REPUBLIC OF RWANDA

MINISTRY OF HEALTH

National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan (2018–2024)

JULY 2018

CONTENTS

FOREWORD

The Family Planning and Adolescent Sexual Reproductive Health Strategic Plan 2018-2024 is the guiding document outlining strategic directions towards family planning and adolescents to improve the Rwandan well-being. It contains a deep analysis of FP/ASRH need in Rwanda and based on technical input from different stakeholders, including health managers and other public institutions, development partners as well as private sectors and civil society. The foundation of the FP/ASRH Strategic Plan was synthesized from a variety of evidenced-based input and practical insights gathered through a series of consultations, including both virtual and in-person meetings that were designed to engender participation and collaboration involving all stakeholders working in FP and ASRH.

Rwanda is committed to achieve the Sustainable Development Goals by 2035 and has declared family planning (FP) and adolescent sexual reproductive health (ASRH) a national priority for poverty reduction and socioeconomic development of the country. As such, a strategic plan is needed to coordinate FP and ASRH efforts around a well-defined set of objectives and responsibilities. The FP/ASRH Strategic Plan is aligned with different Rwandan strategic documents, including Vision 2020 and 2050, EDPRS III and HSSP IV.

The assessment of the previous policies, secondary analysis of the RDHS and a specifically commissioned situation analysis conducted in 2017 was the basis for the drafting of the current joint strategic plan. The core components of this 5 year plan, the strategic objectives and strategies, were finalized through an iterative process led by the Family Planning/ASRH Technical Working Group and culminating in a validation workshop on March 19th and 20th, 2018.

In developing this new strategic plan, the MoH is renewing its commitment to the importance of FP and emphasizes the need to involve both men and youth in solidifying FP programs. Expanding adolescent sexual reproductive health programs is a pillar of this plan that will help motivate the next generation of FP users. Building upon the lessons of past experiences, this plan focuses on meeting FP needs with the intent of reaching universal access to a full range of modern contraceptive methods. The plan takes a pragmatic approach, identifying education and training as the principal means for increasing service quality and promoting FP use. Moreover, the strategic objectives are built upon the existing six pillars of Rwanda's health sector.

In order to achieve the Government of Rwanda's ambitious goal, strong effort in coordination from MoH and stakeholders will be needed. Since the MoH is resolute in taking on this issue through results and evidence-based approaches, while providing room for innovation, positive results are anticipated. The MoH will continue to reinforce coordination efforts for alignment of implementation efforts, thus promoting greater efficiency and effectiveness of the FP program.

The Ministry of Health shall at all stages involve its partners and stakeholders during implementation and solicit beneficiaries on services that best respond to their needs.

Dr. Diane Gashumba,
Minister of Health

ACKNOWLEDGMENTS

The Ministry of Health (MoH) would like to express its deep appreciation to everyone who participated in the development of the 2018-2024 FP/ASRH National Strategic Plan. This document is a labor of passion among each one of us to ensure that all Rwandan citizens, women, girls, men and boys will benefit from improvement in health and contribute to the progress of Rwanda as a middle income country.

The development of this strategy was through a wide consultative approach. All stakeholders and actors at the national, district and health center levels are particularly commended and enjoined to remain partners in the implementation of the FP/ASRH Strategic Plan in the coming 5 years.

The ministries and other government agencies—Ministry of Finance and Economic Planning (MINECOFIN), Ministry of Education (MINEDUC), Rwandan Parliamentarians' Network on Population and Development (RPRPD), Rwanda Biomedical center (RBC), National Women's Council, National Youth Council—are all accorded special recognition for their active engagement and for providing valuable input.

Development partners, such as the United States Agency for International Development (USAID), the United Nations Population Fund, World Health Organization as well as international and local FP/ASRH-implementing partners, deserve special appreciation for their contribution to the process of elaboration of this strategic plan.

The MoH would like to specifically recognize USAID in particular for its financial and technical assistance to lay out coherently the the FP/ASRH Strategic Plan, through the Maternal and Child Survival Project (MCSP).

RWANDA BIOMEDICAL CENTER

Dr. Jeanine Condo,
Director General
Rwanda Biomedical Center

LIST OF ABBREVIATIONS AND ACRONYMS

AA-HA	Accelerated Action for the Health of Adolescents
ANC	Antenatal Care
ASRH&R	Adolescent Sexual Reproductive Health & Rights
CEDAW	Convention of the Elimination of all Forms of Discrimination against Women
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
EDPRS	Economic Development and Poverty Reduction Strategy
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GOR	Government of Rwanda
HPV	Human Papilloma Virus
HSSP	Health Sector Strategic Plan
IOSC	Isange One Stop Center
KAP	Knowledge, Attitude and Practice
LMIC	Low- and Middle-Income Countries
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MOH	Ministry of Health
NCIFP	National Composite Index on Family Planning
PAC	Post Abortion Care
PRB	Population Reference Bureau
RBC	Rwanda Biomedical Center
RDHS	Rwanda Demographic and Health Survey
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
RPRPD	Rwandan Parliamentarians on Population and Development
SBCC	Social Behavior Change Communication

SGBV	Sexual Gender Based Violence
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
SWOT	Strengths, Weaknesses, Opportunities, Threats
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1 EXECUTIVE SUMMARY

Rwanda's Family Planning/Adolescent Sexual Reproductive Health Strategic Plan (2018-2024) highlights its commitments and priorities for the coming six years. This Strategic Plan builds on, merges and replaces two distinct expiring strategies: the Family Planning Strategic Plan 2012-2016 and the National Adolescent Sexual Reproductive Health & Rights (ASRH&R) Strategic Plan 2011-2015.

While Rwanda has made great strides in improving modern contraceptive prevalence, in the last five years, this progress has stagnated and a reformed multi-sectoral response is required to align forward thinking national strategies with the Sustainable Development Goals (SDGs) focusing on People, Planet, Peace, Prosperity, and Partnerships. Indeed, the Global Strategy for Women's, Children's and Adolescent's Health (Global Strategy) outlines a shift from a focus on reducing mortality rates, to ensuring that women, newborns, children, and adolescents not only survive, but also thrive and realize their full potential.

This Rwanda Family Planning/Adolescent Sexual Reproductive Health Strategic Plan (2018-2024) is consistent with existing national policies and strategies, and proposes that health care services should be people-centered, integrated, and sustainable in line with the fourth Health Sector Strategic Plan.

The strategic plan addresses findings from a desk review, secondary analysis of the RDHS 2014-15, FP Goals consultation, an FP roundtable, an online ASRH stakeholders survey and focus group discussions with 16-19 year-old boys and girls in four districts. A stakeholder prioritization exercise was held to set forth strategic objectives that directly align with policy objectives in the RMNCAH Policy 2017-2030, followed by meetings with the Family Planning/ASRH Technical Working Group to further review, refine and finalize the document. It provides a framework for addressing reproductive health challenges currently facing Rwanda, and aims to develop and restructure new and existing interventions to improve and increase their impact on family planning and adolescent sexual reproductive health to achieve national and international targets.

The overall goal of the strategic plan is that every Rwandan citizen (or resident) of reproductive age fully exercise their sexual reproductive health and have access to the services of their choice, improving sexual and reproductive health and enabling an overall increase in contraceptive prevalence by 2024. The vision is that all Rwandans achieve their highest attainable standard for sexual reproductive health across the life course, understanding their options for family planning pre-pregnancy, post-abortion or postpartum so as to manage their fertility aspirations and have equitable access to the services they need, close to where they live. The mission is for all women, men, adolescent girls and boys in Rwanda to have universal access to quality integrated FP/ASRH information and services in an equitable, efficient and sustainable manner. This will be attained through the following six strategic objectives:

1. Increased demand for FP/ASRH services for all Rwandans through awareness raising and community engagement

2. Improved availability and accessibility of FP/ASRH services through maximizing opportunities for efficient integration of quality services at all levels of service delivery
3. Improved availability of quality youth-friendly FP/ASRH services
4. Enhanced use of innovation to increase uptake of FP/ASRH services
5. Strengthened governance systems that utilize reliable disaggregated FP/ASRH data to inform decision making and accountability
6. Strengthen a policy that is inclusive and inter-sectoral for FP/ASRH programming that is supportive and contributes to Rwanda realizing its demographic dividend

The implementation of this strategic plan will require dedicated investment to achieve broad reaching sustainable impact. The strategic plan puts forward a resourcing plan and provides an estimate of approximately RWF 52,961,611,090 /USD 60,875,415.05 for the implementation of the interventions required to achieve the desired targets.

The Ministry of Health will coordinate the implementation of these interventions and will ensure high performance and financial accountability to achieve the anticipated outcomes. This will be accomplished through strategic and collaborative partnerships with key Government Ministries, local authorities, civil society, development partners, private sector, and community but also through reliable sources of funding.

In order to determine the effectiveness of the strategies and interventions contained in this strategic plan, the output, outcome and impact indicators will periodically be measured through a baseline, midterm and endline review. Findings from the midterm review will be compared with targets (and baselines where applicable) to assess the implementation status of the strategic plan and to make course corrections as necessary while the endline review will assess the overall success of the strategic plan.

2 INTRODUCTION

Every Rwandan citizen of reproductive age fully exercise their sexual reproductive health and have access to the services of their choice, improving sexual and reproductive health and enabling an overall increase in contraceptive prevalence by 2024

This goal statement reflects that all Rwandans, whether men or women, as well as adolescents, have sexual and reproductive health needs that have to be satisfied, beginning from pre-teen to end of teen age (10-19 y.o., WHO). It includes contraceptive prevalence as the primary metric and quantitative performance measure. It implies not only contraception and family planning but also other components of Sexual and Reproductive Health such as Prenuptial care, antenatal care, safe delivery, Post-natal care, HIV/STI prevention and treatment, Gender based violence prevention and management and gender mainstreaming, Information and counseling on ASRH and Postabortion care. These services must be provided in an equitable manner without any discrimination, leaving no one behind.

Linkages to policy and development frameworks

Rwanda is among the signatories of the 1994 International Conference for Population and Development (ICPD) where 179 countries had a remarkable consensus that individual human rights and dignity including the equal rights of women and girls and universal access to SRH and rights are a necessary precondition for sustainable development. The actual FP/ASRH SP is linked to the RH policy that was put in place in 2003, following the ICPD plan of action. It is also linked to the Millennium Development Goals (MDGs) of which the Government of Rwanda (GoR) adhered to and included in its Economic Development and Poverty Reduction Strategies (EDPRS) to guide programming and to prioritize resource allocation. The MDGs and their priority strategies serve as a foundation for Vision 2020, the national framework that defines Rwanda's long-term development goals (Republic of Rwanda, Ministry of Finance and Economic Planning, 2000).The strategic plan is also linked to the Demographic Dividend Study which was conducted to assess Rwanda's prospects for harnessing the demographic dividend; and articulates priority policy and program options that should be adopted in order to optimize Rwanda's opportunity of maximizing demographic dividend for its youthful population and achieving the medium, long-term socio-economic development aspirations.

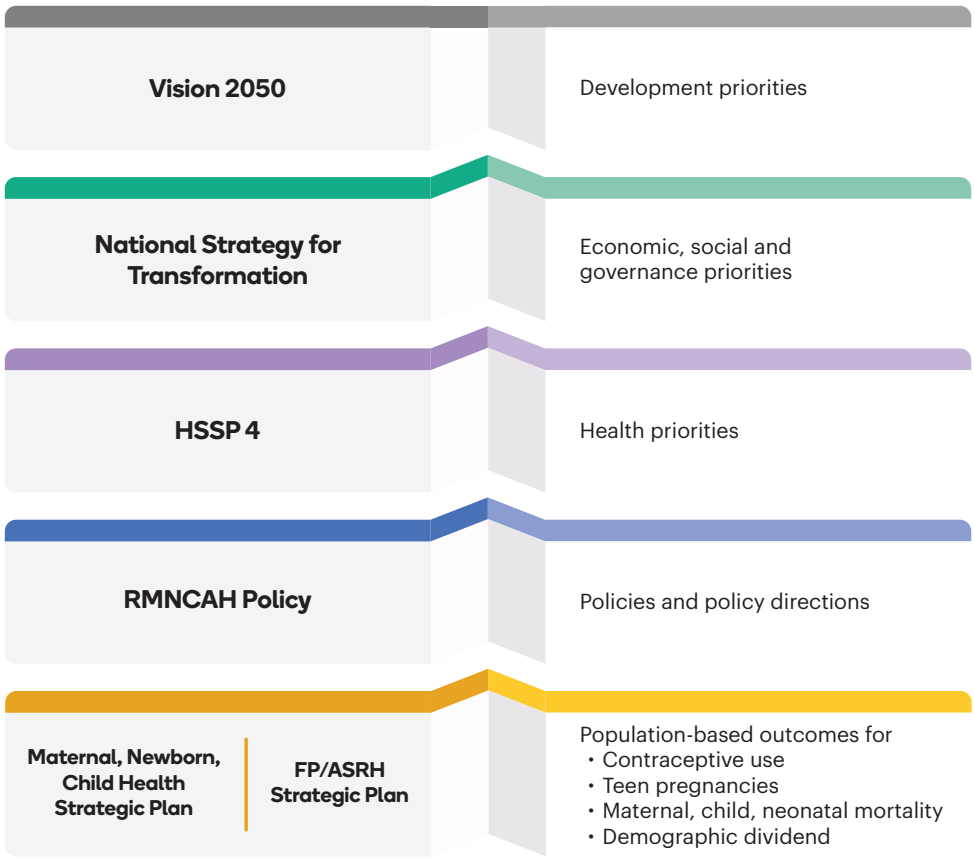
The FP/ASRH strategy affirms existing national and international policies and frameworks like; Agenda 2030 for Sustainable Development, FP2020, Universal Declaration of Human Rights (1948), United Nations Declaration on the Elimination of Violence Against Women (1994), Beijing Platform for Action (1995), the International Covenant on Economic, Social and Cultural Rights (1966), The Convention of the Elimination of All Forms of Discriminations Against Women (CEDAW) (1979), the International Conference on Population and Development (ICPD), Programme of Action (1994), the Addis Ababa Declaration (2014), and the Maputo Protocol (2016), among others. The President of Rwanda is a highly visible international champion for the SDGs, not just for his own country, but for Africa as a whole. Additionally, Rwanda made commitments towards meeting the FP2020 goals at the 2012 London summit and renewed those commitments in July 2017. This FP/ASRH strategy aligns to the most current national strategic documents such as the National Strategy for Transformation (NST 2017-2024) which highlights the required investments for adolescents and youth. Other policies such as Vision 2050, the Health Sector Policy 2015, HSSPIV, ESSP, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Policy and youth policy are key sources for aligning the FP/ASRH Strategic Plan as illustrated in Figure 1.

Reproductive, Maternal, Newborn and Child Health (RMNCH) remain priorities for low- and middle-income countries (LMICs). This is reflected in the SDGs and the UN Secretary General's Global Strategy for Women's, Children's, and Adolescents' Health in 2015.

The Ministry of Health has recently developed the new National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy 2017-2030 (Republic of Rwanda, Ministry of Health, 2017)This new policy replaces a number of existing MOH policies including the:

- Reproductive Health policy
- Adolescent Sexual Reproductive Health and Rights (ASRH&R) policy (Republic of Rwanda, Ministry of Health, 2012)
- Family Planning Policy [(Republic of Rwanda, Ministry of Health, 2012)

Figure 1: Summary of GOR Sectoral Policy Systems and context for RMNCAH



The MOH has further chosen to define two national strategic plans to guide the implementation of the RMNCAH Policy. These are the present Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan 2018-2024 and the *Maternal, Newborn and Child Health Strategic Plan 2018-2024*.

The GoR has long been a vanguard in RMNCAH programming producing Family Planning Strategic Plan 2012-2016 (Republic of Rwanda. Ministry of Health, 2012), National Adolescent Sexual Reproductive Health and Rights Strategic Plan 2011-2015 (Republic of Rwanda, Ministry of Health, 2012) Strategic Plan to Accelerate Progress towards Reducing Maternal and Newborn Morbidity and Mortality, 2009-2012 (Republic of Rwanda. Ministry of Finance and Economic, n.d.) and the Rwanda National HIV/AIDS Strategic Plan 2013-2018 (FP2020 Annual Commitment update questionnaire response. Family Planning 2020, n.d.). The new FP/ASRH strategic plan (2018-2024) takes advantage of leveraging the successes achieved under the prior strategic plans, draw program experience to identify critical challenges and opportunities of moving forward, and to incorporate the latest research findings that will rapidly accelerate Rwanda's achievement of its health sector goals.

