



## ***Coffee and Contraception: Combining Agribusiness and Community Health Projects in Rwanda***

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***Edited Transcript  
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Thank you. So, I'm here to talk about the USAID SPREAD project. It's a unique PHE approach, Population Health and Environment. I'm not going to go into too much of what PHE means. I think Jason's going to talk a little bit about it. I'm assuming many of you know a little bit about this approach, and if not we can field questions. But basically, it's an integrated approach to development that crosses sectors to promote synergy across disciplines and more holistically meet community needs.

So, the SPREAD project: I'm actually going to start by giving you a bit of a context first, for those of you that may not know much about Rwanda and Rwandan coffee and I'll give you a little bit of the background of the PHE challenges and a little bit of the background on SPREAD. And then I'm going to talk specifically about the integrated health and coffee interventions and the accomplishments that we've had and the challenges over the last couple of years and then share some lessons learned and then we can have some time for questions.

So, for those of you that don't know, Rwanda is small -- it's a tiny landlocked country in East Central Africa and it's bordered by Uganda to the north, DRC Congo to the left -- to the west, Burundi to the south and Tanzania to the east. It's about the size of Maryland. It's very small but with twice the population. It's estimated over 10 million today. And it's the highest population density in Africa. There are about 356 people per square kilometer so it's very, very densely populated.

Rwanda is known as the Land of a Thousand Hills. This is a photo taken from where the majority of our coffee and health activities have taken place. This is in the southern province. I believe it's Huye district. Rwanda is primarily an agrarian based society where 90 percent of the population relies on these hills for food and for their livelihood. As you can see, almost every inch is cultivated and the average land size per farmer is about .8 hectares



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per farmer, per family. And about a quarter of the population lives on .2 hectares per household, which is far less than what's required to meet their nutritional needs. Population pressures and diminishing landholdings due to high fertility rates, war and genocide and subsequent migration have caused a rapid decrease in forested and protected areas and increased soil infertility and food insecurity. And close to 57 percent of the population lives under the poverty line.

Here's just some data and statistics about population health and environment issues. There's still a high fertility rate, about 5.5 children per woman. The growth rate is at 2.8 percent, and at this current rate the population is projected to reach over 14 million by 2025. Again, there's this problem of diminishing landholdings with each passing generation, with large family sizes and small plots of land. Poor soil is as a result of over cultivation, cultivating on steep hillsides and problems with erosion. Again, poverty and food security. HIV AIDS: it's about 3 percent prevalence nationally which is quite low relative to the region, but it rises to 7 percent in urban areas. And condom use is quite low. And there are other factors such as gender issues, gender based violence, alcohol, which could exacerbate -- and rapid urbanization which could escalate the epidemic.

The unmet need for family-planning is around 36 percent, and infant mortality and maternal mortality are still quite high. And common to many developing countries, there are severe water and sanitation access issues in many areas; it varies where you go. But you know as well as high rates of diarrheal disease, respiratory infections, preventable diseases and malaria is also common in certain areas.

And then post-war and genocide: There are many effects. Since 1959, this country has been going through conflict which culminated in the civil war in the early 1990s and genocide in '94. There are over one million orphans. There are high rates of depression and posttraumatic stress disorder. So these are things just to keep in mind, the context.

But it's important to note that, despite all these challenges, Rwanda -- there's hope in Rwanda. The country has made remarkable progress over the last 16 years. They've become sort of a development success story, especially in terms of reproductive health. Just from 2005 to 2007, contraceptive prevalence rates went up from 10 percent to 27 percent which is unprecedented. The total fertility rate went from 6.1 to 5.5 in just these two years, and again, gains in infant mortality, under five mortality. This can greatly be attributed to the strong government leadership. The government really takes -- sees family planning as crosscutting





tool to fight poverty, to develop families in their country so it's definitely -- that's been key to this success. It's also one of the safest countries in Africa. Despite some recent problems, up until this year it was the -- I think it's still called the safest country in Africa. Tourism is on the rise. People come visit the mountain gorillas and other natural areas. Corruption is relatively low and lots of foreign investment. As a result, it's got one of the highest economic growth rates in the region. It's really been remarkable recovery.

