Advancing the PPFP Agenda
Building Partnerships to Meet Rwanda’s FP2020 Commitments

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History of expansion of PPFP services in Rwanda

2010-2012
- **Pilot**
  - ANC counseling @ 3 HCs
  - PPFP Couns & PPIUD @ Muhima

Expansion of PPFP/PPIUD
- 4 districts/hospitals
- 8 HCs

2014
- **Zambia Regional PPIUD Meeting**
  - (11 African countries)

2015
- WHO MEC change &
  - Chiang Mai Global Meeting

2018
- **Today**
  - MOH guidelines, tools, aligned with 2015 MEC
  - 20+ districts implementing PPFP
  - Multiple donors

2018
Of Rwandan women 0–23 months postpartum, fifty-one percent have unmet need for family planning.

Total family planning use and prospective unmet need among women 0–23 months postpartum.

Summary of Commitments

“The Government of Rwanda in collaboration with its partners and private sector commits to:

• Programming at scale postpartum family planning in health facilities by 2020
• By 2024, total demand for FP will have increased from 72% to 82%
• Improve its rights-based FP programming by adding to its available method mix long-acting and reversible methods
• Using the evidence base of high-impact practices to focus its FP programming resources for greatest impact by 2020.”

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
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<tbody>
<tr>
<td>Scale up of PPFP in all health facilities in Rwanda</td>
<td>PPFP is scaled up to facilities 20+ districts</td>
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<td>Review ongoing PPFP approach including the use of qualitative data to</td>
<td>In progress</td>
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<td>inform scale up/scale up PPFP interventions in 10 remaining districts</td>
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<td>by training service providers</td>
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<td>Ensure quality services through mentorship sessions</td>
<td>Ongoing</td>
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<td>Determine a package of PPFP services to be integrated in Immunization</td>
<td>Ongoing</td>
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<td>and ANC services</td>
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<td>Ensure that the two PPFP indicators are captured in the HMIS</td>
<td>Completed</td>
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<tr>
<td>Expand/scale up PPFP services in private health facilities of Kigali</td>
<td>In progress</td>
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<td>City</td>
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Immediate PPFP intervention goal and strategy

**PPFP intervention strategy components**
- Counseling on all methods
- Competency-based training on PPFP counseling and follow up
- Clinical training on providing all methods of pre-discharge PPFP and follow up
- Quality improvement and mentorship

**Improved skills among providers**
- Improved counselling skills among clinical staff and community health workers
- Improved skills to provide PPFP methods among clinical staff

**Key clinical practices improved**
- More women counseled on all available methods and making choices
- More women receive PPFP method of their choice

**Health outcomes improved**
- Reduction in unplanned pregnancy
- Improvements in birth spacing
Scale up of immediate PPFP (2016-2018)

Phase I

- MCSP assisted the MoH to introduce PPFP in four districts (Musanze, Rwamagana, Kamonyi, and Ngoma)
- Stakeholders workshop conducted December 2016 to share lessons learned from Phase I districts and plan for expansion to six new districts

Phase II

- MCSP assisted the MoH to expand PPFP interventions to six additional districts (Nyabihu, Nyaruguru, Gatsibo, Huye, Nyamagabe, and Nyagatare)
- The MOH either alone or with other partners (UNFPA, Partners in Health) introduced immediate PPFP in other districts as well
Monitoring scale-up through existing systems and dashboard

• Added a column to the maternity register margin to capture pre-discharge PPFP
• Using codes, the provider documents if PPFP counselling is done (Y) and outcome
  • Y/Accepted a method
  • Y/Refuse
  • Y/Plan
• Mentorship checklist

Key items on PPFP dashboard
• No. of providers trained on PPFP (counselling and clinical)
• Stock-out of FP commodities
• Counselling outcome
• Action plan
Key progress

Outcomes of PPFP counseling and proportion of postpartum women who initiated a PPFP method before discharge
Costing Analysis: Annual cost per district