The consolidation of FP and ASRH into one SP is a significant development particularly in concretely articulating the national aspiration for the youth to have access to SRH services. All adolescents have a right to have access to quality sexual and reproductive health (SRH) services (see Box 1) so that they may safeguard their health and avoid negative long-term impacts on their future and that of the next generation (Chandra-Mouli V. e., 2015), (Assembly, United Nations General, n.d.); (Maurice). The impact of a healthier population will also be felt in the nation's economy and social development. (Assembly, United Nations General, n.d.). The GoR has addressed adolescent sexual reproductive health (ASRH) and access to contraceptive services in a number of sector policies, including the Ministry of Education's (MINEDUC) Education Sector Strategic Plan 2013/14-2017/18 (Republic of Rwanda, Ministry of Education., 2014), the Ministry of Finance and Economic Planning's Rwanda Vision 2020 (Republic of Rwanda, Ministry of Finance and Economic Planning, 2000), and the Economic Development and Poverty Reduction Strategy 2013-2018 (Nash, 2014).

Box 1: Core Youth-Friendly ASRH activities from the 2011-2015 ASRH&R Policy

- Information and counseling on ASRH, Contraception and Family Planning
- Access to Family Planning Methods, including Emergency Contraception (EC)
- Youth-friendly antenatal care (ANC), skilled attendance at delivery, and postnatal care (PNC) regardless of marital status
- Youth-friendly confidential counseling and testing for HIV, prevention and treatment of STIs, including HIV
- Information, counseling, and HPV vaccination
- Youth-friendly prevention and management of gender-based violence (GBV)
- Prenuptial consultation
- Post-abortion care (PAC)
- Life-skills education

In 2011, the Rwandan Ministry of Health (MOH) released its Adolescent Sexual and Reproductive Health and Rights Policy (ASRH&RP) and Strategic Plan 2011-2015. The policy and SP listed a number of core youth-friendly ASRH services (Box 1) which have been variably implemented. One of the notable successes is the school-based HPV vaccination campaign which achieved 93% coverage of girls in grade 6 in 2011 and 97% in 2012, including in- and out-of-school girls (Republic of Rwanda, Ministry of Health, 2017) (Maurice, 2016). Continued, sustainable implementation of effective intervention and critical examination of those which are less impactful will remain imperative in the implementation of the FP/ASRH strategic plan.

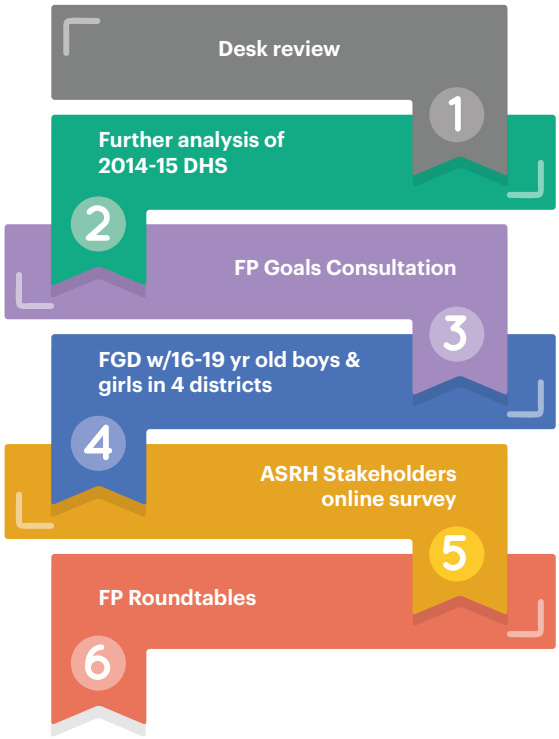
Family planning and adolescent reproductive health programs are governed by the laws of the GoR. In 2016, Rwanda's parliament passed the Reproductive Health law (Republic of Rwanda). The RH Law Article 3, which defines key components of reproductive health, also include a) "prevention of gender-based violence and care for victims thereof"; b) "raising awareness with the aim of attitudinal behavior change". While the MIGEPROF leads on the

Gender Policy and the strategic plan against gender-based violence (Republic of Rwanda, Ministry of Gender and Family Promotion, 2011), the FP/ASRH strategic plan takes this into account and highlights linkages between the two strategies. Thus, the FP/ASRH Strategic Plan has a central role to play in operationalizing the new law.

3 METHODOLOGY FOR STRATEGIC PLAN DEVELOPMENT

The development of the Family Planning/Adolescent Sexual and Reproductive Health & Rights (FP/ASRH) Strategic Plan 2018-2024 was undertaken in parallel with the development of a new National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy and its sister strategy, the Maternal, Newborn, Child Health Strategic Plan 2018-2024. The current FP/ASRH Strategic Plan builds on, merges and replaces two distinct expiring strategies: the Family Planning Strategic Plan 2012-2016 and the Adolescent Sexual and Reproductive Health (ASRH) Strategic Plan 2011-2015. A core team of MOH/RBC and key partners has been meeting regularly since August 2016 to support and guide the development of the policy as well as the two strategic plans.

Figure 2: Steps undertaken to complete FP/ASRH Situation Analysis



The steps undertaken for the situational analysis is summarized in Figure 2. The activity took into account the 2016 report, results and conclusions of the Mid-term Review of the Health Sector Strategic Plan III and a number of other health sector evaluations (for a complete list, see bibliography). Furthermore, the data from older as well as recently completed surveys and assessments were also considered including the Rwanda Demographic and Health Surveys (2001, 2007/8, 2014/15) and the 2014 Rwanda National Composite Index on Family Planning (NCIFP) assessment and brief (Avenir Health, 2015) (Avenir Health, 2016). This particular index was used to design a Strengths, Weaknesses, Opportunities, and Threats (SWOT analysis) for the FP sub-sector.

The essential activities for each of the steps in the situational analysis are listed below:

1. Desk Review
2. For the family planning sub-sector:
    - Additional analysis of Rwanda DHS data causative factors in contraceptive use deceleration

- FP Goals Model to identify interventions for greatest impact on increasing contraceptive use among Rwandans
- National Family Planning Roundtables Consultation in May 2017 involving Minister of Health and 110 multi-sectoral representatives in both public and private and donors

3. For the ASRH sub-sector:
    - Survey to assess the expiring ASRH strategic plan, national program performance on ASRH issues such as the enabling environment for ASRH, availability/accessibility/equity of ASRH services, quality & appropriateness of ASRH services, whether services reflect best practices for being integrated, comprehensive, multi-sectoral, multi-level, accountability-related factors, such as cost-effectiveness, M&E, evidence based information use and financing of ASRH services. National ASRH stakeholders completed the survey online. The ASRH&R focal points in 4 districts were interviewed using the same survey tools, and their responses entered into the online database.
    - Focus Groups Discussions[1] with unmarried adolescent boys and girls, age 16 to 19, in 4 districts of Rwanda (Gicumbi in the North; Gisagara and Rutsiro in the South; and Rubavu in the West). The central MoH requested the youth officer in the district administration to assist in recruiting FGD participants. It is likely that participants were among adolescents active in existing youth centers. The topics covered by the focus group discussion guide were adolescents contraceptive KAP, sources of information and services where there is less associated stigma, barriers to accessing contraception and SRH products and services; and recommendations for improving ASRH services.

The situation analysis informed the articulation of 6 strategic domains for family planning and ASRH programs to contribute to achieve the RMNCAH policy vision and mission and the FP/ASRH overarching goal. Subsequently, a systematic process of pulling existing recommendations from Rwandan policy documents–inclusive of the results of the FP Goals and the FP Roundtables consultations–as well as international norm-setting guidelines such as the High Impact Practices Briefs for Family Planning[2] and the WHO Global Accelerated Action for the Health of Adolescents (AA-HA)—May 2017 (World Health Organization. 2017., 2017). The Strategic Framework section of this plan was derived from these recommendations with FP/ASRH stakeholder input[3].

Included in annex of this strategic plan are the outputs of these various efforts including:

- The commissioned report of the additional DHS analyses
- The National Composite Index on Family Planning (NCIFP) Brief
- The results of the ASRH stakeholder surveys.
- A literature review of the gender context in Rwanda, inclusive of results from the latest Rwanda DHS on women's decision making and gender-based violence as a component of reproductive health and rights.

3.1 SITUATION ANALYSIS SUMMARY RESULTS

The FP/ASRH strategic plan builds from the comprehensive situation analysis laid out in the RMNCAH Policy and expands on a few elements directly affecting family planning and ASRH. The following succinctly summarizes each of the elements critical to the FP/ASRH strategy

1 Participation was voluntary and ethical principles of human subject research were observed (including training of data collectors on ethics, verbal consent with instructions on voluntarism and non-penalties for refusing to participate or to respond to any specific question), however, these focus group discussions were not conducted under ethical review by an approved scientific committee.

2 https://www.fphighimpactpractices.org/briefs/

3 Consultation with national FP/ASRH&R stakeholders conducted at Lemigo Hotel on 26 May 2017. Note that stakeholders were asked to review recommendations, but also reflect on what is working and should be continued, what is not working (or has not been proven to be evidence-based) and should be dropped and to suggest adding interventions). Time was short for this process and thus should be enriched through a review of the draft document.

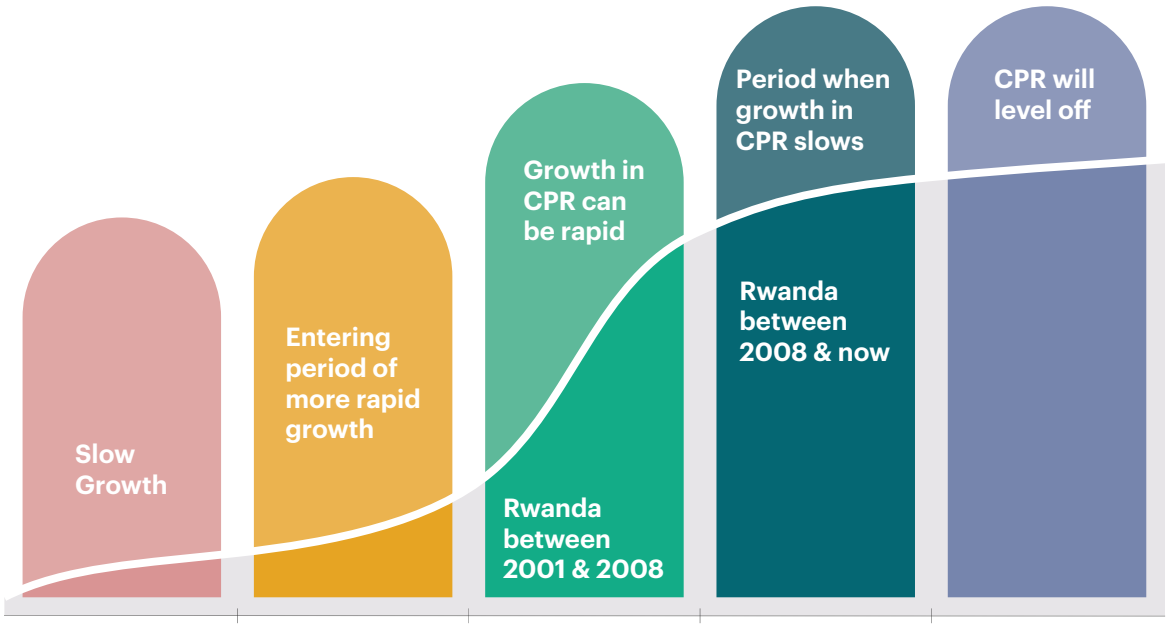
3.1.1 SOCIO-ECONOMIC AND POLITICAL CONTEXT

The Rwandan economy is growing with 2016 reporting a 6% growth. The country is one of the few in the continent where investments in voluntary family planning and child survival have led to significant declines in both fertility and mortality which, theoretically, would place Rwanda on the path towards achieving the demographic dividend. Countries that achieve demographic dividend, are poised for rapid economic growth. It is projected that if Rwanda continues to make progress in lowering fertility and mortality, it will achieve demographic dividend's accelerated economic growth by 2030 (PRB, ref 2.31). This is the opportunity that the FP/ASRH 2018-2024 Strategic Plan seeks to optimize and move Rwanda towards a middle income country.

3.1.2 POPULATION, HEALTH AND SERVICES STATUS

Rwanda's total fertility rate (TFR) of about 2 children today is attributable to a fourfold increase in modern contraceptive use over the last decade. However, the pace of change has not held steady over recent years with the last 5 years showing significant decelerations of TFR, use of modern contraception and narrowing of the met-unmet needs gap. This slowdown is consistent with the pattern seen in other countries, that once a certain level of contraceptive prevalence is reached, additional increases are more difficult to achieve. This is represented in the S-curve in Figure 3. For Rwanda, the Family Planning program needs to both continue to engage in those strategies that have generated past successes, but also explore and develop new strategies for reaching more Rwandan of reproductive age with unmet needs. The 2012 census estimated that adolescents comprised over 22% of the Rwandan population. To maintain the accelerated pace of contraceptive uptake, Rwanda will need to focus on developing strategies for reaching new users, such as postpartum women, unmarried women, sexually active adolescents and young adults as well as decreasing discontinuation particularly the younger cohort of 15-19.

Figure 3: Typical S-Curve Pattern for Contraceptive Prevalence Rate Change Over Time

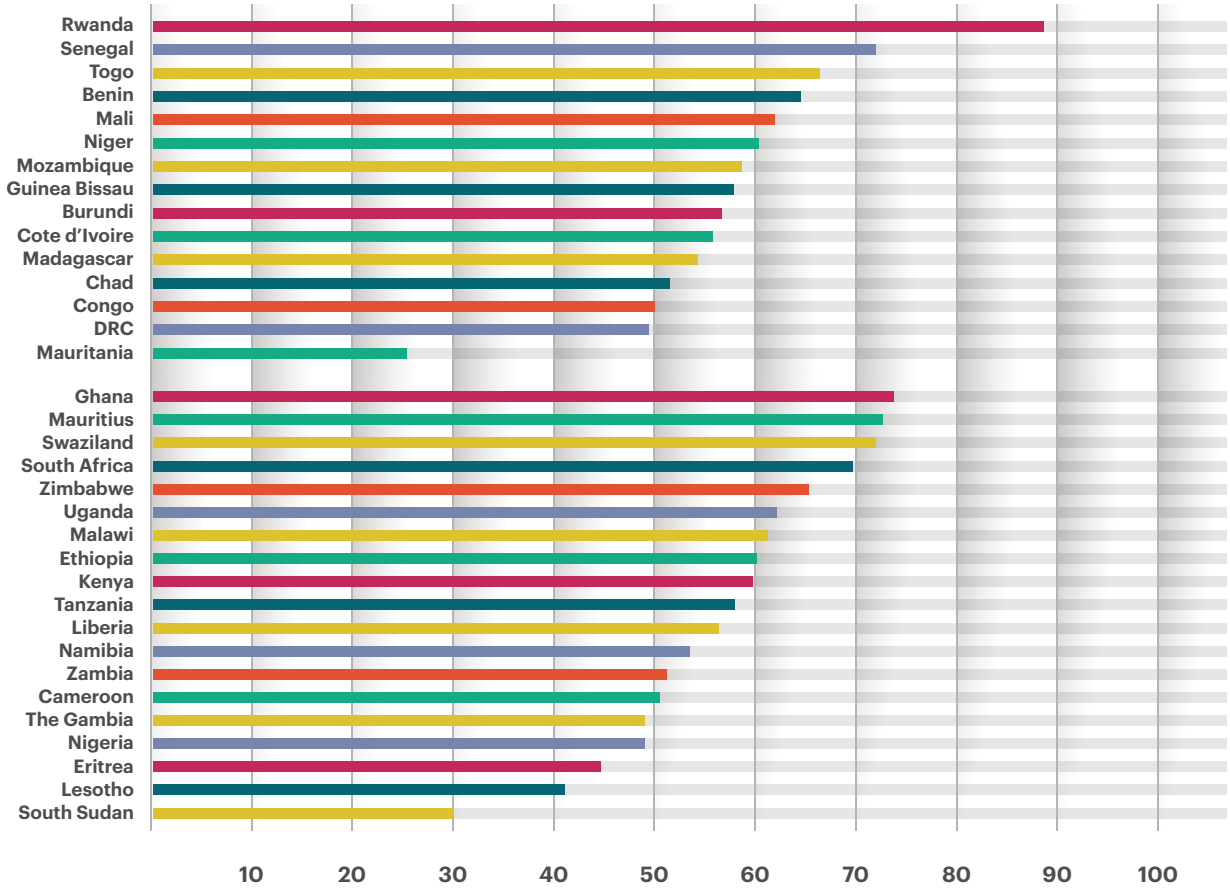


Recent Achievements, Gaps and key health issues

3.1.3 NATIONAL COMPOSITE INDEX ON FAMILY PLANNING

Using global standards for performance assessment, Rwanda's program performs very well (Avenir Health, 2015) (Avenir Health, 2016) and outpaces 5 of the 6 East and Central African countries for modern contraceptive prevalence rate (mCPR) among women in union. Rwanda is also the second of the 6 countries in terms of the lowest unmet need for FP. It also has one of the lowest one-year discontinuation rates. However, Rwanda lags significantly behind most countries in the region with respect to mCPR among unmarried sexually active women, keeping in mind the generally lower rates of sexual activity among 15 to 19 year olds.

