence. CPR increased from 10% of currently married women using a modern FP method in 2005 to 27% in 2007/8,[1] but fertility remains high, and there are high rates of discontinuation among users.

Findings and recommendations. The Assessment Report recognizes that the Government of Rwanda has done a commendable job to increase the availability and quality of services through facilities and communities; strengthen decentralized management of services; and provide considerable budgetary resources to contraceptives. The report tracks the seven "axes" of the current FP Policy within a broader "supply-demand-enabling environment" framework. On the supply side, the report looks at both quality and access dimensions. Use of innovative financing schemes, such as performance-based financing (PBF) and use of *mutuelles,* helps to motivate and equip service sites, but training (especially for side effects) must continue. Use of secondary health posts, faith-based organizations (FBOs), non-governmental organizations (NGOs) and the private sector is growing, and can be expanded. This is important, given the personnel shortages and the need for updated training and continuing education for all levels of workers. There is an expanding community component, but stronger links with clinics and efforts are required to ensure that community health workers (CHWs) are not overburdened and to ensure quality. Policies have encouraged the expansion of long-acting and permanent methods (LA/PMs) of FP, but these methods are still limited in availability despite high demand for implants. The Assessment Team concluded that current mass media efforts help to address myths and misconceptions about FP and that they should continue and be better targeted. There is also scope to improve interpersonal communication and counseling, and to develop special programs for men and youth. In the area of advocacy ("enabling environment"), the Assessment highlights the need for increased collaboration and coordination with FBOs and the private sector, and the continued support of community-based services through innovative worker configurations (*agents sanitaires, binomes,* etc.).

[1] Rwanda Interim Demographic and Health Survey, 2007/2008, p. 35. Use of all methods among currently married women increased from 17% in the 2005 DHS to 36%. Current health management information system (HMIS) data indicate that CPR may be as high as 50%, an astounding rate of increase to be confirmed by the DHS that is currently underway.

The way forward. The Assessment Report constitutes Phase 1 of a new FP policy/strategy development process. Phase 2 (described in section VI of this report), lays out the steps needed to plan and draft a new document, including agreement on an outline and a new "results framework" (RF) to guide the focus of a new policy. We suggest that a "coordinator" be appointed to manage the process, and serve as a focal point for the various government, non-governmental, donor, and other actors who will be involved, organize meetings, and (if necessary), connect the various working groups with further technical assistance support which also must be identified. Phase 3 will be to launch and disseminate the document by an agreed-to date (to be determined by the Ministry of Health).

I. INTRODUCTION AND BACKGROUND

Rwanda's Family Planning Policy and vision for the future. As Rwanda's National Family Planning Policy 2006-2010 completes its latest phase, the country has much to be proud of. The FP Policy is based on the country's Vision 2020, "…a modern, strong and united nation, proud of its fundamental values, politically stable and without discrimination amongst its citizens."[2] The Vision strives for social and economic cohesion, and has six "pillars:"

- Reconstruction of the nation and good governance
- Transformation of agriculture into a productive, market-oriented sector
- Development of an efficient private sector
- Comprehensive human resource development (education, health and ICT skills)
- Infrastructure development (transport, energy, water and ICT)
- Promotion of regional economic integration and cooperation

The FP Policy is one of several health sector policies and strategies designed to help Rwanda achieve its long-term vision. It aims to enable Rwandans to give birth to the number of children their households can support, thereby contributing to the country's productivity in a sustainable fashion, and has seven elements or "axes:"

1. Advocacy
2. Mainstream FP in all health services
3. Partnerships
4. Community mobilization
5. Quality and formative supervision in public and private sectors
6. Sustainable financing
7. Evidence-based decision making

At the March 2010 Kigali Repositioning Family Planning meeting, priority challenges were identified: as a basis for developing an action plan:

1. Improve geographic accessibility to family planning services
2. Increase accessibility to family planning for adolescents
3. Increase community mobilization; address myths and misconceptions

Progress to date and remaining challenges. Rwanda has made impressive progress in its efforts to provide a full range of FP services to its people. CPR increased rapidly from 10% of currently married women using a modern FP method in 2005, to 27% in 2007/8.[3] Further increases are expected to be reported in the DHS, which is currently completing a preliminary report of findings. Innovations are many. To meet the high demand for injectables, the Government of Rwanda (GOR) plans to expand community-based provision of this method from three to thirteen districts. Its integration of FP into prevention of mother to child transmission (PMTCT) of HIV/AIDS, antenatal care (ANC), and other health services has created greater access to services through a "one stop shop" approach. Uses of

[2] Rwanda Vision 2020, p. 3.

[3] Rwanda Interim Demographic and Health Survey, 2007/2008, p. 35. Use of all methods among currently married women increased from 17% in the 2005 DHS to 36%. Note the high use of traditional methods.

long-acting methods, such as implants, are increasingly popular.[4] Still, many challenges remain. Fertility remains high at 5.5 children per woman, and many women (especially those in rural areas) still lack access to FP methods, despite a desire to space or limit births.[5] An estimated 38% of Rwandan women of reproductive age would like to space or limit births but are not using any method of FP (this is referred to as "unmet need"). Although the trend for long-acting and permanent methods (LA/PMs) is upward, most women who want to *limit* births do not use a permanent method of FP. Instead, they use short-acting (or even traditional) methods to limit family size, which are less effective than sterilization. Infant and maternal mortality rates have declined, but are adversely affected by high fertility and frequent, closely spaced births. More effectively timed and spaced births can contribute significantly to lowering maternal and infant mortality and morbidity. Access to FP has increased, but quality, myths and misinformation are still problematic.

High fertility and the growing population threaten to limit Rwanda's economic growth and its efforts to reduce poverty and achieve its social and economic goals. Approximately 53% of the population is below 20 years of age[6] creating further pressure on the country's ability to provide education, jobs, healthcare and social services for its citizens.

A supportive policy environment. In Rwanda, strong policy support begins at the very top—at the Presidential level. The current FP Policy is an integral part of Rwanda's development agenda and its goals for economic growth and social progress and stability. The policy framework includes the Vision 2020; the National Decentralization Policy, which describes the administrative arrangements for service delivery; the Economic Development and Poverty Reduction Strategy (EDPRS), which recognizes the limits high fertility places on development; the National Population Policy for Sustainable Development 2003; the National Reproductive Health Policy 2003, whose six elements include FP; the National Health Policy, which describes a minimum and comprehensive package of services, including FP, to be provided at various levels of the health care system.[7] Interestingly, although the first PRSP (2002-2005) did not mention family planning, the next iteration (EDPRS 2008-2012) addresses FP as helping to reduce the sources of poverty and conflict. The EDPRS has a CPR goal of *70%* by the year 2012,[8], and the Government Programme 2010-2017 aims to increase this to 90% by 2017. Innovative financing, including basket funding, and performance based financing, and contracts, and donor leveraging provides resources for the country's ambitious FP goals.

