

PD-AX-067

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	01 Amendment Number	DOCUMENT CODE 3
2. COUNTRY/ENTITY RWANDA		3. PROJECT NUMBER [REDACTED]		
4. BUREAU/OFFICE AFRICA [06]		5. PROJECT TITLE (maximum 40 characters) MATERNAL AND CHILD HEALTH AND FAMILY PLANNING II		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 07 15 94		7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4) A. Initial FY [89] B. Quarter [4] C. Final FY [92]		

A. FUNDING SOURCE	B. COSTS (\$000 OR EQUIVALENT \$1 =)					
	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	800	635	1,435	4,764	4,236	9,000
(Grant)	(800)	(635)	()	(4,764)	(4,236)	(9,000)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country					8,170	8,170
Other Donor(s)						
TOTALS	800	635	1,435	4,764	12,406	17,170

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
		(1) DFA	444			0		1,435	
(2)									
(3)									
(4)									
TOTALS				0		1,435		9,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 420 430 450						11. SECONDARY PURPOSE CODE	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)							
A. Code	BWW	RPOP	DEL	TNG	PVON		
B. Amount	5,000	450	450	1,500	400		

13. PROJECT PURPOSE (maximum 480 characters)

To expand and improve the delivery and use of Family Planning information and services in Rwanda, through both the public and private sectors.

14. SCHEDULED EVALUATIONS				15. SOURCE/ORIGIN OF GOODS AND SERVICES			
Interim	MM YY	MM YY	Final	MM YY	MM YY	MM YY	MM YY
	06 92			03 94			
				<input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input checked="" type="checkbox"/> Other (Specify)	935		

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY	Signature <i>James A. Graham</i>		18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION:			
	Title James A. Graham USAID Mission Director		Date Signed MM DD YY 07 12 89		MM DD YY	

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EXECUTIVE SUMMARY

A. Project Background

Rwanda's development prospects are being increasingly shaped by demographic trends that threaten to overwhelm economic growth. Its population is growing at a rate of 3.7% and population density on arable land has already reached 351 per km², largely offsetting increases in production. As perceptions of the problem became increasingly sharp among Rwanda's leadership, support for measures to address it have grown. 1981 marked a turning point. In that year the GOR created a National Population Policy and established a National Population Office (ONAPO) and turned to A.I.D. for assistance.

ONAPO, charged with responsibility for population policy, education and research, has significantly increased popular consciousness of Rwanda's population problem and defined its parameters through surveys and research. It has also begun developing the human resource capacity and administrative machinery for family planning, (FP) counselling and training and for providing FP services to the population. A.I.D., through the Maternal and Child Health and Family Planning (MCH/FP I) Project (696-0113), rendered important support to this process with long and short term technical assistance, staff training, equipment and supplies (including contraceptives), construction and rehabilitation of health and training facilities, and funding a share of the agency's operating costs.

Other recent developments have improved the environment for FP. These include: a significant broadening of support among the donor community; and important and positive GOR policy measures to liberalize access to FP methods and to effect a rapprochement with the Catholic Church. As a result of a reorganization in 1984, MINISANTE was charged with including FP and nutrition services as part of its MCH responsibilities. In 1987 it began gearing up to implement this expanded role as provider of FP services with the help of a \$10.8 million IDA (World Bank) credit. Other donors -- Germany, UNFPA and UNICEF -- have joined A.I.D. in assisting ONAPO in its supportive role as coordinator and monitor of the FP program through its involvement in policy formulation, research, training, and IEC (Information, Education, Communication) activities.

Yet as the current A.I.D. project draws to a close, it is evident that progress to date represents only a beginning. The number of Rwandans practicing contraception is still extremely low (approx. 30,000), an adequate service delivery infrastructure is still in its infancy, integration of FP services within MINISANTE is not complete, and project experience has revealed weaknesses in ONAPO's management, budgeting and financial procedures. Moreover, much remains to be done to sharpen motivation and to increase interest and demand for child spacing and family limitation by a population whose attitudes are shaped by lack of purchasing power, widespread illiteracy and a strong pro-natalist tradition.

B. Project Description

The Maternal Child Health and Family Planning II Project is a five-year, \$9 million project whose goal is to reduce fertility rates in Rwanda. The project purpose is to expand and improve the delivery and use of family planning information and services through both the public and private sectors.

Building on the successful elements of the ongoing MCH/FP I project, MCH/FP II will strengthen the capacity of both the public and private sectors to promote population and family planning programs in Rwanda. Specifically, the Project aims to expand family planning services, and provide a broad range of contraceptive methods, and better target potential acceptors of FP information and services.

The project consists of four mutually supportive elements as follows:

- (1) Support for Policy Development and Research: Under this component, the project will support various types of research, data collection, and analyses that will be used by the GOR to evaluate the impact of its family planning activities, to define and target high risk groups, and to identify and improve the critical variables that limit the delivery of family planning services, such as equipment needs, training needs and improved integration of services. The Project will also provide technical assistance and training and assist ONAPO to organize seminars for GOR and donor officials, and for private sector entities to present and discuss the results of population research and policy analyses, and to facilitate coordination of family planning efforts in Rwanda.
- (2) Family Planning Service Delivery: The Project will improve and expand FP service delivery in both the public and private sectors in Rwanda. It will continue to support the integration of FP services with maternal child care in health centers throughout Rwanda so that family planning becomes an integral part of routine health care and acceptable and accessible to the population. Activities to improve the integration of FP service delivery in the public sector health facilities will include: (a) improving service delivery and supervision; (b) improving the logistics system and FP health information system; (c) providing grants to private sector entities to expand the delivery of FP services; and (d) expanding the non-medical family planning distribution networks.
- (3) Information, Education and Communication: Under this component, the project will support the population and family planning information, education and communications (IEC) program, which will be progressively integrated into GOR private sector political, socio-economic, educational and cultural programs. The project will: (a) provide training for personnel of public and private organizations to enable them to provide accurate information on the national population program and on the availability of FP services; (b) develop, test and distribute educational materials to trained FP promoters; (c) support the development of a National IEC Training Plan to be developed by ONAPO in collaboration with MINISANTE; and (e) collaborate with the SOMARC II project to develop a Contraceptive Social Marketing (CSM) Program.

(4) Institutional Support to Increase Management Capability: Under this component, the project will provide management and institutional support to both public and private sector entities involved in population and family planning. Within ONAPO, the improvements in management capability will focus on accounting and financial management systems, planning and budgeting, human resource management, procurement and management of physical plant, equipment and vehicle fleet. The project will assist MINISANTE to develop the capability to distribute contraceptives and FP materials by strengthening its logistics system. In addition to public sector entities, the project will provide technical assistance to non-governmental organizations to develop the management capability required to design and carry out family planning service delivery activities.

C. Financial summary:

The total cost of this five-year project is estimated at \$17,170,000. This estimate is based on a USAID contribution of \$9,000,000 and a GOR in-kind contribution of \$8,170,000 as summarized below:

	<u>A.I.D.</u>	<u>GOR</u>	<u>TOTAL</u>
Technical Assistance	2,095	-	2,095
Training	2,172	-	2,172
Personnel	-	6,669	6,669
Commodities	749	-	749
Other Costs	2,942	741	3,683
Evaluation/Audit	200	--	200
Contingency	429	389	818
Inflation	<u>413</u>	<u>371</u>	<u>784</u>
Total	<u>9,000</u> =====	<u>8,170</u> =====	<u>17,170</u> =====

D. Summary of Analyses:

The Project Paper demonstrates that the project is (1) technically, socially, environmentally, and economically sound and administratively feasible; (2) the technical design and cost estimates are reasonable and adequately planned, thereby satisfying the requirements of Section 611 (a) of the Foreign Assistance Act, as amended; (3) the timing and funding of project activities are appropriately scheduled and the implementation plan is realistic and establishes a reasonable time frame for carrying out the project; (4) adequate provision has been made for evaluation and audits; (5) the economic analysis provides a cost effectiveness analysis which shows that, for the public sector portion of the project, increased efficiencies during the life of the project are expected to reduce the cost per FP acceptor by 78%, from \$87 currently to \$19 by the end of the project; (6) the financial plans developed for the project are adequate to ensure proper implementation to meet the requirements of the FAA Section 611 (a).

E. Involvement of Small and disadvantaged and Women-owned Firms:

The Project will, whenever feasible, utilize contracts with small business concerns, small disadvantaged business concerns, and women-owned small business concerns. Furthermore, the Request for Proposals for the Institutional Contract will include language encouraging all small business concerns to submit proposals.

F. Procurement Under the DFA:

The funding source for this project is DFA. Although DFA gives Missions new flexibility to purchase commodities from code 935 countries without obtaining a waiver, this project is designed to maximize purchases from the USA, whenever possible, and to comply with the intent of the DFA legislation.

G. Conditions and Covenants:

The only Condition Precedent established for the Project requires the GOR to furnish to A.I.D., the names and titles of persons having the authority to act as the representative for the Grantee. The Grantee will covenant to: (1) establish an evaluation program as part of the project; (2) permit none of the funds made available under this Grant to be used for the finance, support or promotion of abortion or involuntary sterilization; (3) develop an IEC plan and a National Family Training Plan; (4) facilitate the autonomy and self-financing of the ONAPO Training Center by taking several actions identified in the Project Grant Agreement; (5) make available suitable candidates for training, not discriminate against women in recruitment for positions under the project, and promptly issue all travel documentation required by participants selected for training outside Rwanda; (6) convene a Donors Coordinating Committee of all parties who provide support for family planning services and information at least twice a year; (7) sign a Memorandum of Understanding with each private sector entity which will define the status and operating procedures for each entity; and (8) submit annual workplans and budgets for each component of the Project.

H. Environmental Considerations:

A categorical exclusion is recommended on the basis that this project supports nutrition, health care and population and family planning services, as stipulated under Section 216.2(c)2(viii) of A.I.D.'s Environment Procedures (Regulation 16). The project does not anticipate any activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.).

I. Design Team Composition

REDSO/ESA

Greg Wiitala, Project Development Officer
Ben Severn, Economist
Cliff Brown, Regional Legal Advisor

Outside Consultants

Futures Group

John May , Team Leader
Thomas Murry
Mchael Vekemans
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Peter Koener, Financial Analyst
John Blumgart, Coordinator
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Carina Stover, Health and Population Officer
Joan LaRosa, Health and Population Officer
Henderson, M. Patrick, Project Development Officer

LIST OF ACRONYMS

AA/AFR	Assistant Administrator, Bureau for Africa, A.I.D.
ADRA	Adventist Development Relief Agency
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AVSC	Association for Voluntary Surgical Contraception
BUFMAR	Bureau des Formations Medicales Agreees du Rwanda
CBD	Community-based distribution system
CDC	Centers for Disease Control
CDSS	Country Development Strategy Statement
CRS	Catholic Relief Services
CSM	Contraceptive Social Marketing
CY	Calendar Year
DFA	Development Fund For Africa
DOA	Delegation of Authority
DHS	Demographic and Health Survey
EPI	Expanded Program of Immunization
FFYP	GOR Fourth Five Year Development Plan
TFG	The Futures Group
FP	Family Planning
FY	Fiscal Year
GDP	Gross Domestic product
GOR	Government of Rwanda
GSA	General Services Administration
GTZ	German Development Cooperation Agency
HIS	Health Information System
HPO	Health and Population Officer (USAID)
IC	Institutional Contractor
IDA	International Development Association (World Bank)
IEC	Information, Education and Communication
INPLAN	Integrated Population Development Planning
INTRAH	International Program for Training in Health
IPPF	International Planned Parenthood Federation
IRR	Internal Rate of Return
IUD	Intra Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitudes and Practices
L/COM	Bank Letter of Commitment
LOC	Federal Reserve Letter of Credit
LOP	Life of Project
MCH	Maternal and Child Health
MCH/FP	Maternal Child Health/Family Planning
MIJEUCOUP	Ministère de la Jeunesse et du Mouvement Coopératif
MINAGRI	Ministère de l'Agriculture, de l'Elevage, et des Forêts
MININTER	Ministry of the Interior and Community Development
MINIPRISEC	Ministère de l'Enseignement Primaire et Secondaire
MINISANTE	Ministère de la Santé Publique (Ministry of Public Health)
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
ONAPO	Office National de la Population (National Population Office)
OPTIONS	Options for Population Policy Implementation

PCS	Population Communication Services
P&E	Program Monitoring and Evaluation
P/H Officer	Health and Population Officer (AID)
PID	Project Identification Document
PIL	Project Implementation Letter
PIO/C	Project Implementation Order, Commodities
PIO/P	Project Implementation Order, Participants
PIO/T	Project Implementation Order, Technical Assistance
PP	Project Paper
PRITECH	Technologies for Primary Health Care
PROAG	Project Agreement
PVO	Private Voluntary Organization
RAPID	Resources for the Awareness of Population Impacts on Development
REDSO	Regional Economic Development Services Offices (AID)
RFQ	Request for Quotation
RFMC	Regional Financial Management Center
RLDC	Relatively Least Developed Country
RF	Rwandan Francs
SAF	Service Administratif et Financier (ONAPO)
S&T/POP	Bureau for Science and Technology, Office of Population (A.I.D.)
SOMARC	Social Marketing for Change
TA	Technical Assistance
TBA	Traditional Birth Attendant
TIPPS	Technical Information for Population in the Private Sector
UNFPA	United Nations Fund for Population Activities
UNDP	United Nations Development Program
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development Mission in Rwanda
WHO	World Health Organization

I. PROJECT BACKGROUND

A. General Setting

Probably no country in Africa faces as critical a resource/population situation as does Rwanda. The annual rate of population growth (estimated to be 3.7% per annum) is one of the highest in the world, implying a doubling of the present population (estimated at 6.8 million) in less than twenty years. With outward migration to neighboring countries presently limited and with life expectancy and infant survival rates growing due to public health advances, estimates of population density per km² of arable land have grown from 144 (1960) to 351 (1987). The result has been an intensification of population pressures on available resources as evidenced by (a) intensification of farming practices, (b) further fragmentation of holdings (an estimated decrease of 20% in average farm size 1978-84), (c) environmental degradation of soils, hillsides and water resources, (d) a reduction in overall quality of nutritional intake, and (e) growing rural underemployment and migration to urban areas where opportunities in Rwanda's minuscule industrial/service sectors are discouragingly limited.