Figure 4: National Composite Index in Sub Saharan Countries.



Source: Weinberger, M. andJ.Ross. The national composite Index for Family Planning (NCIFP). Avenir Health 2015

3.1.4 CONTRACEPTIVE USE AND NEED

Measuring unmet need is critical for tracking the success of FP programs. The reported unmet need in Rwanda is about 17% of women in union. However, understanding met and unmet need is important to program planning. The classic definition of unmet need for FP among pregnant and postpartum amenorrheic women is based on whether they were satisfied with the current pregnancy or the most recent pregnancy, i.e., if the pregnancy was wanted and/or if the pregnancy was sufficiently spaced. A more appropriate criterion is whether these women want to space or limit future pregnancies/births.

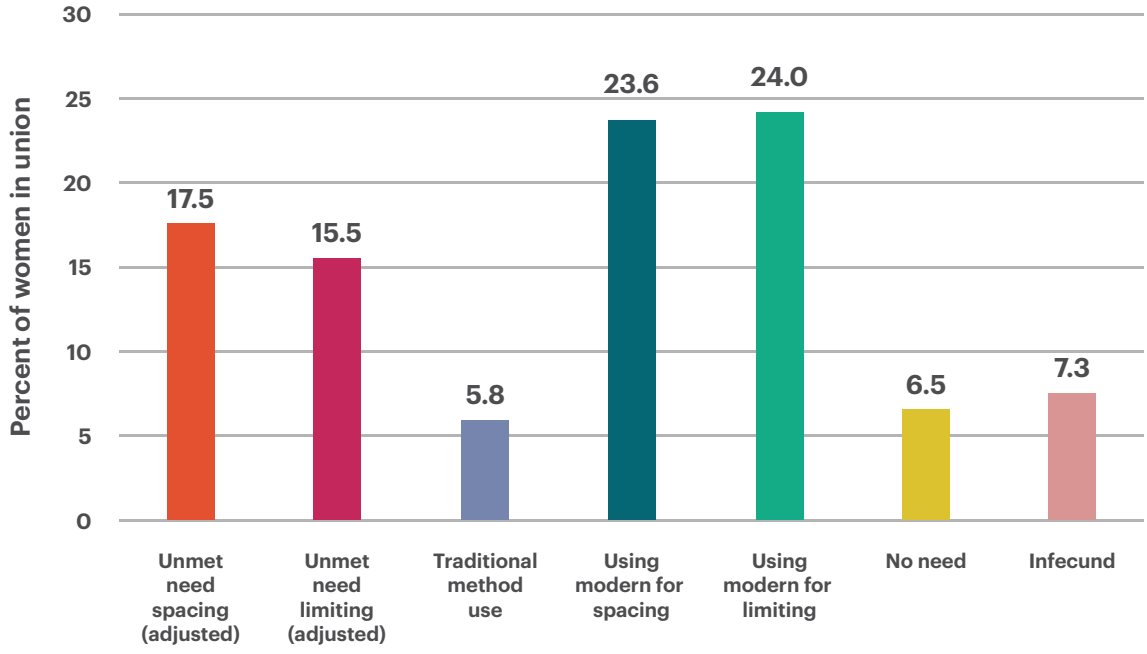
Another point for consideration is that women using FP traditional methods are considered to have met needs but most FP programs do not consider use of traditional methods as a successful instance of family planning. Given the unmet and met needs considerations, the re-analysis of RDHS with adjustments actually point to higher number of 39% women in union have a potential need for FP. Additionally, the key population groups that program planners should focus to maximize outcome would include:

- Pregnant women who can receive counseling for FP use after birth during antenatal care;
- Postpartum women who need counseling and services for appropriate FP methods
- Women using traditional methods who need counseling and services for more effective FP methods
- Women beyond the extended postpartum period[4] who may be the target of demand outreach efforts and appropriate services

The 2014/15 RDHS analysis also noted that the characteristics of these groups of women with unmet need, their intention to use, and reasons for non-use. A regression analysis of the determinants of using more effective methods of contraception found that the poorest women and girls and those with no education were less likely to use it. Rwanda still remains largely rural with 84% of the population living in ru-

4 The postpartum period is defined as 12 months to include provider contacts for both postnatal care and infant immunizations.

Figure 5: Unmet need among women in union, with adjustments for pregnancy amenorrhea, and traditional method use.



ral areas[5], and may have stronger social safety nets, the hardest to reach may actually be found in cities, among street children, people with disabilities or other vulnerable groups. Innovative strategies will be needed to address these gaps both for regular FP and for PPFP.

3.1.5 EVER USE AND DISCONTINUATION

Generally, women with a need for limiting pregnancy are more likely to have used FP methods and this is similar across all limiting groups. In contrast, women with a spacing need are less likely to have used FP. About 1 of every 3 (27.7 %) FP users will discontinue prior to the first year of use. Close to half of all ever users (approximately 50%) have at some point discontinued use of FP. The reasons for discontinuation vary with non-postpartum/non-pregnant women with a need for FP discontinued FP mainly for method-related reasons (i.e., health, other side effects), while women who want a pregnancy soon, postpartum, and pregnant women discontinued most frequently because they wanted to get pregnant.

Discontinuation of FP is perhaps a transition between different stages in a woman's reproductive life. When women in Rwanda discontinue FP, almost ¼ switch to a new modern method, while 1/6 become pregnant in the month immediately following using family planning, which we construe as method failure[6]. Some contraceptive methods are more likely to be discontinued than others. Pills and injectables are disproportionately discontinued. In contrast, implant users tend to discontinue at much lower rates.

What happens to the 61% of women who discontinue their method and move into a status of "non-use" ? The reanalysis of RDHS data essentially shows that almost no women who did not immediately switch to another modern method resumed using FP within 12 months. Moreover, after 12 months, approximately 60% of discontinuers had become pregnant.

A Family Planning barriers study conducted in 2017 found that 2,154 (74.6%) women who have ever used contraceptives, also stopped using them. The discontinuation was more prevalent among women aged 35-39 (82.9%), in urban area (75.8%), illiterate women (80.2%), women without health insurance (68.4%) and those from the lowest quintile wealth category (79.4%). Injectable contraceptives were quoted as the most prevalent method to stop (62.1%, n=1,337) followed by oral contraceptive pills (2.7%, n=489). The main reasons for stopping were side effects related to the methods (for 45.2% of 2,154), the need for having another child (35.9%), switching to another method (5.3%) and method failure (5.1%). Districts with the lowest contraceptive rate (Rusizi) were significantly associated with FP discontinuation. The need for more children was a key factor for stopping contraceptive use. This increased probability to stop with FP methods, four times more than when compared with those who did not want children anymore. The support from husband and sensitization by a senior official were found as protective factors to contraceptive discontinuation. It is important to note that 77.6 % of women who stopped using FP methods in these districts are Protestant (Pentecostist, Baptist, Methodist) and they are 1.32 times more likely to stop FP methods at some point in time than Catholic women. The was confirmed by the FGDs and interviews which highlight the weak management of side effects, religious beliefs and long distance to reach the nearest FP delivery point.

3.1.6 POSTPARTUM FAMILY PLANNING (PPFP) USE

Postpartum women are an important target of the FP/ASRH program. They represent a population with frequent interactions or contacts with the health system – from pregnancy through to the 12 months following a birth – and thus a target for integrated PPFP service delivery. Indeed almost all Rwandan pregnant women (99%) received at least one ANC from skilled personnel and 91% deliver in a health facility. The RDHS calendar data shows that initially there is very low use of modern PPFP, followed by a sharp increase from about three months to seven months However, even at 7 months, use of modern PPFP is low relative to overall FP use in Rwanda. This is particularly unfortunate because if a woman becomes

5 Rwanda Population and Housing Census 4

6 The segment represented by blue in the pie chart figure is the percent of women who became pregnant immediately in the month following discontinuation. Some of these cases may actually be instances of a woman purposefully discontinue use of family planning and immediately become pregnant.

pregnant in the first year following a birth, birth spacing will fall short of the recommendation of at least two years. The use of specific methods in the postpartum period is similar to the use of methods in general in Rwanda (figures available in Annex 1). Injectables increase rapidly, whereas pills increase more gradually. Although use of condoms and implants is steadily increasing over the 12 months of the postpartum period, they never experience a rapid increase.

Use of PPFP is often related to breastfeeding practices and the return of menses. Rates of exclusive breastfeeding are quite high in Rwanda in the first 6 months postpartum, then drop quickly. This is consistent with World Health Organization (WHO) nutrition recommendations and Lactation Amenorrhea Method (LAM) use. However, relatively few women report they are using LAM as a contraceptive method in the RDHS. Initially, the percentage of women who are amenorrheic is also high, then it falls off more slowly than breastfeeding rates. An additional analysis shows that PPFP use is very high among women whose menses have returned, and low among women who remain amenorrheic. This is a very risky situation, especially among women who are more than 6 months postpartum. After 6 months or when breastfeeding is partial, ovulation is more likely to occur prior to menses return.

3.1.7 ASRH PROGRAM PERFORMANCE

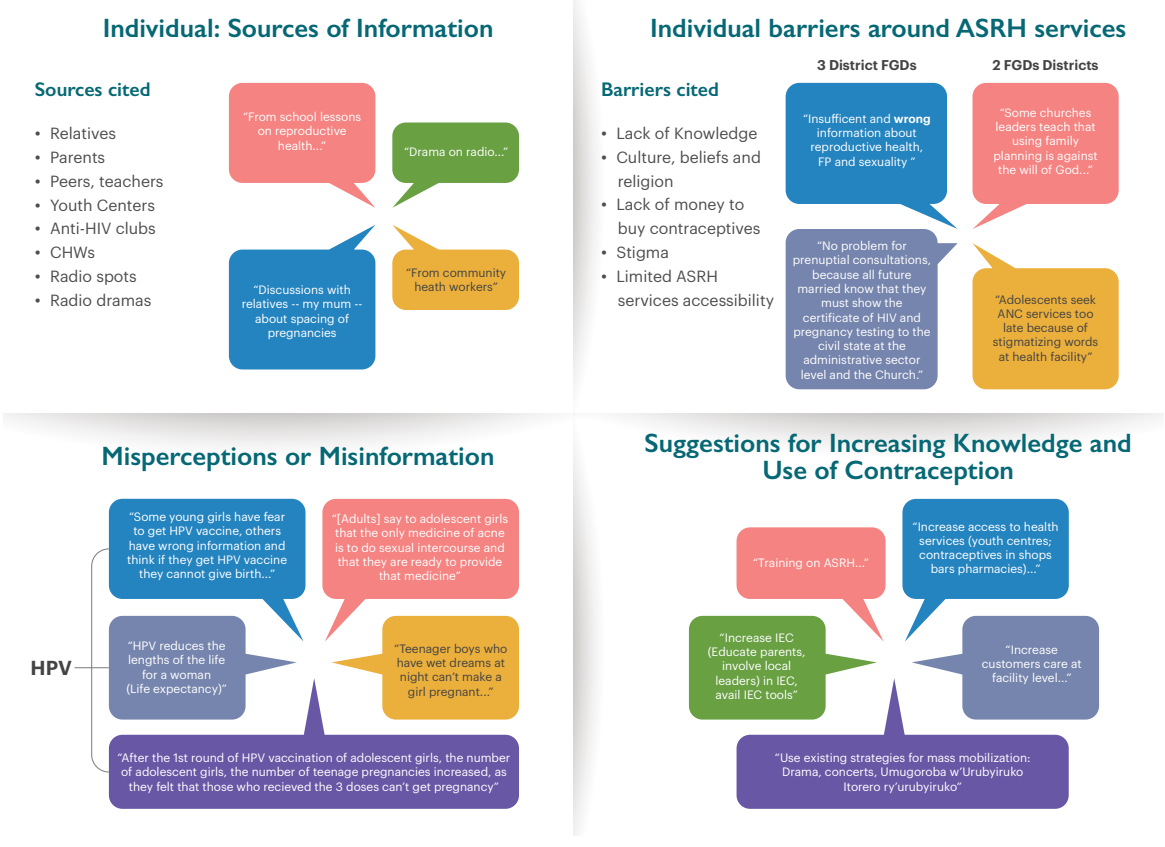
For ASRH, evaluations globally of many life-skills curricula have demonstrated improvements in teen pregnancy rates, girls' empowerment, and self-reported condom use, with evidence showing that most effective curricula address issues of gender dynamics (Patton, 2014) (Kalamar A. M., 2016) (Kalamar A. M., 2016) (Chandra-Mouli V. e., 2013). Continuing to improve access to information and counselling on ASRH through mass media campaigns, schools, or other avenues falls in line with best practices to reduce self-reported risky sexual behaviors, increase utilization of health services, and improve teen pregnancy rates (Patton, 2014) (Kalamar A. M., 2016) (Kalamar A. M., 2016) (Denno, 2015). The MOH should thus continue to support MINEDUC with respect to school-based comprehensive sexuality education (CSE). More teachers will require training and ongoing support in participatory teaching methods (Republic of Rwanda, Ministry of Education., 2014) (Chandra-Mouli V. e., 2013) (Chandra-Mouli V. e., 2015). Coordination should also involve the Ministry of Gender and Family Promotion (MIGEPROF) to implement the gender components of this curriculum, along with the Ministry of Finance and Economic Planning (MINECOFIN), Ministry of Sports and Culture, Ministry of Youth and other relevant ministries.

Evidence has also shown that the most impactful ASRH programs are those which include holistic, multi-sectoral packages of interventions that are based on a theory of change (Assembly, United Nations General, n.d.) (Patton, 2014) (Denno, 2015) (Chandra-Mouli V. e., 2015). These will require long-term investments in protective assets (social, economic, health, etc.), and have multiple touchpoints with young people across the socio-ecological model (Patton, 2014) (Svanemyr, 2015). This includes parents and other community members (Republic of Rwanda, Ministry of Health, 2011). However, many adults in Rwanda support sexuality education for youth and would be willing to provide advice if they were able to overcome cultural difficulties in talking openly about SRH (Republic of Rwanda, Ministry of Health, 2011) (RDHS). Mass media campaign and community sensitization are cited as effective to reach these important gatekeepers (Denno, 2015) (Salam, 2016). MINEDUC has suggested similar outreach via existing parents' meetings called "umugoroga w'ababyeyi" (Republic of Rwanda, Ministry of Education., 2014). Finally, even with high rates of school attendance, MOH/RBC and its CSO partners should continue to implement and expand targeted interventions for out-of-school adolescents (including very young adolescents (10-14 year-olds)) and youth, adolescents living with HIV, men who have sex with men, female sex workers, and cross-generation sex victims and people living with disabilities to prevent these populations from being left behind (Chandra-Mouli V. e., 2015) (Chandra-Mouli V. e., 2015).