The need for greater accessibility and quality of health services. Recently, the Government's Health Systems Strengthening Framework and Consolidated Strategic Plans (2009 – 2012), and the Health Sector Strategy Program II addressed the issues of geographic accessibility, quality and specialized services for the health sector. All of these affect the delivery of accessible, affordable, high quality FP services, and are reflected in the current FP Policy. HSSP II and the Health Systems Strengthening Framework focus directly on improved accessibility and quality of FP/RH services, especially *long-term contraceptives*. Interventions to increase access to quality FP services at the clinic and community levels include construction of secondary health posts, organizing MCH weeks nation wide twice a year to provide a range of services, including FP methods (with the exception of permanent

[4] The Interim DHS reflected an increase in use of all methods, but most striking for implants, based on couple years of protection (Family Planning in Rwanda, IntraHealth International, June 2008, p. 7).

[5] For all age groups, fertility is higher in rural areas (5.7) than in urban areas (4.7), Interim DHS 2007/2008, p. 24.

[6] National Institute of Statistics of Rwanda, National Population Projections 2007-2022, July 2009.

[7] Developed further in the National Family Planning Policy and Its Five-Year Strategies (2006 – 2010), Ministry of Health, Republic of Rwanda.

[8] Family Planning in Rwanda, IntraHealth, p. 13.

methods), community-based provision of injectables (and other methods), and introduction of performance-based financing (PBF) as an approach to both improve service quality and to motivate providers, including CHWs.[9] Decentralization aims to more directly benefit local households, but coordination must be improved, especially with faith-based organizations and the private sector. Finally, the growing demand for short-term contraceptives (and LA/PMs) requires increased supplies and strengthened logistics systems. The GOR has introduced a line item for contraceptives in its budget, and donor financing (mainly USAID and UNFPA) for contraceptives has increased[10], but requirements continue to grow.

Towards a new FP policy. To ensure that Rwanda's health goals are met, the Government decided to assess the status of the FP Policy and its Five-Year Strategies (2005 – 2010) and review the progress of its elements, or axes. Where necessary, this Assessment Report suggests areas for improvement that will inform an updated policy/strategy and ensure that it is line with other GOR goals and objectives. This new effort will help meet the current (and increasing) demand for and use of voluntary FP services.

[9] Cf. the Framework, pp. 75, 79, 82. FP is part of an integrated Programme Objective 1 (to improve the accessibility to, quality of and demand for FP/MCH/RH/Nutrition services).

[10] USAID's contraceptive budget increased from $500,000 in 2006 to $2.7m in 2008. Implants alone (Jadelle) took up 50% of the total contraceptive budget of $5.7m in 2008 (Family Planning in Rwanda, p. 16).

II. PURPOSE OF THE ASSESSMENT AND KEY QUESTIONS

The purpose of the Assessment was to determine the status of implementation and impact of the existing National Family Planning Policy and its Five-Year Strategies (2006 - 2010), and identify current needs, challenges and opportunities to inform the development of an updated policy/strategy for 2011- 2015.

This Assessment presents an analysis of the current situation regarding the FP Policy and Strategy, and responds to a number of questions, including:

1. To what extent are stakeholders and implementers at the district level aware of the existing strategy?
2. What within the strategy has been done or not done (results and challenges)?
3. What has been learned about what works (or not), and what could be scaled up?
4. What are current needs?
5. What are the existing challenges and opportunities?
6. What existing and potential partners could be involved in future efforts?

III. ASSESSMENT METHODOLOGY AND TEAM COMPOSITION

Engagement of a consultant team. Three local FP/MCH experts were engaged by the Ministry of Health to conduct the assessment. The three consultants included Mr. Charles Louis Bigabiro, ITS, MPH; Mr. Marc Ndayambaje, MPH; and Dr. Gerard Twahirwa, MD/MPH. Consultant costs were supported by USAID through the JHPIEGO MCHIP Project. The USAID-funded RESPOND Project, led by EngenderHealth, provided periodic short-term technical assistance, both prior to the Assessment and for preparation of this report.[11] (See section on *additional inputs* below).

Document and data (desk) review. This included review of the current FP Policy and Strategy (2006-2010), Vision 2020, various health/FP/SRH/MCH policies, regulations and laws; policies related to youth and to gender, related plans and strategies; recent studies and other reports. Please see Attachment B for a complete list of Government of Rwanda and other documents related to health and family planning that informed this report.

Key informant interviews. The Team met with central level officials in Kigali and conducted extensive interviews with personnel from various ministries. They then traveled to ten districts selected by the MOH. The Team met with an array of stakeholders, including local authorities, program managers, service providers, community leaders, partners, and clients. In the ten districts, the Team reviewed areas in which community-based distributors (CBDs) are piloting injectables, pills, standard days method (SDM) and condoms (three districts); and interviewed representatives of seven provinces, as well as service providers from selected health centers, and users and non-users of FP. The process included structured interviews with key informants, focus group discussions, and other meetings. A list of people interviewed is included as Attachment A, and stakeholder/informant/field visit instruments are available upon request.

Senior level briefings. Dr. Fidele Ngabo, head of the MCH Department in the MOH, was periodically briefed on the progress of the Assessment. Mr. Thomas Nsengiyumva, head of the MOH's Family Planning Unit, worked with EngenderHealth staff to develop the draft results framework. The National FP Technical Working Group (NFPTWG) was informed about plans for the assessment. USAID/Rwanda, UNFPA/Rwanda , FHI and MCHIP gave input and advice to the assessment team regarding data collection and at various points throughout the process. The team shared the results of this report with the NFPTWG on April 13, 2011 and debriefed at USAID on April 14, 2011.

Additional inputs to the assessment process. The process included visits by RESPOND Project/EngenderHealth staff who helped the Assessment Team to reflect on WHO's "six building blocks"[12] for health systems strengthening, as well as priorities identified in the March 2010 Kigali Repositioning Family Planning meeting:

- Improve geographic accessibility to family planning services
- Increase accessibility to family planning for adolescents

[11] EngenderHealth Trip Reports by Ms. Jan Kumar (Sept. 10, 2010 and Oct. 22, 2010) provide background on the preparation carried out prior to this Assessment.

[12] The "Six Building Blocks of a Health System" (WHO, 2007) include service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance.

- Increase community mobilization; address myths and misconceptions

RESPOND/EngenderHealth also helped develop a Scope of Work for this Assessment, and a draft "results framework" (Attachment C) which is discussed below.

While the assessment process was proceeding, a new DHS was processing household level data on FP, HIV/AIDS and other health areas. This Survey should report new data within the next few months and findings will be critical to informing a new policy.

How the report is organized. This Assessment report is organized around the different components of the FP program that are critical for access, quality and use of these services. The Team addressed the current FP Policy's seven axies (advocacy, integration, partnership, community mobilization, quality and formative supervision, sustainable financing, and evidence-based decision making) within a broader "supply, demand, enabling environment" framework.