Rwanda has managed to cope remarkably well to date in terms of food self-reliance through its ability to increase agricultural production. However, due to population pressures and soil fertility depletion, this is unlikely to continue without considerable investment in agricultural inputs and new technologies, or, conversely, without a reduction in living standards and considerable social cost.

Although these trends were perceived with increasing concern by public authorities and opinion leaders in the years following independence, the momentum of population growth continued because of long-held social traditions, a conservative and cautious public policy and the strong opposition of the Catholic Church to modern methods of contraception. It was not until the 1970's when GOR-commissioned studies started to quantify the magnitude of the problem that a more activist attitude began to evolve. A major turning point was marked in 1981 with the adoption of the Third Five-Year Plan (1982-86) -- with its objective of stabilizing and eventually reducing population growth -- and the creation of the National Population Office (ONAPO) to study population problems and carry out a family planning (FP) program. In the same year the GOR moved to start implementing these objectives by concluding an agreement with A.I.D. for a five year \$6.25 million Maternal Child Health and Family Planning Project (696-0113), which was subsequently amended in 1987 for an additional \$400,000, and in 1989 for an additional \$565,000, the first major advent of donor support in the field.

B. Constraints, Opportunities and Strategy

Efforts to address Rwanda's population growth problem face a complex set of interrelated factors. Rwanda has a strongly pro-natalist tradition. Children are commonly perceived as prized and beneficial, representing "wealth, good fortune and helping hands". The tradition is particularly strong among the rural population (95% of the total) who live dispersed on the hillsides, are less mobile, mainly illiterate and lack access to most means of modern communication. Fragmentation of holdings may also lead to a stagnation in already low living standards and purchasing power. Another impeding factor is the influential attitude of the Catholic Church and its opposition to

"artificial" methods of family planning. Reinforcing these influences is the relatively low status of women who have fewer educational and employment opportunities and are mainly confined to low input agricultural tasks.

These considerations have implied a relatively low social acceptance and demand for FP services, an implication supported by the 1983 Fertility Survey which showed that a plurality of women (49%) had no plans to use contraception. On the other hand, the survey also showed that 20% of the women and 34% of the men wished to stop having children - an indication that there is an existing demand which is not being met. Such data points, in turn, to the need for programs that will (a) increase the availability and accessibility of FP services in both public and private sectors to those who are ready and motivated to use them to space births and (b) carry out educational and social marketing interventions on the benefits of limiting family size, provide practical information on how it can be done and promote specific devices and procedures.

The prospects that such programs can be carried out with positive results in both public and private sectors have improved significantly since 1981. The policy environment for family planning has shifted from cautious to strongly positive including, for example, (a) enunciation of a reduction in population growth as a major national priority, (b) integration of FP in all public health facilities, (c) legalization of a wide range of FP methods and (d) removal of most restrictions on FP services provided by the private and commercial sectors. The shift of policy, in turn, reflects the growing concern and support by Rwanda's political and social leaders for an activist FP program. In addition, perhaps most important of all, is the evidence of a growth in public awareness and national consciousness of the need to limit population growth for the sake of future generations.

Thus a major aim of FP strategy is to build on this awareness and particularize it to the perspective of the rural family by showing the impact of each additional child on the family budget and on the health of existing children and the mother. At the same time, as growing motivation to limit family size is expressed in growing demand for services, the importance of having delivery systems in place throughout the country, in both public and private sectors, will increasingly become the critical factor for program success.

It is also evident that advances in policy development at the national level may be of limited value unless accompanied by improvements in the quality and quantity of services offered. Impediments include regulations which restrict access of potential FP clients (e.g. unaccompanied women) to services, the poor quality of GOR health care, including chronic shortages of drugs and medicine, which motivate patronage of private (mostly Catholic) health centers. The bifurcation of FP facilities between ONAPO and MINISANTE results in inconvenience (and often embarrassment) for clients wishing to use ONAPO clinics. A major objective of the project is to support MINISANTE in its role as provider of all health care services, including family planning, through the integration of FP into all MCH services and to support ONAPO in its normative role as coordinator of activities which support the delivery of FP services.

The GOR has very strict policies on abortion and does not allow abortion as a form of birth control. Although not very popular, voluntary sterilization is permitted if certain conditions are met and consent is given by both partners following consultations with medical staff. The Rwanda MCH/FP II Project,

therefore, complies with A.I.D. policy, which forbids assistance to any activity which directly or indirectly supports abortion or involuntary sterilization.

C. Conformity with Rwanda's Priorities

As indicated above, Rwanda's policy on FP has evolved from one of caution, then through a period of examination and review, to a present position of high level proactive support. The President of the Republic, Juvenal Habyarimana, has repeatedly emphasized in public statements the priority of population growth reduction efforts. He has stressed that Rwanda must bring its demographic situation into equilibrium with the country's ability to feed its people and has asked for all Rwandans, within their own cultural and religious backgrounds, to look for ways to accommodate smaller family sizes.

Rwanda's Fourth Five Year Plan (FFYP) identifies food self-reliance as its major goal and identifies a reduction in population growth as an essential means to that end. The FFYP states that "it will legitimize all forms of birth spacing and limitation and will launch a mass education and research campaign for social well being. An ideal family size of four children in the year 2000 will be the education theme."

Policy priorities have guided financial priorities. During the period 1984-87, GOR financing for the local costs of ONAPO's programs rose from RF 48.6 million to RF 75.7 million. During that same time the GOR contribution to ONAPO's recurrent costs rose from 43.3% to 68.1%. The GOR's willingness to commit financial resources for FP services is also reflected in the additional \$2.9 million it has pledged to finance the local costs MINISANTE will incur as its contribution to the World Bank's Family Health project.

A serious FP policy problem facing Rwandan government officials today is supporting modern FP methods while trying to accommodate the opposition of the Catholic Church, a major consideration given the country's large Catholic population (est. 51%, 1978). Given the influence of the Church in the rural areas and the important role of its health facilities, the GOR officials need to continue to dialogue with Church authorities to maintain Church support and promotion of natural FP. (See Annex J)

D. Conformity with A.I.D.'s CDSS

USAID's current Country Development Strategy Statement (CDSS) identifies A.I.D.'s principal objective in Rwanda as that of raising the per capita income of the rural majority. The major means of achieving that objective are seen as: (a) managing population growth and (b) raising rural incomes. The CDSS goes on to state: "A.I.D.'s strategy gives highest priority to reduce Rwanda's population growth rate." In doing so, A.I.D. aims "to provide through a range of institutions, information, education and technology to assure that informed decisions about family planning can be made and that family size decreases." Areas of emphasis for A.I.D. assistance in support of FP are:

- training of health workers and medical professionals;
- increasing public knowledge of modern FP methods and particularly targeting high risk audiences, such as secondary school students;
- sponsoring research for improving management, service delivery and social marketing; and,
- promoting greater use of condoms in the light of the President's recent call for greater public education for the prevention of AIDS.

E. A.I.D. Support to FP in Rwanda

Initiated in September 1981 (and subsequently extended to September 1988 with \$500,000 and in 1989 with \$565,000 in additional financing), the A.I.D. Rwanda Maternal Child Health and Family Planning I Project goal was to create widespread awareness and understanding of Rwanda's population problem and build a GOR capacity to deliver MCH/FP information and services throughout the country. Implementation responsibility rested with ONAPO which had been designated as a parastatal under the tutelage of the Ministry of Health (MINISANTE). Project assistance included: (a) long and short-term advisory services, (b) a share of ONAPO's local operating costs, (c) construction or rehabilitation of four MCH/FP centers and a training center and related equipment and furnishings, (d) commodities and supplies, including contraceptives and (e) the training of ONAPO and other health personnel staff through in-country, third country and U.S. programs.

Thanks to the Project, local leadership and GOR support, ONAPO—a paper institution in 1981—has achieved legitimacy and widespread recognition as the GOR's center for expertise in matters concerning population and FP. The preparation and adoption of the population policy material in the FFYP is an example of ONAPO's capability and achievements.

In addition to a central office with a staff of over 200, ONAPO has built a regional network of 10 Prefectural (regional) offices to support the delivery of FP information and services. Project accomplishments include a series of surveys and studies (including a nation-wide fertility survey) which have clarified many parameters of the Rwandan population situation and pointed the way for policy choices. ONAPO's IEC campaigns, using a variety of media techniques, have transformed the demographic issue in the population's consciousness from virtual complete ignorance to one of widespread recognition. FP and demographic subject materials have been introduced into the country's school system, as well as the training programs of medical and para-medical health care providers. Starting from scratch, the Project's training program is well into building the human resource capabilities needed to manage and staff the agency and to instruct other health care personnel in FP knowledge and skills. The completed training center is functioning and the MCH/FP centers are completed. The Project has also stimulated the interest of several other donors in the Rwanda population problem (the World Bank in particular), leading to significant additional financial support.

Short term technical assistance and training activities, financed or provided by S&T/POP, were used to deliver specialized services to ONAPO. They included (a) JHPIEGO - physicians training, (b) MSH - management training, (c) PRITECH - mid-term evaluation, (d) CDC - analysis of statistics and contraceptive procurement planning, (e) FHI - bio-medical research, (f) SOMARC - social marketing, (g) Futures Group - policy formulation and institutional analysis, (h) Columbia University - operations research on community based distribution of contraceptives, (i) INTRAH - training of medical and non-medical personnel, and, (j) PCS - development of IEC strategies.

A final evaluation of the Project in 1987 pinpointed several areas where improvements should be made in future A.I.D. project activities. They included management of personnel, finances and commodities at the central level, supervision of project activities at the regional and local levels, raising the priority of FP activities and expanding services in MINISANTE, formulating a policy for the delivery of services, and improving IEC materials. Some of these concerns (i.e. those concerning MINISANTE and delivery policy) are already being addressed - see discussion on the Family Planning project and the MINISANTE Directive of March 3, 1988 (Annex F). Measures to deal with the others have been incorporated into the design of the MCH/FP II Project.

F. Other Donor Activity

Other donors are playing a growing role in assisting the GOR to deal with its population and demographic problems. Of principal note is the World Bank (IBRD) which provided a \$10.8 million IDA credit (supplemented by a \$725,000 WHO grant for technical assistance) in 1987 to assist the Ministry of Health to strengthen its MCH/FP facilities and services. This project, which includes a \$2.9 million GOR contribution, represents the largest health investment in Rwanda to date and complements A.I.D. assistance to ONAPO.

In summary, the IBRD project aims at helping MINISANTE incorporate FP and nutrition services into its MCH program to strengthen the Ministry's physical infrastructure and staff capabilities. The project includes (a) a major in-service training program for 1,400 Ministry and ONAPO staff in MCH/FP practices, (b) provision of MCH/FP supplies (including contraceptives) and equipment, (c) the upgrading and rehabilitation of 30 health centers (with emphasis of FP, nutrition and MCH facilities), (d) strengthening the FP, MCH and nutrition offices of the Ministry at headquarters with TA and training, (e) increasing the effectiveness of field operations by supporting the establishment of 8 regional offices together with upgrading the quality and supervision of FP, nutrition and health services, (f) expanding the output of para-medical personnel through pre-service training and the construction of two nursing schools, and (g) assistance to ONAPO for two policy studies.

In addition, two other agencies--the United Nations Fund for Population Activities (UNFPA) and the West German Development Cooperation Agency (GTZ)--are co-donors with A.I.D. in supporting the work of ONAPO. UNFPA is (a) providing general support to ONAPO including help to 22 rural hospitals, setting up mobile FP teams and the construction of a warehouse, (b) technical assistance to strengthen ONAPO's research and analysis functions; and (c) financing a pilot community-based FP promotion/distribution scheme in the Ruhengeri Prefecture. In close coordination with A.I.D. inputs, UNFPA also provides contraceptives to ONAPO.

GTZ support is concentrated in the Prefectures of Gikongoro and Butare. It involves construction or rehabilitation of health facilities, retraining of health care staff, provision of equipment, operating costs, supplies and contraceptives and the services of a resident technical advisor.

UNICEF provides some minor assistance to ONAPO and may provide more. Canada is a potential source of FP assistance in training and demography. A detailed description of all other donor activity is given in Annex F and a discussion of donor coordination is included in Section B of the Implementation Plan.

II. PROJECT DESCRIPTION

The Rwanda Maternal and Child Health and Family Planning II (MCH/FP II) Project is a \$17.170 million (A.I.D. \$9 million and GOR: \$8.170 million) follow-on to the MCH/FP I Project (PACD of September, 1989). Centrally funded A.I.D. Population Office projects will provide additional support for project activities. The five-year Project aims at achieving 15 percent contraceptive prevalence or approximately 175,800 family planning acceptors by the Project Assistance Completion Date.

To strengthen and expand family planning information and service delivery in Rwanda, the Project will build upon the existing FP delivery system, as well as expand into new sectors and develop and test alternative service delivery systems. Project inputs will complement and supplement support provided by other donor agencies.

The Project will help the Government of Rwanda to improve its capacity to develop, analyze, reformulate and promote the national population policy and to plan, implement, and evaluate FP activities. The Project includes the expansion of FP services offered by public and private sector institutions. Alternative FP service delivery systems such as, Community Based Distribution (CBD) and Contraceptive Social Marketing (CSM), will provide contraceptives through private sector health and commercial outlets, and in public sector health facilities. MCH/FP II will strengthen the public sector delivery capability by providing support for research, training, supervision, commodities and technical assistance. In addition, through IEC activities, the Project will assist the GOR and the private sector in reaching target audiences with FP messages and method information. To provide for a self-sustaining FP effort in Rwanda, fee-for-service systems will be studied and tested and the GOR and non-governmental entities will be given technical assistance and training to strengthen their administrative and financial management capabilities.