An effort index is not available for ASRH program performance but 32 national and district ASRH stakeholders participated in a survey of ASRH program performance. Respondents felt that real progress had been made in ensuring that girls and boys adopt safer SRH behaviors, but were less convinced that high quality ASRH services were accessible and used, or

that the work of enhancing the legal and policy environment to be supportive of ASRH was completed. They reported progress in making services more youth-friendly, but noted the absence of standardized norms and protocols, lack of services for drug and alcohol abuse and were unsatisfied with the wide availability of ASRH products and services. They noted the presence of laws and policies, but inadequate progress in making available programs to ensure that adults, parents in particular, readily support SRH services for adolescents. Lastly, they felt that coordination among stakeholders and partners was strong, but that there was insufficient attention to developing, budgeting, monitoring and evaluation workplans for ASRH. Respondents were also asked to rate their agreement related to various aspects of the ASRH program, including the enabling environment; availability, accessibility, and equity of ASRH services; the quality and appropriateness of services; whether these services and programs were integrated, comprehensive, multi-sectoral, multi-level; dimensions of accountability such as cost-effectiveness, monitoring and evaluation (M&E), evidence based information; and lastly, financing for ASRH programs and services. The detailed results of the survey are available in a separate report.

A summary presentation of the results of focus group discussions with unmarried adolescents 16-19 year olds in 4 districts is available with the Ministry of Health. Following are some of the results:



Rwanda has already considerable experience with supporting innovations including for ASRH:

- An Accelerated project that promoted competition among young people to propose ideas for improving ASRH. Four winners were selected and given skills in entrepreneurship, a grant to develop their business case and launch their product. These winning ideas range from mobile apps in Kinyarwanda to a television program and a serial comic book on ASRH&R. A local foundation is also developing its own digital health platforms for young people.
- "Growing Up Smart" experience is one example of rigorous design and evaluation.

Given that evaluations demonstrated effectiveness, the FP/ASR strategic plan should identify the means of expanding this program targeting very young adolescents needs', working in partnership with the original NGO/CSO partners and MINEDUC and the Ministry of Youth and ICT. This would help ensure that those programs the GoR is investing time and resources into, such as the youth corners or youth clubs, are implemented in such a way as to reap maximum benefits in terms of ASRH outcomes.

One area of improvement is youth participation in ASRH programs. The new WHO Global Accelerated Actions for the Health of Adolescents (World Health Organization. 2017., 2017) articulates the necessity of youth participation in the designing, validating and monitoring programs. Adolescents should be engaged throughout the process and are a key constituency for the governance of ASRH programs (Villa-Torres, 2015) (Svanemyr, 2015) (Nair, 2016). While youth engagement may have limited impact on behavior and health outcomes, many consider it a right (Villa-Torres, 2015) (Chandra-Mouli V. e., 2015) and it is becoming a norm for ASRH programming at the international level.

One concern among sexually-active adolescents is potential legal and regulations conflicts around access and consent for SRH products and services. The new RH law defines a child as anyone aged 17 and under (1 in 5 of 18-24 year olds had initiated sexual activity prior to their 18th birthday, 2014/15 DHS). Under Article 7, the law states that "every person having attained the majority age has the right to decide for oneself in relation to human reproductive health issues" leaving no question about the rights of those aged 18 and above. Yet, Article 8 of the law also states that "every person has a right to education and medical services related to human reproduction" and Article 13 states "every person has the obligation to protect himself/herself and protect others against sexually transmitted diseases". What is lacking in the law is a definition of an adolescent rather than a child and clarification as to whether an adolescent who engages in sexual activity has self-protection rights under the Convention of the Rights of the Child and the Law related to the Rights and Protection of the Child and the Maputo Protocol (Article 14 2(c)). There is also a need to clarify the legal standing and ensure legal protections to health workers against parental complaints if they provide their child with a contraceptive method. Furthermore, there may be conflicts between the medical insurance law and the RH law with respect to parental consent which would then need to be reconciled allowing for adolescents aged between 16 and 18 to have access to sexual and reproductive health services without parental consent.

4 NATIONAL FP/ASRH STRATEGY PLAN

VİSİON, MİSSİON AND KEY STRATEGİC OBJECTİVES

The FP/ASRH strategic plan's vision and mission reflect the vision and mission of the RMNCAH policy, while also representing a few of the RMNCAH Policy guiding principles and values (section 3.3.) that will be critical to achieve the FP/ASRH overarching goal. Therefore, the vision and mission attempt to capture elements of the guiding principles of leadership and political will, a human rights-based approach, equity and social inclusion, continuum of care, assurances of integrated high quality services, coherence, efficiency and sustainability.

4.1 VISION:

All Rwandans achieve their highest attainable standard for sexual reproductive health across the life course, understanding their options for family planning pre-pregnancy, post-abortion or postpartum so as to manage their fertility aspirations and have equitable access to the services they need, close to where they live.

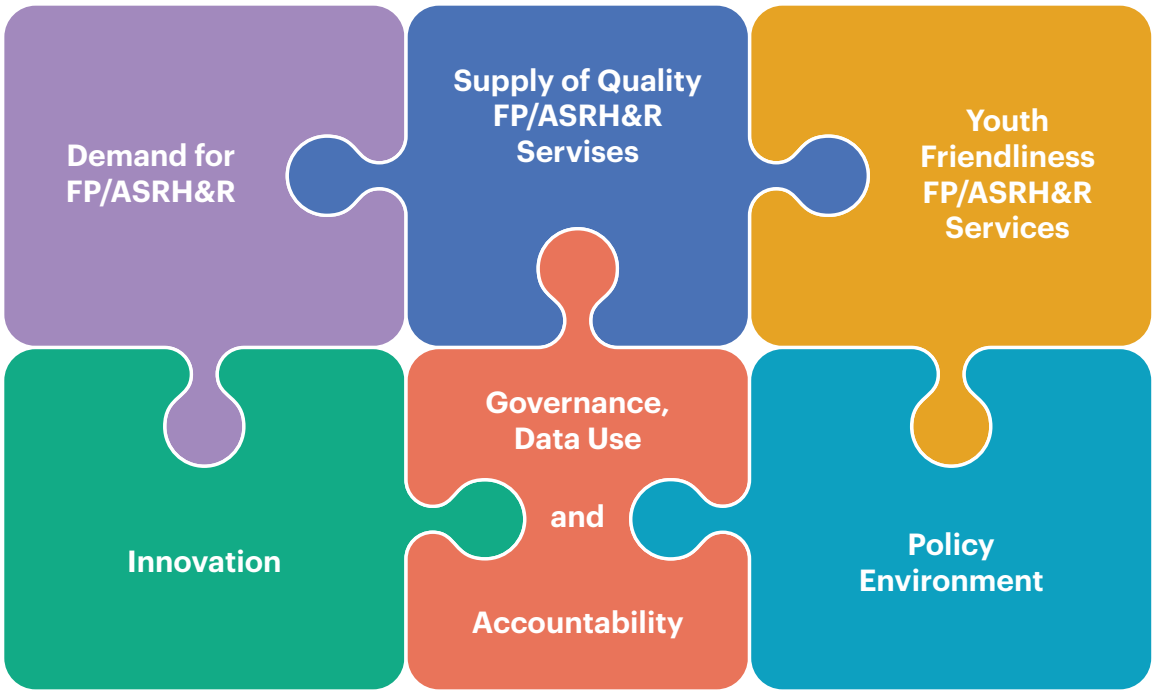
4.2 MISSION:

All women, men, adolescent girls and boys in Rwanda have universal access to quality integrated FP/ASRH information and services in an equitable, efficient and sustainable manner.

4.3 STRATEGIC OBJECTIVES:

The FP/ASRH 2018-2024 Strategic Plan is organized around 6 objectives representing 5 components of the health system, and the addition of a 6th objective around programmatic Innovation as a priority to address the unique challenges and opportunities described in the results of the situation analysis, i.e. the Stage of Rwanda FP program on the S-curve and opportunities afforded by the Demographic Dividend.

Six components of FP/ASRH& Framework



4.3.1 STRATEGIC OBJECTIVE 1 (SO1):

Increased demand for FP/ASRH services for all Rwandans through awareness raising and community engagement

FP Goals modeling demonstrated the need to multiply demand-side efforts for Rwandans of all ages. Community engagement, using existing or new groups, has the greatest potential, but may require careful strategizing to determine a common approach for scaling it up. The work on Care Group Model should be reviewed as part of a larger community group engagement and social and behavior change strategy. One related intervention, improving interpersonal communication skills and the accuracy of information offered by providers links strategic objective 1 (SO 1) to SO2 and 3 on service and youth friendliness. Finally it is critical to align this demand creation objective to the existing "Health Promotion Policy".

Strategies:

1. Strengthen and/or design and implement youth-friendly multi-channel interventions to reach various segments of the adolescent population, including youth with disabilities and other vulnerable groups

Illustrative Activities:

- Expand educational outreach targeting youth through existing successful mass media campaigns and entertainment emphasizing accurate ASRH information, including addressing barriers to FP/ASRH services.
- Strengthen the capacity of institutions at central and decentralized levels to implement SBCC interventions, including improving the quality of interpersonal communication between facility- and community-based clients through a behavior change approach.
- Strengthen Comprehensive Sexuality Education (CSE) curriculum implementation in schools and out of schools

- Sensitize communities to enhance acceptance and support from teachers, parents, community and religious leaders for adolescents and youth to use FP/ASRH services;
- Strengthen the use of social media and online materials to create awareness of ASRH information and service availability

2. Implement behavior change interventions for the general population with a focus on addressing religious and cultural barriers to uptake of SRH services including family planning services

Illustrative Activities:

- Increase effective use of couple counseling and engage men and boys both as supportive partners and users of methods
- Strengthen initiatives to prevent SGBV for women and girls, men and boys of all ages and improve linkages to Isange One Stop Centers (IOSCs) for victims of SGBV.

3. Foster research into the effectiveness and quality of social mobilization messages and methods for increasing health seeking behaviors

4.3.2 STRATEGIC OBJECTIVE 2 (SO2)

Improved availability and accessibility of FP/ASRH services through maximizing opportunities for efficient integration of quality services at all levels of service delivery.

Currently, the service delivery system performs well with low stock outs of commodities. The FP/ASRH program should maximize the opportunity afforded by the high facility birth rate and frequent health-seeking during pregnancy and the extended postpartum in engaging teen mothers and women. Integration of counseling, to maintain high rates of breastfeeding, and of FP services at ANC, birth and postnatal care should be scaled up to all districts. The RMNCAH policy called for staff trained to provide PPFP to be present 24/7 in hospitals to facilitate the integration of MNH and FP services. Supporting girls and women continue use of their contraceptive method of choice require providers to also be able to talk about and manage side effects.

Strategies:

1. Prioritize investments in proven interventions
2. Improve health provider capacity at all levels to deliver quality and accessible FP/ASRH services

Illustrative Activities:

- Harmonize and formalize pre-service and in service training and mentorship on FP/ASRH
- Strengthen counseling effort that inclusive of couple counseling, HIV and other sexually transmitted infections (STIs)
- Promote the use of outreach (strategies avancées) to offer LARCs and PMs where they are not readily accessible
- Continue to offer judgment-free, comprehensive PAC to all clients, regardless of age or marital status, with additional attention to age-appropriate contraceptive counseling on PA FP for adolescent clients who may lack the self-awareness to pursue contraception.
- Review and address gaps in the competence of CHWs to engage and assist Rwandans of all ages to access FP/ASRH services
- Use digital /mobile health platform for mobile mentoring of CHWs on contraceptive technology and other FP/ASRH concepts – linked to objectives SOs 2 and 3

3. Guarantee the rational deployment of FP-trained providers in all health facilities with clear assignments as focal points for FP and ASRH to ensure 100% coverage of the population.

4. Strengthen the commodity supply chain management system to effectively forecast, quantify, procure and distribute sexual reproductive health commodities at service delivery points

Illustrative Activity:

- Improve commodity supply to support greater method mix in all service delivery assuring clients to exercise informed choice of method. This will include supply of consumables and instrument kits for IUD insertion/removal, tubal ligation and vasectomy, and implant removal.

5. Strengthen overall the scale up of FP in Rwanda including implementation of PPFP Scale Up and community-level provision

6. Monitoring and quality assurance of integrated FP/ASRH services including the linkages between FP/ASRH and SGBV services

4.3.3 STRATEGIC OBJECTIVE 3 (SO3)

Improved availability of quality youth-friendly FP/ ASRH services

The program needs to continue to mainstream youth-friendly services, not just in FP but ANC and maternity care, in existing facilities and community strategies. In addition, adolescents and youth who lack confidence in the privacy of public sector services need alternative channels such as school condom dispensers, drug shops and community based distribution (CBD) by CHWs to access SRH products and services.

Strategies:

1. Improve provider capacity in youth-friendly service delivery, including for HIV testing and counseling, and for services for reproductive health, care and treatment of HIV/AIDS and other sexually transmitted infections (STIs).

2. Strengthen institutional capacity of the Ministry to engage, support and provide youth-friendly services in a variety of platforms as well as using youth corners, youth clubs and safe spaces.

Illustrative Activities:

- Ensure that youth corners are equipped with up-to-date and appropriate IEC materials and have counseling tools that support providers in tailoring counseling based on the client's age and life stage (particularly older versus younger adolescents, pregnant/parenting).

- Provide appropriate youth friendly services at different levels of the Ministry of education structures, eg at university-level, organize ASRH activities that include not just information and awareness-raising, but the provision of comprehensive ASRH services.

- Conduct sensitization for ASMs and binomes in ASRH

- Identify core health services to support adolescents with disabilities.

- Restructure and scale up in and out-of-school ASRH clubs and ensure ASRH messages are well delivered until the youth feels more comfortable to seek services from CHWs

- Use youth clubs and youth corners as a 'safe space' where youth can be trained in life skills including self-efficacy.

3. Create opportunities for inclusion and participation of adolescents and youth designing, validating and monitoring ASRH program and services.

4.3.4 STRATEGIC OBJECTIVE 4 (SO4)

Enhanced use of innovation to increase uptake of FP/ ASRH services.

The evolving resource environment and the dynamic needs of the Rwandan population will require innovations for the FP/ASRH program to be agile and ahead of the learning curve in providing responsive and cost effective services. Efficiencies can be found in

the use of newer approaches and technologies, including, for example, problem-solving design that focuses on end-users and digital technologies. Expanding choice of contraception to meet women's and girls' lifestyle and needs will require innovative approaches to introducing and accessing these products to Rwanda. Finally, Rwanda's effort to sustain increase its contraceptive prevalence rate, the FP/ASRH program needs to find newer and better ways to reach women and girls not currently reached.

Strategies:

1. Organize "innovation challenges" to address seemingly intractable service delivery challenges

   Illustrative Activities:

   - Provide grants for "human centered design challenge" that includes developing and testing effective approach to engaging faith-managed birthing facilities to expand PPFP method choice
   - Put out a funded challenge to propose and test practical approaches to reaching the most vulnerable women and adolescent girls.

2. Develop, evaluate and scale-up culturally acceptable strategies and materials to help parents have conversations with their adolescent children around sexuality, pregnancy and STIs, focusing on vulnerable groups

3. Foster research and effectiveness evaluation of innovation to scale up of RMNCAH service delivery models and technology, with a focus on adolescents and other hard-to-reach groups

   Illustrative activity:

   - Assess the effectiveness of interventions (i.e youth corners) prior to scale-up or further investments
   - Explore use of digital and mobile health technologies in support of SBCC, FP/ASRH service delivery (e.g. sharing accurate knowledge, addressing misconceptions) and support of data collection

4. Transform positively public perception of FP and couples, men, women and girls who are practicing it.

   Illustrative activity:

   - Support activities that foster role models and champions in FP/ASRH e.g. Parents Evenings, FP Goodwill Ambassadors, Miss Rwanda, opinion leaders, etc.

4.3.5 STRATEGIC OBJECTIVE 5 (SO5)

Strengthen governance systems that utilize reliable disaggregated FP/ASRH data to inform decision making and ensure accountability

Governance includes mechanisms, processes and relationships by which initiatives, programs or projects are managed and directed. The governance structure also identifies roles, responsibilities of actors and other stakeholders, and includes standards, processes and procedures for making decisions, implementation and accountability which will be monitored and evaluated.