Drafting a new vision for FP. In order to prepare for a new FP Policy, the Team (assisted by Mr. Thomas Nsengiyumva, in charge of FP for the MOH, and NFPTWG coordinator) used both the draft results framework and the FP Policy axes to organize its findings. This framework (developed in October 2010, and reviewed by the NFPTWG) is one example of how a future policy and strategy can be organized in order to have a more comprehensive approach to supporting integrated, comprehensive FP services which are accessible and sustainable, and fully meet the population's needs. The proposed results framework has a goal of 75% CPR (modern methods) among women of reproductive age by 2015. This will result in achievement of couples' fertility goals, improved sexual and reproductive health, and reduced maternal and child mortality. These results will, in turn, support achievement of the government's health and development goals. See Attachment C.

IV. FINDINGS AND RECOMMENDATIONS

A. Service capacity and performance (supply-related) issues

A functional FP program ensures that quality, accessible and affordable FP services are offered in the public and private sectors, through a variety of modalities (facilities, community distributors, pharmacies, drug shops, etc.). It ensures that a full range of quality services is offered by trained and supported health workers, that there are functioning systems which ensure commodities, supplies and equipment needed to provide methods; and that effective quality improvement mechanisms and a program monitoring and data collection system are in place. FP may be integrated into HIV/AIDS and other health services, such as antenatal care (ANC), postpartum services, immunization, male circumcision (MC), integrated management of child illness (IMCI) to ensure a full package of services.

The National FP Policy addressed supply issues in several Axes. *Axis 2* sought to "reinforce FP integration and increase access to [a] full range of methods." Its planned activities included upgrading of standards and guidelines for service provision; refresher training and contraceptive updates for staff, including minilap training; provision of infrastructure and equipment; and expansion of integrated services.

Axis 3, "strengthen partnerships for increased coverage," considered the fact that 40% of Rwanda's primary and secondary health facilities (dispensaries, health posts, health centers) were operated by non-governmental facilities, most of which are owned by faith-based organizations and religious missions. It was expected that many of these clinics, as well as for-profit private sector clinics, would agree to provide some level of FP services, whether through secondary posts, referrals or other means.

Axis 5 "quality and formative supervision in the public and private sectors" addressed the need for written guidelines and protocols, quality improvement tools (e.g., *partenariat pour l'amelioration de qualité* or PAQ, is an example of a quality improvement tool);[13] adequate human resources to staff facilities (including pre-service preparation and production of workers), and supervision of the private sector, NGOs and FBO facilities. In addition, the use of "newer technologies" and methods such as LA/PMs, including minilaparotomy, were stressed as improving access to services.[14]

The March 2010 *Kigali Repositioning meeting* called for increased geographic accessibility to FP for Rwandans.

Findings

1. **Facilities equipped, organized and staffed to provide services:** Interviews of service providers and visits to health centers reflected needs in the areas of *space*. While space is allocated in all facilities (including Catholic facilities), it is often crowded. There are shortages of *equipment* (which is used for multiple services, and shared). This includes surgical equipment (for implant insertion,

[13] PAQ seeks to involve communities in health center decision-making and management, thereby improving access to high quality FP services. It was used extensively by the Twubakane Decentralization and Health project in Rwanda (cf Assessment of the PAQ Approach, IntraHealth, June 2009). "Client-Oriented Provider Efficient" approaches (utilized by EngenderHealth, JHPIEGO and others, fosters greater links between clients and providers to improve quality of services.

[14] National FP Policy, p. 39.

infection prevention, scales, and blood pressure machines).[15] Often, equipment from the general operating theater must be used to sterilize equipment used for routine IUD insertions. Rwanda is currently upgrading "A2" nurses to A1 levels, and as a result, training of A2s have stopped, leaving *fewer personnel trained in FP* who can provide services at health facilities. It was proposed by some informants to have one person designated as a full-time FP service provider[16]. In some cases, *FP is only offered on specific days*, despite the official policy to integrate FP with other services and have it available all the time. The Assessment Team determined from providers and users that there were still issues of inadequate *counseling and treatment of side effects*, which may contribute to Rwanda's high discontinuation rates. Roman Catholic sites (which focus only on "natural" FP methods), usually lack staff equipped to deal with clients who experience side-effects from modern methods [17]. Although providers reported that they screen and counsel clients, users and non-users of FP reported that "clients are *not properly screened*". As a result, clients are often not prepared for common method side effects. The Team believes that counseling may be sacrificed at the expense of serving as many clients as possible. *Standards and guidelines for service provision* were not seen by the Team, but we understand that these were developed within the last five years and are available. However, they may still contain medical barriers. The 2010 study, "Expanding Contraceptive Use in Rwanda,"[18] pointed out that out-of-date requirements—like requiring women to be menstruating when seeking FP (thereby ruling out pregnancy)--could be corrected by introducing the use of a pregnancy checklist, and that there were other barriers to access.

2. **Motivation for workers:** Specialized training was cited as helping to motivate staff. This included FP clinical training in implant and IUD insertion, surgical training for female and male sterilization, and training for CHWs. PBF and *mutuelle* reimburse costs to the facility for the supplies and equipment needed to provide certain FP methods. These reimbursements help to motivate staff, even though they are not paid to them directly.[19] The new FP strategy should ensure that good provider performance is encouraged and supported to provide clients with accurate information and a full range of *voluntary* FP services.

3. **Management information and supervision**: Public health facilities provide data, but *reporting* from referral hospitals and from FBO sites needs improvement. Catholic sites usually offer only natural methods (for example, the standard days) which they report on. However, secondary health posts cannot report through the same facility unless the supervisor from the district collects the data. Private sector sites report data to the district hospital , but only if there is an MOU with the Ministry of Health. Otherwise, their performance is not recorded. FBO organizations felt that coordination from the government side needed improvement, and that they were generally left to their own devices regarding services and service quality. In general, the Team observed that supervision from districts is done sporadically. There is a *lack of standardized tools*, guidelines and checklists.

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[15] The 2007 Service Provision Assessment found infection prevention items and equipment were in short supply, as was equipment for conducting pelvic examinations.

[16] Under a new policy effective February 2011, every MOH health facility is to have an assigned nurse in charge of FP. The status of implementing this policy is not known to the assessment team

[17] Because the sites supported by the Church do not provide contraceptives, the government created secondary health posts in close proximity to Catholic-run hospitals to fill this gap.

[18] USAID, FHI, Rwanda Ministry of Health, October 2010, p. 4.

[19] Family Planning in Rwanda (pp. 20 – 21) also considers the use of PBF to better motivate performance, and the pitfalls contained therein. It was confirmed to the Team that under current PBF policy, providers are not reimbursed directly for performance.

4. **Method mix and integration:** The good news is that there are currently *no shortages* of short-term methods. At this point, the pipeline seems full, despite growing demand. Central level informants also reported that procurement delays and delays in inspections can impede contraceptive logistics. Progress toward the current FP Policy's aim to make LA/PMs widely available will have to be determined by results from the ongoing DHS, but there is a growing demand for implants, and few surgeons are trained in minilaparotomy or vasectomy. The Team observed that clients were resupplied with oral contraceptives every three months. Clients brought up the need for better advice and counseling for side effects, and wished that there was a "reversible" FP method for men (!). Regarding *integration,* Rwanda offers a "minimum" package of services which incorporates FP into PMTCT, ANC, well-baby, immunization and other services. Again, while this is official policy, there are ways to make this more efficient and ensure that there are "no missed opportunities."

