Family Planning in Rwanda

A Review of National and District Policies and Budgets

Prepared by:
Gitura Mwaura & Annette Mukiga

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RWANDA WOMEN'S NETWORK
Kinyinya Sector, Gacuriro (next to SOS Technical School)
KG 428 Street
P.O Box 3157, Kigali, RWANDA
Tel: +250 788 334 257

Email: rwawnet@rwanda1.rw / info@rwandawomennetwork.org
Website: www.rwandawomennetwork.org

and

DSW (Deutsche Stiftung Weltbevoelkerung)
Hatheru Road, Hatheru Court (Lavington)

P.O Box 2438 - 00202 Nairobi, Kenya
Tel: +254 20 2731398/20 3592302
Mobile: +254 726 603768/ 736 616491

Email: info@dswkenya.org
Website: www.dsw-online.org

Authors: Gitura Mwaura & Annette Mukiga

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
CPR	Contraceptive Prevalence Rate
EDPRS II	Economic Development and Poverty Reduction Strategy 2013–2018
FP	Family Planning
FY	Financial Year
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
iHRIS	Ministry of Health Human Resources Database
IUD	Intrauterine devices
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMI	Military Medical Insurance
MoH	Ministry of Health
OECD	Organisation for Economic Co-operation and Development
PRSP	Poverty Reduction Strategy Papers
RAMA	La Rwandaise d'Assurance Maladie
RDHS	Rwanda Demographic Health Survey
RH	Reproductive Health
RIDHS	Rwanda Interim Demographic Health Survey
RWF	Rwandan Francs
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
WHO	World Health Organization

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Thank you!
The Reproductive Health Rwanda Consortium

ARBEF - Association Rwabdaise le Bein Etre Familial

RWANDA WOMEN'S NETWORK

AJPRODHO - JIJUKIRWA

HAGURUKA NGO

HDI HEALTH DEVELOPMENT INITIATIVE
Striving for a healthy society

Urunana DC

BENISHYAKA

RESEAU DE DEVELOPMENT DES FEMMES PAUVRES
Poor Women's Development Netwok

1. Executive Summary

The Family Planning Policy 2012 has received particular attention as a development priority to ensure maximum contribution to Rwanda achieving of MDGs and overall development. FP has been highlighted in related policies and in the Vision 2020 and the Economic Development and Poverty Reduction Strategy 2013–2018 (EDPRS II).

Government commitment can be seen in the commendable achievements gained in FP. Modern contraceptive prevalence rate more than quadrupled from 10% in 2005 to 45% in 2010. The total fertility rate decreased from 6.1 per woman in the same period to 4.6 children.

However, many challenges remain. Some of these challenges include myths, rumors and misperceptions about FP methods and their side effects, requiring efforts to address them with correct information and FP counseling sessions. There also exist gaps in SRH education at different levels, while socio-cultural and religious influences that affect service demand from the population.

The challenges have defined the national priorities articulated in the FP Policy. Among others, the priorities include improving awareness of FP and access to FP services for women, men and youth using social communication and mobilization programs. Others are integrating FP in Safe Motherhood and Child Health services and strengthening men's participation through community-based structures, organizations and network.

An assessment was conducted to establish the national FP trends as they manifest at the village level. This allowed for a deeper interrogation of the national policies from the grassroots perspective. The assessment is part of a regional study to establish the level of policy engagement and budget commitment at national and district level that address unmet needs of family planning.

Gatsibo District was identified as a case study for this analysis in Rwanda, as it is representative of most districts across Rwanda in demography and socio-cultural attitudes.

Findings from the district reflected the national trends. The key issues of concern identified at district level are youth pregnancies and high prevalence of myths and misperceptions about FP methods and their side effects.

The following recommendations for advocacy are therefore proposed enjoining the Government and international partners to allocate adequate resources, both financial and human to:

- Fight misperceptions, myths and rumors about FP methods and their side effects, including improvement of method mixes, through the media and at the community level through CHWs;
- Reach and involve the youth in relevant RH & FP programmes;
- Advocate towards the government to increase FP budget, and the international community to begin offering FP budgetary support by start of next financial year, 2014/2015.

2. Introduction and Background

Reproductive health (RH) and family planning (FP) have received global and national recognition not only as key to individual well-being, but collectively to national development. The Government of Rwanda (GoR) is committed to various international policy protocols which it is signatory, including the ICPD and Maputo Plan of Action, both of which relate to the MDGs. The Rwanda National Family Planning Policy 2012 aims to ensure the maximum contribution to Rwanda's achievement of MDGs and overall national development relative to its population growth trends.

2.1 Country Profile

As per the last census (2010) Rwanda's population stood at 10,537, 222, up from 8,128, 553 in 2002. This presented a 29.6 per cent rise in the population during the period. Annual population growth rate stood at 2.6 per cent, down from 2.9 per cent in 2002. Women constitute 51.8 per cent of the total population; down from approximately 53 per cent in 2002.Population density grew from 321 people per square kilometer in 2002 to 416 in 2012. The Census put the average household size at 4.37, reflecting a drop in the fertility rate, from 5.5 to 4.6 children per woman by 2010.