And just to tell you a bit about Rwanda coffee, since that's the context: Rwanda boasts almost ideal growing conditions for the Arabica variety of coffee, which is used to produce the finer specialty grade coffees. It's been the leading export since the early 1900s when it was introduced, and it's been a major source of rural revenue since then. USAID has been the principal provider of technical assistance since 2000. Projects such as PEARL and the 8R project, ACIDI/VOCA, there was about, I think over \$12 million invested. And it's really been instrumental in putting Rwanda on the map for specialty coffee and for those of you that know coffee, it's become a highly sought after specialty coffee origin. These projects built close to 40 washing stations, creating thousands of jobs and exports for fully washed coffee, fully washed specialty grade coffee went from zero to eight million in seven years. And as result, over 20,000 farming families doubled their incomes and in 2005, and to date over 50,000 have benefited from the gains in specialty coffee.

So, the SPREAD project, as Sean said, stands for Sustaining Partnerships to Enhance Rural Enterprise and Agribusiness Development. And SPREAD is a follow-on from the PEARL I and PEARL II projects, also funded by USAID from 2000 to 2006. SPREAD is a five-year cooperative agreement between Texas A&M University and USAID from 2006 to 2011, so we're coming up to the final year and a half of implementation. And funding is a total of six million dollars from USAID, five million dollars for economic growth, and \$1 million for health for the five years. Health money is primarily PEPFAR for HIV AIDS prevention, then family-planning, population followed by a maternal and child health funds. There's been additional funding from private investors, primarily those involved in the U.K. and U.S. specialty coffee sector, as well as the Global Development Alliance public-private partnership between USAID and private companies to develop Birdseye chili pepper and as well as pyrethrum, which is a flower found in Rwanda that's used to make insecticide; it's a natural insecticide. So, the goal of SPREAD was to continue to expand or build on the successes of PEARL in specialty coffee as well as expand to pyrethrum and Birdseye chili pepper later in the project, as well as integrate this community health program.





Coffee is still the main activity for SPREAD, so I'm just going to tell you a bit about the primary coffee activities. SPREAD aims for value chain management every step of the way, from seed to cup, to improve quality. There are programs for research, equality, co-op development, organic agricultural practices, trying to promote better agricultural production. And capacity building happens at all levels: the farmer level, the cooperative level, the national coffee board. And the health program focuses primarily on those two levels, the farmer and the cooperative level.

So, the rationale for integrating this community health program and the assumptions upon which the program was based was first that coffee revenue could be spent on family health needs given appropriate access to health information and services. Seeing that these farmers had seen increases in their incomes, they could feasibly spend more money on things like commodities such as condoms or water purification solution or the mutuelles -- the community-based health insurance. Secondly, integrating health outreach and to coffee and co-op opportunities could enable rapid access to otherwise underserved rural income generating population. And thirdly, the integration would lead to programmatic synergy across health and agribusiness programs. Just realizing that farmers, when they're unhealthy, are not able to put in the work involved to produce a high-quality coffee, or to become involved and engaged in their cooperative activities, to have a strong cooperative. And in general, having these health services was thought to help fulfill the overall SPREAD goal of improving lives and livelihoods.

The target areas of the health program for -- in the southern province -- for coffee. We've intervened in two districts since October 2008, two cooperatives and one private female owned enterprise totaling over 10,000 farmers, but we're also reaching their families and neighbors during these community outreach interventions. And in the northern and western provinces, we just started expansion to pyrethrum and scaled up to work with five pyrethrum farming cooperatives around the Volcanoes National Park. And that's pyrethrum there on the bottom.