5. **Quality improvement and quality assurance systems:** The Team did not observe the presence of national FP service standards and guidelines in facilities, but these do exist and were supported by the FP Policy (axis 2). Dissemination and orientation may be limited, and some medical barriers may still exist. Another problem is the lack of standardized tools for supervision or criteria for quality, and the lack of a regular schedule for supervision. It is also unclear whether Partnership for Quality Improvement (PAQ), as piloted under the Twubakane Decentralization and Health project, has been rolled out nationally.

6. **Referral systems:** Referrals do take place (for example, for permanent methods at higher level facilities), but there is not much in the way of follow- up by the provider who gives the referral to the client.

7. **Community-based provision (CBP) of services:** A way to increase access to FP services is to move services out of the clinic and into the community. Community Health Workers (CHWs) deliver FP services, and injectables, pills, SDM, and condoms are being piloted in three districts. The plan (per the current FP Policy) is to extend these services to 13 districts by the end of 2011.

8. **Private sector FP services:** The Team determined that a limited number of private sector facilities and pharmacies have signed MOUs with the MOH. Despite the fact that the private sector is a potentially large source of FP services (there are 159 pharmacies and many private clinics), the number of MOUs signed is limited mostly to pharmacies. At this point, only five clinics have MOUs with the Government. PSI's *Confiance* social marketing program includes condoms, oral contraceptives, cycle beads and injectables. It receives funding from KfW, as well as USAID and the Global Fund. In 2010, PSI's social marketing contributed approximately 1% of the market share for injectables and around 3% for oral contraceptives (combined pills) – the latter representing a decline in recent years due to limited availability of contraceptive products in the private sector. In addition to product distribution, PSI also contributes significantly to behavior change communications (BCC) activities and training of private sector providers (e.g., pharmacists and nurses).

Recommendations

1. **Continue to strengthen services and focus on quality:**
   - *Improve training on counseling and side effects, and ensure that standards and guidelines for service provision are up-to-date.* Nurses, midwives, doctors and CHWs in both the public and private sectors need to regularly receive refresher training and proper training on counseling, to include permanent methods, and explanation of side effects for all methods. Current standards and guidelines

should be reviewed, updated and disseminated to service sites, and providers need to be oriented.

- *Regular supervision and reporting must be organized and tools developed.* There is no regular supervisory schedule or system, and again, private/FBO sites must be supervised as well. Reporting to the national HMIS from non-public sites should be required.
- *Continue to expand the method mix, strengthen integration and ensure voluntarism within the FP program.* Despite the FP Policy's aim to expand LA/PMs, these methods are still limited as far as availability is concerned, and knowledge about them is also low. The new strategy should continue to widen the availability of all methods on a regular basis, and ensure that accurate information is provided, to enhance choice and decision-making by clients.[20] Training of surgeons and doctors (in minilaparotomy and vasectomy), nurses and others in implants and IUD insertion, as well as provision of training materials, equipment/supplies and client information, are all required. There are further opportunities to integrate FP into HIV/AIDS care and treatment programs, male circumcision sites (information and counseling for men who come for MC services), and postpartum services.
- *Continue to ensure that FBOs, including Roman Catholic sites, fully participate in the national FP program.* 40% of health services are non-governmental. Staff at these sites require regular updating and supervision, and the sites should report regularly to the national HMIS. Catholic facilities are officially charged by the Episcopal Conference of Rwanda with providing natural methods. They need to ensure that secondary posts are staffed with a FP provider who works every day and has adequate supplies and equipment, and that these providers give clients information on all FP methods and make referrals for services.[21] Training and supervision of FBO and NGO staff generally will help improve quality, especially treatment of problems and side effects, and bolster referrals.

2. **Continue to expand services:**
   - *Support the supply chain and continue to provide adequate financing for the growing contraceptive "bill."* The new strategy should make contraceptive security a top priority. Adequate financing (basket funding, donors) and technical assistance for supply chain management should continue.
   - *Continue expansion of community-based FP services, and incorporate private sector providers into the national FP program.* Community-based provision of FP methods (pills, condoms, injectables, cycle beads) is critical to program success. In particular, the CHW injectables pilot is scheduled to expand to ten more districts and could be rolled out nationwide. If this is part of Rwanda's new FP policy/strategy, the current pilot should first be assessed to identify lessons learned and problems encountered, assure quality, and be closely linked to the nearest health facility. For example, if an injectable user experiences minor bleeding or spotting as a side effect, she needs proper counseling and reassurance to avoid discontinuation or drop-out. MOUs with private sector providers and pharmacies should continue to be developed, and PSI's work with oral contraceptives (funded by KfW) could be expanded.

[20] Expanding Contraceptive Use in Rwanda (p. 4) suggests that neither providers nor clients have as much information on LA/PMs as they should. Actual availability of these methods should be assessed by the upcoming DHS.

[21] "Instructions de la Conférence Episcopale du Rwanda Portant sur les Conditions et les Modalités de Mise en Oeuvre du Programme de la Planification Familiale Naturelle dans les Formations Sanitaires Catholiques," Kigali, 18 December 2009. This document stresses collaboration with government; responsible parenthood; promotion of natural FP methods; and abstinence/be faithful messages for HIV/AIDS prevention. Personnel in Roman Catholic facilities are also required to provide accurate, complete information on all FP methods ("artificial" methods) during group education or counseling sessions, but that these methods are not available on site. These methods can be obtained at the secondary health post (*poste secondaire).*

B. Knowledge and use of services (demand-related issues)

Demand interventions focus on increasing awareness and acceptability of FP among clients, couples and communities. Information/education/communications (IEC) or behavior change communications (BCC) efforts address common myths and misinformation which may limit demand. They explore the gender, religious and other sociocultural barriers that inhibit access to and use of services, and examine (and address) discontinuation of FP among women who don't want to become pregnant.

Axis 4 of the National FP Policy, "increase community mobilization," addressed demand-side issues. This Axis drew upon a common language (Kinyarwanda) and a well-organized local government structure, to ensure that IEC materials were produced; mass media campaigns were carried out; health outreach workers (*animateurs/animatrices,* now known as *agents de santé communautaires)* received refresher training; and community-based distribution of contraceptives was carried out. Men and youth were considered important target groups, and supervision of community-based workers was key. Also noted was the need to deal with barriers created by religious institutions (some of these issues are addressed under supply side above).

The March 2010 *Kigali Repositioning FP meeting* called for greater accessibility to FP for adolescents, and increased community mobilization to address myths and misconceptions about FP.