The infant mortality rate decreased from 86 per 1,000 live births in 2004 to 50 per 1,000 live births in 2010 and the under-five mortality rate declined from 152 to 76 per 1,000 live births over the same period (Rwanda Demographic Health Survey [RDHS], 2010). The 2010 RDHS shows a significant reduction in the maternal mortality ratio from 750 per 100,000 live births in 2005 to 476 per 100,000 live births in 2010. If the pace of this decline continues, Rwanda is likely to meet the MDGs related to child and maternal mortality by 2015.

HIV prevalence has remained constant at 3% between 2005 and 2010. There was a decline of malaria prevalence by half since 2007–08 from 2.6% to 1.4% among children age 6 to 59 months, and from 1.4% to 0.7% among women aged 15–49 (RDHS 2010). Notably, these two diseases place a significant burden on the health system. In 2008, they accounted for 35% of hospital mortality cases (Rwanda Interim Demographic Health Survey [RIDHS], 2007/2008).

While FP services have been, and continue to be provided free of charge, approximately 23% of patients have to walk for more than one hour or more than 5 kilometers to reach the nearest health facility (Health Management Information System [HMIS]; 2009). The WHO recommended maximum time to access healthcare is 30 minutes, with the implication that there exists a need for closer health services to nearly a quarter of all patients. On average, 96% of the population was covered by Community based Insurance in 2012 (HMIS). Availability of health care professionals has improved: in 2011 there were 625 doctors and 8,513 nurses/midwives working in Rwanda. Based on 2012 data from the Ministry of Health Human Resources Database (iHRIS), this corresponds to a ratio of 1 doctor per 15,428 inhabitants, 1 midwife per 23,364 inhabitants, and 1 nurse per 1,138 inhabitants. For midwives, this represented an improvement from I midwife per 66,749 inhabitants in 2010 (Annual Report, Ministry of Health 2012).

Family planning services are delivered largely within the public sector health system and include community-based distribution (CBD) of contraceptives, though CBD of injectable contraceptives is yet to be fully implemented in 10 out of the 30 districts nationally. Improvement of HIV and MNCH is also attributed to improved access to anti-retroviral drugs and integration of health services.

Despite commendable progress in meeting RH and FP needs of Rwandese people, there is still unmet need for FP. One out of five (19%) currently married women has an unmet need for FP (an improvement since 2005, when the figure was 38%): 10% have an unmet need for spacing and 9% have an unmet need for limiting. Consequently, the total demand for FP among currently married women is

72%, and almost three quarters of that demand (74%) is satisfied. The demand for limiting is slightly higher than the demand for spacing (39% and 34%, respectively; RDHS 2010).

Key Rwandan Health Indicators

Population and Medical Personnel

- Total population: 10,537,222 (2012 Census)
- Per Capita Utilization of Health Facilities: 0.79 visits per capita
- (HMIS, 2012) – DHS 2010 reports 1.8 women, 1.5 men.
- Doctors: 1/15,428 inhabitants (Annual Report of the Ministry of Health 2012)
- Nurses: 1/1,138 inhabitants (Annual Report of the Ministry of Health 2012)

Key Health Indicators	RDHS 2005	RDHS 2010
• Neonatal Mortality (per 1,000 live births)	37	27
• Infant Mortality (per 1,000 live births)	86	50
• Under 5 Mortality (per 1,000 live births)	152	76
• Proportion of stunted children	51	44
• Proportion of wasted children	5	3
• Proportion of underweight children	18	11
• Maternal Mortality (per 100,000 live births)	750	487
• Modern Contraceptive Prevalence Rate (CPR)	10%	45%
• Total Fertility Rate	6.1	4.6

HIV and AIDS and Other Epidemics

- HIV Prevalence: 3% (DHS, 2010)
- TB case detection rate 27% (TRACPlus/WHO 2009)
- Malaria prevalence in children <5: 1.4% (RDHS, 2010)
- Children under five sleeping under LLIN: 70% (RDHS, 2010)

Rate of Enrolment in Community Based Health Insurance (Rwanda health statists Booklet, 2011)

Insurance enrolment at 96% as of 2012

In order to inform efforts towards meeting the demand for FP services and satisfying the unmet need for FP, there is need to understand to what extent the policy environment for FP in Rwanda is addressing the FP needs of Rwandese people and track allocation of resources for FP at national and sub-national levels. To address this gap, a study was conducted in Rwanda as part of a regional policy and budget analysis of RH and FP in East Africa to establish the level of policy engagement and budget commitment at national and district level that address unmet needs of family planning.

2.2 Objectives of the Study

The primary objectives of the study was to

- Assess the extent to which family planning and other reproductive health issues are prioritized in broad development and health policies and strategies.
- Understand key policy and programme priorities, including policy implementation challenges and responses considered critical for the achievement of national policy objectives
- Establish the extent to which key family planning issues identified by communities' members are reflected in the policies.

The report highlights policy gaps existing in the national family planning programme at the district and grassroots levels (using Gatsibo district as a case study). It draws out policy and budgetary recommendations for advocacy by the Rwanda Women's Network and the civil society reproductive health and family planning platform in the country. . Importantly, the report also draws government attention to the issues at the community level and also identifies priority areas for both the government and development partners at the grassroots level.