Rwanda's health system already incorporates strong planning and management systems, including a vibrant health information and data system. Structures have also been established to ensure the involvement of stakeholders outside of the MOH, including Health Sector Working Group and other Technical Working Groups. These groups, through strengthened governance system especially by the MCH and FP/ASRH TWGs will be responsible for the ensuring the implementation of the strategic plan. The single project implementation unit (SPIU), mechanism for coordination, supports the MOH and expected to reduce the administrative burden for management and reporting. In 2017, tools for collecting age-disaggregated service statistics were validated by the MoH and rolled out to all public facilities. These initiatives need to be continued and strengthened, with an eye towards efficiency, cost-effectiveness, commodity security, and sustainability. As noted in the RMNCAH Policy,

the "central level leadership needs to have systems and mechanisms in place to ensure availability of cost effective and safe commodities and infrastructure".

Strategies:

Governance

1. Improve integration and coordination approaches for central, district and community level consultative and technical working groups, as well as in budget and financial management.
2. Strengthen existing governance and leadership structures (Minisanté, MINALOC, MINEDUC, MIGEPROF, MININFRA, MINECOFIN, MYICT and private sector, religious organizations, CSOs, youth associations, etc..., at central and district level) leading to effective FP/ASRH services and accountability for resources and results.

Use of Data for Decision-making

1. Establish mechanisms to ensure and maintain FP/ASRH data quality at all levels.

   Illustrative Activity

   - Follow up on use of tools to gather age-disaggregated service data to ensure that the tools are in use,
   - Merge the various CHW reporting systems into a single, unified and simplified one.

2. Complete the process of designing data use dashboards at central, district and facility levels to guide informed decision-making concerning service quality improvement, coverage of services, performance of the health workforce, etc. Note that these dashboards should be flexible and evolve over time, involve a limited set of indicators that change as priority gaps or issues changes.
3. Strengthened governance to foster data are used for decision-making
4. Review ASRH related indicators and propose inclusion of new ASRH-specific indicators in the HMIS to help target interventions, e.g. % of schools teaching comprehensive sexuality education according to standards in MINEDUC guidelines.

Supply Chain Management

1. Ensure reproductive health commodity security
2. Implement and maintain a robust electronic Logistics Management Information System (eLMIS) and continue to undertake and refine regular quantification exercises, taking into accounts FP/ASRH interventions in place.
3. Improve logistic data visibility to ensure family planning commodity security.

Accountability

1. Develop and institutionalize a harmonized quality assurance improvement model and mutual accountability mechanisms between all stakeholders (providers, beneficiaries, managers and leaders).
2. Train and mentor youth groups, youth leaders of both genders to build their competencies to play an effective role in governance and accountability processes for ASRH and youth issues. Efforts should be made to include broad representations of adolescents, not just middle-class urban youth.

   Illustrative Activity:

   - Adapting and using he Advance Family Planning SMART advocacy toolkitas a resource training youth leaders to use effective advocacy
   - Building awareness and literacy among adolescents about available health services for FP/ASRH.

3. Review the financing mechanism to ensure family planning service provision sustainability, e.g. advocacy for budget lines and community health service provision

4.3.6 STRATEGIC OBJECTIVE 6 (SO6)

Strengthen a policy that is inclusive and inter-sectoral for FP/ASRH programming that is supportive and contributes to Rwanda realizing its demographic dividend.

Rwanda's development and economic growth is closely tied to fertility and population growth. Positive returns of prior investments are materializing and the country is poised to reap the benefits of the demographic dividend in a relatively short horizon. Engaging both the social cluster ministries and those that drive the economic and development agenda to support sustained investment in family planning and ASRH remains a top priority. The engagement extends to the parliament and other political decision-makers at national and sub-national level. Mayors, for example, could learn to see investing in family planning and positive youth development as a vote-getting enterprise, rather than falling back on traditional cultural norms and religion for their populist messages. This requires systematic, concerted efforts from the FP/ASRH actors and stakeholders to champion the program. As noted earlier, the International Family Planning Conference provides an opportunity that can also be capitalized on to appeal to national pride. Let that opportunity translate into additional government resources for FP/ASRH& and greater independence from the international donor community.

Strategies:

1. Advocacy for a legal reform of the consent clauses under various laws and seek their advice on strategies to reconcile and harmonize the respective laws to ensure access to FP/ASRH services by women and adolescents girls, including rights and protections for adolescents with disabilities.

   Illustrative Activity:

   - Strengthening advocacy for youth friendly health laws

2. Strengthen multi-sectoral strategies and mechanisms at the central, decentralized and community levels to address key inter-sectoral issues in FP/ASRH, including gender-based violence and eradicating teen pregnancies.

   Illustrative Activities:

   - Clarify the role and accountability of other sectors in contributing to improved health outcomes for women and adolescent girls.
   - Strengthen partnerships and coordination for FP/ASRH service delivery at central, decentralized and community levels to minimize overlap of activities

3. Advocate for higher investments in FP/ASRH including increased budget allocations for FP/ASRH and SBGV both at national level and in terms of district allocations of their own revenues; ensure that a full package of FP/ASRH services is included in health insurance schemes.

   Illustrative Activity:

   - Review and strengthen 'business case' for the CHP/CBP by engaging the Ministry of Finance and Economic Planning and key partners and donors aimed at exploring financing options for the program.

4. Foster synergies of public and private sectors collaboration for effective, efficient and sustainable service delivery, including social marketing of contraceptives and SRH commodities (e.g. standard days method kits, locally produced menstrual hygiene management products).

   Illustrative Activities

   - Identify the potential role of public private partnerships (PPP) to effectively address constraints of demand creation, service delivery, supply chain management, and fostering innovations through research and development.
   - Support innovative public private partnerships (PPP) to effectively address constraints of service delivery including supply chain management.

5 IMPLEMENTATION AND RISK MITIGATION PLAN

GOVERNANCE, COORDİNATİON AND İMPLEMENTATİON ARRANGEMENT

The Rwanda Biomedical Center (RBC) will lead the implementation of the strategic plan, in coordination with internal MOH entities, other Ministries and development partners. Civil society is invited to join these efforts.

The Health Sector level coordination is defined in the Health Sector Policy 2015 [Ref 1.24]. Below that, the RMNCAH Technical Working Group coordinates overall implementation of the RMNCAH policy including the two sub-sector strategies. Currently, this group is led by Director MCCH and comprised of MOH, RBC and development partners. There is need and opportunity to formally request relevant social cluster ministries directly involved in the implementation of RMNCAH to assign representatives to join these forums.

For FP/ASRH Strategic Plan implementation, RBC once again leads implementation at the national level. Coordination of actors and partners occurs within two distinct sub-technical working groups for FP and ASRH, respectively. It may be productive to aski MIGEPROF, MYICT and MINEDUC to each appoint a representative to participate in one or both sub-working groups. Additionally, any entity from civil society engaged in FP and/or ASRH activities that contributes or complements the objectives of strategic plan will be enjoined to approach the MOH and RBC and share their technical expertise and learning to the sub-working groups.

District level implementation and structures

The Health Sector Policy delineates the implementation of health sector interventions. MINALOC is a key MOH/RBC partner in implementation at sub-national level. The implementation of the FP/ASRH strategic plan should not neglect to engage with local political and community leaders to nurture ownership and buy-in of the the programs.

Annual operating plans

The multi-year FP/ASRH strategic plan should guide the development of annual operating plans and budgets at both national and district level.

Development partners

The GoR has a Rwanda Aid Policy [Ref 1.25] which articulates the expectations of the government vis-à-vis its development partners.

Monitoring and evaluation plan

Data systems and flows

Routine systems in Rwanda rely on the DHIS-2, which captures family planning service delivery from both community health providers and from public sector health facilities excluding tertiary hospitals and most but a few select private service delivery points [Ref 3.10]. The DHIS is a web-based system, which means it can be accessed anywhere with the right cre-

dentials. In addition, there is a separate Logistics Management Information System (LMIS) that tracks the movement and utilization of contraceptive commodities. Data managers have been hired and are placed in all health centers and district hospitals.

Routine FP data management tools:

Community

Client-held card: date of enrollment, method applied and the next appointment

CHW monthly summary form: information on FP users

Facility Family Planning Service Areas

- Client-held card: individual and unique number of registration linking card with FP register
- Client Family Planning consultation form (with notes on medical and FP history and next appointment)
- The Family Planning Client Register
- The monthly summary form

Facility Pharmacy

- Monthly report and requisition form to district pharmacy
- Store card: kept for each product to track stock movements (physical inventory), quantity of product (existing stock) and expiration date.
- Internal requisition form: used for requisition of FP products from the health facility warehouse/storage to the point of FP service provision.

Data aggregation is first done at the cell level where CHWs meet once a month and the cell coordinator consolidates the FP data of all the villages in one summary monthly report. All the cell coordinators meet at the health center level and under the leadership of the Community health supervisor, check the data and aggregate again in the Health center summary report form. The health center data manager enters the form into the DHIS-2. Separately, data managers enter health facility FP data (whether health center or hospital) from the summary monthly report into the DHIS-2.

In addition to data available on an ongoing basis, Rwanda Demographic and Health Surveys (RDHS), covering a representative sample of the population, occur every 5 years or so. Given that the last RDHS took place in 2014/15, the next one can be expected to serve as a mid-term review of this strategic plan. It will be fortuitous if it can be timed such that results are available in 2020.

Use of data for decision making

At each health facility, a quality management committee composed of all heads of department reviews their standards of care and set benchmarks and indicators of quality care. Existing governance framework at each work unit will be strengthened to include use of data to drive decision making processes. The leadership, management and provider teams will analyzes, interprets and use FP/ASRH data on a monthly basis for continuous quality improvement. In addition, data reviews do occur periodically at district leadership level (DHMTs) and national Level (TWGs and MCCH division). However, this could be optimized with more reliance on data visualization or dashboards, to make the interpretation of the data more user-friendly.

Indicators

The main outcome measure of success of this strategic plan will be the contraceptive prevalence rate among all women of reproductive age as indicated in the goal statement. For all women, the current baseline is 30.9% (with 27.8% for modern contraception). Typically, people cite the CPR for married women which is higher at 53.5% (47.5% for modern contraception). However, given focus of this strategic plan on both adolescents and adults, the all women indicator is preferred.

The logframe (to be included in Annex X) will also include indicators for each strategic objective or results. So for example, unmet is an important indicator. Currently, unmet need is

higher for married women at 18.9% than it is for all women (12.6%). Only women who report sexual activity in the last 30 days prior to the survey are included in the unmet need indicator. In preparing the logframe (see Annex X) for the FP/ASRH strategic plan, every effort has been made to ensure that anticipated HSSP 4 as well as the list of common FP2020 indicators are included. In so doing, it is expected that performance in family planning, in particular with regards to CPR and the teenage pregnancy rate, are included in joint health sector performance reviews.

The FP/ASRH program would rack the composite indicator for demand met with modern contraception as this is one of the indicators under the SDG accountability framework. The indicator is made up of 3 other measures, typically drawn from the RDHS, namely: total contraceptive prevalence rate (modern + traditional CPR), unmet need (the latter two combine to represent total demand for family planning), and modern contraception prevalence rate (mCPR). The indicator is calculated as follows: mCPR / (CPR + unmet need). This new indicator fluctuates depending on the use of traditional versus modern contraception and as demand or unmet need fluctuates. Because total demand is in the denominator, it is considered a metric that is comparable across setting with varying social norms for desired family size. The RDHS 2014/15 Demand met by modern contraceptives in Rwanda for all women was 63.9%. The target for 2030 is 75% of demand met with mCPR. It is not possible to calculate unmet need or this indicator without a population-based survey.

6 RISKS AND ASSUMPTIONS

The first assumption is that the MOH will succeed in rallying other GOR line agencies, donors and development partners to this strategic plan; and mobilizing the requisite resources to implement it. Given that Rwanda was one of the first countries to make a commitment to FP2020, the coordination mechanism under FP2020 can be useful to support these efforts over the next 5 years.

One of the risks pertains to dissemination of the FP/ASRH strategic plan down to the level of implementation. As with many new documents that also combines strategies for both FP and ASRH for the first time, there is a possibility that the dissemination will remain at the central level of the health sector. However, district stakeholders will need a forum to understand the directions this FP/ASRH strategic plan offers and the important roles they must play in its implementation.

7 RESOURCE PLAN

Implementation of this FP/ASRH will require resources. The Ministry of Health alone cannot implement all the interventions listed above, but will request that other ministries incorporate elements into their budgets and activities (for example, MINEDUC for training teachers on ASRH&R and rolling out the CSE curriculum). Through effective linkages, efficient use of resources, and support from both local communities and partners, the strategies outlined here are feasible to implement.

COSTING OF THE STRATEGIC PLAN

The One Health Tool has used for costing the strategic plan. The current proposal to cost the inputs is to use past expenditures and interventions to understand what maintaining current level of support costs under high level categories of costs. From this "baseline" level, to build some estimation of costs for "new" strategies including scaling up ASRH&R demand and supply interventions as well as key interventions. Assumptions were made about the number and rigor of research activities and those results should be interpreted with caution, as it

The costing was carried out based on the key strategic activities of the logical framework. It was conducted through a participatory method, consulting a group of FP experts from the MoH principally those who are members of the FPTWG. In the first step, activities were broken down into several milestones, including a timeline and the level of implementation. In the second step, the cost of each activity was estimated using a standardized framework involving three sets of assumptions: Quantity, frequency and unit cost variables. To ensure consistency of the costing, the assumptions were additionally revised by an M&E and costing expert, and were further based on institutional budgets and real expenditures, as well as national standards. The outcome of this process is provided in a summary form and categorized by output in the table below. The details and the basis of calculation of the cost of each activity are provided in a separate excel file.

7.1 COSTING METHODOLOGY AND ASSUMPTIONS

The Rwanda Family Planning, Adolescent Sexual Reproductive Health (FP/ASRH) Strategic Plan cost estimation was achieved through a participatory, iterative process using input-based costing approach.

7.1.1 SCOPE OF COSTING

The costing was facilitated by an excel framework specifically developed for the purpose, used concurrently with the UN One Health Tool's program costing module. The assignment scope included estimating the cost of interventions defined in the FP/ASRH strategic plan for the period 2018–2024.

1. For the costing purposes, all planned interventions were categorized under thematic areas including; training and mentorship, equipment, medicines and supplies, communication media outreach, advocacy, production & printing, workshops & co-

ordination, monitoring and evaluation, program management. This allowed the process to identify resource intensive areas, which will guide future planning accordingly.

2. The costing estimated expected expenditure for the implementation of each objective area as defined in the FP/ASRH strategic plan, i.e.:
    - Increased demand for FP/ASRH services for all Rwandans
    - Improved availability and accessibility of FP/ASRH services
    - Improved availability of quality youth-friendly FP/ASRH services
    - Enhanced use of innovation to increase uptake of FP/ASRH services
    - Strengthened governance systems that utilize reliable disaggregated FP/ASRH data to inform decision making and ensure accountability; and,
    - Strengthened policy that is inclusive and inter-sectoral for FP/ASRH programming to be supportive and contributing to Rwanda realizing its demographic dividend
3. Finally, the cost of implementing planned interventions at different levels of the health system (i.e. national, district, health center and community levels), was estimated. Outputs derived from the above analysis are presented under tables 1, 2 and 3; in sub-sections 7.2 through 7.4, accompanied by a detailed narrative.

The scope of the costing did not include:

1. One Health tool's health services module for scenario analysis. The interventions in the FP/ASRH strategic plan are program-focused (e.g. training, M&E, mentorship...etc.), and hence more appropriately costed using program costing module of the One Health tool.
2. The costs of health system inputs such as human resources, logistics, general infrastructure, financing systems, etc., were considered as already costed under the HSSP IV.

7.1.2 PROCESS

As mentioned above, this costing was accomplished through a consultative process. To start with:

1. Entry and briefing meetings were held with stakeholders including MoH Clinical Services Directorate, RBC, USAID, MCSP program managers, and; others ––to discuss the process, obtain further insights and guidance, and receive the draft of the FP/ASRH strategic plan. The costing approach was also discussed in a wider audience of the Maternal Child Health Technical Working Group (MCH TGW which also oversees FP/ASRH) meeting held at the MSCP head office in December 2017. Convening bi-monthly, the MCH TWG brings together implementers of the MCCH programs (including FP and ASRH). Many participated in the development of the FP and ASRH strategic plan itself.
2. The draft strategic plan was extensively reviewed, and inputs/activities envisioned, under each strategic objective for delivering planned interventions were identified by the consultant. This was done iteratively with members of the core team. Each input was simplified into milestones with unit costs, quantities and/or frequency. Structured in an excel spreadsheet, the milestones were shared with core team members for feedback, which was incorporated. Data was also derived from program managers, the HSSP IV/FP costing files, standard government expenditure rates for items such per diems, accommodation, travel...etc.
3. A two-day work session was organized with members of the core team who also happen to implement and/or manage FP/ASRH programs in different organizations. They included representatives from MoH, RBC, UNCEF, UNFPA, PIH, and MSCP; as well as others familiar with implementation of similar activities. Working in groups, participants reviewed milestones, unit costs, quantities or frequency, and provided comprehensive input. Data cleaning was subsequently completed by the consultant.
4. Customization of OneHealth program costing module was completed in line with milestones' defined from the above process, and data migrated into the tool.