Findings

1. **Myths and misconceptions**: According to partners and providers, Rwanda's mass media campaign has reduced—but not eliminated—negative rumors about FP (e.g., the mistaken belief that FP causes cancer or infertility), but there is still more to be done. Users confirmed that media efforts had corrected rumors they had heard. Still, rumors are an issue. "Expanding Contraceptive Use in Rwanda" (p. 4) cited common misconceptions about return to fertility or pregnancy risk that need to be addressed.

2. **FP for youth and male involvement:** The central level (Ministry of Health and Ministry of Youth) informed the Team that youth reproductive health centers have been set up in a number of urban and rural sites, but these are quite limited in number. The Team did not see any special services provided for youth in the health facilities. There were fairly negative comments from community members about FP causing "prostitution" and risky behavior among youth. Regarding the role of men, they were seen as potential partners, and were beginning to accept vasectomy, or support their partner's acceptance of FP. However, there is still no "reversible method" for men, which is an issue.

3. **Community health workers effectively mobilized**: CHWs seem to have universal support, and are key to program success. They are considered to be well educated and good at mobilizing the community. CHWs provide useful information and are respected by the community. Providers saw them as closely aligned with the health center, and effective at linking the clinic with the community through outreach. They bring many clients to the facility and provide follow-up (they are supervised by the community health officer based in the health facility).

Recommendations

1. **Continue mass media BCC and interpersonal communication efforts to combat myths and misconceptions about FP:** Mass media messages should be targeted to defined population groups (men, women, married couples, and youth); address specific misconceptions (e.g., "contraceptives cause cancer"); and be method specific. LA/PMs in particular should be

"unpacked," as sterilization (for example) may have a different target audience than do long-acting methods. Messages about using long-acting methods for delay of first birth, or for younger clients or for HIV positive clients can widen the scope of these methods and increase choice. Providers (clinic and community-based) use interpersonal communications, which requires materials, job aids and training. This enables providers to give full and accurate information to the client about all methods, and deal with any side effects or problems that may arise. Use of leaders, champions, service providers, local officials and "peer families" (*parrainage)* can be useful ways to help inform the community about FP. "Proximity mobilization" (door to door) at the village level provides opportunities for CHWs and opinion leaders to visit families and provide information.

2. **Involve men and youth more actively in FP:** The current Policy made a good start on reaching out to men and youth , but both groups require their own programs and messages. Informants suggested that "single mothers" are important target groups for information and education about FP. Their needs have not yet been addressed, but this could be a new group to focus on. *Men* can be motivated for vasectomy acceptance (community members suggested that a new Policy emphasize "men as users") and provide greater support for their female partners. Regarding *youth*, the Team noted that both in and out of school youth are at risk of unintended pregnancy, including those at technical training colleges and the university. Services for youth should be expanded within the districts. (The Adolescent Reproductive Health Policy provides guidelines for youth services.) The National RH Strategy 2006-10 emphasizes the need for "youth-friendly" services and the need to integrate FP into youth programs, providing the policy basis for further work with youth.[22] Other ministries need to participate in the NFPTWG to roll out more effective youth services in a multi-sectoral fashion.

3. **Ensure that CHWs are properly supported and motivated:** This includes refresher training and updating; remuneration or compensation (through PBF or *mutuelles,* as well as non-monetary rewards)*;* regular supervision; provision of materials they can use in talking with clients; and regular updating. Better, community-based campaigns, with materials that are in Kinyarwanda, and harmonization of messages is needed.

C. The socio-political and resource environment (enabling environment-related issues)

A positive environment for FP can encourage leadership and champions for FP within the health system, within communities, the media, government, etc. It requires supportive policies which ensure equitable access to FP services. Resources must be allocated to make policies operational. There should be evidence-based guidelines and protocols as well as routine monitoring and supervision of policy implementation. Financing of FP services is critical, to ensure availability and equitable access, including use of the private sector and other government sectors.

The National FP Policy addressed the enabling environment in *Axis 1* ("strengthen and focus advocacy"); *Axis 6* ("sustainable financing); and *Axis 7* ("increase use of evidence-based decision making").

Axis 1 considered the problem of "unfocused and inconsistent" national messages, lack of information and uneven coordination, and a lack of a nationwide community outreach system. It aimed to utilize the RAPID model to disseminate the new FP policy and mobilize Parliamentarians, RALGA, Women's Council, Youth Council, and health professional associations; utilize the private

[22] Family Planning Program Review in Selected Countries in Sub-Saharan Africa, USAID, August 2010, p. 66.

sector more effectively for FP; create a dialogue with religious leaders; and ensure that districts included FP in their budgets.

Axis 6 addressed "sustainable financing." FP/RH services in Rwanda are free of cost to clients; however, they too must be financed, and costs have been estimated (for FP alone) at $1.7m/year for the public health system.[23] Insurance schemes (*mutuelles)* donor financing, and private insurance were options for financing, as well as further analysis through a National Health Accounts study and a contraceptive pricing study.

Axis 7 planned a robust survey agenda (including periodic conduct of the DHS and SPA, both of which were carried out in 2007/8 as well as the 2010 and future DHS and SPA surveys), strengthening of the health management information system (HMIS) and CAMERWA commodity forecasting system, as well as use of this data to inform district level action plans.

Findings:

1. **Political commitment and coordination from national and central authorities**: All informants reported to the Team that Rwandan government leaders are very committed to FP as a national health strategy. The Government of Rwanda is committed to implementing the United Nations Millennium Development Goals (MDGs) through the FP Policy and other initiatives by 2015. At the Parliamentary level, there is a Rwandan parliamentarian's network on population and development, and a forum for female parliamentarians for development, sensitizing and advocating for FP. Coordination among government departments is good. However, there is still only one person in charge of FP within the MOH. RALGA[24] is working to mobilize and involve local authorities in outreach activities for the increased use of FP methods.

2. **Adequate, sustainable financing**: The National FP Policy gave considerable attention to financing FP services, breaking costs down into commodities, routine service delivery and essential support costs for advocacy, partnerships, community mobilization and quality improvement/formative supervision. The expectations were that the relative share of public sector expenditures for commodities would *decline* to 50% by 2010, and that by 2015, the private sector would assume more than 60% of commodity costs. It was estimated that if at least 60% of MOH health centers provided a full range of services, the costs would be at least $1.7m/year for basic service delivery in the public sector.[25] Essential support costs were estimated at $3m for a preliminary one-year implementation plan. At this point, informants praised the "common basket" as at least providing a minimum level of funding. For example, partners are putting money into the basket fund and CAMERWA distributes products, resulting in free distribution of FP methods in public facilities as well as private ones which have an MOU with the Government. Basket funding helps CAMERWA, for example, to supply and distribute health products on an equitable basis.[26] Further, PBF and other schemes helped support improved performance and services. PBF provides workers with measurable objectives, and indicators for measuring FP performance at the district, clinic and community levels. The monthly results reported are carefully monitored for data