So, the approach SPREAD uses to integrate its activities is we really try to build on the existing assets of the cooperative, you know, the existing management and extension structure of meeting farmers where they are with both coffee and health services. We also really try to complement local public health, local and national public health policy and partners. For example, rather than recreating our own curricula we tried to -- we used Ministry of Health curricula and their own IEC materials, and we printed them, as well as





materials for peer education from PSI and FHI. As these have already been validated, there's no point in recreating the wheel.

So, to get into the activities now, we've trained and mentored over 300 -- I think it's close to 400 now -- so coffee extension agents and these guys were already in the cooperative as employees, extending information on better farming practices, how to -- and other cooperative issues. So we approach them and ask them if they would be willing to also be health extension agents and there were very willing. So we've trained them to also extend health information, as well as peer educators, both youth and adults, for behavior change communication. Again, realizing -- I guess I should say that our mandate from USAID was to do more of a community health approach, because there were several partners in the country already supporting clinics, doing the clinical support, so we were tasked with trying to change those behaviors such as increasing uptake of available health services. There are services available in these rural areas but people often weren't going, whether they didn't know about them or it was little bit far or there was stigma around getting, asking for condoms or family planning. There's many myths around family-planning and the side effects, a lot of stigma around HIV and, as I said, condom use. And so we were asked to sort of graft these kinds of behavior change communication methods into the work with the coffee farmers. So, that's what these guys are doing. So, on the bottom there we have some youth being trained on how to do condom demonstrations and there's a coffee agent on the right doing an extension both coffee and health meeting in the rural -- in the hills.

So, they do both coffee and health at the same time. The adult peer educators and coffee extension agents also refer to health services. They have little slips that they give to clients to go to the health center, where they get it stamped and bring it back, so we also know not only how many people were referred but how many people actually received the services at the health centers. They're also selling Siro and Prudence. PSI -- Population Services International has these socially marketed health commodities available in Rwanda, so Siro is for water purification and Prudence are condoms. So these were also extended through the coffee washing stations, sold there during coffee season as well as sold via these extension agents in their communities. We also focused on mobile clinics, bringing services to the farmers during harvest time, trying to choose locations that were convenient to their either coffee sales or processing activities at the washing stations or other areas, working with the cooperatives and the local health centers. This is also a strategy the government uses to reach the people. They have special campaigns, so we're actually supporting the government to get out there and we facilitate health centers to go out and do the actual HIV testing,





family-planning, treatment of intestinal parasites during the three months of coffee harvest. There's also a radio program, Imbere Heza, which means bright future and it's primarily a coffee talk show that's promoted and supported by the Coffee Lifeline program, and they've agreed to integrate five to ten minutes of health at the end of each program.

So, this photo down here is a group of youth waiting to be tested outside a coffee washing station during the mobile clinics. And on the right is a local lab technician from a health center nearby who's doing the rapid testing analysis in these mobile clinics.

And lastly, you know we try to leverage the strengths of local partners, knowing that we have a small health program; we don't have all of these resources and equipment. So, we've looked around and seen what's out there and the Health Unlimited, for example, they're experts in community theater for health advocacy. So, we brought them in to help train some farmer groups because they really love community theater and they always ask for it. So, this photo right here is the competition that took place in Nyaruguru district last year, and it's discussing -- there's a man holding a bottle of wine and yelling at his wife -- and it is discussing the issues around coffee, using money for alcohol and the conflict that it can bring into the household. There's films. PSI has films that we try to use and their guides with our peer educators. We try to engage local partners like the Planned Parenthood Federation and PSI to help with follow up for sustainability so if they have contact with these farmers and could maybe continue with them after SPREAD has finished.

We support district health plans for their activities, such as family planning clubs, their own mobile services, trying to be flexible outside of our work plan to also support local districts in their needs, and also some hygiene and first-aid activities to help fulfill Fair Trade requirements for our cooperatives that are Fair Trade certified.

