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REPRODUCTIVE HEALTH at a GLANCE RWANDA

May 2011

Public Disclosure Authorized
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Country Context

Rwanda's innovations and investments in the health sector since the end of the 1994 genocide and civil war have brought significant improvements in the health sector.[1] Rwanda has been a forerunner in performance-based financing whereby incentives reward quality and quantity of maternal, child and HIV services. However, an estimated 57 percent of Rwandans still live below the national poverty line, with nearly 37 percent classified as extremely poor.[2]

Rwanda's large share of youth population (42 percent of the country population is younger than 15 years old[3]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[4] In Rwanda, the literacy rate among females ages 15 and above is 66 percent. Fewer girls are enrolled in secondary schools compared to boys with a ratio of female to male secondary enrollment of 90 percent.[3] Nearly 90 percent of adult women participate in the labor force[3] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Rwanda ranks 140 of 157 countries in the Gender-related Development Index.[5]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[4]

Rwanda: MDG 5 status

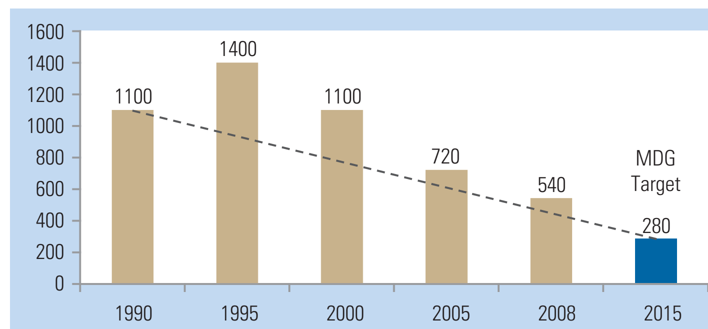
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	540
Births attended by skilled health personnel (percent)	52.1
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	36.4
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	36.2
Antenatal care with health personnel (percent)	95.8
Unmet need for family planning (percent)	37.9

Source: Table compiled from multiple sources.
[a] The 2005 DHS estimate is 750.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Rwanda has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[6]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Rwanda

The Bank's current ***Country Assistance Strategy*** is for fiscal years to 2009 to 2012. The Bank's new ***Country Assistance Strategy Progress Report*** under preparation (P119488) is scheduled to be approved by the Bank's Executive Board on March 10, 2011

Current Project:
P104189 RW-MultiSec HIV/AIDS – Add Fin (FY07) ($5m)

Pipeline Project: None

Previous Health Project:
P071374 RW-MultiSec HIV/AIDS (FY03)

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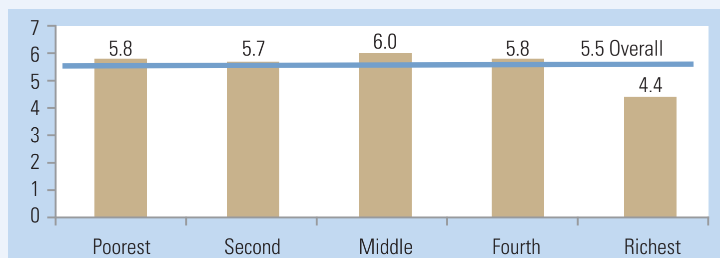
Key Challenges

High fertility

Fertility has been declining over time but remains high among the poorest. Total fertility rate (TFR) decreased from 6.2 births per woman in 1992 to 5.8 births per woman in 2000 to 5.5 in 2007–08.[7] Fertility remains high among the poorest at 5.8 in contrast to 4.4 among the wealthiest (Figure 2). Similarly, TFR is 3.8 among women with secondary education or higher compared to 6.1 among women with no formal education. It is also lower among urban women at 4.7, compared to rural women at 5.7 births per woman.[7]

Figure 2 ▪ Total fertility rate by wealth quintile

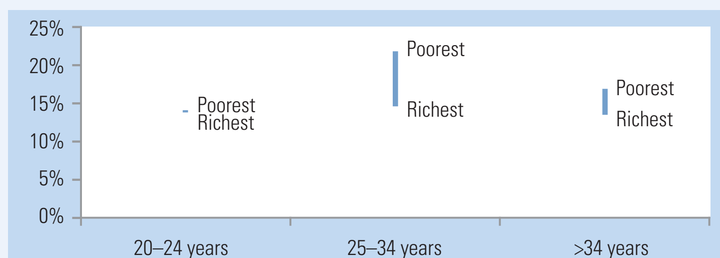


Source: Interim DHS Report, Rwanda 2007–08.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[4, 8] In Rwanda, adolescent fertility rate is moderate at 36.2 reported births per 1,000 women aged 15–19 years.