[23] National FP Policy and Its Five-Year Strategies, 2005-2010. Note that this data is old, and costs have significantly increased overall, including higher demand for FP.
[24] RALGA: Rwanda Association of Local Government Authorities
[25] National FP Policy, p. 52.
[26] CAMERWA : Centrale d'Achat des Médicaments Essentiels au Rwanda

quality and service quality, and payments are used for clinic or other improvements (like bags or umbrellas for CHWs).[27]

3. **Supportive policies in place:** As mentioned elsewhere in this report, Rwanda has a strong and diverse set of health and development policies FP and fertility are woven into goals into all of these documents. Population growth and healthy timing and spacing of births is critical to achieving the country's MDGs. These include (*inter alia*) the National Decentralization Policy, Economic Development and Poverty Reduction Strategy (EDPRS 2008), National Population Policy for Sustainable Development 2003, National Reproductive Health Policy 2003, The Ministry of Health Decentralization Guidelines, National FP Policy and its five years 2006-2010, the Community Development Strategy and others. However, the private sector is not yet fully integrated into the health system nor is it completely aligned with official policies. Another area to consider is that of FP/HIV integration. A formal policy could ensure that FP/RH and HIV services are integrated at a variety of levels, where it is appropriate to do so. (Kenya's FP/HIV Integration Strategy was discussed at the March 2010 Kigali conference on FP repositioning).

4. **Community participation:** The Team was informed by community members that they are encouraged by both the Community Health Policy and CHWs to freely choose the number and spacing of their children. Performance based contracts (*imihigo)* between local and central authorities agree on health objectives to be attained during a specific timeframe. Offering a range of FP services is a major element of healthcare for which facilities are held accountable. In addition, a consumers' law is under discussion in Parliament. Some of the partners and NGOs support community-based distribution of FP methods, and also participate in PBF schemes which help reimburse some of the costs to the CHWs (e.g., transport) of carrying out their work. Peer families (*parrainages)* and "*binomes*" (male and female CHWs) help provide positive role models and services at the community level.

5. **Support by religious leaders:** Central level informants say that discussions are underway with religious networks to engage them more fully in the national FP program. Protestant FBO facilities, for example, are relatively supportive of FP and usually provide a full range of methods (although youth and unmarried persons may encounter obstacles).[28] As discussed in the "supply" section of this report, the Rwanda Episcopal Conference has laid down clear guidelines for Catholic health facilities: natural methods are provided; clients for permanent FP methods are referred to government hospitals; and clients for long-acting or short term methods are referred to "secondary posts." While other FBOs may provide the full range of FP methods, Catholic leaders have committed themselves through an MOU to providing a full range of accurate information on FP, and supporting the Government's overall health policies and goals.

6. **Private sector involvement**: PSI socially markets condoms, pills and injectables through the *Confiance* social marketing program, and for-profit clinics and pharmacies are growing in number.

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[27] Meeting the Family Planning Demand to Achieve Millennium Development Goals: Vision 2015, conference report, March 21-26, 2010, Kigali Rwanda, p. 4. This conference stressed scale up through community-based approaches; resource mobilization and sustainability; political commitment; costing and costing and cost-effectiveness through analysis; client-centered access to contraceptive supplies; human resources for health; integration; focus on youth and women. Rwanda showcased program examples in several of these areas.

[28] See Christians and Muslims Promoting Maternal and Infant Health: A Sermon Guide Based on the Holy Bible and the Holy Qur'an, USAID/ACCESS, RCLS, MOH, 2010. This work quotes biblical and Koranic references to child spacing, antenatal care, male responsibility, nutrition and other health topics that can be used in sermons.

Limited numbers of clinics have signed MOUs with the Government, but about 150 pharmacies have done so. NGOs active in advancing FP/RH include ARBEF (Association Rwandaise pour le Bien-Etre Familial**),** an IPPF-affiliate that supports advocacy to gain support for family planning and offers a range of sexual and reproductive health service; and the White Ribbon Alliance (WRA) Rwanda Chapter, a grassroots organization that nurtures a supportive environment for safe motherhood and women's reproductive health.

Recommendations

1. **Ensure that national commitment is translated to the local level:** Community leaders would like to see more national leaders visit local areas to help mobilize support for FP, including resource mobilization. Civil society informants added that it would be helpful to integrate sexual and reproductive rights in FP strategies.

2. **Sustained (and increased) financing is needed:** Although this Assessment did not review cost information in depth, informants reported that resource mobilization and financing was key. A new FP Policy should include costing information, as well as source of financing (government, donors), with special attention paid to contraceptive commodities and logistics, and equipment (especially for LA/PMs), as well as other supply, demand and enabling environment needs. Increasing demand for FP will require a variety of public, private and individual financing schemes, including extending PBF to the community level.

3. **Ensure that a new FP policy and strategy continues the goals of integration, quality, accessibility and voluntarism:** Rwanda has a comprehensive policy approach to FP which makes it an integrated and important part of all of its economic, social and health goals. This is an example that could be emulated by other countries. Innovative financing schemes (PBF), an expanded community component, and facility strengthening all contribute to a successful program. The new policy and strategy should address quality, information and education, and greater accessibility of services at all levels (and in public, private and NGO/FBO sites), to encourage FP uptake. The country's CPR goals can be achieved within a program where people continue to freely choose the number and spacing of their children.

4. **Community participation, women's empowerment, and participation of men and youth should continue:** Rwanda's efforts to deliver services to a well-informed, engaged community needs to incorporate the reproductive rights of women (including single mothers), men (as users and partners) and youth.

5. **Coordination between and among government, FBOs and the private sector should continue:** District Health Officers are supervised by Local Government authorities (mayors), not the MOH. This creates problems of coordination at the district level because there is no one person in charge of FP; also, the district may have priorities other than FP. There should be a cluster or taskforce focused on FP alone. In addition, the Joint Development Action Forum Officer should include FP in the Forum's activities. Rwanda has many examples of active and full participation in FP by Protestant and Muslim denominations. National policies and strategies should include FBO and private sector providers in training programs, and orient them to national guidelines. Roman Catholic facilities are critically important in Rwanda and considerable progress has already been made to establish secondary health posts which provide modern methods. Secondary health posts need to be properly supervised and supported, and expanded if possible.

The private sector is growing and wants to participate in FP. Coordination with NGOS, including ARBEF and WRA, should be further explored. MOUs with these resources should be developed in order to expand access to FP. Social marketing (e.g., PSI) is also another "engine" which can expand access to FP.

V. LESSONS LEARNED AND BEST PRACTICES

The Rwanda FP program has made remarkable strides in a relatively short period of time. It has many lessons learned as well as "best practices" to share with other countries and programs. The ongoing DHS will illustrate more concretely where progress has been made in areas such as expanding services to rural areas, and improving the method mix. The Assessment Report has highlighted some of its own findings below.

Strong political commitment helps create a positive environment for FP. Political commitment, supported by "performance based contracts" with local leaders at all levels, makes FP an important part of district based programs. Rwanda's political and policy support for FP is exemplary.

