Sources of Family Planning

Rwanda

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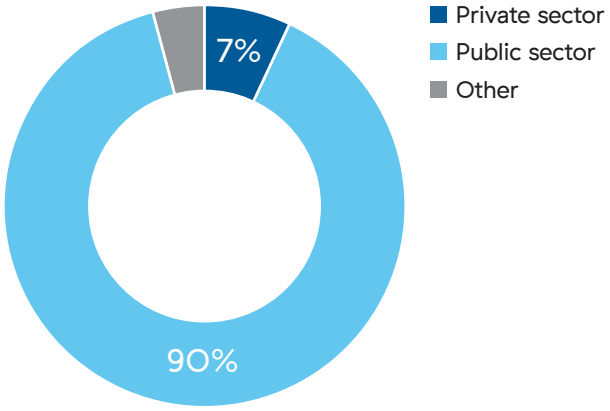
Understanding where women obtain their family planning methods can help programs to better target their resources and increase overall access to modern contraception. This brief is one of a series of country briefs that examines where women obtain modern contraception by method, geography, age, and socioeconomic status. Through a secondary analysis of the 2014—15 Rwanda Demographic and Health Survey, the brief explains where married modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Rwanda.

Key Findings

- Most modern contraceptive users (90%) rely on the public sector for their method.
- Among married women, the modern contraceptive prevalence rate increased slightly from 45% in 2010 to 47% in 2014—15 due to increases in use of long-acting reversible and permanent methods.
- Private sector use varies greatly by region: one-quarter (24%) of users in Kigali City obtain their method from private sector sources versus 5% or less in other regions.
- Only one-third (36%) of condom users rely on the private sector, which is substantially lower than in many other countries in sub-Saharan Africa.
- The majority (82%) of the wealthiest contraceptive users obtain their method from public sector sources.

Source of modern contraceptives



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at **PrivateSectorCounts.org**.

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Modern contraceptive prevalence rate and method mix

Among married women of reproductive age, nearly half (47 percent) use modern contraception. This brief focuses on married women because very few unmarried Rwandan women report using modern contraception. Rwanda's modern contraceptive prevalence rate (mCPR) among married women increased by two percentage points between 2010 and 2014–15 (from 45 to 47 percent). The leading method in Rwanda is injectables (used by 24 percent of married women) followed by implants and pills (used by 8 percent each). Use of short-acting methods (SAMs) has remained stable at 36 percent, meaning almost all growth in the mCPR is attributable to long-acting reversible contraceptives and permanent methods (LARCs and PMs), the use of which increased from 8 percent in 2010 to 10 percent in 2014–15.[1]

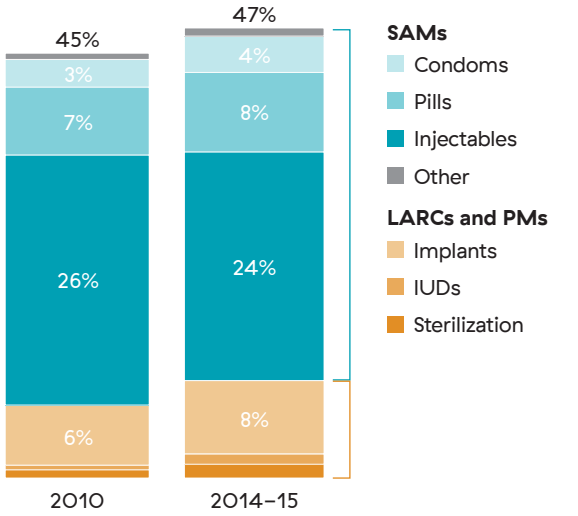
Sources for family planning methods

The public sector is the primary source of modern contraceptives for married women in Rwanda (90 percent). High public sector reliance is in part a result of the Rwandan government's efforts to make family planning accessible through multiple outlets. These efforts have included the creation of health posts and a robust community health worker program to provide contraceptives to women in remote areas. Few users (7 percent) rely on the private sector. Among private sector users, 42 percent obtain their method from a pharmacy, 36 percent from a shop, and 22 percent from a private hospital or clinic. Less than 4 percent use other sources.[2] These source patterns are similar to those reported in 2010.