7.1.3 MAIN ASSUMPTIONS

The FP/ASRH cost estimation was projected based on the current market value rates, government spending guidelines and inputs from program experts familiar with implementation of similar FP/ASRH activities. A currency exchange rate of Rwanda Franc 870 to the United States dollar (US$) was applied. Inflation was assumed at 5.0% from 2018 and remained constant throughout the planning horizon. The two deliverables from the above process are:

1. Microsoft Excel with an aggregate computation of cost estimates in different thematic areas, in line with the costing scope. It has the following worksheets:
    - Breakdown of strategic interventions into milestones, unit costs of each (named – costed FP/ASRH milestones).
    - Aggregated cost estimate by strategic objective(s) per year (named – costs by FP/ASRH objective); and a corresponding summary (named – summary by FP/ASRH objective & levels)
    - Detailed and aggregated cost estimate by program area per year (named detailed FP/ASRH program costs); and a corresponding summary (named - summary by FP/ASRH program area)
2. An OneHealth file with aggregated cost estimates by program area per year (named – program module costing).

7.2 RESULTS

The entire FP/ASRH plan is projected to cost RWF 50,283,290,504 billion for the 7 years. The current year (2018) takes up the least of the projected cost, possibly because interventions for this period are already budgeted for in the current operational plans. The cost is projected to increase remarkably in the next year, and depict steady upward trend in the final five years of this strategic plan term. The tables that follow, 1-3; respectively provide estimated cost by program area, objective, and level of health system.

7.2.1 DETAILS OF PROJECTED COSTS FOR THE FP/ASRH STRATEGIC PLAN (IN RWF)

Table 1: Total cost for FP/ASRH in RWF

Program Area	YR 2018	YR 2019	YR 2020	YR 2021	YR 2022	YR 2023	YR 2024	Total
Advocacy	93,330,000	18,902,100	76,413,400	40,289,100	78,762,800	12,110,000	78,166,400	397,973,800
Communication media outreach	187,128,000	508,044,600	420,954,600	788,916,100	686,618,400	856,392,500	743,836,600	4,191,890,800
Program Management	1,300,000	123,774,000	175,997,800	75,161,700	203,611,200	123,220,000	73,392,800	776,457,500
Equipment & Infrastructure	-	715,750,700	191,766,667	200,483,333	209,200,000	852,084,167	226,633,333	2,395,918,200
Monitoring and Evaluation	-	225,695,400	145,145,000	112,120,400	116,995,200	121,870,000	126,744,800	848,570,800
Medicines or supplies	-	3,138,144,631	3,573,650,775	4,039,380,995	4,536,037,096	5,064,347,214	5,625,082,510	25,976,643,221
Production & Printing	63,780,000	725,949,000	760,518,000	795,087,000	829,656,000	864,225,000	898,794,000	4,938,009,000
Training and mentorship	296,329,000	1,400,057,400	1,965,043,280	2,061,968,362	1,596,298,250	2,017,648,177	1,973,257,000	11,310,601,469
Workshops & coordination	76,565,000	182,796,600	111,771,000	116,851,500	177,014,400	127,012,500	191,765,600	983,776,600
Other	48,000,000	156,065,700	196,167,400	174,034,100	181,600,800	189,167,500	196,734,200	1,141,769,700
Total	766,432,000	7,195,180,131	7,617,427,922	8,404,292,590	8,615,794,146	10,228,077,058	10,134,407,243	52,961,611,090

Results in table 1 above show substantial increase of the projected expenditure over the years of implementation of this FP/ASRH strategic plan. The two main cost drivers are medicines and capacity building activities (training and mentorship); which together are expected to account for nearly 70 % of the total cost required for the implementation of this plan. Others relate to the production, printing and distribution of materials; communication and media, and purchase of equipment such as kits and/or equipment required to fully rollout youth corners across health facilities.

7.2.2 PROJECTED COSTS BY STRATEGIC OBJECTIVE (IN RWF)

Table 2. Cost for FP/ASRH per strategic objective area in RWF

Strategic Objectives	YR 2018	YR 2019	YR 2020	YR 2021	YR 2022	YR 2023	YR 2024	Total
S Objective 1	391,865,000	654,280,200	731,827,800	642,215,200	670,137,600	698,060,000	725,982,400	4,514,368,200
S Objective 2	239,640,000	1,734,020,400	1,280,420,880	1,361,951,862	1,250,441,450	1,922,160,677	1,272,642,800	9,061,278,069
S Objective 3	24,080,000	1,404,592,700	1,721,050,467	2,018,741,433	1,268,377,600	1,686,069,167	1,496,176,933	9,619,088,300
S Objective 4	11,128,000	160,442,100	11,710,600	12,242,900	67,857,600	13,307,500	73,512,400	350,201,100
S Objective 5	99,719,000	102,912,600	294,321,200	325,111,900	723,741,200	840,662,500	937,401,400	3,323,869,800
S Objective 6	-	787,500	4,446,200	4,648,300	99,201,600	3,470,000	3,608,800	116,162,400
Medicines, supplies, storage license	-	3,138,144,631	3,573,650,775	4,039,380,995	4,536,037,096	5,064,347,214	5,625,082,510	25,976,643,221
Total	766,432,000	7,195,180,131	7,617,427,922	8,404,292,590	8,615,794,146	10,228,077,058	10,134,407,243	52,961,611,090

Table 2 above shows the projected costs of implementing planned interventions by strategic objective area. As a reminder, the FP/ASRH strategic objectives focus on:

1. Objective one: Increased demand for FP/ASRH services for all Rwandans
2. Objective two: Improved availability and accessibility of FP/ASRH services
3. Objective three: Improved availability of quality youth-friendly FP/ASRH services
4. Objective four: Enhanced use of innovation to increase uptake of FP/ASRH services
5. Objective five: Strengthened governance systems that utilize reliable disaggregated FP/ASRH data to inform decision making and ensure accountability; and,

6. Objective six: Strengthened policy that is inclusive and inter-sectoral for FP/ASRH programming to be supportive and contributing to Rwanda realizing its demographic dividend

In this table, medicines, supplies and storage have been presented separately from objective under which they fall in the strategic plan. If they were to be combined with the strategies in this same objective, it would to account for more than half of the total cost, because of medicines and supplies (which are major cost drivers). This is followed by the cost of implementing activities under objectives 3 and 2 respectively (i.e. availability and accessibility of FP/ASRH services; and availability of quality youth-friendly FP/ASRH services); followed by objective one (Increased demand for FP/ASRH services).

7.2.3 PROJECTED COSTS BY HEALTH SYSTEM LEVELS (IN RWF)

Table 3. Cost for FP/ASRH by levels of health system in RWF

System Levels	YR 2018	YR 2019	YR 2020	YR 2021	YR 2022	YR 2023	YR 2024	Total
National	235,454,000	4,458,397,831	4,265,749,575	4,523,464,295	5,237,921,496	6,233,407,214	6,231,111,310	31,185,505,721
District	257,154,000	709,592,100	1,331,069,280	1,350,843,820	830,325,600	1,080,875,000	1,133,181,400	6,693,041,200
Health Center	161,340,000	1,709,855,000	1,851,776,667	1,993,711,875	2,166,446,250	2,330,889,844	2,357,255,333	12,571,274,969
Community	112,484,000	317,335,200	168,832,400	536,272,600	381,100,800	582,905,000	412,859,200	2,511,789,200
Total	766,432,000	7,195,180,131	7,617,427,922	8,404,292,590	8,615,794,146	10,228,077,058	10,134,407,243	52,961,611,090

As per results presented in the table 3 above, the national level is expected to take up the biggest share of the cost of implementing the FP/ASRH strategic plan (nearly 60% of the overall projected cost), with the health center accounting for the second biggest share (24%), while the other two levels will account for the remaining share of the total cost. In practice, many community-level activities such as training of CHWs actually take place at the health center, partly explaining the substantial cost projected there compared with other lower levels.

7.3 DISCUSSION OF THE COSTING RESULTS

The total cost of implementing the FP/ASRH is estimated at more than 52 billion RWF for the 7 year term; with the biggest expenditure anticipated to take place at the central level (60%). This is mainly driven by the fact that procurement of medicines, supplies and equipment plus their storage and distribution (which accounts for a large portion of projected expenditure) remains the central level's responsibility. In fact, when taken out of expenditure equation, the health center takes the lead with 46%, followed by the district level, 25%, while the national level coming third with a 19% share of the total projected cost (if medicines, supplies and equipment are not considered). It likely indicates that actual implementation has progressively been relegated to the lower levels of the health system. The high cost share of activities related to training and mentorship reflects the value the FP/ASRH plan attaches to capacity building and skills development. Other areas emphasized are communication, outreach and media activities; production and printing of different resources, all possibly designed to create awareness and stimulate demand for services.

8 CONCLUSION

This 7 year strategic plan is the result of a thorough assessment of the situation for both FP and ASRH programs and a careful analysis of opportunities and challenges to address in order to maximize chances of Rwanda benefitting from the Demographic Dividend. In so doing, the FP/ASRH strategic plan will ensure that every Rwandan woman, man, adolescent boy and girl fulfill their maximum potential and contributes his and her part to fulfilling Rwanda's vision to become a middle-income country.

9 ANNEX

9.1 INDICATOR MATRIX

In order to determine the effectiveness of the strategies and interventions contained in this strategic plan, the following output, outcome and impact indicators will periodically be measured through a baseline, midterm and endline review. Findings from the midterm review will be compared with targets (and baselines where applicable) to assess the implementation status of the stategic plan and to make course corrections as necessary while the endline will assess the overall success of the strategic plan.

- Impact: Long-term effect
- Outcome: Intermediate effect
- Output: Immediate effect

Impact (Long-term)	Indicators	Baseline	Target (2024)	Data Source
Reduce fertility rates to improved maternal and health outcomes	Total Fertility Rate	4.2	3.3	RDHS 2014/15
Outcome (mid-term)	**Indicators:**	**Baseline**	**Target (2024)**	**Data Source**
Outcome: Increased Demand and supply of FP services.	1. Contraceptive Prevalence Rate (married women, women of reproductive age, modern CPR)	48	60	RDHS 2014/15
	2. Unmet need of FP			
	3. Percentage of teenage pregnancies	19	15	RDHS 2014/15
	4. Demand satisfied for FP	7.3	< 7	RDHS 2014/15
	5. One year discontinuation rate	27.7	20	RDHS 2014/15

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
Strategic Objective 01: Increased demand for FP/ASRH services for all Rwandans through awareness raising and community engagement				
1. Strengthen and/or design and implement youth-friendly multi-channel interventions to reach various segments of the adolescent population, including youth with disabilities and other vulnerable groups. 2. Implement behavior change interventions for the general population with a focus on addressing religious and cultural barriers to uptake of SRH services including family planning services 3. Foster research into the effectiveness and quality of social mobilization messages and methods for increasing health seeking behaviors	a) FP/ASRH social and behavior change (SBC) strategy document available and being used	a) No	Yes	SMM Minutes
	b) Percentage of schools with capacity to teach CSE (with curricula, materials and teacher trained)	b) (check with REB)	80%	REB
	c) Percentage of people of reproductive health age who have comprehensive knowledge on contraceptive methods	c)		
	d) Percentage of young people receiving FP/ASRH messages through M4RH	d)		
Strategic Objective 02: Improved availability and accessibility of FP/ASRH services through maximizing opportunities for efficient integration of quality services at all levels of service delivery.				
1. Harmonize and formalize pre-service and in service training and mentorship on FP/ASRH. 2. Improve health provider capacity at all levels to deliver quality FP/ASRH services 3. Guarantee the rational deployment of FP-trained providers in all health facilities with clear assignments as focal points for FP and ASRH to ensure 100% coverage of the population. 4. Strengthen the commodity supply chain management system to effectively forecast, quantify, procure and distribute sexual reproductive health commodities at service delivery points.	Percentage of service delivery points with no stock out for FP commodities	93	98	
	Number of additional users of modern methods of contraception			HMIS

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
5. Strengthen overall the scale up of FP in Rwanda including implementation of PPFP Scale Up and community-level provision 6. Monitoring and quality assurance of integrated FP/ASRH services and supply chain management of SRH commodities at all levels 7. Strengthen the linkage between FP/ASRH and SGBV services 8. Prioritize investments in proven interventions				
Strategic Objective 03: Improved availability of quality youth-friendly FP/ASRH services				
1. Improve provider capacity in youth-friendly service delivery, including for HIV testing and counseling, and for services for care and treatment of HIV/AIDS and other sexually transmitted infections (STIs). 2. Strengthen institutional capacity of the Ministry to provide youth-friendly services to include youth corners, youth clubs and safe spaces. 3. At university-level, organize ASRH activities that include not just information and awareness-raising, but the provision of comprehensive ASRH services. 4. Conduct a review of community ASRH services provision (including insurance and end-user barriers) and design improvements in ASRH by CHWs. 5. Conduct sensitization for ASMs and binomes in ASRH	Percentage of health centers that provide youth-friendly services as per national standards	60% (HSSPIII MTR report)	95%	HSSPIV MTR & Final Report
	Number of young people accessing youth-friendly services	Available from January 2018		HMIS report
	Number of active youth clubs linked to youth corners			ASRH data collection tool
	Review of community ASRH services provisions conducted	No	Yes	

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
6. Support Ministry of Education and schools to expand menstrual hygiene management support to girls. 7. Offer screening and psycho-social support service interventions, such as counselling, mental health therapeutic approaches for adolescents, and "second chance" programs for juvenile offenders. 8. Ensure core health services to support adolescents with disabilities. 9. Restructure and scale up in and out-of-school ASRH clubs and ensure ASRH messages are well delivered until the youth feels more comfortable to seek services from CHWs 10. Use youth clubs and youth corners as a 'safe space' where youth can be trained in life skills including self-efficacy. Ensure that adolescents and youth participate in designing, validating and monitoring ASRH programs. 11. Include youths in the design of youth-friendly initiatives and services				
Strategic Objective 04: Enhanced use of innovation to increase uptake of FP/ASRH services.				
1. Organize "innovation challenges" to address seemingly intractable service delivery challenges 2. Develop, evaluate and scale-up culturally acceptable strategies and materials to help parents have conversations with their adolescent children around sexuality, pregnancy and STIs, focusing on vulnerable groups	Number of digital health technologies (apps, websites, hotlines, online chat rooms, etc.) introduced to support FP/ ASRH information and service delivery	0		TWG minutes
	Percentage of FP/ASRH operational budget dedicated to "innovation challenges" and innovative solutions	N/A		

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
3. Explore use of digital and mobile health technologies in support of SBCC, FP/ASRH service delivery (e.g. sharing accurate knowledge, addressing misconceptions) and support of data collection 4. Foster research and effectiveness evaluation of innovation to scale up of RMNCAH service delivery models and technology, with a focus on adolescents and other hard-to-reach group 5. Transform positively public perception of FP and couples, men, women and girls who are practicing it. 6. Foster research and innovation on the adoption and scale up of innovative RMNCAH service delivery models and technology as well as improving access and utilization of FP/ASRH with a focus on adolescents and other hard to reach groups (linked to objective 3).				
Strategic Objective 05: Strengthen governance systems that utilize reliable disaggregated FP/ASRH data to inform decision making and ensure accountability				
Governance				
1. Improve integration and coordination approaches for central, district and community level consultative and technical working groups, as well as in budget and financial management. 2. Strengthen existing governance and leadership structures (Minisanté, MINALOC, MINEDUC, MIGEPROF, MININFRA, MINECOFIN, MYICT and private sector, religious organizations, CSOs, youth associations, etc..., at central and district level) leading to effective FP/ASRH services and accountability for resources and results.	• Number of DHMT meetings discussing FP/ASRH per year (coordination at district and national level) • No of district strategic plans that integrate ASRH activities • FP Strategic plan reviewed in Health Sector Review Meeting	N/A N/A 	 30 	DHMT meeting minutes District annual plans Health Sector Review Meeting Minutes