Community health workers are critical to expanding and extending FP services. Rwanda has tried a number of innovative approaches to improve health services at the community level. The number of CHWs has expanded rapidly over the past three years, and many are relatively well educated. They perform a variety of health related duties, and are the entry point to the facility. The *binome* (*Agent de Sante Communautaire* or CHW) which has one male and one female in each village, appears to be an effective approach. Motivation for these CHWs is provided by helping them to form cooperatives, with PBF funding. Government pays benefits for CHWs for *mutuelle* (health insurance) coverage. Expansion of the CHW role to distribute injectables, oral contraceptives (pills), SDM, and condoms can be studied as it expands to more districts.

Commodity security exists. Although this should be confirmed by the DHS and other data, the Team found adequate supplies of contraceptives at service sites. Use of basket funding and commitment of Government resources helped to ensure supplies of contraceptives.

Innovative follow- up tools for "missing" clients ("echeancier") can be effective. This is a card and calendar system that keeps track of clients and their schedule for resupply. If the client does not come to the clinic, the CHW goes to the home to follow up and find out why the client is missing.

Door-to-door sensitization increases demand. This is conducted by CHWs, opinion leaders, *binomes*, and neighbors, in order to educate and inform people about FP. It helps people to understand the benefits of FP and to decide voluntarily to plan their families.

VI. THE WAY FORWARD: STEPS FOR DEVELOPING A NEW FIVE-YEAR FP STRATEGY

Phase 1: Gather and synthesize the evidence

This Assessment Report constitutes Phase 1 of a new FP policy and strategy process. As stated in Section III, Phase 1 included a review of existing policies and strategies, data gathering from existing sources and from key informants, desk reviews and analysis of previous DHS and other studies. This report assesses the status of the existing FP policy and proposes recommendations for a new document. The report results will be shared with stakeholders through the NFPTWG and used to inform the new policy/strategy developed in Phase II.

Proposed timeframe: NFPTWG (and any other relevant stakeholders) should review the Assessment Report and provide feedback to EngenderHealth (via USAID/Rwanda). EngenderHealth will finalize the report within four weeks of receiving feedback. This entire process should be completed and a final version of the report returned to Rwanda by May 31, 2011.

Phase 2: Plan and draft the new Policy/Strategy

1. **Agree on a new results framework (RF) and document outline.** Based on the findings of the Assessment Report, the NFPTWG should agree (in consultation with other stakeholders) on a final RF to guide the policy development process. This will constitute the heart of the new policy and strategy, and will include goals, objectives, results, activities and indicators. So far, there are three documents which outline the components of an FP policy or strategy: the current FP Policy and its seven axes; the report from the Kigali FP Repositioning meeting; and Attachment C (drafted in late 2010), which outlines the Government's overall goals and objectives for the FP program, and the results critical to achieving the objectives. In this case, a goal (increased modern method CPR and sustainable service quality) has been laid out, as well as three objectives (or results) necessary to achieve the goal. Ultimately, the actual activities must be *refined and prioritized*. Attachment C includes three objectives or results:

> *Sustainable, convenient, quality FP services provided consistently by both the public and private sectors (or "supply")* (focused on infrastructure, supplies, equipment, staff; accessible, affordable services; administrative, financial and management systems; use of data for decision-making for quality improvement)

> *Widespread community knowledge, acceptability and use of FP services (or "demand")* (focused on increased awareness and knowledge, linking BCC to services, correcting myths and

> *Supportive sociocultural political and resource environment or ("enabling environment")* (focused on supportive FP policies, adequate financial and human resources, updated guidelines and protocols, and evidence-based planning and decisions)

Other frameworks (the current Policy's seven axes, or the Kigali meeting) could also be the basis of a new document that outlines objectives, results, activities and indicators.

Potential timeframe: The NFTWG can use the draft Assessment Report as a basis to finalize a new RF, prioritize areas for the next strategy and develop an outline for the new document. This could be done before the end of May, 2011.

The MOH may decide to appoint a person to coordinate the overall policy development process (under the supervision of the MCH Department). This person should be a Rwandan national or resident, with experience in public health policy development and FP/MCH. External technical assistance (TA) will probably be required for the policy development process, especially if a costing plan is required. An external TA consultant can visit Rwanda intermittently to support the coordinator and participate at key points. Funding for *both* the coordinator position and provision of external TA should be identified as soon as possible (discussions are already underway with USAID). The level of effort (LOE) and Scopes of Work for both the local coordinator and external TA provider should be developed, and a timeframe for completion of their work should be determined. The process should be ready for a "policy launch" by July 30th 2011.
Potential timeframe: TBD but as soon as possible.

2. **Form individual working groups** (through a two day meeting or workshop) to focus on supply, demand, and enabling environment issues in order to develop five year workplans, including activities and budgets for each. If further work on costing and monitoring and evaluation is required, the coordinator may need additional analytical support from donor, Government or other sources.
   Potential timeframe: TBD

3. **Develop a short summary document** (the "policy") to reflect the overall vision, goals and objectives, and illustrative activities that will guide the individual focused strategic workplans.
   Potential timeframe: TBD

4. **Orient stakeholders** possibly through a workshop, with government, NGOs/FBOs, private sector, donors, and other stakeholders to discuss the new policy document.
   Potential timeframe: TBD

Phase 3: Launch and disseminate the document

5. **Develop a dissemination plan and launch the document.** At the national level, possibly HE the President of the Republic of Rwanda may wish to personally launch the new policy. Events would be replicated down to the local level. This step may require formation of a planning committee; coordination between ministries; preparation of a dissemination plan; and resource mobilization for launches at the provincial and district levels.
   Potential timeframe: by September 30th, or any other date determined by Government

ATTACHMENTS

A. List of People Interviewed and Sites Visited
B. List of Documents Consulted
C. Results Framework
D. Assessment Tools (available)

ATTACHMENT A:
PEOPLE INTERVIEWED, SITES VISITED

1. District level

Location	Function	Name
Administrative Districts:		
Burera	Health officer	Mr. UWIRAGIYE Clément
	JADF Coordinator	Mr. Hermogène
Rubavu	Health officer	Ms. UMULISA Brigitte
	JADF Coordinator	Mr Emmanuel SENZOGA
Ngororero	Health officer	Mr. MUGANZA JMV
Gatsibo	Health officer	NTUYAHAGA Bosco
	JADF Coordinator	KANYAMIBWA Athanase
Rusizi	Health officer	Mr. GAHAMANYI Jules
Nyaruguru	Health officer	Mr. KAREMERA Athanase
Muhanga	Health officer	Mr. MUTONIWASE KAMANA Sosthene
Gicumbi	Health officer	Mr KAYUMBA Emmanuel
	JADF Coordinator	Mr Anastase NDUWAYEZU
Kicukiro	Health officer	Mrs GATERA Emmerence
	JADF Coordinator	Mr HIGIRO Emmanuel
Ngoma	Health officer	Mrs Angélique
	JADF Coordinator	Mr Augustin HARELIMANA
Hospital:		
Burera	FP Supervisor	Mr. SADIKI MINGINGO Alexis
Gisenyi	Hospital Director	Dr KARUMUGABO Patrice
	FP provider	Ms. Ange MUGERENTE
Muhororo	FP IMCI/Immunisation	Ms. MUKARUBIBI Florence
	FP provider	Ms. NKIZURWO Clementine
Munini	FP Supervisor	Mr NIYOMUGABO Gilbert
Kabgayi	FP Supervisor	Ms. DUSABEYEZU Goretti
Kiziguro	Hospital Director	Dr MUKAMA Dioclès
Kanombe	Hospital Director	Dr Ben KARENZI
	FP Supervisor	Mr Anastase MUHASHYI
Kibungo	Hospital Director	Dr NAMANYA William
	FP provider	Mrs Epiphanie KAMABERA
Byumba	Hospital Director	Dr HISHAMUNDA Bonaventure
	FP Supervisor	Aloys NSABIMANA
Gihundwe	Hospital Director	Dr DUSHIME Theophille
	FP provider	Ms. NYIRARUKUNDO Jeanne