It is anticipated that a secondary outcome of the Project will be a reduction in the incidence of AIDS virus infection due to the increased promotion, distribution and use of condoms, and improved information and counseling on sexual education, family planning, and sexually transmitted diseases (STD), especially AIDS. USAID will monitor the linkages between the MCH/FP and AIDS programs and, if needed, will request additional assistance to supplement project inputs to enhance the impact of the AIDS prevention program.

A. Assistance Strategy

The GOR has established MINISANTE as the institution responsible for all health services in Rwanda. In 1981, however, ONAPO was established under the supervision of MINISANTE, with a broad FP mandate. ONAPO originally was the sole provider of FP information and services, but that role has evolved in recent years as MINISANTE has developed a strategy to completely integrate FP services into the health care system. ONAPO, on the other hand, now plays a more normative role, supporting and enhancing the GOR's provision of FP services by conducting research studies, analyzing data and formulating policy, developing and producing IEC messages, and training and supervising health care workers who provide FP services. Although ONAPO continues to order and distribute contraceptives and FP supplies and equipment, this task

will be transferred to MINISANTE by the end of the Project. The Project is designed, therefore, to strengthen the complementary roles of each institution.

In developing the A.I.D. strategy for assisting in the provision of FP services and information in Rwanda, several issues were raised during the PID development which were addressed in the diagnostic studies and analyses in Annex E of this Project Paper. Other issues, however, arose during the negotiation of the Project Agreement, when ONAPO did not fully agree with the design and implementation arrangements for the private sector activities. An issue of particular importance was the definition of the private sector. Approximately 50% of MINISANTE health centers are operated by churches (80% of them Catholic). Since these centers are staffed by MINISANTE health care providers, they are not distinctly public or private. Until very recently, private medical practice did not exist in Rwanda. There are only a handful of private clinics operating in two or three major cities. During final negotiations, ONAPO and USAID decided that the private sector activities would be carried out primarily by non-governmental organizations (NGO), both U.S. and local. Authorization and coordination of these activities will rest primarily with ONAPO, since ONAPO is charged with coordinating all population and FP activities in Rwanda. The strategy, therefore, is to strengthen and develop NGO's to provide FP services, and, at the same time, develop a capability within ONAPO to support, coordinate and foster private sector activities.

The NGO's will be able to test and implement innovative FP delivery systems. Some will have specific types of expertise, such as the Catholic Family Life Society (SNAF), which teaches natural family planning (NFP) courses throughout the country. Contraceptive Social Marketing, begun under the AIDS prevention program, will be expanded to supplement the GOR contraceptive distribution system, in order to reach a larger proportion of the population. The GOR recognizes that non-governmental assistance is essential, if the objective of 15% contraceptive prevalence is to be reached by the end of the Project. With the exception of the Catholic Church, however, private sector entities are small and relatively undeveloped, with little or no experience in delivering FP services. The Project, therefore, will seek to develop the capabilities of NGOs to manage and deliver FP services by providing technical assistance in management, as well as clinical training to NGO staff, and local cost support.

In summary, the project strategy is to strengthen the GOR FP program and, at the same time, assist the GOR to promote, coordinate, and support private sector FP activities. While the PID recommended that approximately 30% funding be provided to the private sector, the lack of private sector entities to implement programs has resulted in a more conservative private sector budget (approximately 18%). Additional inputs, however, which will be provided to NGOs by the GOR (training, technical assistance and contraceptive supplies), and centrally funded population projects, such as CSM II, will increase the total amount of support going to the private sector.

Although IEC activities are essential to maintain and increase the demand for FP services and will be continued in this Project, priority will be given to improving and expanding the delivery of FP services. Experience has shown that when FP information is provided without the necessary services available to meet the growing demand, contraceptive prevalence does not rapidly increase. Rwanda's current low contraceptive prevalence and relatively high demand indicate a need for improving the availability and accessibility of FP services.

B. Goal, Purpose, and End of Project Status

- GOAL:** The goal is to reduce fertility rates in Rwanda by increasing the availability of voluntary family planning services to couples seeking to reduce their family size or space their children.
- PURPOSE:** The purpose is to expand and improve the delivery and use of family planning information and services through both the public and private sectors.
- EOPS:** It is anticipated that by completion, the Project will reduce the total fertility rate from 8.6 to 8.0;
- Increase the prevalence of modern contraceptive methods from the current 3% to 15% for women in union between the ages of 15-49;
- Reduce the annual population growth rate from 3.7% per annum to an estimated 3.2% per annum;
- Decrease the desired family size from 6 to 5; and
- Increase the number of men and women between the ages of 15 and 49 having knowledge of all FP methods from 70 to 95 percent.
- OUTPUTS:**
1. Improved GOR research, evaluation, coordination and policy analysis capability;
 2. Improved delivery of FP services in public and private sectors;
 3. Improved dissemination of FP information through public and private sectors;
 4. Effective financial, procurement and management systems in place to support FP programs in the public and private sectors.
- INPUTS:**
1. Technical Assistance: 6 person-years of long-term and approximately 32 person-months of short-term technical assistance.
 2. Training: 8 person-years of long-term graduate degree training in Public Health; 30 person-months of (U.S. or third country) short-term training (including attendance at seminars and workshops); and approximately 2,810 person-weeks of in-country training, three 5-day, in-country seminars, and two 2-week, study tours.

3. **Commodities:** contraceptives, FP supplies and medical equipment; 10 vehicles and office equipment for ONAPO, including six computers; and household furniture and equipment for the long-term technical advisors.
4. **Other Costs:** Certain local costs, particularly those related to transport associated with supervision of FP workers, production of IEC materials, in-country training, project monitoring activities, evaluations, research studies and CSM program activities will be supported.
5. **Private Sector Sub-Grants:** Approximately \$800,000 of project funds will finance sub-grants to NGO's.

C. Project Elements and Related Inputs

Achievement of the outputs of the Project will involve A.I.D. assistance to both the public and the private sectors in Rwanda, with 70% of support going to FP service delivery activities. The principal implementing agencies will be ONAPO and MINISANTE, while U.S. and local NGOs will be given sub-grants to carry out smaller scale activities. An institutional contractor providing long-term technical advisors will assist ONAPO and MINISANTE with public sector implementation activities, and provide assistance as needed to private sector entities. The Contraceptive Social Marketing program will receive assistance from the AID/W contractor--SOMARC II. Project elements are divided into four distinct yet interrelated activities:

1. Support for Policy Development and Research
2. Family Planning Service Delivery
3. Information, Education and Communication (IEC)
4. Institutional Support to Increase Management Capability

Support for policy development will include activities such as research, data collection and analyses that will be used by the GOR to evaluate the impact of its FP activities, to define and target high risk groups and to identify and improve the critical variables that limit the delivery of FP services. The role of the private sector regarding the delivery of FP services will be developed and expanded during the life-of-project.

The integration of FP services into the public health care system involves a new direction in FP in Rwanda. FP services previously were provided by ONAPO medical and non-medical workers who were supervised by a regional ONAPO physician. Integration means that ONAPO will progressively turn over to MINISANTE the responsibilities for supervising service providers, coordinating and monitoring the distribution of commodities (including contraceptives), and collecting and reporting FP statistics in the health information system. New systems of delivery will be studied, such as Community Based Distribution (CBD) and Contraceptive Social Marketing (CSM), and NGOs will play an increasingly more important role in delivering FP services.

With better defined target audiences and effective methods of communicating FP messages, the Project will support the production and dissemination of IEC (Information, Education, Communication) materials to community leaders, trainers and teachers, who, in turn, will inform and train the general population on FP.

Another important component of this Project will be strengthening the management capabilities of both public and private sector institutions involved in the delivery of FP services. Although ONAPO has made significant improvements in administrative and financial management during the past year, additional support is needed to successfully implement the Project. MINISANTE will need assistance in logistics management with regard to the distribution of contraceptives. NGO administrative and financial management systems will need strengthening, to increase their capacity to deliver FP services. The Project will provide a management specialist for two years under an institutional contract, who will evaluate management constraints and assist in the design of appropriate interventions, including training of ONAPO, MINISANTE, and appropriate NGO staff.

1) Support for Policy Development and Research

The GOR has demonstrated its ability to formulate population policy, as exemplified in the Fourth Five Year Plan. As the call for a smaller family size is adopted by the Rwandan population and as the availability of family planning methods and services expands, the GOR policy and strategy to reduce fertility will continue to evolve. The research, data collection and analyses included under this element of the Project, will be used by the GOR to evaluate the impact of FP activities, define and target high risk groups and identify the obstacles which limit the delivery of FP services, such as lack of trained personnel, equipment or supplies.

Several proactive directives and announcements of new policies have significantly expanded the opportunities for increasing access to FP services (see Attachment F, MINISANTE Family Planning Guidelines, dated 3 March 1988). The GOR has opened family planning to the private sector and is recommending that FP services be made available to all women of reproductive age in Rwanda. Rwanda has some of the most progressive family planning policies in Francophone Africa. There are no major legal or policy restraints to increased delivery of FP services and information. The GOR, however, has been slow to effectively implement FP directives which would increase contraceptive prevalence.

The full integration of family planning with maternal and child health services is a major objective of the Project. ONAPO's planning, evaluation and research sections, working in collaboration with MINISANTE's studies and evaluation section, will collaborate on investigations to determine the best approaches and strategies for progressively integrating services and establishing annual intermediate targets.

ONAPO's ability to perform such functions will depend on the further improvement of its research and planning capabilities. Funding will be available to ONAPO's research, planning and evaluation sections to organize in-country seminars, and to present and discuss the results of population research and policy analyses. In addition, training, technical assistance, and local cost financing will be provided to support the collection and analysis of data and to undertake policy studies as described below:

a) RAPID III Models

With assistance from A.I.D. Washington's RAPID III Project, ONAPO and the Ministry of Planning are collecting data, which are available at present, to develop models that will define and clarify targets for different methods of contraception (Bongaarts Model) and show the effects of population variables on different socio-economic sectors, such as the effect of spacing births four years apart on the infant and maternal mortality rates.

These RAPID III models will allow the creation of presentations designed to inform leaders of the implications of alternative population growth rates for health and development in Rwanda. A financial planning presentation will allow leaders to weigh the health benefits and public sector expenditure savings associated with FP programs against the costs of these programs. The presentation will enable GOR decision makers to examine the costs and benefits of varying scenarios for raising the contraceptive prevalence rate (and for increased child spacing and nursing practices). The models permit the selection of the most cost effective approaches and to establish quantifiable targets for measuring results.

Once the models are developed using population and health data, they can be expanded to include other variables and other sectors. New data collected from the census and DHS will be used to update these models over the next five years. The Project will provide additional funds to RAPID III for four person-months of technical assistance, training, and microcomputer support. The Project will also supply ONAPO with six microcomputers for this and other research and project management activities.

b) Demographic and Health Survey (DHS)

The Project will finance a demographic and health survey (DHS), which will be carried out in 1990 by the ONAPO research section with assistance from the A.I.D. Washington DHS II Project. The DHS results will provide information regarding changes in FP knowledge, attitudes and practices that have occurred since the Rwandan National Fertility Survey of 1983. The DHS is designed to: (1) collect information on fertility and FP; (2) identify the characteristics of women having large and small families and those using and not using FP; (3) collect information on health related matters such as immunization, breastfeeding, and prenatal care; (4) assist in conducting periodic surveys to monitor changes in birth rates, health status, and the use of FP; and (5) provide additional data for researchers investigating topics related to fertility and the use of FP. With this information, strengths and weaknesses of the existing program can be identified and operations research studies designed to test and implement more effective and efficient FP information and service delivery systems for Rwanda.

Funding provided for the DHS will support two person-months of short-term technical assistance, material, logistics, and local costs. The DHS II Project will provide training for ONAPO researchers, specialized computer software, and participation at regional workshops.

c) Operations Research

Because the FP service delivery system is one of the greatest constraints to increased contraceptive prevalence in Rwanda, training in operations research and a number of research studies will be carried out during the life of the Project to improve and expand the system, and develop alternatives. Approximately 11 person-months of short-term technical assistance will be provided to accomplish the following objectives:

- analyzing macro and micro-economic issues (e.g. contraceptive tariff policies, household allocation and control of resources) that may influence FP;
- examining recurrent cost issues and recommending methods (e.g. fee-for-service options) for improving GOR financing and delivery of FP activities;
- expanding and developing a more timely system of service delivery statistics for better monitoring the progress of Rwanda's FP program; and improving coordination between the collection of service statistics, research, and IEC for planning purposes; and
- developing reporting systems for measuring the results of the program supervision, monitoring, and evaluation systems.

d) Seminars and Policy Implementation

The Project will also assist ONAPO to organize three 5-day seminars for officials, religious and private sector leaders on population issues, to present and discuss the results of research and policy activities.

Lack of coordination among implementing agencies, rather than erroneous policy is a major obstacle to project implementation. The Project, therefore, will support efforts directed toward sustaining the current momentum brought about by recent policy reforms which liberalized distribution of all FP methods by seeking to effect these new policies. Furthermore, through in-country seminars, the Project will help to reinforce among prefectural, communal, sectoral and cellule authorities awareness of population issues, the importance of FP for maternal-child health and nation well-being, and the need to increase the availability and use of contraception. Special attention will be made to include the participation of representatives of the Catholic Church in these seminars and to encourage their continued support for natural family planning activities.

e) Improved Coordination

To ensure maximum results from policy development and research activities, USAID and the GOR will promote greater coordination of FP efforts in Rwanda, and will through formal, bi-annual meetings, promote the following objectives:

- development of clear guidelines of responsibility for policy and program actions to supplement the National Strategy for Maternal and Child Protection and Family Planning developed by MINISANTE;
- improved coordination with other GOR agencies, donors, and the private sector; and
- continued collaboration with the Catholic Church, particularly in expanding and improving training and monitoring of acceptors of natural family planning.