3. Methodology

3.1 Research Methodology

The study undertook a case study approach. Both quantitative and qualitative methods were used to collect data including:

Review of existing policies related to reproductive health and family planning and budget documents. These included the Vision 2020 and the Economic Development and Poverty Reduction Strategy 2013–2018 (EDPRS II); the National Population Policy for Sustainable Development 2003; the National Health Policy 2004; the National Reproductive Health Policy 2003; and, the Family Planning Policy 2012. Other documents included national development plans, including those of Gatsibo District, the national demographic and health survey, newspaper reports, and the national and district budgets. Policies were reviewed to examine the extent to which FP concerns are addressed. Budget documents were reviewed to identify any budgetary gaps and funding available for effective FP implementation.

Four focus group discussions (FGDs) comprising two women only groups, and one men only group and a youth only group. FGDs sought to draw out community perceptions on access and hurdles to FP services. Key informant interviews (KIIs) were conducted with the Head of Budgets at the Ministry of Finance, Head of Family Planning at Ministry of Health, Gatsibo District Health Officer and sub-district health supervisor. KIIs sought to provide an overview of policy implementation on the ground, including access and any hurdles thereof to FP services from the national to the grassroots levels.

A standard FGD guide developed for countries in the region under the DSW program was adapted to suit a Rwandan local community situation. Priority issues arising were ranked as identified by each group during the discussions. The ranked issues for all the groups were synthesized to draw out similarities and crosscutting concerns to come up with representative community priorities. Similarly, a discussion guide was used to conduct KIIs and data collected thematically analyzed to bring out issues of convergence regarding the priorities identified by the FGDs.

The priority issues synthesized from the FGDs and KIIs were then analyzed against the existing family planning policy and implementation strategy, including the national and district budgets, to draw out the advocacy issues.

Gakenke Health Centre in the District was visited to sample FP services offered at the grassroots level. The health center was identified as the most appropriate as it serviced the widest cross-section of community members in the district. A survey tool developed for the regional analysis was used.

3.2 Limitations

One of the study limitations was inability to obtain budget information from the MoH to analyze against the national budget allocation. The budgets available from the district were only Financial Years 2012/2013 and 2013/2014 making it impossible to analyze trends. Time allocated to conduct the analysis was not sufficient. Unlike the other countries, the Rwanda team conducted the study in only one district while the study could have benefited from examining another district where community-based FP services are not fully implemented

4. Findings and Analysis

4.1 Policy Analysis

This section offers an overview as well as an analysis of the existing policies related to RH and FP, and how they relate to priorities identified at the community level.

The Government of Rwanda (GoR) accords reproductive health and family planning importance to national development. GoR is committed to the various international policy protocols and is signatory to the ICPD and Maputo Plan of Action, both of which relate to the MDGs (also see Table 2 below for summary of principles observed).

The National Family Planning Policy 2012 aims to ensure the maximum contribution to Rwanda's achievement of MDGs and overall national development. The FP responsive polices affirm aim at attaining MDG 2 (achieving universal primary education) and MDG 3 (promoting gender equality and empowering women). This includes MDG 4 (reducing child mortality) and MDG 5 (improving maternal health).

Other broader policies that recognize the benefits of FP include, the Vision 2020, the Economic Development and Poverty Reduction Strategy 2013–2018 (EDPRS II), National Population Policy for Sustainable Development 2003, National Health Policy 2004 and the National Reproductive Health Policy 2003.

The Vision 2020 is Rwanda's leading planning framework, which is used to guide overall development in Rwanda. Vision 2020 places emphasis on the harmonization of population growth with the country's economic development and reduction of the main causes of mortality—specifically aiming to reduce the total fertility rate (TFR), decrease infant and maternal mortality, and ultimately reducing population growth. Vision 2020 singles out FP as crucial for reducing birth rates and the prevalence of HIV and AIDS if double protection is used as recommended.

The EDPRS II identifies high population growth as a major challenge and articulating the existing association between poverty and population density. It highlights FP as a key intervention to address this challenge. EDPRS II set its priorities as: strengthening reproductive health (RH) services and FP; ensuring free access to information, education and contraceptive services.

The National Population Policy for Sustainable Development 2003 takes into account Rwanda's adoption of resolutions of the 1994 International Conference on Population and Development in Cairo. The Policy presents a multi-sectoral approach to improving the population's quality of life. In addition to reducing the population growth rate, this policy also focuses on economic growth, food security, health, education, human resource development, and rational management of the environment and good governance. It presents a number of quantitative targets consistent with those presented in Vision 2020 and the Poverty Reduction Strategy Papers (PRSP). The 2003 Policy affirms FP aims to ensure maximum contribution to Rwanda's achievement of MDGs and overall national development.

The National Health Policy outlines the roles of the central government, provincial and district structures and emphasizes the norms established in 1998 for the minimum package of activities, which includes FP, and the complementary package of activities to be provided at the hospital and health center levels. This policy describes the role of FP as contributing positively to the health status of the family. It also highlights the concept of partnerships as a key means of achieving integration, including inter-sectoral integration of services. The National Health Policy calls for greater health sector financing and urges initiatives to strengthen solidarity, such as community-based health insurance, prepaid health insurance and other health insurances. It establishes the principles of cost recovery and fee for service, while ensuring the establishment of financing methods for those unable to pay. As with the above, National Health Policy affirms FP aims to ensure maximum contribution to Rwanda's achievement of MDGs and overall national development.