Private sector's contribution to method mix

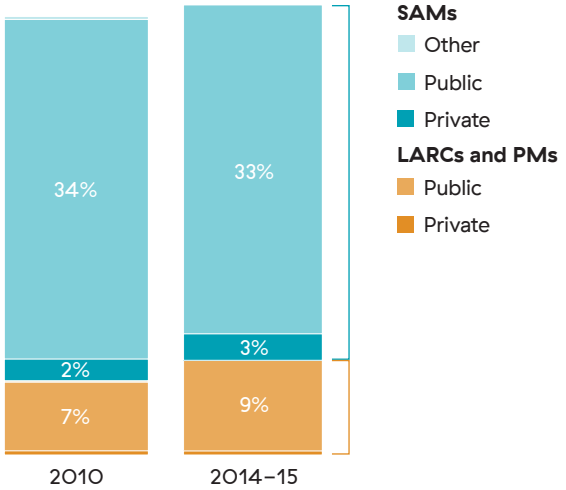
Few married women in Rwanda rely on the private sector to obtain SAMs (3 percent) or LARCs and PMs (less than 1 percent). Between 2010 and 2014–15, public sector provision of LARCs and PMs increased from 7 to 9 percent.

Rwanda's mCPR among married women increased slightly between 2010 and 2014—15



Note: Numbers may not add due to rounding.

Since 2010, the largest changes in contraceptive source are in public sector LARC and PM provision



[1] SAMs include injectables, contraceptive pills, male condoms, diaphragm, female condoms, and fertility–awareness methods. LARCs and PMs include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Survey does not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

[2] Public sector sources include hospitals, health centers, health posts, outreach, community health workers, and youth centers. Private sector sources include clinics, polyclinics, and family planning clinics; pharmacies, dispensaries, kiosks, shops, and bars. Other sources include friends, relatives, and women who did not know or report the source. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

Among users of injectables, Rwanda's leading method, just 3 percent rely on private sector sources. A slightly higher percentage (6 percent) of pill users in Rwanda rely on private sector sources. More than one-third of condom users (36 percent) rely on private sector sources—primarily shops and kiosks. Private sector use for injectables, pills, and condoms is quite low compared to many countries in sub-Saharan Africa. National policy in Rwanda restricts service provision at pharmacies and other dispensaries, making it difficult for women to obtain injectables or pills from a nonclinical private source like a pharmacy or shop.

Rural and urban areas

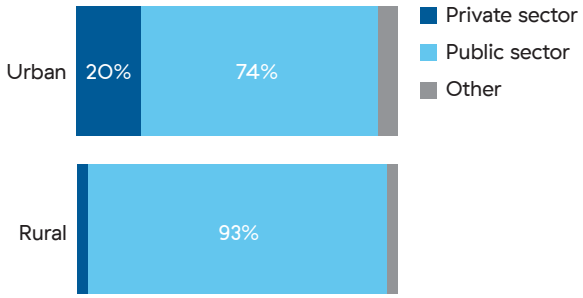
The mCPR is slightly higher among married women in urban (51 percent) than in rural (47 percent) areas. Urban users are more likely to purchase their method from the private sector (20 percent) compared with rural users (4 percent). There are some differences in method mix between urban and rural users, as well. Injectables are more common among rural than urban users (54 versus 35 percent). LARCs and PMs are more popular among urban than rural users: 21 percent of urban versus 15 percent of rural users rely on implants, and 7 percent of urban versus 1 percent of rural users rely on IUDs.

In Kigali City, the urban hub of the country, one in four women (24 percent) obtain their method from a private source. In the remaining regions of the country, private sector use is much lower and closer to the national average, ranging from 3 percent in the north to 5 percent in the east. Despite the higher private sector use in Kigali City, the mCPR there is similar to the national average (49 percent). In addition, contraceptive users in Kigali City are not substantially more likely to rely on methods commonly accessed from private sources, such as condoms.