2) Family Planning Service Delivery

Increasing the availability, accessibility and quality of FP services is the major thrust of this Project. Constraints to service delivery have been identified by both ONAPO and MINISANTE, and also confirmed by several studies which point to weaknesses in the existing service delivery system. As solutions, ONAPO and MINISANTE actively support the expansion of FP in the private sector and complete integration of FP services into the public health care system.

This Project differs from the earlier MCH/FP Project in that it includes support for private sector activities, including contraceptive social marketing, which will complement the public sector efforts. Nearly half of the health facilities in Rwanda are operated by private sector organizations, many of which have expressed interest in providing FP services.

a) Integration of Family Planning into the Health Care System

FP services are being integrated with maternal and child health care in MINISANTE health centers so that family planning becomes part of routine health care that is both acceptable and accessible to the population. To increase and improve this process of integration of FP service delivery in the public sector health facilities, the Project will provide support to ONAPO and MINISANTE in the following areas:

i) Improved Supervision

Supervision of FP service providers in the public sector currently is carried out by ONAPO regional doctors. The Project will complement the World Bank Family Health Project in supplying technical assistance and training necessary to enable MINISANTE to meet its growing responsibilities for improving the quality and supervision of FP services. One vehicle will be provided to each of the ten prefectures to assist in transportation of FP supervisors.

ii) Improved Logistics System and FP/Health Information System

The Project will provide technical assistance and training to assist MINISANTE to fully integrate FP statistics into the health information system. Technical assistance and training inputs also will assist MINISANTE to modify and improve the logistics system for distributing contraceptives and medical equipment which will be financed under the Project. During the life of the Project, the responsibility for contraceptives and medical supplies, necessary for FP service delivery will, be progressively transferred from ONAPO to MINISANTE.

b) Improved FP Service Delivery Systems

To expand the FP service delivery system beyond the public and private sector health facilities, the following delivery systems will be tested:

i) Community Based Distribution (CBD)

FP information, education and communication and the distribution of FP methods, such as condoms and spermicides, do not require medical assistance and could be provided to target groups by non-medical personnel at a reasonable cost. One such system to promote FP services is being tested in Ruhengeri as part of an operations research study financed by Columbia University. Based on the results of this study, which is being evaluated, the system could be extended to include the entire country during the life of the Project.

ii) Contraceptive Social Marketing (CSM)

Contraceptive Social Marketing will make non-clinical contraceptives readily available through a large number of retail outlets at subsidized, affordable prices to special target groups, such as men and young people. Commercial marketing, distribution, and promotional techniques will be used to promote increased use of contraceptive products, such as condoms and pills. At present, condoms are being marketed through retail outlets in Kigali at subsidized prices under the MINISANTE AIDS Prevention Program. The CSM program included under this Project, will expand and improve on the present program and will provide the linkage between the FP and AIDS programs.

The CSM program will provide short-term technical assistance, and support for in-country CSM activities such as, advertising, promotion, marketing research, distribution, management, packaging and training. The Project will provide \$.80 million and the AID/W centrally funded CSM II Project will provide additional financing.

iii) Public Sector FP Delivery System

Reinforcing a strategy of providing quality FP services, a large component of the Project will support training of medical and non-medical FP workers (See Annex K, In-country Training Plan). Medical equipment and contraceptives also will be provided to public health centers to enable the delivery of services necessary to meet demands.

iv) Private Sector FP Delivery Systems

Private sector entities--defined as U.S. and Rwandan non-governmental organizations, both for profit and not-for-profit, cooperatives, and health facilities and practitioners who receive all or a portion of their support from non-governmental sources--will be selected to receive support to initiate or expand the delivery of FP services and information. Through the award of sub-grants, recipients will receive necessary training, technical assistance, IEC materials, contraceptives, and operating funds. Criteria for awarding of these sub-grants will be jointly agreed upon by the Comité Consultatif, and the Comité Mixte as described in the Implementation Plan in Chapter V.

The Project will provide short-term technical assistance to ONAPO to develop its strategy for the private sector and to the sub-grantees to strengthen technical and management capabilities. The Project will provide \$800 thousand in sub-grants, in addition to GOR contributions of contraceptives and training.

3) Information, Education, and Communications (IEC)

The Project includes support for the population and family planning information, education and communications (IEC) program, which will be progressively integrated into GOR and private sector, political, socio-economic, educational, and cultural programs. Personnel of public and private organizations will receive training that will enable them to provide accurate information on the national population program and the on the availability of FP services. Appropriate educational materials will be developed, tested and distributed to these trained FP promoters. The IEC Program will target groups most in need of FP information, including young people.

Seventeen thousand abakangurambaga, or village level FP promoters, who have already been trained by ONAPO, will receive in-service training under this Project. The IEC Program also will include participation of CCFDP (Village Community Development Centers), MRND (the national political organization), URAMA (the Rwandan Women's Associative Movement), health educators of the MOH and NGO's, and agricultural extension workers.

In addition to the development and distribution of materials for and training of FP promoters, the Project will support IEC activities related to the Contraceptive Social Marketing Program. These private sector materials will be developed, produced and distributed in collaboration with the CSM II Project. Scholastic IEC activities will be strengthened and expanded as the curricula, which were developed under the MCH/FP I Project, are refined and fully integrated into the primary, secondary, CERAI (Rural Artisan Training Centers) and university level curricula. Teacher training on the use of the curriculum guides will be supported by the Project.

To meet the objectives of the IEC Program, the Project will finance short-term technical assistance, as well as, in-country and participant training. A National IEC Training Plan will be developed by ONAPO in collaboration with MINISANTE each year as part of the Annual Operational Plan.

4) Institutional Support to Increase Management Capability

With assistance and support from the MCH/FP I Project, ONAPO's management capability has been strengthened and improved. This Project will continue to provide support in this critical area to both public and private sector entities involved in population and family planning activities. Participant training in financial management, human resources management and the use of microcomputers for FP information systems has been budgeted under MCH/FP I. This training will be supplemented by on-the-job training that will be provided to ONAPO and MINISANTE by the long-term Management/Financial Specialist. The computerized system to track training participants, which was designed with assistance from the A.I.D. Washington Family Planning Management Training (FPMT) Project, will be fully implemented and will serve as a tool for developing the annual training plans for ONAPO and MINISANTE personnel.

Within ONAPO, improvements in management capability will focus on accounting and financial management systems, planning and budgeting, human resource management, procurement and management of physical plant, equipment and vehicle fleet. The Project will assist MINISANTE to develop the capability to distribute contraceptives and FP materials by strengthening its logistics system.

In addition to public sector entities, the Project will provide technical assistance to non-governmental organizations to develop the management capability required to design and carry out family planning service delivery activities. Organizations which have been identified as potential sub-grantees for delivering FP services include, but are not limited to, SNAF (National Secretariate for Family Action), ARBEF (local IPPF affiliate), ADRA (Seventh Day Adventist PVO), CARE and AFRICARE.

III. COST ESTIMATE AND FINANCIAL PLAN

A. Cost Estimate

The total cost of the Maternal and Child Health/Family Planning II Project will be **\$17,170,000**. This estimate is based on the assumption that **\$9,000,000** will be provided by A.I.D. and **\$8,170,000** will be contributed by the GOR. The total AID and GOR contribution represents 52 percent and 48 percent respectively of total project costs.

Table I presents a summary of estimated costs and a financial plan. This is followed by Table II which describes the projected expenditures of A.I.D. and the GOR for each fiscal year. Annex J shows, in detailed, a pro forma budget of the estimated project costs. A weighted average of 5.0 percent was used as an estimate of the annual inflation rate for the A.I.D. budget. In preparing the A.I.D. budget, it was assumed that the compounded annual inflation rate for goods and services procured in the United States (53 percent of the A.I.D. contribution and 28 percent of the total project budget) would be 5.0 percent, and that the compounded annual inflation rate for goods and services procured in Rwanda (47 percent of A.I.D.'s proposed contribution and 25 percent of the total project budget) would be 10 percent. Nevertheless, taking into account the relative rate of expenditures, a weighted average of 5.0 percent was considered adequate for the annual inflation a rate for the A.I.D. budget.

An exchange rate of 75 Rwandan Francs was used to estimate the U.S. Dollar equivalent for local currency costs. A contingency factor of .05 was used for the A.I.D. budget to cover unexpected changes in the estimated level of services and to reflect fluctuating exchange rates in Rwanda. This Cost Estimate and Financial Plan reflect sufficient details for project planning and current cost estimates. U.S. A.I.D. has determined that the project cost estimates are reasonably firm for the project elements. Thus, the requirement of FAA, Section 611, (a)(1) has been satisfied.

B. Funding Obligation Mechanisms

An initial obligation of \$1.4 million will be made in FY 89 and subsequent obligations are planned for FY 90 of \$3.0 million, for FY 91 of \$2.4 million and for FY 92 of \$2.2 million. This approach will strengthen the GOR's ability to coordinate and supervise both private and public sector population and family planning activities. It will also enable A.I.D. to provide GOR greater budgetary flexibility and a rapid response to the mid-term evaluation planned for the end of year three of the project.

C. Financial Plan

Listed below are the major project components and cost estimates for each element for A.I.D. contribution to the project.

1. TECHNICAL ASSISTANCE - \$2,095,000.00

a. Long-term Technical Advisors

Approximately six (6) person years of long-term advisors in family planning and management. These include:

1. Family Planning Specialist - 48 person months
2. Management Specialist - 24 person months

b. Short-term Consultants

Approximately 32 person months of short-term technical assistance will be provided. These include:

1. Policy and Research - 13 person months
2. Service Delivery - 11 person months
3. Information, Education, and Communications - 3 person months
4. Other - 5 person months

2. TRAINING - \$2,172,000.00

a. Long-term (U.S. or third country)

Approximately 8 person years of long-term degree training will be financed. GOR will send four (4) persons for Masters of Public Health degrees.

b. Short-term ("buy-in")

Development of a course for obstetrical/gynecological skills

c. Short-term: (U.S. or third country)

Approximately 30 person months of short-term training will be financed. GOR personnel will be trained in such areas as:

- Planning and Evaluation
- Techniques of Socio-Demographic Research
- Integration of FP into National Plans/Policies
- Psycho-socio aspects of FP
- Accounting
- Administration and Financial Management
- Statistics and use of microcomputers
- Management of Training Programs
- Human Resource Management
- ObGyn Studies
- Contraceptive Technologies
- Management and Supervision of FP services
- Management of Contraceptive Stocks
- IEC (radio and didactic materials production)
- IEC equipment maintenance

d. Short-term (In-country)

Approximately 2,810 person weeks of in-service training for medical and non-medical personnel will be financed. These include:

1. Family Planning Auxiliaries - (1,200 person-weeks).
2. Clinical Training in FP - (800 person-weeks).
3. Training of Trainers - (150 person-weeks).
4. Teacher Training - (600 person-weeks).
5. Operations Research - (60 person-weeks).

e. Seminars - 3 in-country seminars.

f. Study Tours - (U.S. and third country) Two study tours for approximately two weeks for six ONAPO, MINISANTE, or private sector individuals.

3. COMMODITIES - \$749,000.00

Approximately ten vehicles will be financed. Contraceptives and medical equipment will be procured for both the public and private sector FP activities. Office equipment including six computers, associated hardware and software, computer maintenance contracts, desks, chairs, file cabinets, calculators, typewriter, xerox machine, household furniture and appliances will be financed.

4. OTHER COSTS - \$3,784,000.00

Public sector: A.I.D. will finance recurrent costs of ONAPO, MINISANTE, and the Technical advisors, particularly for supervision, IEC materials production, maintenance of project vehicles, in-country training, on-going evaluations, and research activities. The approximate total amount financed will not exceed twenty percent of total A.I.D. contributions to the project.

Private sector: Funds will be made available for organizations such as, Rwanda and U.S., PVOs, NGOs, church groups, women's cooperatives, private physicians and clinics, and commercial entities to carry out family planning activities in Rwanda's private sector. Also, funds will be used to develop a contraceptive social marketing program from an AID/W "buy-in".

5. EVALUATION AND AUDIT - \$200,000.00

These funds will finance two planned external evaluations, one non-federal audit, and financial management assessment of NGO's.

D. METHODS OF IMPLEMENTATION AND FINANCING

The overall financial planning and proposed methods of finance for this project are sound. The financial management capabilities of the Grantee implementing entities have been reviewed and deficiencies and constraints relative to this management were identified during project design. These issues will be addressed, in part, by the project through the provision of a long-term management advisor. Independent annual financial reviews will also be required for ONAPO and MINISANTE. The process of reviewing annual workplans and audits as a prerequisite to subsequent disbursements will assess the degree in which the project entities have been able to rectify internal financial management problems. USAID disbursement of funds under the proposed project will be made in several ways. Direct payment will be utilized for training, offshore and local procurement of project commodities, NGO grants, and staff and contractor support. Periodic advances will be utilized for in-country training and workshops, vehicle operations/maintenance, and local support and operational costs.

The following Table III summarizes the methods of implementation and financing the project activities.