Table 2: Summary of Policies against Principles observed

Principle observed	Details of Policies
Advancing gender equality and equity and the empowerment of women, including education for girls	The FP responsive polices affirm to working towards attaining MDG 2, i.e., achieving universal primary education and MDG 3, promoting gender equality and empowering women
Population issues articulated are integral parts of economic and social development	Population issues are articulated in Vision 2020 and the Economic Development and Poverty Reduction Strategy 2013–2018 (EDPRS II), including the National Population Policy for Sustainable Development 2003; the National Health Policy 2004; the National Reproductive Health Policy 2003; and, the Family Planning Policy 2012
Interrelationships and balance between population, resources and development are fully recognized as an integral part of sustainable development	The interrelationships are recognized in Vision 2020 and the EDPRS II, and in the above mentioned policies
All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so.	The right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so is articulated in the FP Policy 2012, synthesizing from the above mentioned policies.
Allocation of least 15% of national annual budgets to improve the health sector.	Rwanda has achieved 18.8 per cent in the period 2010 – 2012 achieving the 2006 Abuja Declaration targets on health
Policies explicitly reaffirm commitment and universal access to:	
Safe abortion	Safe abortion affirmed in the penal code only where the life of the mother is medically proved to be in danger, though not explicitly mentioned in the National

	Population Policy for Sustainable Development 2003; National Health Policy 2004; National Reproductive Health Policy 2003; Family Planning Policy 2012
Adolescent SRH information and services	ASRH is affirmed in FP Policy 2012 as above noted
Contraception	Affirmed in the FP Policy 2012 as above noted
Sexual rights	Affirmed in the FP Policy 2012 as above noted

4.1.1 Prioritization of FP

The Family Planning has received particular mention as a development priority to ensure maximum contribution to Rwanda achieving of MDGs and overall development. It is recognized that FP not only allows families to space and limit their births when desired, but it can also reduce the costs of meeting multiple MDGs as a crosscutting development issue.

FP has been highlighted in Vision 2020 and the EDPRS II. Vision 2020 singles out FP as crucial for reducing birth rates and the prevalence of HIV and AIDS. Under EDPRS II health is generally placed under the Foundational Sector in "The pursuit of long-term priorities in health and basic education, macroeconomic stability and public finance management, justice, peace and stability, food security and nutrition and decentralization that constitute the platform of Rwanda's sustainable development."

Rwanda's strong political support for FP is noted in the status report on implementation of the 2006–2010 National FP Policy and Five-Year Strategy and is a key driver of government commitment for FP. The President has been at the forefront championing family planning agenda locally and internationally, most recently at the 2012 London Summit on Family Planning. However, while there is laudable political leadership on FP issues at all levels leaders should be continually reminded of their obligations at the personal, local, national and global levels.

It is due to the existing political will that FP receives high priority under MCH, including having its own national policy and implementation strategy. However, the FP budget allocation has been declining in the last three years (see Budget Analysis) implying a need to push for an increase in prioritization of FP in the MoH hierarchy.

4.1.2 Sustainability of FP Programs

FP is funded from recurrent budget without external support (see OECD Support below). Sustainability of the FP programme has been seen as a challenge. As noted above, there is recognition that as demand and use of FP services increases; it will become more and more of a challenge to cover the costs of contraception.

Plans to addressing the programme sustainability are implicit in achieving and maintaining high levels of awareness, increasing literacy among women and girls, gender equality and socio-economic empowerment. And with the goal of attaining 70 percent CPR, it is inevitable that the costs of contraception will rise that may necessitate external support. This underscores the aim for resource mobilization under the Eurolevarage project.

4.1.3 Policy responses to unmet need

The RDHS 2010 shows that unmet need for FP is 19%. These are equally split between the need for spacing (10%) and the need for limiting the number of children (9%). While impressive gains by method have been reflected over time, the current method mix does not appear to address women's wide range of fertility preferences.

According to the 2010 Survey, the method mix is dominated by short-acting methods, particularly injectables (26%), but the contribution of pills (7%) and condoms (3%) is also significant. The only long-acting method that contributed significantly was implants (6%), with female sterilization and intrauterine devices (IUDs) at less than 1%, and tubal ligation at 0.8%. The data indicate that male participation is mainly through the use of condoms, mainly by youth and unmarried men.

The FP Policy 2012 observes that dependence on short-acting methods, in a setting where the demand is high and unmet need is significant, calls for further examination.

The FP Policy 2012 aims to reduce unmet need for FP through a number of approaches:

- Improving awareness of FP and access to FP services for women, men and youth using social communication and mobilization programs
- Integrating FP in Safe Motherhood and Child Health services
- Strengthening men's participation through community-based structures, organizations and network
- Improving FP service providers' skills utilizing recommended eligibility criteria for contraceptive prescription from the World Health Organization (WHO)
- Increasing availability and revival of FP services in all health facilities (public and private)
- Establishing a system to monitor FP activities in all health centers at all levels (community, district, province, national); and
- Involving political and administrative authorities and community leaders in FP mobilization.