Contraceptive source by age

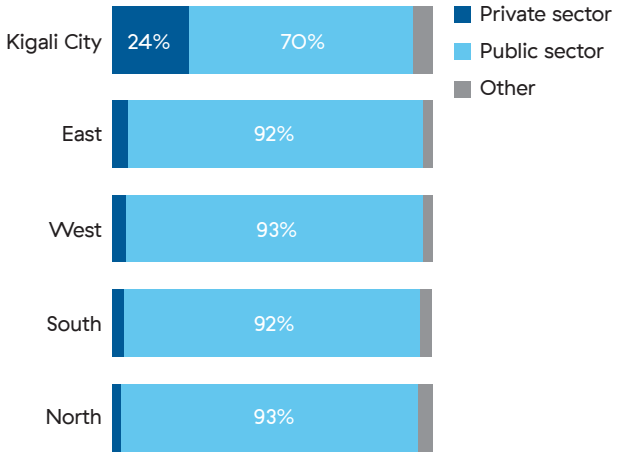
The mCPR is slightly higher among contraceptive users ages 25 and older (48 percent) than those younger than 25 (43 percent). Nevertheless, contraceptive sources are similar for married women across age groups.

Urban users are five times more likely than rural users to rely on private sources



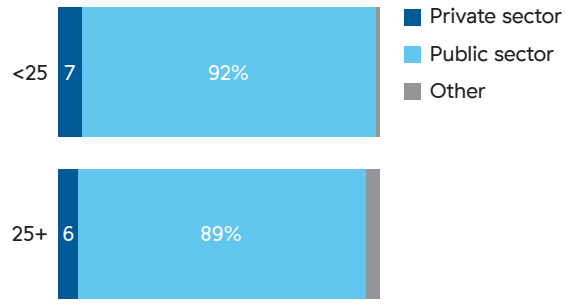
Percent of users in each group who obtain modern contraception from each source

One in four contraceptive users in Kigali City obtain their method from a private source



Percent of users in each group who obtain modern contraception from each source

Use of the public and private sectors are similar across age groups



Percent of users in each group who obtain modern contraception from each source

Contraceptive source by socioeconomic status

In Rwanda, the poorest married women have a slightly lower mCPR than the wealthiest married women (45 versus 49 percent).[3] Among the poorest users, 3 percent obtain their method from the private sector. Geographically, 6 percent of the poorest urban and 3 percent of the poorest rural users obtain their method from a private source. The wealthiest users are more likely than the poorest to obtain their method from the private sector (12 percent). However, the large majority (82 percent) of the wealthiest users rely on the public sector. The wealthiest users rely more on the private sector for SAMs (14 percent) than they do for LARCs and PMs (8 percent).

Very few of the poorest contraceptive users in Rwanda rely on the private sector

The majority of the wealthiest contraceptive users in Rwanda rely on public sources

Implications

Rwanda's public sector is the primary source of contraceptives for all population segments. This contrasts with patterns in most other sub-Saharan African countries, where the private sector often plays a more substantial role, particularly in supplying SAMs. The government of Rwanda has voiced intentions to deepen its collaboration with the private sector to provide contraceptive services (GOR, 2012) and has committed through Family Planning 2020 to increase demand for contraception, particularly among young couples, who have a lower mCPR. To help meet these goals, Rwanda could consider how to increase the private sector's role and engagement, including through public-private partnerships and expanded inclusion in decision making at the national, regional, and community levels. Rwanda could increase sustainability of contraceptive supplies and access among youth by facilitating greater provision of SAMs through the private sector. For example, allowing pharmacies to provide pills and injectables without a prescription and to administer injectables would increase the private sector's contribution to these methods and might enhance access for youth, who use the private sector at relatively high levels in many neighboring countries. By complementing public sector approaches, the private sector can serve as an ally to the Rwandan government and ultimately help the country achieve its family planning goals.

References

Government of Rwanda (GOR). 2012. "Third Health Sector Strategic Plan."

[3] The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset–based wealth index. The wealthiest women are those in the top two wealth quintiles.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five–year cooperative agreement (AID–OAA–A–15–00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse–Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the generous support of the American people through USAID. The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

May 2019