Rwanda

PROJECT OVERVIEW

The project was conceived in the context of a period of post-emergency policy development and of government reforms. Approved in 2003, it formed an integral part of the fifth UNFPA Country Programme.

The National Reproductive Health Policy developed in 2003 set the priorities for the project which was in line with national policy and key development frameworks including PRSPs, UNDAF, ICPD priorities and the MDGs. Implemented by the Ministry of Health through the Reproductive Health Division (Kigali-based MINSANTE) in three of the country's 12 provinces, the project covered 11 health districts encompassing 84 health facilities. Key partners for programme implementation were Memisa Cordaid and ARBEF.

The project employed a number of core strategies designed to support and reinforce the Health Sector Strategic Plan (2005–2009) as well as addressing the specific RH needs of the population.

The project has made a very real contribution to improved maternal health in hard-to-access areas of the country.

With the project emphasis on community involvement, community structures and volunteers also played a major implementing role in project activities which focused specifically on four core problems; limited coverage and availability of quality reproductive health services; lack of youth-friendly clinical RH services; very low contraceptive utilization rate; and unacceptable levels of gender-based violence. The project has made a very real contribution to improved maternal health in hard-to-access areas of the country.

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The performance-based contract was undertaken between the Ministry of Health and primary health care centres and revolved around the transfer of funds on the basis of performance. The contract included indicators related to adequate coverage (quantity), as well as effective coverage (quality) of services.

An evaluation of results of the pilot phase showed impressive improvements in SRH indicators (2005–2007) including a 218% increase in new family planning users, a 150% increase in referrals for obstetric emergencies and a 61% increase in institutional deliveries.

The successful piloting of PBF in Cyangugu contributed to its adoption by the Government of Rwanda and the approach has been rolled out in all districts of the country with the World Bank having stepped in. Again, this approach has been highlighted as a best practice.

Support to community-based insurance schemes (mutuelles) and performance-based management was a significant contribution to increasing access to services for poorer segments of the community. Subsidized and affordable RH services have proved to be an incentive for women to use antenatal care services and give birth at a health facility.

FACTFILE

Title **Improving SRH Services in Cyangugu, Kibuye and Umutara Provinces**

Aim **To increase utilization of RH services in line with national RH policy, and key development frameworks including the MDGs.**

Duration **66 months: 2003–2008**

Budget **US$2.692 million**

KEY ACHIEVEMENTS

- **Performance-based financing to improve the quality of service delivery.**
- **Support to ARBEF clinics for improved RH service delivery targeted at young people.**
- **Referral and counter-referral systems.**

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SUSTAINABILITY

At national and policy level, there is strong evidence of commitment to improved RH policies and strategic plans at national level along with the political will to support district activities. Family planning and the reduction of maternal and neonatal mortality have been identified as priorities in the Economic Development and Poverty Reduction Strategy 2008–2011 (PRSP). As a component of this strategy, the government has decided to allocate a dedicated budget line within the annual work plan to fund its RH activities and strategies.

Among the innovative interventions supported directly by the project with important implications for exploring sustainable financing options to health service provision, it has been highly encouraging to note that compliance rates among the population for the health mutual funds (health insurance) has been of the order of 60–80% – a very encouraging sign for its potential as a replicable approach.

Support to community-based insurance schemes (mutuelles) and performance-based management was a significant contribution to increasing access to services for poorer segments of the community.

Support to ARBEF for RH service delivery for young people

The two IPPF affiliated ARBEF integrated RH clinics established under this project have been cited as models for best practice. They provide quality-assured dedicated RH services and their clients particularly appreciate being able to have all their RH needs met under one roof. Many HIV positive clients, who receive VCT at the clinics, stay with the clinic for follow-up care and treatment even when there are facilities closer to where they live. The ARBEF services have particular appeal to youth and are the main providers of youth-friendly services. There is a good chance that the ARBEF clinics will be sustainable through cost-recovery after programme closure.

Referral and counter-referral systems

The support to, and the expansion of, the obstetrical referral system is regarded as one of the major contributions to reducing MMR in the districts. The supply and rehabilitation of ambulances has allowed the transporting of emergency obstetrical cases to referral units. District hospitals have been able to station ambulances in prime locations which allow more rapid transportation to the maternity units. Communities have greatly valued and supported this initiative. Some have built and maintained stretchers which allow women to be transported by foot to points that the ambulances are able to reach. Radio telephone communication was not feasible or sustainable, thus health facilities have bought dedicated mobile phones so families or community health workers can call staff who in turn can contact the referral units and the ambulance drivers.

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LESSONS LEARNED

There is an urgent need to accelerate the process of establishing an effective data management system capable of collating and analyzing key RH data. The lack of a strong evidence base for decision making and planning is recognized to have hampered project activities. It is important that systems are put in place so that all stakeholders have access to reproductive health data and that this is used as a teaching and remedial tool at all levels of management.

The government should clarify its role as the process of decentralization becomes more fully understood and takes root. The role of the Department for Reproductive Health needs to be clear to all. While setting policy and planning are its primary roles, taking on the mandate to ensure quality of services and explore innovative and cost-effective means of doing so are important.

There is a need for long-range planning for the maintenance and replacement of equipment. A long-term maintenance and purchasing plan needs to be implemented to ensure the sustainability of referral systems.

This project was funded by The European Union.

UNFPA 220 East 42nd Street, New York, New York 10017, USA
Tel: +1 212 297 5000 • Fax: +1 212 370 0201 •Email: hq@unfpa.org • www.unfpa.org
UNFPA EUROPE 14 Rue Montoyer, 3rd Floor, B-1000 Brussels, Belgium
Tel: + 32 2 550 1830 • Fax: + 32 2 550 1833 • Email: unfpa-brussels@unfpa.org • europe.unfpa.org