This woman here on the right is using a kanikuli. It's a water-saving portable hand washing mechanism that's setup at the coffee washing station.

So, over the last couple of years -- these are some of our monitoring data that I just wanted to share with you to give you an idea of some of the scope. So far, over 120,000 people were reached with HIV AIDS prevention messages. Close to 98,000 were reached with family planning and reproductive health messages; close to 40,000 for MCH messages, maternal and child health; and close to 4,000 people were tested for HIV during these mobile services; 248,000 liters of drinking water were purified. This was calculated by the number of bottles





of siro water purification that was sold by the cooperatives, and close to 1500 condoms were sold by the cooperative structures. Three hundred and forty-seven women are new Family Planning users. There could maybe be more, but these are what we actually track in terms of the referrals and mobile services and over 1,000 people were referred for BTC family planning and received care at local health centers. And it's also quite cost-effective; just a basic cost breakdown with our budget over the last year-and-a-half and the number of people that were reached: Just with HIV AIDS prevention, education alone cost less than two dollars a person.

So, this is some qualitative data that came from a midterm evaluation that we just did, and just to take a look people's perceptions of the program over the last year-and-a-half. And I won't read them all but one female beneficiary says, "Family planning has been very important because it has allowed us to put some of our money into savings." And then a SPREAD agribusiness manager, because somebody who had worked in the PEARL project only doing agribusiness before said, "We used to talk about growing coffee, making money, buying material things like bikes, not about problems like malaria, HIV AIDS, etc. Someone could have five million Rwandan francs in the house, but could suffer from malaria where medicine costs 500 francs do to ignorance. You have to teach people about production. You have to also think of their health to improve their lives." And then one cooperative manager says, "The big lesson I learned is that you cannot achieve your coffee production objectives at a hundred percent without addressing the health of the farmers." And a district official says, "The fact that SPREAD uses a community health approach enables us to work with populations that were previously difficult to reach." And the last quote has to do with the reduction in emergency loans that have happened as a result of decreased family conflict potentially as a result of the behavior change communication around gender and sharing money management responsibility within the household. And these problems would trickle down to the cooperative as well who people go to for emergency loans and conflict resolution.

So, some of the challenges that we've had: just the community barriers in general around gender, alcohol, reproductive health, are often barriers to reproductive health. Men are often barriers to starting family-planning and using condoms because they often will leave these education sessions to be for women only, and they won't necessarily participate. But I have to say that coffee has been a better entry point to reach these men because they are interested in the coffee work because it's income generating and so we've had some peer educators say yeah, I'll often start off a meeting and talk about health and then go into coffee so that we





know that people will stay and listen. So, we're fairly confident that the message is getting out some of these men. But the barriers are still there. Also around savings, people need better capacity to learn how to manage their money and save. Just increasing incomes alone is not enough. And also they request, you know, income generating opportunities outside coffee, because that's only once a year. And again, those gender relations, choosing when to start family planning, how to spend family revenue. Those have been issues.

Another challenge is the short length of the program. We sort of got a slow start. The health program was a bit of an add-on because the agribusiness staff who were managing the project in the beginning didn't really have much health expertise, any, actually. And there was supposed to be a subcontract with PSI that never materialized, and so we sort of -- it of a couple of years to get the program really off the ground. So, now that it's happening and going well, it's difficult, because there's only a year and a half left and it may not be enough time to build the capacity required for sustainability. And there's a very high remaining need, especially in the pyrethrum areas. Those areas around the Volcanoes National Park are extremely difficult to access. Health knowledge is very low. Even access to drinking water and sanitation is extremely difficult because of the volcanic rock. You can't dig. So, that's been, that's a big challenge up there with pyrethrum partners.