TABLE I
SUMMARY OF COST ESTIMATE AND FINANCIAL PLAN
FOR THE MATERNAL AND CHILD HEALTH/FAMILY PLANNING II PROJECT (696-0128)
(\$000s)

Use of Funds	Source of Funds								
	FX	AID LC	SUBTOTAL	FX	GOR LC	SUBTOTAL	TOTAL		GRAND TOTAL
							FX	LC	
1. Technical Assistance	1706	389	2095	0	0	0	1706	389	2095
2. Training	1337	835	2172	0	0	0	1337	835	2172
3. Commodities	300	449	749	0	0	0	300	449	749
4. Other Costs	800	2142	2942	0	7410	7410	800	9552	10352
5. Evaluation and Audit	175	25	200	0	0	0	175	25	200
Subtotal * * * *	4318	3840	8158	0	7410	7410	4318	11250	15568
Inflation	219	194	413	0	371	371	219	565	784
Subtotal * * * *	4537	4034	8571	0	7781	7781	4537	11815	16352
Contingency	227	202	429	0	389	389	227	591	818
TOTAL * * * *	4764	4236	9000	0	8170	8170	4764	12406	17170
Percentage			52.4 %			47.6	27.7	72.3	

TABLE III
METHODS OF IMPLEMENTATION AND FINANCING
FOR THE MATERNAL AND CHILD HEALTH FAMILY PLANNING II PROJECT (696-0128)
AID INPUTS (\$000)

TYPE OF ASSISTANCE	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROXIMATE AMOUNT
Technical Assistance	PIO/T - Direct AID Contracts	LOC-TFCS ^{1/} or Direct Payment or Reimbursement	2,095
Training	PIL - Host Country PIO/P PIO/T - Direct AID Contracts	Direct Payment Direct Payment Direct Payment or Reimbursement	2,172
Commodities	PIO/C - Direct AID Contracts	Direct Payment or Direct L/COM ^{2/}	749
Other Costs	PIL - Host Country PIO/T - Direct AID Contracts	Direct Payment Direct Payment or Reimbursement	3,784
Evaluation/Audit	PIO/T - Direct AID Contracts	Direct Payment or Reimbursement	200
TOTAL AID FINANCING (including inflation and contingency)			9,000

^{1/} LOC-TFCS = Letter of Credit - Transfer of Federal Cash Status

^{2/} L/COM = Letter of Commitment

IV. SUMMARY OF PROJECT ANALYSES

A. Summary of Technical Feasibility of Project

The following discussion summarizes the technical feasibility of the MCH/FP II Project. It provides a brief review of the soundness of the GOR's five year population and family planning program strategy, priorities and challenges, and the appropriateness of the second phase of A.I.D.'s bilateral assistance program in Rwanda. [Note: The analyses were conducted in early 1988. Since that time, the Office of Social Affairs was taken out of the Ministry of Health and Social Affairs (MINISAPASO) and MINISAPASO has become MINISANTE, the Ministry of Health. The summary analyses reflect the recent update and findings which are still valid].

1. GOR Commitment and Family Planning Program Strategy

In its national development plans, public policies and programs, the Government of Rwanda has demonstrated its concern over the social and economic consequences of rapid population growth and its commitment to reducing high fertility rates by increasing the availability and use of family planning in both the public and private sectors.

The GOR population strategy for the next five years, as outlined in more detail in the full Technical Analysis, Annex A, is ambitious but technically feasible and necessary to achieve the ultimate objective of reducing fertility rates. It is a comprehensive and balanced strategy with a coordinated set of activities designed to support research and population policy development, improve FP service delivery, increase IEC coverage, provide training, and improve program management. Similar strategies have been tested and proven effective in a wide variety of settings in the developing world during the last twenty-two years of A.I.D.'s population assistance program.

There are several policy and institutional conditions which favor the expansion of the FP program in Rwanda. These include:

- Strong government commitment to population and family planning;
- Supportive policy environment;
- Public knowledgeable about the problems of rapid population growth;
- Unmet demand for family planning;
- Baseline data on contraceptive knowledge, attitudes and practice;
- Eight years of experience developing population policies and implementing FP programs;
- Expanding institutional capabilities and a core staff at ONAPO of trained and committed individuals ready to address the challenges of the next phase of the program;
- A comprehensive and well-designed population and family planning program strategy for the period of the Fourth Development Plan;

- Implementing institutions (ONAPO and MINISANTE) committed to improving the program, implementing evaluation recommendations and testing new strategies of FP service delivery (e.g. community-based distribution and contraceptive social marketing);
- The MINISANTE directive calling for the integration of family planning in all health facilities and promoting the use of family planning for spacing as well as for limiting family size;
- Legalization and availability of a wide range of family planning methods (including voluntary surgical contraception) to meet the varying needs of the target population;
- No apparent restrictions on the expansion of family planning services in the private and commercial sectors; and
- Increased GOR contributions to recurrent costs.

2. Program Challenges and Priorities

The Rwandan family planning program is now entering a critical phase. The emphasis to date has been on raising public awareness of the problems of rapid population growth and the importance of family planning. ONAPO has been successful in achieving this objective. The weakest part of the program has been in the area of service delivery. With only a limited number of well-trained personnel and limited availability and accessibility of family planning services, there has been only a small increase in the use of modern methods of contraception. The major challenge during the next five years will be to expand and improve substantially the quantity and quality of family planning services in the public and private sectors.

The targets of Rwanda's Fourth Five-Year Development Plan (FFYP) are feasible within the policy/social environment. The Project supports GOR efforts to achieve the levels of contraceptive prevalence which are targeted in the FFYP. Table 1 roughly presents how population numbers figure into contraceptive prevalence and numbers of acceptors for the previous year and for each year of the Project.

Table 1 (000s)

	1988	1989	1990	1991	1992	1993	1994
Population, estimated Absolute nos. (Annual growth rate: 3.7%*)	6,800	7,052	7,312	7,583	7,864	8,155	8,456
X							
% Women of Reproduc- tive Age (15-49 yrs) (estimated 22%*)	1.496	1.551	1.609	1.668	1.730	1.794	1.860
X							
% Women of Reproduc- tive Age in Union (estimated 63%*)	.942	.977	1.014	1.050	1.090	1.130	1.172
X							
Contraceptive Use (contraceptive Preva- lence) for modern methods of FP	3%	3.9%	5.1%	6.7%	8.8%	11.5%	15%
=							
Number of Acceptors	28.274	38.103	51.714	70.350	95.920	129.950	175.800

*Note: For rough projection purposes, these % increases have been left constant

To ensure that contraceptive prevalence targets for the IVth Plan are met, the Project strategy (supported by financial and technical assistance from A.I.D.) includes the following activities:

Support for Policy Development and Research

- Reinforcing among prefectural, communal, sectoral and cellule authorities awareness of population issues, the importance of family planning for maternal-child health and national well-being, and the need to increase the availability and use of contraception;
- Testing and replicating alternative service delivery strategies to increase the availability and use of contraception (e.g. CBD and contraceptive social marketing);
- Undertaking operations research studies to improve accessibility, such as charging a fee for family planning services;
- Improving the reporting and analysis of service statistics and monitoring of project activities; and
- Conducting a Demographic and Health Survey to determine changes in contraceptive knowledge, attitudes and practices.

Family Planning Service Delivery

- Fully integrating family planning into all health facilities and making contraceptive information and services available in all maternal and child health care consultations;
- Targeting FP services to high risk audiences;
- Developing standards for service delivery and for monitoring the availability and quality of services;
- Improving the frequency and quality of supervision;
- Implementing the nationwide program of voluntary community workers offering family planning information, contraceptive supplies, and referral;
- Increasing the number of medical personnel trained to provide quality family planning services;
- Strengthening family planning services in private voluntary organizations;
- Launching a contraceptive social marketing program.

IEC

- Developing and testing messages targeted to key audiences, emphasizing family planning method and source-specific information;
- Increasing the number of paramedical and nonmedical personnel trained to provide quality FP information; and
- Expanding teacher training and including population and family planning in the curricula of all levels of the educational system.

Increasing Management Capability

- Developing annual workplans and budgets;
- Improving financial and program planning and management;
- Developing standardized systems for control of finances, vehicles, equipment and supplies;
- Improving the service statistics and contraceptive supply systems of ONAPO and MINISANTE; and
- Improving coordination between ONAPO, MINISANTE, the private sector and donors.

B. Summary Economic Analysis

The purpose of this analysis is to examine the cost effectiveness of the proposed program in reducing fertility and population growth rates.

It may be acknowledged that the existing state of family planning in Rwanda is highly unsatisfactory. Costs per couple-year protection are estimated elsewhere at \$105. Even with some unamortized capital costs, the recurrent cost per couple-year for public sector family planning efforts alone are estimated at \$76. These costs are high by any standard and must be reduced. With less than 30,000 acceptors, donors now have to shoulder 30 percent of the GOR's recurrent costs, clearly an unacceptable situation.

Reasons for this unsatisfactory state of affairs include: an overemphasis in the GOR's present program of IEC; little capacity on the part of ONAPO to evaluate the effectiveness of its IEC efforts; few attempts to achieve costs recovery so as to reduce the need for permanent donor subventions; and very modest private sector participation in service delivery.

To achieve greater prevalence of family planning at reduced costs, it is necessary both to improve the effectiveness of ONAPO's IEC efforts and to build a cost effective delivery system which would, to the extent possible, cover its own costs. Operations Research under this Project will provide a detailed blueprint for achieving the former and will develop sufficient information to select the most cost effective service delivery system. There is not now sufficient experience in either of these areas to allow an informed decision. Instead, an information system of the Project will give USAID and ONAPO the tools to evaluate the effectiveness of ONAPO's IEC messages in reaching various target groups and suggest ways in which messages can be fine-tuned to make them more cost effective. A demographic and health survey may also suggest other correlates with family planning use, such as education, urbanization, or increased employment opportunities for women, which may suggest other public policy measures to increase family planning prevalence. Such information would have to be used with care, however, because the direction of causality can be very difficult to determine.

The Project will test four separate delivery systems--the MINISANTE clinic-based system, a community based system, a non-subsidized private sector system, and a social marketing system--in order to determine the most effective approach for reducing costs. This will enable the GOR to balance cost-effectiveness and recurrent cost goals and lessen its dependence on donor support for the recurrent budget.

Experience of the past decade clearly indicates that the continuation of rapid population growth rates for sub-Saharan Africa, including Rwanda, will impose unacceptable social costs. Stagnant or falling per capita GDP growth and escalating costs of providing minimum social services such as education and health are normally associated with high population growth rates.

However, studies have demonstrated that reductions in population growth rates can be obtained at costs much lower than the costs societies will incur if the rapid population growth rates are allowed to continue. There is, thus, an acceptance that the social benefits to be derived from the reduction in high population growth rates far outweigh the costs.

The Table below shows the tremendous task ahead for Rwanda's FP program. It also amplifies the Mission's intention to encourage more private sector FP involvement to help the GOR with the tremendous service delivery challenge which lies ahead. [Note: Table 6, below, has been updated to reflect the incremental costs of A.I.D., GOR and other Donors. Thus, it differs from a similar table presented in the economic analysis which only includes costs for this project].

Table 6
Annual Cost Per Acceptor
For Family Planning Services

	Incremental Program Costs US Dols	Incremental Couple-Year of Contraception	Cost per Couple-Year of Contraception US Dols
1989	3,333,333	38,103	87
1990	3,333,333	51,714	64
1991	3,333,333	70,350	47
1992	3,333,333	95,920	35
1993	3,333,333	129,950	26
1994	<u>3,333,333</u>	<u>175,800</u>	<u>19</u>
Total	19,999,998	561,837	\$36 (Average Cost)

* Includes: A.I.D., \$1,500,000/yr.; GOR, \$1,333,333/yr.; and other donors, \$500,000/yr.

C. Summary of Social Soundness Analysis

Rwandan culture is fundamentally pro-natalist: children represent wealth, good fortune and helping hands. Children "belong" to the man, and his patrilineage, the complex customary law that governs dowry, land allocation, marriage and divorce. One of the ways a woman earns the love of her husband is by bearing him many children. The man with many children is, in turn, admired by those on his hillside as one who has done well - even if the family has barely enough to eat. The Catholic Church, which is the largest denomination and provides at least thirty-five percent of maternal and child health services in the country, has traditionally opposed all "artificial" methods of family planning. These motivational factors, combined with a rapidly declining infant mortality rate, have generated among the highest total fertility rates in the world: 8.5 children per woman.¹

¹ 1978 Population Census and 1983 Enquete sur la Fecondite.

These attitudes are not static, however. The realities of demographic change and increasing pressure on resources are generating shifts in long held beliefs. These pressures are not merely a national statistical problem: a large percentage of rural families recognize that there is no hope of adequate land in their vicinity for the sons already born. In addition, the population has become widely informed about the demographic problem and contraceptive possibilities in the last eight years. The policy and legal context for limiting family size have likewise become increasingly favorable.

Evidence of attitudinal change is reflected in the National Fertility Survey conducted by ONAPO in 1983. Fully thirty-one percent of the women of childbearing age who were interviewed nation wide said they planned to use contraception in the future compared to forty-nine percent who did not plan to (the remaining twenty percent being infertile).² At the time of the survey only 1.5 percent of fertile women were actually using modern contraceptive methods, and six years later the prevalence rate is still less than five percent. The new Project must address the service delivery gap and other impediments which constrain access to FP services or which might motivate changes in attitude by the unconvinced plurality.

The four key questions from a sociological point of view are:

- (1) How to reach the rural population with targeted messages?
- (2) How to get accurate knowledge and experience of specific methods quickly to the medical and lay, urban and rural populations?
- (3) How to continue to improve relations with the Catholic Church and increase promotion and training of natural FP? and,
- (4) How to encourage the factors which tend to increase demand for FP services?

The rural population comprises about 95% of the total, and lives in dispersed homesteads, not villages, with an average of only 61 ares³ of fields. The lowest quintile of households consumes only three quarters of the necessary daily caloric equivalent, and has less than half a hectare of land. It is harder to reach than the urban population, but this is all the more reason to continue support for the strategies being developed to make FP available to it.

The rural population has very limited mobility although some recent studies indicate this may be changing. Urban residents travel regularly to the hills they come from, but ONAPO researchers report that sex and family planning are taboo subjects of conversation in most families. Therefore, there is little informal communication of new attitudes toward family planning from the more open urban population to their rural cousins. Of the mass media, only the radio reaches rural residents, and audiences are predominantly male. National literacy is 53% for males and 33% for females and rural literacy is much lower. The most common printed materials in circulation are the Bible and religious publications. Printed handouts, nevertheless, have substantial potential to reach rural populations, since there is lively interest in the

² ONAPO, Rwanda 1983, Enquete National sur la Fecondite, version resumée, p.34.

³ One 'are' = 0.10 hectares.

interpretation of pictorial and written handouts, and nearly every family has ready access to a literate interpreter.