Annual maintenance costs per district are approximately 60% less than costs during first-year of introduction (excluding mentor salaries)

Note Preparation category includes training equipment replacement in maintenance years
Estimated costs of package suggest it is a relatively low-cost intervention

• **Average annual district cost**
  • RF 27 million (approx. $31,800) in first year of introduction
  • RF 11 million (approx. $12,900) in subsequent years to maintain intervention

• **Annual cost per capita**
  • First year of introduction: RF 75 ($0.09)
  • Annual per year maintenance: RF 28 ($0.03)

• **Annual cost per woman of reproductive age**
  • First year of introduction: RF 285 ($0.34)
  • Annual per year maintenance: RF 105 ($0.12)

• Estimated RF 300-450 million ($353-530 thousand) total cost per year for full scale-up in Y3-Y5 represents less than 1% of total government expenditures on health** (excluding PPFP commodities)

*Based on approx. 3 million women aged 15-49 (2017 UN Population Prospect); 11.92 million pop
**Source: Rwanda National Health Accounts 2014
Rwanda Government Strategic Planning

Development priorities

Economic, social and governance priorities

Health priorities

Policies and policy directions

Population-based outcomes for
- Contraceptive use
- Teen pregnancies
- Maternal, child, neonatal mortality
- Demographic dividend

Vision 2050

National Strategy for Transformation

Health Sector Strategic Plan 4 (2018-2024)

RMNCAH Policy

Maternal, Newborn, Child Health Strategic Plan

FP/ASRH Strategic Plan
Development of RMNCH policy and FP/ASRH strategy

- MoH formed a core team of partners to support strategy development and costing
- Led assessment of previous strategies and used secondary DHS 2015 analysis to guide and target gaps
- Led multi-stakeholder, collaborative process seeking strategic inputs from all levels
- TWG convened multiple forums for stakeholders to validate strategic plan
- Health Sector Strategic Plan 4 (2018-2024) - FP/ASRH inputs included
Situation Analysis prior to development of FP/ASRH Strategy

1. Desk review*
2. Further analysis of 2014-15 DHS
3. Consultation FP Roundtables (MOH/RBC with all districts)
4. FP Goals
5. ASRH Stakeholders online survey
6. FGDs w/ 16-19 yr old boys & girls in 4 districts
7. FP Roundtables (MOH/RBC with all districts)

* Rwanda-specific: HSSP III MTE, FP Effort Index Brief, Expiring policies and strategies, CHP eval
International: CIP Toolkit, HIP Briefs, WHO AA-HA, other misc. WHO documents
Results of FP goals Analysis showed that scaling up PPFP would generate greatest impact in increasing CPR (among married women) in Rwanda.
Postpartum Family Planning is mentioned in draft new FP/ASRH strategy as well as HSSP4
Integration;
Operationalizing contact points

Pre-pregnancy adolescents
ANC visits I-4+
Birth
• home
• facility
PNC visits
• home
• facility
Immunization visits
Measles immuniz.
Pharmacy/drug shop visits

Pregnancy
Neonatal period
Introduction of complementary foods, return to fertility
Post-neonatal → 2nd year

Family Planning… Every Girl/Woman, Every Time!
Engaging Communities

• PPFP scale-up strategy focused on pre discharge PPFP
  • Extending the intervention to community level with outreach

• Training of binomes and ASM split by technical intervention previously
  • Now they are coming back together to work on PPFP
Strengthening Linkages Between Facility and Community
Challenges and opportunities

Challenges:
• PPFP was not in the HMIS
• Ensuring quality of FP counseling
• National TWG has many competing priorities
• No direct control of commodity supply

Opportunities:
• National FP2020 Commitments
• Strong political will
• Strong implementing partners (WHO, UNFPA)
• District to district technical support
• High facility delivery rate in Rwanda
• Established Scale up management team
Thank you!