Additional strategies towards the FP policy implementation, further to the above mentioned prioritized approaches:

- Designing and disseminating appropriate FP messages for mass media (radio, TV, newspapers, etc.), and information, education and communication (IEC)/FP tools (posters, flyers, flipcharts, etc.)
- Raising FP awareness among men during political and administrative meetings
- Involving community-based associations and organizations of women and youth in FP awareness-raising activities
- Integrating FP in training curricula at primary, secondary and higher education levels, with the collaboration of the Ministry of Education
- Training and conducting refresher training of health providers in contraceptive methods and communication/counseling techniques; strengthening logistics for contraceptives and related materials
- Developing postnatal care, including FP strengthening men's participation in FP programs
- Prevent early pregnancies (among adolescent populations) as well as highlighting benefits of FP use among most-at-risk populations, such as sex workers, through contraceptives offering dual protection against pregnancy and HIV.

4.1.4 Challenges to implementation FP programs

The main challenges for implementing FP include:

- Increased cost of contraception as demand increases. (The Government aims to increase contraceptive use to 70 percent from the current 45 percent)
- There are still myths, rumors and misperceptions about FP methods and their side effects, requiring efforts to address them with correct information and FP counseling sessions.
- There still exists a gap in SRH education at different levels, including in families and schools, yet these represent a great window of opportunity for children and adolescents to learn about such issues at an early age.
- There still exist socio-cultural and religious influences that affect FP service demand from the population.
- Lack of decision-making power of women about use of FP and insufficient support, participation and sometimes violence from their male partners.
- Perception of FP as "limitation of births" and therefore only appropriate for married people.
- Impact of the genocide (post-genocide desire to replace those lost).

4.2 Conclusions from Policy Analysis

The FP Policy 2012 and the attendant policies have anticipated needs to ensure effective provision of FP services nationally under the existing political will and Government commitment. The only major challenge appears to be the eventual inability to meet the costs as the demand increases. This results to a call for support from international partners. The target group in the FP policy 2012 is principally women of reproductive age (15–49 years) and men (15–59 years).

4.3 District Analysis: Gatsibo

Gatsibo district serves as a case study to understand the perceptions of community members and services offered at the grassroots level.

4.3.1 District Profile

The status of RH and FP indicators in Gatsibo District for the most part closely mirrors the national level. HIV prevalence stands at 1.7 percent, below the national average of 3 percent. 36percent of pregnant women go for Antenatal Care compared to23.9 percent national average. Total fertility rate is at 4.9 children per woman, slightly above national average of 4.6 percent.

49.7 percent of women between the ages of 15-49 are using modern family planning contraceptives, above the national average 45.1 percent. Maternal mortality rate per 1000 live births is 350/100,000 compared to 487/100,000 national average. Infant mortality rate per 1000 live births is at 50/1000, similar to the national average. Children under 5 years mortality rate is at 113/1000, below national average 103/1000. Children fully immunized stands at 94.8, above national average of 85.4%. Percentage of-women delivery in a health facility is at 63.9, below the national average 69.0%.

Gatsibo district is experiencing rapid population growth which is threatening to curtail progress on RH and FP indicators. Its Population stood at 433,997ins 2012. The population increased by 53.1 percent between 2002 and 2012. The District currently has a population density of 275 persons per square kilometer. Males represent 48 percent of the population and females 52 percent. Moreover, health facilities are not equitably distributed in the District. Patients often walk over 5 km to get to a health center, post or hospital diminishing access to health services. Gatsibo has 19 health centres, a district pharmacy and 2 district hospitals at Kiziguro and Ngaram. There are 2,412 community health workers in 11 health posts, with each administrative village having 4 CHWs. According to the District development Plan 2013 - 2018"most of the health centers are in a very bad state and urgently require rehabilitation or expansion." Available laboratories are inadequate in number and often lack the necessary equipment. There is also an acute shortage of health personnel - "insufficient both in terms of quality (skills) and quantity." In addition only 58.4 percent of the population is covered under community based health insurance.

4.3.2 Health Facility Analysis

Gakenke Health Centre serving Kirimuruzi Sector was visited to assess the level of FP service provision at community level. The following were the findings:

- FP service as identified in the survey tool was readily available
- Staffing is inadequate, according to the Director of the Health Centre
- Staff at health facility are aware of FP, ASRH policy, procedure and guidelines
- Staff have received regular on job training on RH & FP as stipulated in policies and strategies
- There is low turn up at youth center, while reaching youth at their spaces is still new and needs strengthening
- All FP methods are available, except combined injectable contraceptives
- There are regular supervisory visits, at least once a month
- IEC materials displayed, though not a wide selection on FP messages
- Staff interviewed agreed with the issues identified by the community, including widespread misconceptions and myths on FP and youth inadequately accessing FP services

Priority issue for the health center is the shortage of staff, as articulated by the head of the facility. This had an overall effect on community outreach, which he identified as a key challenge. The key recommendation is to strengthen outreach with additional community health workers.