Early childbearing is more prevalent among the poor. While the rich-poor gap in prevalence of early childbearing is negligible among 20–24 year olds, 22 percent of the poorest 25–34 years old women have had a child before reaching 18 compared to 15 percent of their richer counterparts did (Figure 3).

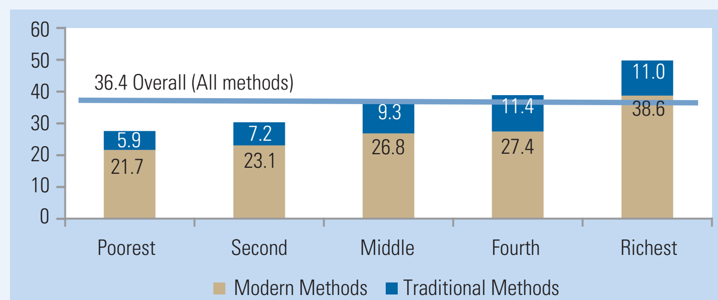
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: Interim DHS Report, Rwanda 2007–08 (author's calculation).

The majority of women who use contraceptives use modern contraception. Current use of contraception among married women was 36 percent in 2007–08.[7] More married women use modern contraceptive methods than traditional methods (27 percent and 9 percent, respectively). Injectables are the most commonly used method (15 percent), followed by the pill (6 percent). Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 37 percent among women in the wealthiest quintile and 22 percent among those in the poorest quintile (Figure 4).[7] Similarly, just 19 percent of women with no education use modern contraception as compared to 43 percent of women with secondary education or higher, and 26 percent for rural women versus 36 percent for urban women.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: Interim DHS Report, Rwanda 2007–08.

Unmet need for contraception is high at 38 percent[9] indicating that women may not be achieving their desired family size.[10] Unsafe abortion is common, accounting for half of all obstetric complications.

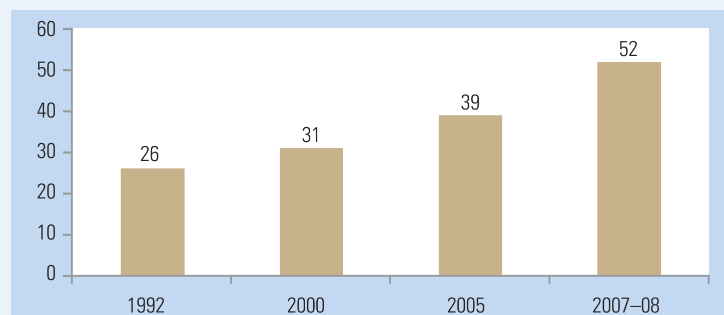
Opposition to use and fear of side effects are the predominant reasons women do not intend to use modern contraceptives in future, not including fertility related reasons (such as menopause and infecundity). Nine percent not intending to use contraception cited fear of side effects as the main reason while 12 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion.[7] Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While the majority of pregnant women use antenatal care, institutional deliveries are less common. Ninety-six percent of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife) with 24 percent having the recommended four or more antenatal visits.[7] Fifty-two percent of women deliver with the assistance of skilled medical personnel, an increase from 39 percent in 2001 (Figure 5). While 71 percent

of women in the wealthiest quintile delivered with skilled health personnel, only 43 percent of women in the poorest quintile obtained such assistance. Eleven percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[11]

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) 1992–2008



Source: Interim DHS Report, Rwanda 2007–08.

Among all women ages 15–49 years who had given birth, 96 percent had no postnatal care within 6 weeks of delivery.[9]

Seventy-one percent of women report that getting money needed for treatment was a challenge in accessing health care (Table 1).[7] Forty percent of women report that distance to the facility and nearly the same amount reported that having to take transport was a problem in accessing health care.

Table 1 ▪ Barriers in accessing health care (women age 15–49)

Reason	%
At least one problem accessing health care	80.8
Getting money needed for treatment	70.8
Distance to health facility	40.0
Having to take transport	39.0
Not wanting to go alone	17.0
Concern no female provider available	9.3
Knowing where to go for treatment	4.7
Getting permission to go for treatment	3.0

Source: DHS final report, Rwanda 2005.

Human resources for maternal health are limited with only 0.024 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.448 per 1,000 population.[3]

The high maternal mortality ratio at 540 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[6]

HIV prevalence in Rwanda is higher among women

Rwanda's HIV prevalence rate among adults is 2.8 percent, making it a generalized epidemic. Women bear greater burden of the epidemic as seen in the higher HIV prevalence rate among women ages 15–49 (3.6 percent) compared to men in the same age group (2.3 percent).[9]

Knowledge of HIV prevention methods is high. Approximately eighty percent of people in Rwanda know that condoms can help reduce risk of transmission, know about mother-to-child transmission through breastfeeding, and know that the risk of transmission from mother-to-child can be reduced by using medication.