ONAPO has instituted a program of volunteer community mobilisers, called abakangurambaga. Because of the dispersed character of settlement and the fact that the vast majority of women deliver babies at home without medical attendance, such a community based distribution program is justified, even though it is expensive in terms of both time and budget. One of the essential missing ingredients in the approach currently being tested, however, is simple technical handouts on each method. This gap can rapidly be remedied with the information and publication facilities already functioning at ONAPO.

The efficiency of different channels of communication and different messages also needs to be tested as part of the ongoing program of operational research ONAPO conducts. The messages spread to date have focused on the dangers of population growth for the nation and the need to join the ONAPO movement to counteract it. Comparative research suggests that people respond more quickly to messages addressed to the individual family perspective:

- (1) the economic message: can we afford to clothe and pay school fees for another child?
- (2) the health message: high risk pregnancies are dangerous to the health of existing children and the mother. (Mothers are even more concerned about their children's health than their own.)

The latter two issues are related. The population is currently caught up in rumors of contraceptive side-effects often started by members of the Catholic Church. Because the debate on FP in Rwanda is engaged on a national and theoretical level, and inadequate supplies of contraceptives are available at the local level, the population cannot develop its own experience and rumors are widely believed and are actively hampering the spread of FP acceptance. Hence the need for accurate and printed information on methods, side-effects, and risk (including comparison of risks of pregnancy, which are extraordinarily high in Rwanda, with maternal mortality estimated at 7 per thousand live births).

The Catholic Church is the major social institution for an estimated 51% of the population. (See 1978 census.) Of the 60% of health facilities that are privately run, which provide at least 35% of maternal and child consultations, 80% are maintained by the Catholic Church. It has regular radio programs, the only newspaper circulating widely in rural areas, and a series of congregational groups which often make it the central focus of life outside the family. ONAPO has worked out a viable accord with the Church and it is important to continue this dialogue, preferably by encouraging and supporting the willingness of some churchmembers to promote natural FP.

More needs to be done to identify and harness motivational factors which encourage adoption of FP practices. The 1983 fertility surveys showed that 50% of the men plan to use birth control and that 45% claimed to be practicing contraception by natural means. While a large potential clientele appears to exist among the male population, however, most IEC attention has been directed toward women. Since by custom the children belong to the husbands, men want to control the process of procreation. The IEC program should build on this

existing role of family management. Its economic messages should ask such questions as: Can I afford to feed and clothe another child? Can I pay the school fees? Will my land suffice for my sons--and theirs? Will my next child find a job when s/he grows up?

Rwandan statistics, like those of many other developing countries, show a strong correlation between women's schooling and declines in fertility. Thus any measures which serve to increase female participation in education should tend to increase demand for FP. ONAPO and MINISANTE need to open a policy dialogue with MINIPRESEC on policy changes and incentives that would encourage increased female school attendance.

Summary of Recommendations

Many of the following recommendations--discussed at greater length in Annex 5--have already been proposed by ONAPO but not yet fully implemented. They should receive priority attention:

- Time constraints affecting patients, especially women, should be considered in improving integrated service delivery;
- FP should be recommended during consultations of all sick men, women and children, and vaccination visits of infants;
- Non-clinical FP should be offered in all pharmacies of clinics and hospitals including communal pharmacies;
- A cost-recovery proposal should be developed for the FP program and phased in during the Project;
- IEC should focus on pretested, simple, technical handouts in large quantities for mobilization meetings;
- IEC should develop new messages based on (a) individual family concerns (socioeconomic, health) and (b) specific information on different methods (how and when used, and possible side effects especially compared to potential complications of pregnancy);
- ONAPO should develop a united policy of encouraging and supporting the Catholic Church in teaching natural FP;
- USAID should support efforts to reach the rural population from the beginning and not assume that FP will "trickle down" from the city to the countryside; and
- ONAPO, in collaboration with MINIPRESEC, should promote measures that would encourage fuller female participation in the primary secondary school systems.

D. Summary of Recurrent Cost Analysis

The largest portion of recurrent costs for the Project are for salaries and other operating items together with some increases in incremental costs from new IEC, service delivery and training activities. The increases in recurrent costs to ONAPO as a result of this Project are not expected to be significant over its term.

Estimated increases in ONAPO's recurrent costs will be from \$1.8 million in 1989 to \$2.16 million in 1993, an increase of 20%. While this increase is modest for ONAPO, overall funding to FP activities in Rwanda will increase significantly through anticipated growth in private sector FP activities and to a lesser extent through integration of FP services with MCH in MINISANTE. Private sector participation in FP activities will not lead to increased GOR recurrent costs, and the World Bank Staff Appraisal Report for the Family Health Project does not anticipate significant GOR recurrent cost increases as a result of that project.

Total recurrent cost estimates for public sector family planning are \$2.0 million in 1989 raising to \$2.67 by 1993, an increase of 20% over a five year period, or an average annual increase of 4%. GOR total contribution to public sector FP services are projected to remain at a constant percentage of about 75%. The table below estimates total recurrent costs for family planning in the public sector through 1993 and source of funding.

Public Sector Recurrent Cost Estimates/Funding Source

	(\$ millions, rounded)				
	1989	1990	1991	1992	1993
Annual Recurrent Costs	2.0	2.2	2.3	2.5	2.7
Financed by:					
GOR	1.4	1.6	1.8	1.9	2.0
USAID	.3	.3	.3	.3	.3
UNFPA)					
IDA) combined	.3	.3	.3	.3	.3
GTZ)					

The ability of the GOR to meet these recurrent costs depends in part on external factors. The recent drop in world coffee prices (85% of Rwanda's export earnings) have reduced export tax-generated revenues. In April the GOR reduced ONAPO's 1988 recurrent cost budget submission to the 1987 level. If the reduction is applied proportionately in future years it would result in a 14.6% annual reduction from the estimated level of GOR's financing of ONAPO's recurrent costs or a total of \$1.1 million over the period 1989-93 (see Annex D, Table 4).

As indicated elsewhere in the project paper, ONAPO has experienced problems with internal management. This has undoubtedly resulted in higher recurrent costs for management and administration. The Project will address this constraint through direct assistance which will improve management and administrative efficiency. Furthermore, it is likely that reductions in recurrent costs could be realized through the adoption of improved management and administrative practices.

The integration of FP with MINISANTE MCH services will reduce duplication of administrative costs and efforts related to the previous program of separate ONAPO sponsored FP service delivery. Also, to the extent that the private sector is able to assume an increasing role in FP service delivery, recurrent cost obligations to the public sector will be further reduced.

A reduction in recurrent cost support to the GOR will probably necessitate a contraction in ONAPO personnel and operations at a time when A.I.D. is pressing the GOR to intensify and expand its delivery of FP services throughout the country. A.I.D. will be faced with a choice of seeing a reduction of ONAPO operations, outputs and activity targets or of increasing its funding of ONAPO local costs. The latter choice has the advantage of maintaining program momentum. The disadvantage is increased financial dependence on A.I.D. and a diversion of project resources from investment (TA, training, etc.) to recurrent expenditures. A.I.D., therefore, has decided to adopt a modified scheme of reduction for support of recurrent costs. The Project will continue to support specific local cost activities but will expect an increase of GOR support of these activities annually.

Detailed information on recurrent costs related to the FP program are presented in Annex D.

E. SUMMARY ADMINISTRATIVE ANALYSIS

The Project will be implemented by two Rwandan public agencies--the National Population Office (ONAPO) and the Ministry of Health (MINISANTE)--as well as through non-governmental organizations and other private sector groups. Because of this structure, the Project includes arrangements for the effective coordination of its various components.

ONAPO

ONAPO was established in 1981 as the country's official policy, advocacy, public awareness and research/analysis instrumentality for family planning and demography. An autonomous agency under the supervision of MINISANTE, ONAPO has grown from a fledgling entity to an organization with 241 employees and an annual budget of \$1.4 million. Its organizational structure (Chart 1, Annex 5) shows that all of its units report directly to the Director but that its major functions are performed by two "Services", Research and Programs and Administration and Finance. In addition, ONAPO's organization includes ten regional offices and a training center.

Emphasis in ONAPO has focused on initiating and expanding program activities while less attention and priority has been given to management and financial procedures. Weaknesses in these areas have been noted in the past, although many improvements are evident. They are summarized below with a discussion as to how the Project proposes to deal with them.

Management and administrative difficulties include: (1) over centralization of authority, (2) inadequate coordination with MINISANTE, (3) inability to prepare annual work plans, (4) poor management of equipment, supplies and vehicles, and (5) divided inventory controls. The training center has inadequate autonomy. These problems have been discussed frankly and at length

with ONAPO and there is agreement that corrective measures are an essential element to the provision of further assistance. They are covenants to the Project. Technical assistance in this area will be provided by a long term management/financial adviser.

Financial management, fiscal control and budgeting practices represent other areas in which ONAPO is experiencing problems. For example, ONAPO still has problems preparing an annual budget while its accounting, disbursement and cash management procedures are regarded as being less than timely. This situation is being rectified as part of the MCH/FP I Project with considerable training, (external, in-country and in-service) of ONAPO staff. ONAPO is filling the vacancies which have contributed to the problem. The new Project will provide technical assistance to guide and monitor further improvements.

MINISANTE

MINISANTE has responsibility for policy, regulation and public sector health services in Rwanda. Its organizational make up is shown in Chart 2 Annex 5. Of particular interest for the purpose of this Project is its Offices of Family Planning, Nutrition and EPI, which are included in the Division of Maternal and Child Health. These offices had, until recently, little authority and their staffs were lacking in experience and training. Major improvements in this situation are underway as a result of the World Bank's Family Health project. (See Annex F.)

Sixty percent of Rwanda's health infrastructure is operated by MINISANTE, the remainder by religious missions. The MINISANTE facilities are by in large dilapidated, overcrowded and lacking equipment. They also suffer from lack of staff at all levels, but particularly with respect to nurses and nurses aides. Programs for upgrading existing staff are lacking. The World Bank Family Health Project aims at strengthening the Ministry's capability to deliver maternal and child care, nutrition and FP services to the population. It involves in-service training, upgrading of 30 health centers and 8 regional offices, expanded training of new staff and strengthening of headquarters backstopping of MCH, nutrition and FP services. A.I.D. assistance to MINISANTE (short term TA and training) will complement and reinforce that being provided by the World Bank.

Public Sector Coordination

The FP program in Rwanda has suffered from problems of coordination and jurisdiction between MINISANTE and ONAPO due to historical and attitudinal reasons. ONAPO's family planning campaign and service delivery network overlapped with MINISANTE's more general family health mandate, although the Ministry had neither the resources, nor until recently the inclination, to provide FP services. However, improved coordination is likely as a result of recent events. The World Bank Family Health Project will strengthen the Ministry's capability to provide FP services as part of an integrated MCH approach. In addition, a March 1988 Directive by the Ministry clearly assigns coordinating responsibility for health services at the regional level to MINISANTE, while permitting ONAPO to continue its activities in that framework. The new Project will reinforce coordination by establishing a Management Team and coordinating committee with representation from MINISANTE, ONAPO and USAID.

Private Sector Arrangements

The private sector FP program will be a new initiative of the Project. A new body, Comité Consultatif, will be established with ONAPO, USAID, and private sector representatives to develop the role of NGOs, provide assistance in designing proposals, review and approve sub-grants and coordinate the private sector component of the Project.

V. IMPLEMENTATION PLAN

A . USAID Project Administration

The project will be monitored by a direct hire Health and Population Officer (HPNO) who will be assisted by a local hire Project Assistant. The major tasks of the Project Officer will be to:

- (1) maintain liaison with ONAPO, MINISANTE and the private sector and monitor all program implementation activities;
- (2) collaborate with the senior Family Planning Adviser, to monitor project activities and to ensure the timely provision services by the contractor.
- (3) review and recommend approval to the USAID Director of annual workplans and subsequent disbursement of funds for local cost support;
- (4) maintain liaison with technical backstop offices in REDSO and AID/W.

Until such time as the technical advisors are in place, USAID will procure necessary commodities and engage short-term technical assistance as appropriate. The HPNO will respond to requests by the public and private sector advisors and arrange procurement of necessary contraceptives.

In performing his/her responsibilities, the Health and Population Officer will be able to call upon technical resources within USAID and REDSO/ESA for needed collateral services:

1. The USAID Program Office to advise on program and funding considerations and to assist in carrying out project monitoring and evaluation;
2. The USAID Project Development Office to assist with project implementation and to ensure that the project complies with the terms and conditions of the Project Agreement and to manage A.I.D. participation in evaluations;
3. The USAID Controller, who will review all financial management activities to ensure that they comply with A.I.D. regulations and that adequate financial control is maintained by the recipients;
4. The Regional Population Officer (REDSO) to advise on a broad range of technical matters;
5. The REDSO Contracting Office to assist with contracting for technical services, training and commodities;
6. The Regional Procurement Officer (REDSO) to check on ONAPO performance in the procurement of contraceptives and other commodities and to assist USAID on direct procurement matters; and
7. The Regional Legal Advisor to advise the U.S.I.A.D. Director on whether conditions precedent have been satisfactorily met.

B. Coordination: ONAPO, in its capacity as the GOR implementing agency, will have primary responsibility for the coordination of all Project activities, including those activities in the public sector, as well as in the private sector. In this regard, the Director of ONAPO will designate an individual to act, on her behalf, as the principal Coordinator for all Project activities. This individual will report directly to the Director of ONAPO and will liaise with all of the major Project participants.

In view of the importance that both ONAPO and USAID attach to the integration of the delivery of maternal child health services with those of FP, ONAPO in consultation with MINISANTE, will designate a MINISANTE Coordinator, who will assist with the implementation of all Project activities which involve MINISANTE, such as FP service delivery.