Location	Function	Name
Health center:		
Nyamugali HC	Head of HC	Mr. NDAYISABYE Tharcisse
	FP provider	Ms. MUKESHIMANA Judith
	Community health officer	Mr. HABIYAREMYE Landouald
Kigufi HC	Head of HC	Mr. MULISHO Djuma
	FP provider	Ms. DUKUNDIMANA Esperance
	Community health officer	Mr. NYARUGABO Jacques
Muramba HC	Deputy Head of HC	Mr. IGIRAMABOKO Chadrack
	Hygiene and sanitation	Mr. NSABIMANA Gilbert
Nkanka HC	Deputy Head of HC	Ms. MUKAMANA Jeanne d'Arc
	FP provider	Ms. NSEKAMBABAYE Adele
	Community health officer	Ms. MUKANKUSI Chantal
Kabilizi HC	Acting Head of HC	Mr Gaspard NZAKAMA
	FP provider	Ms DUSABIREMA Françoise
	Community health officer	Ms IRATURORA Rachel
Shyogwe HC	Head of HC	Mr. NDUHUYE Eugene
	FP provider	Ms. NIYOMBAZA Sarah
	Community health officer	Mr. UWIZEYE Wily
Remera HC	Head of HC	Mr MUNYANGANGO Josué
	FP provider	Mrs Vedrine MUKESHA
	Community health officer	Mrs Félicité MWANANAWE
Masaka Health Post	FP Provider	BUSERUKA Jacqueline
Masaka HC	FP provider	Sr NYIRABAHUTU Félicitée
Miyove HC	Head of HC	Mr MANIRIHO KANEZA Bonaventure
	FP provider	Ms UWIZEYIMANA Jeannette
	Community health officer	Mrs MUTEGWARABA Jacqueline
KIZIGURO Health Post	Health Provider	Mr MUREGO Donat
Kabarore HC	Head of HC	Mrs Assumpta UWAMWEZI
	FP provider	Mrs Peruth UWAMWEZI
Administrative Sector:		
Nyamugali	Social affairs officer	Mr. NIZEYIMANA Jean Claude
,Nyamyumba	Executive secretary	Mr. DUKUNDIMANA Esperance
Hindiro	Social affairs officer	Mr. SEBYENDA Athanase
Munini	Social affairs officer	Mr KABANDA Claudien
Nkanka	Social affairs officer	Mr. MILINDI Antoine
Shyogwe	Social affairs officer	Ms. GATESI Charlotte
kabarore	Executive Secretary	Mr MUREGO Richard
Miyove	Executive Secretary	Mr NDEJEJE Pascal
Masaka	Social affairs officer	Mr SINDIKUBANA Joseph
Remera	Social affairs officer	Mr BUHIKARE John

2. Central level

Name	Function/Institution
Dr. NGABO Fidele	MCH Unit Director/MOH
Dr. NZABONIMPA Anicet	FP/VIH integration Focal point/MOH
Dr. KAGABO Leonard	Vasectomy Focal point/MOH
Mr. NSENGIYUMVA Thomas	FP Focal point/MOH
Ms. MUGENI Cathy	Community health Coordinator/MOH
Mr. MUGENZI Jean Nepomuscene	Engender Health
Dr MUKARUGWIRO Beata	JHPIEGO/MCHIP
Mr.SINZAHERA Jovit	JHPIEGO/MCHIP
Ms. NYIRANGENDO Sophie	JHPIEGO/MCHIP
Mr. NZEYIMANA Anastase	FHI
Ms. NYIRASAFALI Daphrose	UNFPA
Mr. MUNYAMBANZA Emmanuel	FHI
Ms. MUKAKABANDA Suzanne	Intrahealth international/HSCP
Mr. AIME-PEHE Norbert	Deliver project
Ms. Jennifer WESSON	FHI
Dr NTAGUNGIRA Celestin	FHI
Dr RUSA Louis	PBF
Dr NZEYIMANA Bonaventure	Public Health expert
Phn. TAYARI Jean Claude	Centrale d'Achat des Médicaments essentiels au Rwanda (CAMERWA)
Phn. UWAMUNGU DISI Dlane	CAMERWA
Mr Enock NIYOMBERA	Association Rwandaise pour le bien être Familial (ARBEF)
Ms. Janina GASANA	MINEDUC
Mr. Alice BUMANZI	MINIYOUTH
Mr. Emmanuel SEBAHUTU	MINIGENDER
Mr. Oscar NZIRERA	Rwandan Association of local Government Authorities (RALGA)
Ms. Adrienne NTAGUNGIRA	LA CROIX DU SUD CLINIC
Mr. Michel NIYOYITA	KImisagara Youth Center
Dr Prince Bosco KANANI	CARITAS
Mr. SINGIRANKABO Ignace	Network of Religious Confessions Against Aids (RCLS)
Dr HABIMANA valens	Seventh –Day Adventist Church

ATTACHMENT B: DOCUMENTS CONSULTED

1. Rwanda Health System Strengthening Framework and Consolidated Strategic Plan (2009-2012), Ministry of Health, Republic of Rwanda, July 2010
2. Economic Development and Poverty Reduction Strategy (EDPRS), Republic of Rwanda
3. Health Sector Strategic Plan II, Ministry of Health, Republic of Rwanda
4. National Health Policy, Ministry of Health, Republic of Rwanda
5. Rwanda Vision 2020, Ministry of Finance and Economic Planning, Republic of Rwanda, July 2000
6. National Family Planning Policy and Its Five-Year Strategies (2006-2010), Ministry of Health, Republic of Rwanda, March 2006
7. MINALOC strategic plan
8. National Policy for Quality of Healthcare in Rwanda (2008)
9. Rwanda Demographic and Health Survey (DHS), Macro International, 2005
10. Rwanda Interim DHS 2007/08, Macro International, 2008
11. Rwanda Service Provision Assessment (SPA) 2007, Macro International, 2007
12. Family Planning in Rwanda, IntraHealth International, June 2008
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ATTACHMENT C – DRAFT RESULTS FRAMEWORK