4.3.3 Key FGD findings

Focus group discussions were held in Kirimuruzi and Murambi Sectors in Gatsibo District and sought to gain an in-depth understanding of: FP awareness and attitude; Availability and access; and main causes of FP unmet need.

a) **FP awareness and attitude:** Though there has been an increase in FP awareness and service uptake in the past few years, there still exists high prevalence of misperceptions, myths and rumors about FP methods and their side effects. Also prevalent is the perception of FP as a source of conflict when husbands sire outside the family, despite wife limiting births.

b) **FP availability and access:** FP services are readily available in Government health facilities, though there is lack of over-the-counter contraceptives at private pharmacies, except for condoms.

c) **Causes of FP unmet need:** Several causes of unmet need were identified. These include a gap in SRH information at different levels, especially in families and among the youth. The youth avoid approaching CHWs who are often their elders and known to them. Another cause was widespread misconceptions and myths about the effects of FP.

d) **Community recommendations to address above challenges include the following:**

- Approach the youth in their organized spaces, and employ peer CHWs/counselors. The government should organize meetings and conversations, activities with the youth encouraging them to participate.
- NGOs to collaborate with Government on sensitization, and in youth employment as poverty was one of the causes of early sex; advocacy on issues on the ground
- Involve church leaders and pastors more in disseminating FP messages
- Collaboration between different stakeholders, including development partners, Government and local authorities on provision FP services
- Local authorities and CHWs to identify specific cases at village level that have many children but don't use FP, or don't participate at community meetings, and engage them individually. There should be increased use existing spaces, including monthly community meetings to encourage and engage with men and women
- Government to invest on fight against drug abuse as it leads to irresponsible behavior among the youth.
- Put more effort in talking and discussing issues with children, parents also to be trained to talk to their children

4.3.4 Policy Responses to Unmet need issues Identified by Communities

The FP issues identified by the communities are reflected in the FP Policy 2012 and found resonance with the key informants, including the Head of the Gakenke Health Facility, Gatsibo District Health Officer and sub-district health supervisor. This suggests that the District and Government are aware of the challenges and has anticipated how to address them as articulated in the FP Policy 2012. Community recommendations are also implicit in the government plan to address the challenges nationally. Despite the above concern of district priorities appearing to be overlooked by the government and development partners, not to mention the seeming decline in FP budget share nationally, there have been adequate FP supplies. However, the district has anticipated an increase in community mobilization with consequent doubling of FP budget allocations of Rwf 12,615,000 for FY 2014/2015 from the current Rwf. 6,415,000 for FY 2013/2014. It is to this the district must be held to account.

4.4 Budget Analysis

4.4.1 Overall National Budget Trends

4.4.1.1 OECD Support

Between 2005 and 2011 official development assistance to Rwanda from countries under the Organisation for Economic Co-operation and Development (OECD) amounted to 1.98 billion US Dollars (see Table 1). The country has received no development assistance for Family Planning from 2009 to date, which is reflected in the national budgets under the financial years under review. Total amount disbursed for health during the period was 148 million US Dollars, representing 7.4% of the total OECD support (Table 1). "Reproductive health and Population Assistance" received 58 million US Dollars, with reproductive healthcare receiving no support. "STD control including HIV/Aids" received 51 million

US Dollars. Between 2006 and 2008 Rwanda received FP assistance amounting 3 million US Dollars – one million US Dollars for each year during the period. That family planning has received no support since 2009 clearly points to an advocacy issue.

Table 1: OECD Development Assistance Disbursements

Official OECD Development Assistance (Disbursements) (Millions USD)							
	2005	2006	2007	2008	2009	2010	2011
Total	135	170	204	304	288	415	464
Health	11	15	16	31	24	17	34
Family Planning	0	1	1	1	0	0	0
RH/Population assistance	4	8	7	11	18	6	4
Reproductive healthcare	0	0	..	0	0	0	0
STD & HIV/Aids	4	6	6	9	17	5	4

Source: Euroleverage, 2013

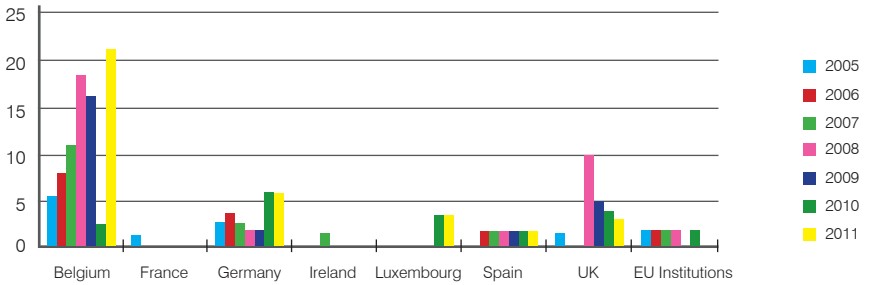
Table 2 below shows health disbursements for 15 countries in the OECD and EU institutions combined for the period 2005 to 2011. Belgium was to a large extent the highest contributor, followed by United Kingdom and Germany in that order (see Figure 1). France contributed in 2005, and Ireland in 2007. 6 of the countries show no contribution during period 2005 to 2011.