USAID will designate a Project Manager who, together with the ONAPO and MINISANTE Coordinators, will be responsible for the day-to-day management of the Project. It is expected that this Management Team will meet on a regular basis to facilitate the execution of the programmed Project activities, identify potential problems and resolve them as quickly as possible. As appropriate, other ONAPO, MINISANTE and USAID officials will be invited to participate in the Management Team meetings. The Management Team members will make monthly field visits to monitor Project activities, and the reports of these field visits will be an important component of the Project monitoring system.

In addition to the regular meetings of the Management Team, the following mechanisms will be put in place within the first six months of the project, to facilitate Project implementation:

1. A Comité Mixte (CM), composed of representatives of ONAPO and USAID, and other representatives deemed necessary by ONAPO and USAID, will oversee the public sector activities of the Project. The CM members will participate in the quarterly meetings of the ONAPO delegates, where progress on the annual workplan is reviewed, problems identified and future activities planned. The CM members also will participate in the December meeting, where the annual workplan for the following year is developed. After the CM reviews and approves the annual workplan each year, it will be forward to USAID with a request for financing.
2. A Comité Consultatif (CC), composed of ONAPO, USAID, and representatives from the private sector, will be established. The CC will meet twice a year to develop private sector family planning initiatives, approve projects and workplans for specific NGO FP activities, review progress of on-going projects and provide support and guidance for the implementation of private sector FP activities.
3. Twice a year ONAPO will organize a meeting of representatives of MINISANTE and the donor agencies which support FP activities in Rwanda. The purpose of these meetings is to coordinate the various inputs that support FP activities, and to share information regarding the planning, implementation and evaluation of FP activities. Regular coordination meetings will facilitate more effective and efficient implementation of the GOR population program.

Public Sector Annual Workplans and Budgets: A detailed annual workplan for each calendar year will be developed each December by the Grantee, in collaboration with MINISANTE and USAID. The workplan will include detailed information regarding research, IEC, training and supervision activities; commodity purchases and distribution plans; contraceptive requirements and distribution plans; and the local cost budget required to implement the workplan. The annual workplan will be reviewed and approved by the Comité Mixte and submitted to USAID for funding. Progress in meeting the workplan targets will be reviewed by the Comité Mixte during the quarterly meetings of the ONAPO delegates, and corrective actions or adjustments of Project targets or activities will be made as necessary.

Upon receipt of the annual workplan, USAID will prepare a Project Implementation Letter (PIL) to earmark and commit local costs, and provide authority to USAID to issue implementation orders for goods and services needed to implement the workplan. Activities will conform to this Amplified Project Description and include: in-country training, research, supervision of FP services and providers, production and dissemination of IEC materials, purchase of computers and office supplies and support for purchase, operation and maintenance of vehicles. A 90 day advance will be provided to cover local costs, and additional advances can be requested upon liquidation of 66.6% of the advanced funds.

Private Sector Annual Workplans and Budgets: Under the guidance of the Comité Consultatif, private sector initiatives will be developed. NGOs, cooperatives and other private entities will be invited to carry out FP activities in collaboration with ONAPO's national program. Once a project has been developed, the private sector entity will sign a Memorandum of Understanding with ONAPO which identifies the relationship and responsibilities of the parties. ONAPO will provide all contraceptives and some training to support these private sector projects. Upon approval of the projects by the CC, an annual workplan will be developed, approved and forwarded to USAID with a request for funding. USAID will issue a PIL to commit local funds for the activity directly to the private agency upon receipt and approval of the Memorandum of Understanding, the project document and annual workplan, and a financial review of the private sector's accounting system. A.I.D. will then issue a direct A.I.D. grant to the PVO consistent with the Memorandum of Understanding. In the case of projects with local NGOs, registration with A.I.D. will be initiated as soon as possible after project is approved for funding.

C. Contracting and Procurement Procedures: On behalf of the Grantee, A.I.D. will enter into an Institutional Contract (IC) to provide the following services to the Grantee:

1. Provide one (1) technical advisor for four years in family planning service delivery and one (1) advisor for two years in organizational management and finance. The services of these two advisors are to be provided primarily to ONAPO, with assistance as needed, to MINISANTE and to the private sector;
2. Provide approximately 10 person months of short-term technical assistance in the following areas: information and management systems, computer procurement, installation and training, short-term clinical and IEC FP training, private sector development and other areas to be defined by ONAPO; and

3. Define public sector commodity requirements, arrange participant training; and organize in-country seminars and study tours. (See Annex J for Commodity Procurement Methods)

Technical Assistance: (1) Family Planning Specialist - A senior level FP Specialist will serve as program advisor to ONAPO for four years, beginning as soon as possible after Project start-up, to assist with the coordination and development of priorities of Project activities and increase their technical effectiveness. S/he also would be available, on request, to assist MINISANTE with problems or activities relating to MCH/FP service delivery and strengthening collaboration between the two institutions and within the private sector. The advisor would provide assistance, upon request, to private sector entities that would be sub-grantees under the Project. S/he will assist the agencies to plan and undertake special studies and organize in-country workshops, seminars and study tours. The advisor will assist the Comite Mixte in the preparation, review, implementation and monitoring of annual workplans for the Project. The FP advisor will assist MINISANTE in identifying contraceptive and medical supply needs and will assist in strengthening the activities that support the integration of family planning into the general health care system.

(2) Management/Financial Specialist - The management/financial advisor will provide two years of services, beginning as soon as possible after Project start-up, to improve ONAPO's management, budgeting and accounting systems. The advisor will develop and install improved procedures and train ONAPO staff in how to operate and maintain the systems. Once these are in place, s/he would be available to assist MINISANTE and private sector entities on similar matters.

(3) Approximately 32 person months of short-term technical assistance will be provided for needs identified and approved in the Annual Workplans.

Buy-Ins: The Project will also "buy-in" to several on-going A.I.D. centrally funded projects. The "buy-in" mechanism is a process which permits the Project to acquire the packages of needed skills and additional resources much more quickly than would normally be permitted under normal A.I.D. procurement procedures. The project will "buy-in" to the following on-going centrally funded projects:

- (1) SOMARC II - This project will provide approximately \$800,000 to SOMARC II for in-country contraceptive social marketing (CSM) activities such as, advertising/promotion, marketing research, distribution management, packaging, and training. Although, the level of SOMARC II financial contribution to MCH/FP II has not yet been determined, it is expected that SOMARC II will provide an additional contribution to this Project.
- (2) JHPIEGO - ONAPO and USAID will negotiate with John Hopkins University, or similarly qualified training institution, to design a training program, specifically tailored to the needs of Rwandan physicians working in family planning service delivery. The exact cost and amount of training will be determined after training curriculum is specified and negotiations are completed.

- (3) DHS - The cost of a buy-in to carry out the Demographic and Health Survey is estimated to be \$250,000-\$300,000, which will finance the local costs of carrying out the survey. The DHS Project will provide an additional contribution to the Project in the form of technical assistance, training in computer programming, and participation of ONAPO researchers at regional seminars.
- (4) RAPID III - Work on the preparation of RAPID III models was begun with financing from RAPID III. The buy-in, estimated to cost \$35,000 to \$50,000, will finance the updating of the three models which will take place when the results of the DHS are available. The three models which are being designed include a Bongaarts Model for targeting contraceptive users, a model for infant and maternal mortality related to fertility and cost effectiveness of FP programs.
- (5) Other possible sources of "buy-ins" will be the centrally funded project with: 1)The Population Council for technical assistance to carry out operations research studies; 2)The Association for Voluntary Surgical Contraception for mini-laproscopy training; and, 3) Natural Family Planning (NFP) to support the extensive NFP activities being carried out in Rwanda.

\$800,000 will be set aside to support sub-grants to private sector entities, participating in the Project. It is expected that after the Comité Consultatif has reviewed the proposals, that ONAPO will request A.I.D. to provide Project funds directly to the sub-grantees. The Institutional Contractor will provide some short-term technical assistance to those private sector entities needing management and institutional support. In addition, the management/financial advisor, assigned to ONAPO, will provide assistance to private sector entities to assure proper accounting procedures are in place.

D. Monitoring and Evaluation: The Grantee and A.I.D. will monitor project implementation through the following monitoring and evaluation mechanisms:

1. Progress Reviews and Yearly Evaluations of Public Sector Annual Workplan: ONAPO central staff and prefecture delegates meet on a quarterly basis to review the progress of achieving annual workplan targets, and each December this group evaluates the achievements of the year and prepares the workplan for the following year. Representatives from MINISANTE and USAID will actively participate in this process, which is already established and on-going. Members of the Comité Mixte will review the results of these meetings and, under the leadership of ONAPO with assistance from the Institutional Contractor, will submit semiannual progress reports to USAID, to serve as the basis for USAID Project Implementation Reports (PIR) to A.I.D. Washington.
2. Progress Reviews and Evaluation of Private Sector Project Annual Workplans: Annual workplans, including budgets, will be prepared by each private sector entity with assistance from ONAPO and the IC, and submitted to the Comité Consultatif for review and approval each calendar year. Twice a year the CC will meet to review progress of the private sector activities. Results of the semiannual reviews will be submitted by ONAPO to USAID to serve as the basis for PIRs for A.I.D. Washington.

3. Semi-annual Reports and Field Trip Reports: In conjunction with trimestrial Project reviews of the Comité Mixte and semi-annual reviews of Comité Consultatif, ONAPO with assistance from the IC will submit semi-annual reports on both public and private sector activities to USAID, to serve as the basis for PIR's sent to A.I.D. Washington. These semi-annual reports will list the activities accomplished during the reporting period, identify problems and recommend solutions. The monthly field trip reports by the Management Team will also provide information for the PIRs.
4. Mid-term Evaluation: Approximately 30 months after the start of the Project an external mid-term evaluation will be carried out. This evaluation will assess whether the objectives of the Project are being achieved and, based on the findings, will recommend changes to improve Project implementation if necessary. In view of the relatively new role being played by the private sector in this Project, the evaluation will put special emphasis on assessing the impact and progress of the private sector interventions.
5. Final Evaluation: A final evaluation will take place near the end of the Project to determine the strengths and weaknesses of the Project design and implementation. Should follow-on FP assistance be justified, this evaluation will assist in defining priority areas for future support.
6. Audits: United States Government audits of all parties involved in the Project may be carried out at any time during the Project.

E. Indicators of Performance:

Crucial to the effective and cost efficient design and implementation of any development program is the donor as well as the recipient country's abilities to assess the impact of various project activities. The MCH/FP project has been evaluated as having made considerable progress in IEC, though not service delivery, and the on-going monitoring mechanism used to evaluate project progress was inadequately defined and practically nonexistent. For these reasons, the MCH/FP II project has defined and will support clear, quantifiable performance indicators that project implementing agencies and evaluators can follow. The mid-term evaluation of the project will look at progress made in respect to these indicators and will make recommendations regarding modifications. Likewise, the final evaluation will look at costs associated with specific activities within the public and private sectors to determine further FP assistance to Rwanda should this be required and desirable.

The following performance targets, as measured by the specific indicators listed below, will be used to measure progress.

PERFORMANCE TARGETS

OBJECTIVE	PERFORMANCE INDICATORS	YEARS				
		1	2	3	4	5
<u>1. Policy Implementation and Research</u>						
GOR support for implementation of FP policy directives	Regular Review	X	X	X	X	X
GOR support for private sector FP involvement	Regular Review	X	X	X	X	X
Improved Targeting of FP acceptance	DHS carried out/analyzed Bongaarts model development/updated	X	X	X	X	X
<hr/>						
<u>2. FP Service Delivery</u>						
Integration of FP into public health system	FP integrated into % of health facilities, FP/HIS integrated, supervision, logistics	20%	40%	60%	80%	100%
Increase coverage of FP services	Contraceptive prevalence rate	5%	7.5%	10%	12.5%	15%
<hr/>						
<u>3. Improved IEC</u>						
Increased awareness of FP	Percent of adult pop. (20+) aware of FP	70%	75%	80%	85%	90%
	Percent of youth pop. (10-20) aware of FP	20%	25%	40%	50%	60%
<hr/>						
<u>4. Improved Management</u>						
Improved financial accounting	Quarterly financial accounting reviews	X	X	X	X	X
Improved planning and monitoring	Annual workplans prepared, approved and followed.	X	X	X	X	X

F. Training

U.S. and third country training programs will be developed in accordance with the priorities outlined in Chapter III, Sections 2a and 2b and will be specified in annual workplans. Candidates will be identified by either the institutional contractor or the GOR, selected by the GOR and approved by USAID. The institutional contractor will make all necessary administrative and travel arrangements as well as paying for tuition, stipends, etc. The contractor will monitor and report on the performance of long term trainees. The contractor will place long term trainees at institutions most appropriate to the needs of the project and will arrange special training and internships during vacations. In-country training will be included in annual workplans with A.I.D. providing in-country costs through earmarking of funds for local costs and the IC providing any consultant services necessary for the training programs.

G. Audit and Financial Reviews

The federal and non-federal audits planned for the MCH/FP II project will examine the financial management procedures and records of ONAPO, MINISANTE and USAID. The federal audit will examine management controls and project implementation to determine if project goals and objectives are being achieved and applicable U.S. laws and regulations are being adhered to by the project. The first audit should probably be done shortly after, or in conjunction with, the mid-term evaluation. Annual financial reviews will be undertaken at ONAPO to verify that annual financial statements are accurate reflections of their financial position.