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
Use of Data for Decision-making				
1. Establish mechanisms to ensure and maintain FP/ASRH data quality at all levels. 2. Complete the process of designing data use dashboards at central, district and facility levels to guide informed decision-making concerning service quality improvement, coverage of services, performance of the health workforce, etc. Note that these dashboards should be flexible and evolve over time, involve a limited set of indicators that change as priority gaps or issues changes. 3. Follow up on use of tools to gather age-disaggregated service data to ensure that the tools are in use, that data are used for decision-making, and to make improvements to tools and processes as needed. 4. Review ASRH related indicators and propose inclusion of new ASRH-specific indicators in the HMIS to help target interventions, e.g. % of schools teaching comprehensive sexuality education according to standards in MINEDUC guidelines. 5. Merge the various CHW reporting systems into a single, unified and simplified one. (Note: platform could also be designed for use in mobile mentoring of CHWs on contraceptive technology and other FP/ASRH concepts – linked to objectives 2 and 3).	Number of FP recommendations from DQA exercises implemented			Semi-annual ISS DQA
	Number of DHMTs taking action based on analysis of FP service data at least once during the year	N/A	30	DHMT meeting minutes

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
Supply Chain Management				
1. Ensure reproductive health commodity security 2. Implement and maintain a robust electronic Logistics Management Information System (eLMIS) and continue to undertake and refine regular quantification exercises, taking into accounts FP/ASRH interventions in place. 3. Improve logistic data visibility to ensure family planning commodity security.	• Number of stock out days of FP commodities (disaggregated by method) • Number of district pharmacies conducting routine LMIS quantification exercises for FP commodities at least once a quarter			HMIS District pharmacies
Accountability				
1. Develop and institutionalize a harmonized quality assurance improvement model and mutual accountability mechanisms between all stakeholders (providers, beneficiaries, managers and leaders). 2. Train and mentor youth groups, youth leaders of both genders to build their competencies to play an effective role in governance and accountability processes for ASRH and youth issues. Efforts should be made to include broad representations of adolescents, not just middle-class urban youth. 3. Review the financing mechanism to ensure family planning service provision sustainability, e.g. advocacy for budget lines and community health service provision	Number of districts reporting that adolescents and youth actively advocate issues that concern them including ASRH issues.			ASRH focal point reports

Revised Strategies	Output Indicators	Baseline	Target	Data Sources
Strategic Objective 06 : (SO6) Strengthen a policy that is inclusive and inter-sectoral for FP/ASRH programming to be supportive and contributing to Rwanda realizing its demographic dividend				
1. Advocacy for a judicial review of the consent clauses under various laws and seek their advice on strategies to reconcile and harmonize the respective laws to ensure access to FP/ASRH services by women and adolescents girls, including rights and protections for adolescents with disabilities. 2. Clarify the role and accountability of other sectors in contributing to improved health outcomes for women and adolescent girls. 3. Strengthen multi-sectoral strategies and mechanisms at the central, decentralized and community levels to address key intersectoral issues in FP/ASRH&, including gender-based violence and ending child marriage. 4. Strengthen partnerships and coordination for FP/ASRH service delivery at central, decentralized and community levels to minimize overlap of activities 5. Advocate for increased budget allocations for FP/ASRH and SBGV both at national level and in terms of district allocations of their own revenues; ensure that a full package of FP/ASRH/RH services is included in health insurance schemes. 6. Review and strengthen 'business case' for the CHP/CBP by engaging the Ministry of Finance and Economic Planning and key partners and donors aimed at exploring financing options for the program. 7. Foster synergies of public and private sectors collaboration for effective, efficient and sustainable service delivery, including social marketing of contraceptives and SRH commodities (e.g. standard days method kits, locally produced menstrual hygiene management products). 8. Strengthening advocacy for youth friendly health laws	Number of ministerial orders issued to clarify access to FP/ASRH services by women and adolescents girls under existing laws			Rwanda official gazettes
	Number of FP priority interventions included in the HSSP IV and the EDPRS			Policy analysis
	Number of institutions whose budgets show increased allocation FP/ASRH and SGBV, disaggregated by district and national level			HRTT
	Number of public private partnership interventions implemented to improve FP/ASRH demand, service delivery, supply chain management, and innovations.			MFL SARA

9.2 A TABLE OF COSTED STRATEGIES PER STRATEGIC OBJECTIVE

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
Objective 1		**391,865,000**	**654,280,200**	**731,827,800**	**642,215,200**	**670,137,600**	**698,060,000**	**725,982,400**	**4,514,368,200**
1.1.	Planning the outreach activities by the national level	-	420,000	440,000	460,000	480,000	500,000	520,000	2,820,000
	Coordination of the outreach activities	-	16,671,900	17,465t,800	18,259,700	19,053,600	19,847,500	20,641,400	111,939,900
	Community outreach theatres to address barriers to FP/ ASRH services.	-	73,500,000	77,000,000	80,500,000	84,000,000	87,500,000	91,000,000	493,500,000
	Production & broadcast of ASRH information to address barriers to FP/ASRH services (Soap opera)	13,500,000	14,175,000	14,850,000	15,525,000	16,200,000	16,875,000	17,550,000	108,675,000
	Production & broadcast of ASRH information to address barriers to FP/ASRH services (radio shows)	4,500,000	9,450,000	9,900,000	10,350,000	10,800,000	11,250,000	11,700,000	67,950,000
1.2.	Assessing current SBCC approaches, and develop a national SBCC strategy	-	71,689,800	-	-	-	-	-	71,689,800
	Updating the national interpersonal SBCC module at facility level	-	-	20,900,000	-	-	-	-	20,900,000
	Roll out interpersonal communication module-1 day dissemination workshop	7,670,000	8,053,500	8,437,000	8,820,500	9,204,000	9,587,500	9,971,000	61,743,500
	Roll out interpersonal communication module-ToT	6,330,000	6,646,500	6,963,000	7,279,500	7,596,000	7,912,500	8,229,000	50,956,500
	Roll out interpersonal communication module-Mentor workshop	49,480,000	51,954,000	54,428,000	56,902,000	59,376,000	61,850,000	64,324,000	398,314,000

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
1.3.	Training of (master) trainers on CSE	3,541,000	7,436,100	7,790,200	8,144,300	8,498,400	8,852,500	9,206,600	53,469,100
	Roll out program of "master CSE trainers" in out of school settings	-	24,343,200	25,502,400	26,661,600	27,820,800	28,980,000	30,139,200	163,447,200
	Production and distribution of the CSE materials to all schools	42,000,000	44,100,000	46,200,000	48,300,000	50,400,000	52,500,000	54,600,000	338,100,000
1.4.	Meeting with MoH, MINALOC, MNIYOUTH and religious leaders…etc. on FP.	1,000,000	1,050,000	1,100,000	1,150,000	1,200,000	1,250,000	1,300,000	8,050,000
	Meeting w/ MoH, MINEDUC, MINIYOUTH, MINALOC examine progress on FP indicators	49,920,000	52,416,000	54,912,000	57,408,000	59,904,000	62,400,000	64,896,000	401,856,000
1.5.	Meetings with members of the community, adolescents on use of use of M4RH	38,640,000	40,572,000	42,504,000	44,436,000	46,368,000	48,300,000	50,232,000	311,052,000
	Updating of M4RH user guide and M4RH information modules	-	-	29,700,000	-	-	-	-	29,700,000
	Hosting of M4RH system servers	-	-	3,960,000	4,140,000	4,320,000	4,500,000	4,680,000	21,600,000
1.6.	Training health providers on couple counselling	27,840,000	58,464,000	61,248,000	64,032,000	66,816,000	69,600,000	72,384,000	420,384,000
	Distribution of FP ASRH information through home-based counselling by CHWs	21,780,000	22,869,000	23,958,000	25,047,000	26,136,000	27,225,000	28,314,000	175,329,000
1.7.	Meetings: MINALOC, MINIJUST, MIGEPROF, RNP etc. to advocate against S&GBV	600,000	630,000	660,000	690,000	720,000	750,000	780,000	4,830,000
	District-level quarterly coordination meetings of GBV activities	17,640,000	37,044,000	38,808,000	40,572,000	42,336,000	44,100,000	45,864,000	266,364,000
	Organizing 16 days of activism against GBV	107,424,000	112,795,200	118,166,400	123,537,600	128,908,800	134,280,000	139,651,200	864,763,200
	Study on the effectiveness: mobilization messages and methods on health seeking	-	-	66,000,000	-	-	-	-	66,000,000
	Dissemination of study results	-	-	935,000	-	-	-	-	935,000

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
Objective 2		**239,640,000**	**1,734,020,400**	**1,280,420,880**	**1,361,951,862**	**1,250,441,450**	**1,922,160,677**	**1,272,642,800**	**9,061,278,069**
2.1.	Upgrade existing in-service training curriculum to introduce practical/mentorship	-	19,798,800	-	-	-	-	-	19,798,800
	Workshop(s) for input and validation of the updated FP&ASRH training manuals	-	36,382,500	-	-	-	-	-	36,382,500
	Orientation of National trainers on the new integrated FP/ ASRH training manual	-	30,030,000	-	-	-	-	-	30,030,000
	Adapt/Review the guidelines according to new development in ASRH and FP	-	-	40,876,000	-	-	-	-	40,876,000
	Develop/Review the guideline according the new developments in FP and ASRH	-	-	17,270,000	-	-	-	-	17,270,000
	Meeting to update PF mentorship tools	-	6,610,800	6,925,600	7,240,400	7,555,200	-	-	28,332,000
2.2.	Orientation trainers on the new integrated FP/ASRH training manuals per DH	-	-	35,462,000	-	-	-	-	35,462,000
	OJT of health service providers on the new integrated FP/ ASRH training manuals	-	-	60,500,000	69,575,000	72,600,000	-	-	202,675,000
	Orient all clinical mentors on the use of FP/ASRH mentorship guidelines	-	-		51,438,542	61,726,250	64,298,177	-	177,462,969
	Mentorship of health service providers on FP/ASRH competencies	104,340,000	219,114,000	229,548,000	239,982,000	250,416,000	260,850,000	271,284,000	1,575,534,000
	Training ANC providers on clinical PPFP and counselling/ district	-	69,484,800	76,433,280	79,907,520	-	-	-	225,825,600
2.3.	Mobile outreach to communities and providing LARCs and PMs (HC to community)	-	50,400,000	52,800,000	55,200,000	57,600,000	60,000,000	62,400,000	338,400,000
	Mobile outreach to communities and providing LARCs and PMs (Hospital to HC)	48,000,000	100,800,000	105,600,000	110,400,000	115,200,000	120,000,000	124,800,000	724,800,000

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
2.4.	Integrated CHWs training program including FP/ASRH based on 2016 CHP Evaluation.	29,000,000	-	-	-	-	-	-	29,000,000
	Workshops to review and validate the integrated CHW training program	-	11,109,000	-	-	-	-	-	11,109,000
	Training of CHWs using the new integrated training program	-	478,611,000	501,402,000	524,193,000	546,984,000	569,775,000	592,566,000	3,213,531,000
2.5.	Training of pharmacy staff on supply chain management (quantification/forecasting)	-	-	26,774,000	27,991,000	-	-	-	54,765,000
	Mentorship on eLMIS as a tool for supply chain management	57,000,000	119,700,000	125,400,000	131,100,000	136,800,000	142,500,000	148,200,000	860,700,000
	Procuring kits for IUD insertion/removal, tubal ligation & vasectomy, & implants	-	532,700,700	-	-	-	634,167,500	-	1,166,868,200
2.6.	Community & facility assessments for RH & FP commodities and services	-	57,913,800		63,429,400		68,945,000	71,702,800	261,991,000
	Workshop to disseminate results	1,300,000	1,365,000	1,430,000	1,495,000	1,560,000	1,625,000	1,690,000	10,465,000
Objective 3		**24,080,000**	**1,404,592,700**	**1,721,050,467**	**2,018,741,433**	**1,268,377,600**	**1,686,069,167**	**1,496,176,933**	**9,619,088,300**
3.1.	Manual on youth-friendly services , HIV T&C care and treatment of HIV/AIDS; and STIs	-	41,361,600	-	-	-	-	-	41,361,600
	Training of health providers at all levels to offer youth-friendly services	-	-	570,570,000	596,505,000	-	-	-	1,167,075,000
3.2.	Advocacy workshops with Ministries, parliament, CSOs on adolescent youth issues	12,540,000	13,167,000	13,794,000	14,421,000	15,048,000	-	-	68,970,000
	Youth workshop for input in integrated design of youth-friendly design interventions,	11,540,000	-	-	13,271,000	-	-	15,002,000	39,813,000
3.3.	Youth Corners-equipment	-	183,050,000	191,766,667	200,483,333	209,200,000	217,916,667	226,633,333	1,229,050,000
	Youth Corners-IEC materials	-	658,980,000	690,360,000	721,740,000	753,120,000	784,500,000	815,880,000	4,424,580,000

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
3.4.	Assessing ASRH needs of education system including higher learning	-	28,560,000	-	-	-	-	-	28,560,000
	Dissemination workshop of assessment results and advocate for resource	-	2,736,300		2,996,900	-	-	-	5,733,200
	Develop an implementation plan to address identified needs and mobilize funding	-	12,847,800	-	-	-	-	-	12,847,800
	Organizing sensitization meetings on ASRH issues across institutions of higher learning	-	16,758,000		18,354,000		19,950,000		55,062,000
3.5.	In-depth analysis of barriers to ASRH at the community level	-	35,166,600	-	-	-	-	-	35,166,600
	Workshop(s) to disseminate results and advocate for resources to address barriers	-	3,996,300	-	-	-	-	-	3,996,300
	Implementation plan to address barriers identified and mobilize required funding	-	12,952,800	-	-	-	-	-	12,952,800
3.6.	Organizing sensitization meetings with CHWs (binome and ASM) on ASRH issues		156,177,000	-	171,051,000	-	185,925,000		513,153,000
3.7.	Supporting MoE to develop/update a Menstrual Hygiene Manual (MHM)	-	-	42,561,200	-	-	-	-	42,561,200
	Supporting training of teachers on menstrual hygiene management	-	-	49,269,000	-	-	55,987,500	-	105,256,500
	Planning the MHM campaign activities by the national level	-	-	-	1,035,000	-	-	-	1,035,000
	Organize and coordinate MHM campaign activities	-	-	-	47,113,200	49,161,600	51,210,000	53,258,400	200,743,200
	Performance of community outreach theatres barriers addressing MHM.	-	-	-	188,715,000	196,920,000	205,125,000	213,330,000	804,090,000
	Production and broadcast of ASRH information addressing MHM.	-	39,312,000	41,184,000	43,056,000	44,928,000	46,800,000	48,672,000	263,952,000

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
3.8.	Assessing capacities of in-school, and out-of-school youth clubs.	-	55,694,100	-	-	-	-	-	55,694,100
	In-school, and out-of-school youth clubs FP/ASRH self-learning and peer curricula	-	44,163,000	-	-	-	-	-	44,163,000
	Training of youth mentors from in-school and out-of-school clubs on FP/ASRH	-	99,670,200	104,416,400	-	-	118,655,000	123,401,200	446,142,800
	Workshops to customize FP/ASRH messages for in-school,& out-of-school youth clubs.	-	-	17,129,200	-	-	-	-	17,129,200
Objective 4		**11,128,000**	**160,442,100**	**11,710,600**	**12,242,900**	**67,857,600**	**13,307,500**	**73,512,400**	**350,201,100**
4.1.	Human centered design to PPFP method choice - Contextualization	11,128,000	-	-	-	-	-	-	11,128,000
	Human centered design to PPFP method choice - District trainers	-	18,433,800	-	-	-	-	-	18,433,800
	Human centered design to PPFP method choice - District mentors	-	55,301,400	-	-	-	-	-	55,301,400
	Funded challenge for test approaches to reaching vulnerable women and girls.	-	3,920,700	4,107,400	4,294,100	4,480,800	4,667,500	4,854,200	26,324,700
4.2.	Workshop to developing/updating parent-adolescent communication (PAC) resources	-	27,909,000	-	-	-	-	-	27,909,000
	Workshop(s) for developing a PAC rollout plan and mobilizing required funding	-	48,197,100	-	-	55,082,400	-	59,672,600	162,952,100
4.3.	Identify RMNCAH service delivery models and technological innovation to evaluate	-	945,000	-	-	-	-	-	945,000
	Workshops to mobilize funds for topics identified, draw up implementation plans	-	-	1,595,000	1,667,500	1,740,000	1,812,500	1,885,000	8,700,000
4.4.	Organizing Annual FP/ASRH Champions and role model forums	-	5,735,100	6,008,200	6,281,300	6,554,400	6,827,500	7,100,600	38,507,100