Table 2: OECD Health Disbursements

Health Disbursements (Millions USD)							
	2005	2006	2007	2008	2009	2010	2011
Europe total	11	15	16	31	24	17	34
Belgium	6	9	11	18	16	2	21
France	1	..	..	0	0	0	0
Germany	2	3	2	1	1	6	6
Ireland	0	0	1	0	0	0	
Luxembourg	0	0	0	0	0	3	3
Spain	0	1	1	1	1	1	0
United Kingdom	1	0	0	10	5	4	3
EU Institutions	1	1	1	1	0	1	0
Total	11	15	16	31	24	17	34

Source: Euroleverage, 2013

Figure 1: OECD Health Disbursements



4.4.1.2 National Budget Trends

There was a general increase in the national budget each financial year from 2009/10 to 2013/14. Financial year 2012/2013 showed the most dramatic increase with a nominal growth of over 38% (see Table 3). Adjusted for inflation, however, there was a significant decrease in real growth (see Table 4 for inflation rates during the period). It is notable that though Rwanda suffered aid freeze from European donors due to its purported meddling in the conflict in eastern Democratic Republic of Congo, the budget grew by over 13% in FY2011/2012and 38% in FY2012/2013. The aid freeze, however, doubled inflation in 2011/2012, and saw an increase during 2012/2013 (see Table 4). This had an effect on the real budgetary growth in both the financial years as indicated below.

Table 3: Overall total budget trends from 2009/10-2013/14

Health Disbursements (Millions USD)					
Year	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**	**2013/2014**
Total Budget (,000 Rwf)	898,962,483 $142 per capita	984,022,047 $155 per capita	1,116,851,388 $176 per capita	1,549,859,475 $245 per capita	1,653, 467, 462 $261 per capita
Nominal		85,059,563 9.46%	132,829,340 13.5%	433,008,087 38.7%	103,607,986,699 6.68%
Real		25,775,635 2.86%	14,758,815 1.5%	28,301,182 2.53%	5,511,063 0.35%

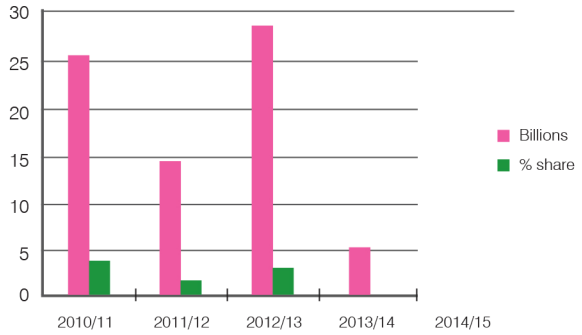
Source: Ministry of Finance

Table 4: Inflation rate 2009/10 – 2013/14

Year	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Inflation		2.3	5.7	6.3	3.5
Deflator	1	3.3	9	15.3	18.8

Source: Ministry of Finance

Figure 2: Real growth and percentage share in 2010/2011 - 2013/2014



4.4.2 National Family Planning Budget (FY 2009/10 -FY 2013/14)

Notably, the national family planning expenditure and disbursements coincided during the period 2009/10 – 2013/14, and that FP interventions were catered for under the Government recurrent expenditure for the same period.

In addition, the FP budget for financial year 2010/2011 rose in real terms by a whopping 1,026%, with a dramatic fall to 2.2% in the financial year 2011/2012. Financial years 2012/13 and 2013/14 saw negative growths.

Table 5: Family planning budget 2009/10 – 2013/14

Year	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
FP (,000Rwf)	12,155,265	424,000,000	510,000,000	506,066,041	483,643,111
Nominal		411,844,735 3,388%	86,000,000 20.2%	-3,933,959 -0.77%	-22,422,930 -4.4%
Real		124,801,434 1,026%	9,555,555 2.2%	-257,121 -0.05	-1,192,709 -0.23

Source: Ministry of Finance

RH and FP categorizations did not coincide during the period (see Table 6). During the financial year 2009/2010 they were categorized separately as family planning and reproductive health. Between 2010/2011 and 2012/2013 they were merged and categorized "Reinforcement of Family Planning and Reproductive Health". During the financial year 2013/2014 FP and RH were incorporated as one budget line under "Maternal and Child Health" (Table 7). This implies that family planning received greatly reduced share during FY2013/14. Generally, however, per capita allocation in the overall MoH budget falls short of the WHO recommendation of $44.

Table 6: Family Planning Budget allocation by thematic areas (2009/10 – 2012/13)

Year	2009/2010	2010/2011	2011/2012	2012/2013
Total MOH Budget		76,694,936,826 $12 per capita	109,523,533,680 $17 per capita	140,150,512,572 $22 per capita
Forcement of Family Planning and Reproductive Health		1,246,300,000	3,404,847,550	2,994,194,752
Family Planning	12,155,265	424,000,000 0.55% of MoH budget	510,000,000 0.46% of MoH budget	506,066,041 0.36% of MoH budget
Reproductive Health	12,155,265	822,300,000	2,894,847,550	2,488,128,711

Table7: Family Planning Budget allocation by thematic area (2013/14)

	2013/2014
Total MOH Budget	127,642,972,458 $20 per capita
Maternal And Child Health	6,863,453,373
Family Planning And Reproductive Health	483,643,111 0.38% of MoH budget
Maternal And Child Health Improvement	3,463,813,923

4.5 District Budget Analysis

4.5.1 FP budget in Gatsibo District

There was no indication of family planning budget in FY2012/2013. Family planning activities were subsumed under the Health component under the Human Development and Social Sectors in the district's EDPRS Priorities. However, family planning in Gasibo District was categorized under "Disease Control" with a budget of Rwf. 6,415,000, for the financial year 2013/2014. Community mobilization was the main activity under the budget allocation. The reason for this is that FP consumables and equipment in all the districts are procured directly from the government. There is a projected increase in the next financial year (2014/2015) of nearly double this financial year's at Rwf 12,615,000. Projections for 2015/2016 are triple at Rwf 18,815,000.