Integration has been challenging to really use the best of all programs to work together and collaborate, because it wasn't very well articulated in the beginning of the program design plan. As I said, health was a bit of an add-on. And the distance between coordinators; we have offices in Kigali and Butare and Musanze. These are each about two hours apart, so it makes consistent collaboration challenging. And again, just the general resource constraints: small staff, small budget to really focus on this. Monitoring and evaluation has been challenging. There was no baseline health data and we were sort of in a rush to get the program off the ground so there's no baseline health data integrated indicators. And communication with all partners could be strengthened. We have a lot of reporting requirements at the district and national level, both U.S. government and government of Rwanda. Sometimes those lower level sector level authorities and local NGOs, communication reporting to sharing information has been a bit challenging. U.S. government restrictions have also been tricky. With the vertical programming of economic growth and health, it's difficult to actually integrate in the field. And there's extremely high volumes of reporting that have to go -- they're very specific across PEPFAR economic growth we have separate indicators, reporting mechanisms, different activity managers. So, really working together and trying to collaborate across programs is difficult.







And also sometimes funding restrictions: The specific line-item of maternal and child health funding that SPREAD received: we weren't able to do any infrastructure developments around the Volcanoes National Park. We were allowed to educate on how to teach people to wash their hands and drink clean water but they had no water to access so that's tough, I think.

Sustainability: there is again the imminent project closure. That's an issue for sustainability, and the low financial and technical capacity of cooperatives and partners. There's a will to continue the activities, but the nuts and bolts of covering transportation logistics, coordination costs, keeping people refreshed and trained and also motivated to do the work, is going to be challenging. And there have been ideas for an exit strategy, but it needs to be finalized over the next year and a half of the program so that appropriate capacity can be built before the end of the project.

So, some of the lessons that I've learned through this process are that farming families do need more than simply increased incomes to improve their lives and livelihoods. Simply giving them more money in their pockets is not enough; there needs to be a whole range of life skills for savings and for planning and for resolving some of these gender issues, thinking of family size and just the whole picture is important. And I think communities realize that; stakeholders have realized that. And although communities may be deemed high-risk say for HIV prevention funds, generally we try to target commercial sex workers or truck drivers or those that are the drivers of the epidemic. However, there is a high unmet need in these rural areas and -- as evidenced by the low knowledge, the amazing community response and the uptake of services, there is a need there. And it is indeed feasible and cost-effective and worthwhile for agribusinesses to combine health outreach in cooperatives or agribusiness activities. And managers also realize that ; that it actually doesn't cost all that much and that the benefits can be huge and can support the business. Although we don't have real data on this synergy, I think it's felt. I think the perception, the perceived benefit is there. And the community-based peer farmer approach is very useful. It's a valuable way to reach farmers with regular health information and behavior change communication. Committee members, beneficiaries, all stakeholders really appreciated this approach, thinking that the message is better heard when it comes from your neighbor, somebody who understands your reality rather than an outside. Sometimes even community health workers are seen to be a little bit of a different status than the farmers themselves. So, that was a good approach, the peer education. Strong support in mentoring and supervision of peer farmers are crucial to ensure





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their quality and consistency of their messages. I think that's one strength that SPREAD really has worked on is to meet with them monthly to do refresher trainings, troubleshoot; they give reports. There's just sort of this constant close mentoring and supervision. Staff go out into the field and supervise them, sort of do surprise visits and see how they're doing, just so they feel supported, and also so you could check and see how the quality of the message is going and how the community is responding. So, that's been key.

And also, community engagement and alignment with government of Rwanda and U.S. government priorities ensures complementary rather than duplicating service delivery. There's been some concern that maybe we are, SPREAD is duplicating services because there are community health workers already working, but it's clear that if you -- and it came up in the evaluation as well -- that because the planning happens together you can sort of divide and conquer. It's not something that is a complete parallel program, but working with the local authorities you can sort of collaborate on outreach activities so that you know you're not reaching the same people twice. You can sort of fill gaps. But it's crucial to spend time doing that community engagement and consistent planning and coordination together.

So, that's it. If anybody has questions. Thank you for your time.



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