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
Objective 5		**99,719,000**	**3,241,057,231**	**3,867,971,975**	**4,364,492,895**	**5,259,778,296**	**5,905,009,714**	**6,562,483,910**	**29,300,513,021**
5.1.	Organize regular Technical/sub technical working group meetings	5,400,000	11,340,000	11,880,000	12,420,000	12,960,000	13,500,000	14,040,000	81,540,000
	FP/ASRH consultative and dialogue forums with stakeholders	2,005,000	4,210,500	4,411,000	4,611,500	4,812,000	5,012,500	5,213,000	30,275,500
5.2.	Meetings w/ stakeholders, HMIS to select indicators for FP and ASRH dashboards	-	5,688,900	5,959,800	-	-	-	-	11,648,700
	Training on the use dashboards at all levels	-	-	-	169,436,400	176,803,200	184,170,000	191,536,800	721,946,400
5.3.	Meetings to review tools in use, their level of disaggregation to include new ones.	-	5,819,100	6,096,200	6,373,300	6,650,400	6,927,500	7,204,600	39,071,100
	Workshop to validate updated tools and newly added indicators for FP and or ASRH.	-	2,051,700	2,149,400	2,247,100	2,344,800	2,442,500	2,540,200	13,775,700
	Training on the use of updated tools and collection of newly added indicators	-	-	56,944,800	-	62,121,600	-	67,298,400	186,364,800

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
	Review existing CHWs reporting systems, identify gaps, paint the ASIS status	-	11,785,200	-	-	-	-	-	11,785,200
	Reprograming of CHWs reporting systems (No need of consultant)	-	37,800,000	-	-	-	-	-	37,800,000
	System optimization and validation through workshops	-	-	12,579,600	-	-	-	-	12,579,600
	System hosting	-	-	99,000,000	103,500,000	108,000,000	112,500,000	117,000,000	540,000,000
	Integrated CHWs reporting System testing	-	-	19,360,000	-	-	-	-	19,360,000
5.4.	Training health providers as trainers on the unified CHWs reporting system	-	-	-	-	93,657,600	97,560,000	101,462,400	292,680,000
	Training CHWs on the use of the new unified CHWs reporting system	-	-	-	-	78,000,000	81,250,000	84,500,000	243,750,000
	Developing mentorship IT modules	-	-	-	-	-	45,000,000	-	45,000,000
	IT Module optimization and validation through workshops	-	-	-	-	-	7,650,000	-	7,650,000
	Training health providers on the use FP/ASRH mentorship module for CHWs	-	-	-	-	-	106,020,000	110,260,800	-
	Training/orientation CHWs on the use of FP/ASRH mentorship IT module	-	-	-	-	-	149,800,000	155,792,000	-

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
5.5.	Procuring all types of FP and ASRH commodities	-	2,854,324,841	3,236,504,139	3,642,675,428	4,073,162,868	4,528,308,675	5,008,487,601	23,343,463,551
	Storage and distribution (9%) of total cost	-	269,733,697	320,413,910	377,016,907	439,901,590	509,434,726	585,993,049	2,502,493,879
	License on donation portion (approx. 85%) of FP products equals 0.2%	-	5,094,970	6,052,263	7,121,430	8,309,252	9,622,656	11,068,758	47,269,329
	License on non-donation portion (approx. 15%) of FP products equals 2%	-	8,991,123	10,680,464	12,567,230	14,663,386	16,981,158	19,533,102	83,416,463
5.6.	Workshops on Advance Family Planning SMART advocacy toolkit to the local context	18,680,000							18,680,000
	Training youth leaders on use of Advance Family Planning SMART advocacy toolkit	50,570,000	-	50,570,000	-	50,570,000	-	50,570,000	202,280,000
	Sensitization for awareness/literacy of adolescents on available services for FP/ASRH	23,064,000	24,217,200	25,370,400	26,523,600	27,676,800	28,830,000	29,983,200	185,665,200
5.7.	Review existing financing mechanisms, to guide a new FP&ASRH financial sustainability	-	-	-	-	58,567,200	-	-	58,567,200
	Workshop to provide input and validate report of the review	-	-	-	-	2,702,400	-	-	2,702,400
	Developing a FP&ASRH financial sustainability strategy	-	-	-	-	33,100,800	-	-	33,100,800
	Workshop to provide input and validate the FP/ASRH financial sustainability strategy	-	-	-	-	5,774,400	-	-	5,774,400
Objective 6		**-**	**787,500**	**4,446,200**	**4,648,300**	**99,201,600**	**3,470,000**	**3,608,800**	**116,162,400**

Objectives and strategies		2018	2019	2020	2021	2022	2023	2024	Total
6.1.	Meetings to identify and document unreconciled, articles in existing FP/ASRH laws	-	787,500						787,500
	Organize advocacy workshops to discuss identified legislative clauses	-	-	3,053,600	3,192,400	3,331,200	3,470,000	3,608,800	16,656,000
	Advocacy workshops explore increased avenues of FP/ ASRH domestic financing			1,392,600	1,455,900	1,519,200	-	-	4,367,700
	Financing models for the CHP to ensure sustained financing and program effectiveness	-	-	-	-	61,764,000	-	-	61,764,000
	Workshop to provide input and validate the CHP financial sustainability model	-	-	-	-	2,836,800	-	-	2,836,800
	PPP model for FP/ASRH demand, service delivery, supply chain management	-	-	-	-	29,750,400	-	-	29,750,400
TOTAL PROJECTED COST		**766,432,000**	**7,195,180,131**	**7,617,427,922**	**8,404,292,590**	**8,615,794,146**	**10,228,077,058**	**10,134,407,243**	**52,961,611,090**

9.3 REFERENCES

Assembly, United Nations General. (n.d.). Convention on the Rights of the Child." OHCHR | Convention on the Rights of the Child. Retrieved from www.ohchr.org: www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

Avenir Health. (2015). Family Planning Program Effort Score in 2014: Rwanda. . Avenir Health 2015. , Track20 NCIFP.

Avenir Health. (2016). The National Composite Index for Family Planning (NCIFP), Rwanda 2014 Results. . Avenir Health , Track20 NCIFP Policy Brief Series. .

Chandra-Mouli, V. e. (2013). WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries. Journal of Adolescent Health, vol. 52, no. 5, pp. 517–522., doi:10.1016/j.jadohealth.2013.03.002.

Chandra-Mouli, V. e. (2015). Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights? Journal of Adolescent Health, vol. 56, no. 1, doi:10.1016/j.jadohealth.2014.09.015.

Chandra-Mouli, V. e. (2015). What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health: Science and Practice,, vol. 3, no. 3, pp. 333–340., doi:10.9745/ghsp-d-15-00126.

Denno, D. M. (2015). Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support. Journal of Adolescent Health, vol. 56, no. 1, doi:10.1016/j.jadohealth.2014.09.012.

FP2020 Annual Commitment update questionnaire response. Family Planning 2020. (n.d.). Retrieved from www.familyplanning2020.org: www.familyplanning2020.org/entities/81

Gatera, M. 2. (2016). Successive Introduction of Four New Vaccines in Rwanda: High Coverage and Rapid Scale up of Rwandas Expanded Immunization Program from 2009 to 2013. Vaccine, vol. 34, no. 29, pp. 3420–3426., doi:10.1016/j.vaccine.2015.11.076.

Kalamar, A. M. (2016). Interventions to Prevent Child Marriage Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. Journal of Adolescent Health, vol. 59, no. 3, 2016, doi:10.1016/j.jadohealth.2016.06.015, Vol 59, no 3.

Kalamar, A. M. (2016). Interventions to Prevent Sexually Transmitted Infections, Including HIV, Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. Journal of Adolescent Health, Vol 59, no 3.

Nair, M. e. (2016). Improving the Quality of Health Care Services for Adolescents, Globally: A Standards-Driven Approach. Journal of Adolescent Health, vol. 57, no. 3, 2015, pp. 288–298., doi:10.1016/j.jadohealth.2015.05.011.

Nash, E. a. (2014). Low-carbon resilient development in Rwanda . London: IIED Country Report; http://pubs.iied.org/10065IIED.

Patton, G. C. (2014). Next Steps for Adolescent Health: a Lancet Commission. . The Lancet, vol. 383, no. 9915, pp. 385–386. doi:10.1016/s0140-6736(14)60039-8.

Republic of Rwanda. (n.d.). Official Gazette n 23 of 06/06/2016. Law Relating to Human Reproductive Health. 2016. Official Gazette no 21/2016 of 20/05/2016. Official Gazette.

Republic of Rwanda, Ministry of Education. (2014). National School Health Policy. Retrieved from www.mineduc.gov.rw: http://mineduc.gov.rw/fileadmin/user_upload/pdf_files/SCHOOL%20HEALTH%20STRATEGIC%20PLAN_NEW.pdf

Republic of Rwanda, Ministry of Finance and Economic Planning. (2000). Rwanda Vision 2020. Retrieved from www.sida.se/globalassets/global/countries-and-regions/africa/rwanda/d402331a.pdf.

Republic of Rwanda, Ministry of Gender and Family Promotion. (2011). National Strategic Plan Against Gender-Based Violence 2011-2016, 2011. Retrieved from www.migeprof.gov.rw: www.migeprof.gov.rw/fileadmin/_migrated/content_uploads/GBV_Policy_Strategic_Plan-2.pdf.

Republic of Rwanda, Ministry of Health. (2011). Rapid assessment of adolescent sexual reproductive health programs, services and policy issues in Rwanda. pdf.usaid.gov/pdf_docs/PA-00J35H.pdf. Kigali.

Republic of Rwanda, Ministry of Health. (2012). Adolescent Sexual Reproductive Health and Rights Policy 2011-2015. . Kigali: Republic of Rwanda, Ministry of Health.

Republic of Rwanda, Ministry of Health. (2012). Maternal and Child Health. Family Planning Policy. 2012. Kigali.

Republic of Rwanda, Ministry of Health. (2017). National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy (2017-2030). Kigali.

Republic of Rwanda. Ministry of Finance and Economic. (n.d.). Your Guide to the Sustainable Development Goals (SDGs) in Rwanda. Retrieved from www.minecofin.gov.rw: http://www.minecofin.gov.rw/fileadmin/user_upload/Guide_to_SDGs_in_Rwanda_ENG.pdf

Republic of Rwanda. Ministry of Health. (2012). Family Planning Strategic Plan 2012-2016. Kigali.

Republic of Rwanda. Ministry of Health. (2012). National Adolescent Sexual Reproductive Health and Rights Strategic Plan 2011-2015.

Salam, R. A. (2016). Improving Adolescent Sexual and Reproductive Health: A Systematic Review of Potential Interventions. Journal of Adolescent Health, vol. 59, no. 4, doi:10.1016/j.jadohealth.2016.05.022.

Svanemyr, J. e. (2015). Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches. Journal of Adolescent Health, vol. 56, no. 1, doi:10.1016/j.jadohealth.2014.09.011.

Villa-Torres, L. a. (2015). Ensuring Youths Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs. Journal of Adolescent Health, vol. 56, no. 1, doi:10.1016/j.jadohealth.2014.07.022.

World Health Organization. 2017. (2017). Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation – Summary, apps.who.int/iris/bitstream/10665/255418/1/WHO-FWC-MCA-17.05-eng.pdf?ua=1.

9.4 LIST OF CONTRIBUTORS

Institutions and Names of Staff	Position	E-Mail Address
Rwanda Ministry of Health/Rwanda Biomedical center/ Maternal, Child and Community Health		
Dr Zuberi Muvunyi	Director General of Clinical Services	Zuberi.muvunyi@moh.gov.rw
Dr Felix Sayinzoga	Division Manager	felix.sayinzoga@rbc.gov.rw
Dr Ferdinand Bikorimana	Facility health Unit director	ferdinand.bikorimana@rbc.gov.rw
Joseph Gitera	MCH specialist	Gitera.joseph@moh.gov.rw
Mecthilde Kamukunzi	Policy Analyst	mecthilde.kamukunzi@moh.gov.rw
Modeste Gashayija	Health QA & Ag MCH Specialist	modeste.gashayija@moh.gov.rw
Sharon Umutesi	MCH specialist	sharon.umutesi@rbc.gov.rw
Dr Anicet Nzabonimpa	FP and HIV integration	Anicet.Nzabonimpa@jhpiego.org
Joel Serucaca	Reproductive Health Officer at MCCH	joel.serucaca@rbc.gov.rw
Eliphaz Karamaga	ASRH Officer	eliphaz.karamage@rbc.gov.rw
Mary Murebwayire	HMPP	mary.murebwayire@moh.gov.rw
USAID		
John Mckay	SCHS Team Lead	jmckay@usaid.gov
Dr Mary Kabanyana	Senior RMNCH advisor	mkabanyana@usaid.gov
Dr Richard Munyaneza	MNCH Specialist	rmunyaneza@usaid.gov
WHO		
Dr Maria Mugabo	FHP	mugabom@who.int
Stella Matutina Tuyisenge	EDM	tiyisenge@who.int
Bosco Gasherebuka	Health Promotion Program Officer	gasherebukab@rw.afro.who.int
UNFPA		
Daphrose Nyirasafali	Program Specialist, RHR	nyirasafari@unfpa.org

Institutions and Names of Staff	Position	E-Mail Address
Marie Claire Iryanyawera	Program analyst- FP/RHCS	iryanyawera@unfpa.org
Furaha Siraji	Program Analyst, ASRH	siraji@unfpa.orgn
Robert Banamwana	SRH Policy Advisor and M&E Specialist	bananwana@unfpa.org
Rhode Janssen	JPO/SRH Analyst	rjanssen@unfpa.org
Liana Moro	JPO/ ASRH Analyst	lmoro@unfpa.org
Christella Favre	International UNV/ASRH Analyst	favre@unfpa.org
Joanna Karenzi	M&E Intern	karenzi@unfpa.org
MCSP		
Dr Stephen Mutwiwa	MCSP Chief of Party	Stephen.Mutwiwa@jhpiego.org
Dr Beata Mukarugwiro	Technical Director	Beat.mukarugwiro@jhpiego.org
Dr Victor M Ndicunguye	Senior RMNCH advisor	Victor.ndicunguye@jhpiego.org
Dr Alfred Twagiramungu	ARH/FP Team Leader	Alfred.Twagiramungu@jhpiego.org
Dr Nicholas Karugahe	Senior MER Advisor - Quality Improvement	Nicholas.Karugahe@jhpiego.org
Bikorimana Ndungutse	ASRH Technical Coordinator,	Ndungutse.Bikorimana@savethechildren.org
Marie Rose Kayirangwa	Gender advisor	marieRose.Kayirangwa@jhpiego.org
Khatidja Naithani	Senior Program Manager	Khatidja.Naithani@jhpiego.org
Anne Pfitzer	Family Planning Team Leader	Anne.Pfitzer@jhpiego.org
Ricky Lu	Director of FP at Jhpiego	Ricky.Lu@jhpiego.org
PIH		
Dr Christian Mazimpaka		mchristian@pih.org
UR SPH		
Albert Ndagijimana	Assistant Lecture	albert.ndagijimana@nursph.org
HDI		

Institutions and Names of Staff	Position	E-Mail Address
Dr Aflodis Kagaba	Executive director	Kagaba@hdirwanda.org
Dr Athanase Rukundo	Director of programs	athanase@hdirwanda.org
HDP		
Alice Bumanzi		alicebumanzi@yahoo.com
VSO		
Clementine Ishimwe	Project Facilitator	Umuhireclemy@gmail.com
Afriyan		
Alexis Kayinamura	HIV/AIDS specialist	aleka8007@gmail.com
Enabel		
Jan Borg	HS/PH expert	Jan.borg@enabel.be
Global Communities		
Grace Kangwagye Nkubito	SHPO	gnkubito@globalcommunities.org