4.5.2 Family planning users experience and opinion on budgeting process

The budgeting process has been inclusive of all the stakeholders, from the grassroots communities, community-based organizations and local authorities. One active development partner was cited, while others have lapsed over time.

Worth noting was an observation by the key informants that despite all broad-based stakeholder involvement in the budgeting process, identified priorities at the district level tended to be overlooked as any support from the government or development partners was through "an envelope", suggesting pre-determined allocations according to the availability of funds from the government or development partners.

4.6 Conclusions from Budget Analysis

There was a general increase in the national per capita health allocation from $12 during the FY 2010/2011 to $20 in FY 2013/2014, reflecting the increase in the national budget each financial year during the same period. This however falls far short of the WHO recommended $44 per capita. On the other hand budget allocations for FP stagnated at around 0.5% of the total MoH budget. The amount is minimal and calls for an increase if the contraceptive uptake is to reach the projected 70% by 2017. It is notable that solely the government as indicated in the national budget has financed FP, with no support from international partners. The apparent lack of donor support for FP in the budget does not preclude as support development partners may have provided in FP outside Government, which calls for further research. It nevertheless creates room to advocate for international partners to offer more budgetary support in FP, especially in anticipated increase of up to 70 per cent uptake in FP services.

Though the budgeting process has been inclusive of all the stakeholders at the district level, both the government and development partners should pay more heed to district priorities as collectively identified and not merely offer an "envelope".

5. Conclusions

Gatsibo District reflects national trends, of which Rwanda has made commendable progress in family planning. Not only did modern contraceptive prevalence rate quadruple from 10% in 2005 to more than 45% in 2010, but total fertility rate decreased from 6.1 children per woman to 4.6 in the same period. While the Government aims to increase CPR to 70% by 2017, supply of contraceptives has continued to meet the demand. However, there is concern that with the increase the Government may not be able to sustain the demand with the anticipated increase in cost of providing FP services. This study finds that Rwanda received no international support for FP beginning 2009 to date. This lays the foundation for FP funding from international partners. International development partners therefore should be lobbied to offer their support in anticipation of any shortfall, especially in ensuring that strategies to address FP challenges come to fruition (see 4.1.2.2).

Despite the CPR of more 45% and an overall decrease of 1.5 children per woman currently, much remains to be done. Unmet FP need stands at 19%, while the current method mix does not appear to address women's wide range of fertility preferences. As this study observes, long-acting and permanent methods are probably most appropriate, while over-reliance on short-acting methods generally presents higher rates of discontinuation. This potentially results in more unintended pregnancies. It is, however, noted that in a setting where the demand is high and unmet need significant it calls for further examination. This underscores the need for technical, in addition to increased financial, support. It is likewise clear that myths and misperceptions about FP and its effects, along with socio-cultural and religious influences affect FP service demand at the community level. The misperception is also apparent in the "stigmatization", demonstrated in the Gatsibo District Budget that it should fall under "Disease Control." This only serves to sideline FP as a key issue in the District.

5.1 Recommendations

The foregoing analysis and according to the priority issues identified by the communities, we recommend three interrelated issues for advocacy, both at the district and nationally. That the Government and international partners allocate adequate resources, both financial and human to

- Fight misperceptions, myths and rumors about FP methods and their side effects, including improvement of method mixes, through the media and at the community level through CHWs;
- Reach and involve the youth in relevant RH & FP programmes
- Lobby the government to increase FP budget, and the international community to begin offering FP budgetary support by start of next financial year, 2014/2015.

Youth inclusion and fighting misperceptions were identified by the communities as their key issues of concern, and have a bearing on community outreach. Strong advocacy efforts' targeting the international partners to allocate funds for FP services is paramount to build for wider and more effective community outreach as above articulated.

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RWANDA WOMEN'S NETWORK
Kinyinya Sector, Gacuriro (next to SOS Technical School)
KG 428 Street
P.O Box 3157, Kigali, RWANDA
Tel: +250 788 334 257
Email: rwawnet@rwanda1.rw / info@rwandawomennetwork.org
Website: www.rwandawomennetwork.org

and

DSW (Deutsche Stiftung Weltbevoelkerung)
Hatheru Road, Hatheru Court (Lavington)
P.O Box 2438 - 00202 Nairobi, Kenya
Tel: +254 20 2731398/20 3592302
Mobile: +254 726 603768/ 736 616491
Email: info@dswkenya.org
Website: www.dsw-online.org