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National policies and strategies that have influenced reproductive health

Health Sector Policy

- **National Reproductive Health Policy** – Priority components include: Maternal and child health, family planning, prevention and treatment of HIV/AIDS and other sexually transmitted infections, adolescent reproductive health, prevention and treatment of sexual violence, and increasing women's decision-making authority in FP/RH.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.

Reducing maternal mortality

- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- Generate demand for the service and address the perception that it not necessary to deliver at a health facility. This will require a combination of Behavior Change Communication (BCC) programs via mass media and community outreach as well as deploying midwives to assist women with home deliveries. During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Promote institutional delivery through provider incentives and implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.

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This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE) and Management Science for Health (MSH). For more information contact, Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: *www.worldbank.org/population*.

RWANDA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2007/08	5.5
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	36.2
Contraceptive prevalence (% of married women ages 15–49)	2007/08	36.4
Unmet need for contraceptives (%)	2005	37.9
Median age at first birth (years) from DHS	—	—
Median age at marriage (years)	2005	20.7
Mean ideal number of children for all women	—	—
Antenatal care with health personnel (%)	2008	95.8
Births attended by skilled health personnel (%)	2007/08	52.1
Proportion of pregnant women with hemoglobin <110 g/L	2008	10.6
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	1100
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	1400
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	1100
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	720
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	540
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	280
Infant mortality rate (per 1,000 live births)	2008	72
Newborns protected against tetanus (%)	2008	85
DPT3 immunization coverage (% by age 1)	2008	97
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	36.1
Prevalence of HIV, total (% of population ages 15–49)	2007	2.8
Female adults with HIV (% of population ages 15+ with HIV)	2007	60
Prevalence of HIV, female (% ages 15–24)	2007	1.4

Indicator	Year	Level
Population, total (million)	2008	9.7
Population growth (annual %)	2008	2.8
Population ages 0–14 (% of total)	2008	42.2
Population ages 15–64 (% of total)	2008	55.3
Population ages 65 and above (% of total)	2008	2.5
Age dependency ratio (% of working-age population)	2008	80.9
Urban population (% of total)	2008	18.3
Mean size of households	2005	5
GNI per capita, Atlas method (current US$)	2008	440
GDP per capita (current US$)	2008	458
GDP growth (annual %)	2008	11.2
Population living below US$1.25 per day	—	—
Labor force participation rate, female (% of female population ages 15–64)	2008	87.9
Literacy rate, adult female (% of females ages 15 and above)	2008	66.1
Total enrollment, primary (% net)	2008	95.9
Ratio of female to male primary enrollment (%)	2008	101.5
Ratio of female to male secondary enrollment (%)	2008	90.1
Gender Development Index (GDI)	2008	140
Health expenditure, total (% of GDP)	2007	10.3
Health expenditure, public (% of GDP)	2007	4.9
Health expenditure per capita (current US$)	2007	37.2
Physicians (per 1,000 population)	2005	0.024
Nurses and midwives (per 1,000 population)	2005	0.448

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2007/08	5.8	5.7	6.0	5.8	4.4	5.5	1.4	1.3
Current use of contraception (Modern method)	DHS	2007/08	21.7	23.1	26.8	27.4	38.6	27.4	–16.9	0.6
Current use of contraception (Any method)	DHS	2007/08	27.6	30.3	36.1	38.8	49.6	36.4	–22.0	0.6
Unmet need for family planning (Total)	DHS	2005	40.0	37.5	39.5	38.1	33.9	37.9	6.1	1.2
Births attended by skilled health personnel (percent)	DHS	2007/08	42.7	45.8	50.8	53.9	70.6	52.1	–27.9	0.6

Development partners support for reproductive health in Rwanda

USAID: Increased use of community health services – focus on HIV/AIDS

DFID: mHealth – mobile phones for maternal/neonatal health

GIZ: Primary health care and combating HIV/AIDS

SNV: Vocational skills training for women

WHO: Reduction of child and maternal mortality

UNICEF: Child survival; HIV; vulnerable children

UNFPA: Integrated approach to sexual and reproductive health and rights

MSH: Preventing unintended pregnancies; averting maternal deaths; promoting healthy families

FHI: HIV/AIDS prevention and care; increasing contraceptive prevalence; expanding family planning service delivery

IntraHealth International: Health systems strengthening and health care workforce capacity building

Engender Health: Obstetric fistula care

IPPF: STIs/HIV/AIDS prevention and care; antenatal and post-natal care; family planning