H. Procurement Plan

The list of commodities to be procured is as follows: (See Annex I for a complete detailed list of commodities and procurement procedures)

<u>Commodity</u>	<u>For Whom</u>	<u>Needs Determined By Whom</u>	<u>Action</u>
Vehicles	ONAPO	ONAPO	USAID
Computers	ONAPO	ONAPO	USAID
Office Equip.	ONAPO	ONAPO	USAID
HH Furniture	Contractors	USAID	USAID
Contracep.	Public /PvtSector	ONAPO/IC	USAID
Med. Equip.	MINISANTE	MINISANTE/IC	USAID

1. USAID Procurement

USAID procured commodities will be purchased from several sources:

(a) Vehicles - A total of 10 vehicles will be purchased to support project activities. Procurement will be phased according to project needs. Because funds for this project are coming from the Development Fund for Africa (DFA), the normal requirements concerning source and origin waivers for vehicles and related equipment do not apply. Instead, per revision of AA/AFR DOA 551--Implementing Special Procurement Policy Rules Governing the Development Fund for Africa--AID Geographic Code 935 (Special Free World) is authorized for DFA procurement. Procurement Plans are expected to assure the maximum practicable purchase of U.S. commodities (State 105351). The intended source/origin of project commodities is indicated in Annex I. Once the decision to purchase a vehicle is made, USAID will prepare a PIO/C for ONAPO's signature and will solicit bids from local car dealers or directly from the overseas manufacturers, as well as, solicit quotations from A.I.D. overseas procurement offices.

(c) Microcomputers - A proprietary procurement of six microcomputers will be purchased under the project, including maintenance contracts, all necessary hardware, software, power supplies, and accessories. IBM computers are necessary to remain consistent with ONAPO's existing computers and training capabilities. Procurement of the six computer systems will be undertaken by USAID with assistance from the REDSO Systems Analyst.

Office Equipment - The project will purchase a photocopy machine, a typewriter, and other necessary furniture for ONAPO. This equipment will be available for use by the long and short-term Technical Assistance Advisors as necessary.

(c) Contraceptives and Medical Equipment - Contraceptive commodities and medical equipment, for both the public and private sectors, will be purchased, as necessary, by USAID drawing on the services of S&T/POP as the supply agent for the provision of contraceptives and certain specialized medical equipment. Technical assistance will be provided, as needed, by the REDSO/ESA Regional Commodity Management Office. See Annex I, for further details regarding these purchases.

The Family Planning long-term Advisor under the IC will work in close collaboration with ONAPO and MINISANTE to determine annual contraceptive and medical equipment needs for the public sector. These needs will be relayed to the USAID Health and Population Officer, who will submit PIO/Cs to AID/W. Contraceptive needs under the CSM program will be submitted to USAID by the SOMARC advisor. Likewise, needs funded by sub-grants to private sector entities will be submitted to USAID for procurement.

(d) Household Furniture - Furniture necessary for the two long-term advisors will be furnished by the project.

2. ONAPO Procurement

Local cost support to ONAPO will, in part, go to the local purchasing of IEC production materials and office equipment. All items purchased will follow A.I.D.'s shelf item procurement rules.

I. Implementation Schedule

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 1/Ort 1 (7/1- 9/30/89)</u>	
Project Paper Authorized	USAID
Project Agreement Signed/First Project Obligation	GOR, USAID
FP Donor Agencies Meet	ONAPO
CP 4.1 Completed	GOR
ONAPO/Comite Mixte Quarterly Progress Review/CY89 Workplan and Budget Prepared	ONAPO, MOH, USAID
GOR Annual Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
Short term TA, TOR, PIO/T Submitted	USAID
Contraceptive Requirements Reviewed	USAID, ONAPO, AID/W
TOR, PIO/T, and RFP for Institutional Contract (IC) Completed and Submitted	ONAPO, USAID, REDSO
PIO/C for Advisors' HH Furniture and Appliances Prepared and Submitted	USAID
ONAPO and SOMARC Agreement Signed	ONAPO
TOR and PIO/T for SOMARC Buy-in Submitted	USAID, AID/W
Comite Consultatif Formed	ONAPO, USAID, NGOs
Rapid III Preliminary Models Prepared	ONAPO, MINIPLAN
<u>Year 1/Ort 2 (10/1 - 12/31/89)</u>	
Operations Research Seminar Held	ONAPO, Pop Council
Bids for IC RFP Reviewed and Selection Made	USAID, GOR
PIO/C for 6 Vehicles Prepared and Submitted	USAID, ONAPO
ONAPO and DHS Agreement Signed	ONAPO, USAID, AID/W
TOR and PIO/T for DHS Buy-in Submitted	ONAPO, USAID, AID/W
Physician Training Program Developed	ONAPO, Trng Inst.

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 1/Ort 2 (Cont)</u>	
Short-term TA Arrives to Assist in Prep. of CY90 Workplan and Budget	USAID
ONAPO/Comite Mixte Annual Progress Review/ CY90 Workplan and Buget Prepared	ONAPO, MOH, USAID
GOR CY90 Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
Project Implementation Review	USAID
Operations Research Study Begins	ONAPO, Pop Council
On-going In-country Training	ONAPO
NGO Sub-grant(s) Developed	NGO, ONAPO, USAID
<u>Year 1/Ort 3 (1/1 - 3/31/90)</u>	
Contraceptive Procurement Cable Prepared	USAID, ONAPO
On-going In-country Training	ONAPO
CSM Research Completed	ONAPO, SOMARC
NGO Sub-grant(s) Awarded	NGO
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
ONAPO Progress Report Submitted to USAID	ONAPO
On-going Operation Research Study	ONAPO, Pop Council
FP Donor Agencies Meet	ONAPO
<u>Year 1/Ort 4 (4/1 - 6/30/90)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
Project Implementation Review	USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
On-going CSM Activities	SOMARC, ONAPO
Long-term Advisors in Place	USAID, GOR

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 1/Ort 4 (Cont.)</u>	
PIO/C for 6 Computers Prepared and Submitted	IC, ONAPO, USAID
PIO/C for Contraceptives Prepared and Submitted to AID/W	IC, ONAPO, USAID
<u>Year 2/Ort 1 (7/1-9/30/90)</u>	
Physician Training Program Initiated	ONAPO, MOH, JHPIEGO
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
ONAPO Progress Report Submitted to USAID	ONAPO, IC
Population Policy Seminar Held	ONAPO
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
DHS Preparation	ONAPO, DHS
<u>Year 2/Ort 2 (10/1 - 12/31/90)</u>	
ONAPO/Comite Mixte Annual Progress Review/ CY 91 Workplan and Budget Prepared	ONAPO, MOH, USAID
GOR CY 91 Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
DHS Begins	ONAPO/DHS
Project Implementation Review	USAID
Study Tour Arranged	IC
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO/Pop Council
<u>Year 2/Ort 3 (1/1 - 3/3/91)</u>	
Contraceptive Procurement Cable Prepared	IC, ONAPO, USAID
Study Tour Conducted	ONAPO

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 2/Ort 3 (Cont.)</u>	
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
NGO Sub-grants Awarded	Comite Consultatif
ONAPO/Comite Mixte Quarterly Review	Comite Mixte
ONAPO Progress Report Submitted to USAID	IC, ONAPO
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
DHS Field Work Completed	ONAPO, DHS
<u>Year 2/Ort 4 (4/1 - 6/30/91)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
Project Implementation Review	USAID
PIO/C for Contraceptives Prepared and Submitted to AID/W	IC, ONAPO, USAID
PIO/C for Medical Equipment Prepared and Submitted to AID/W	IC, ONAPO, USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
FP Donor Agencies Meet	ONAPO
DHS Analysis Completed	ONAPO, DHS
<u>Year 3/Ort 1 (7/1-9/30/91)</u>	
PIO/C for 4 Vehicles Prepared and Submitted	USAID, ONAPO
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
ONAPO Progress Report Submitted to USAID	ONAPO, IC
RAPID III Models Fully Developed	ONAPO, MINIPLAN
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council

Year 3/Ort 2 (10/1 - 12/31/91)

Population Policy Seminar	ONAPO
ONAPO/Comite Mixte Annual Progress Review/ CY 92 Workplan and Budget Prepared	ONAPO, MOH, USAID
GOR CY 92 Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
Project Implementation Review	USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
PIO/T for Mid-term Evaluation Prepared	GOR, USAID

Year 3/Ort 3 (1/1 - 3/31/92)

Contraceptive Procurement Cable Prepared	IC, ONAPO, USAID
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
NGO Sub-grants Awarded	Comite Consultatif
ONAPO/Comite Mixte Quarterly Review	Comite Mixte
ONAPO Progress Report Submitted to USAID	IC, ONAPO
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council

Year 3/Ort 4 (4/1 - 6/30/92)

ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
Project Implementation Review	USAID
PIO/C for Contraceptives Prepared and Submitted to AID/W	IC, ONAPO, USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
FP Donor Agencies Meet	ONAPO
Mid-term Evaluation	USAID, GOR

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 4/Ort 1 (7/1-9/30/92)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
ONAPO Progress Report Submitted to USAID	ONAPO, IC
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
FP Donor Agencies Meet	ONAPO
<u>Year 4/Ort 2 (10/1 - 12/31/92)</u>	
ONAPO/Comite Mixte Annual Progress Review/ CY 93 Workplan and Budget Prepared	ONAPO, MOH, USAID
GOR CY 93 Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
Project Implementation Review	USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
Second Study Tour Arranged and Carried Out	IC, ONAPO
<u>Year 4/Ort 3 (1/1 - 3/31/93)</u>	
Contraceptive Procurement Cable Prepared	IC, ONAPO, USAID
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
NGO Sub-grants Awarded	Comite Consultatif
ONAPO/Comite Mixte Quarterly Review	Comite Mixte
ONAPO Progress Report Submitted to USAID	IC, ONAPO
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
<u>Year 4/Ort 4 (4/1 - 6/30/93)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
Project Implementation Review	USAID

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 4/Ort 4 (Cont.)</u>	
PIO/C for Contraceptives Prepared and Submitted to AID/W	IC, ONAPO, USAID
PIO/C for Medical Equipment Prepared and Submitted	IC, ONAPO, USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
Population Policy Seminar Held	ONAPO
<u>Year 5/Ort 1 (7/1-9/30/93)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
ONAPO Progress Report Submitted to USAID	ONAPO, IC
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
PIO/T for Final Evaluation Prepared	GOR, USAID
<u>Year 5/Ort 2 (10/1 - 12/31/93)</u>	
PP Donor Agencies Meet	ONAPO
ONAPO/Comite Mixte Annual Progress Review/ CY 94 Workplan and Budget prepared	ONAPO, MOH, USAID
GOR CY 94 Workplan Approved	Comite Mixte
PIL for Disbursement of Local Costs Issued	USAID
Project Implementation Review	USAID
On-going In-country Training	ONAPO
On-going Op Research Studies	ONAPO, Pop Council
<u>Year 5/Ort 3 (1/1 - 3/31/94)</u>	
ONAPO/Comite Consultatif Six Month Review	Comite Consultatif
ONAPO/Comite Mixte Quarterly Review	Comite Mixte
ONAPO Progress Report Submitted to USAID	IC, ONAPO

<u>Activity/Event</u>	<u>Action By</u>
<u>Year 5/Ort 3 (Cont.)</u>	
On-going In-country Training	ONAPO
Op Research Studies Concluded	ONAPO, Pop Council
Final Evaluation Carried Out	GOR, USAID
<u>Year 5/Ort 4 (4/1 - 6/30/94)</u>	
ONAPO/Comite Mixte Quarterly Progress Review	Comite Mixte
Project Implementation Review	USAID
In-country Training Completed	ONAPO
FP Donor Agencies Meet	ONAPO
Project Close-out	USAID, IC, GOR

VI. CONDITIONS PRECEDENT AND COVENANTS

A. Conditions Precedent To Disbursement

- (1) Except as A.I.D. may otherwise agree in writing, prior to any disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee shall furnish to or have furnished to A.I.D., in form and substance satisfactory to A.I.D., a written statement setting forth the names and titles of persons holding or acting in the Office of the Grantee and of any additional representatives, and representing that the named person or persons have the authority to act as the representative of the Grantee, together with a specimen signature of each such person certified as to its authenticity.

B. Covenants

- (1) The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:
 - (a) evaluation of progress towards attainment of the objectives of the Project;
 - (b) identification and evaluation of problem areas or constraints which may inhibit such attainment;
 - (c) assessment of how such information may be used to help overcome such problems; and
 - (d) evaluation, to the degree feasible, of the overall development impact of the Project.
- (2) The Grantee covenants that none of the funds made available under this Grant may be used to finance any costs relating to:
 - (a) performance of abortion as a method of family planning;
 - (b) motivation or coercion of any person to undergo abortion;
 - (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning;
 - (d) active promotion of abortion as a method of family planning; or
 - (e) involuntary sterilization

- (3) The Grantee covenants to present to the Comité Mixte, no later than December 31, 1989 an IEC plan and a National Family Planning Training Plan, for both ONAPO and MINISANTE, indicating yearly activities and types of training for each institution.
- (4) The Grantee covenants to facilitate autonomy and self-financing of the ONAPO Training Center by taking, inter alia, the following actions:
 - (a) establish the position of the Director of the Center and fill the position with a qualified person;
 - (b) provide the Center with administrative and operational autonomy; and
 - (c) test and implement cost recovery schemes to progressively achieve self-financing at the Center.
- (5) The Grantee covenants to convene a Donors Coordinating Committee of all parties who provide support for family planning services and information at least twice a year.
- (6) The Grantee covenants to make available suitable candidates for Project financed training for the public sector, to assign participants, after training, to positions within ONAPO or MINISANTE commensurate with their training, and to promptly issue all travel documentation required by participants selected by ONAPO or MINISANTE for training outside Rwanda.
- (7) The Grantee covenants to recruit and assign, in a timely manner, all GOR personnel necessary to implement the Project. The Grantee also agrees to consider women, as well as men, in selecting candidates for participant training and in recruitment for positions under the Project.
- (8) The Grantee covenants to ensure that Annual Workplans and detailed budgets describing expenditures for private sector entities involved in the Project, will be reviewed and approved by the Comité Consultatif on a timely basis.
- (9) The Grantee covenants to sign, in form and substance satisfactory to the Comité Consultatif and A.I.D., a Memorandum of Understanding with each private sector entity which will define the status and operating procedures for each entity and the terms and conditions under which the funds will be used.
- (10) The Grantee covenants to furnish to A.I.D., in form and substance satisfactory to A.I.D., a Project Annual Workplan and a detailed budget describing expenditures required for each Party to carry out the workplan, reviewed and approved by the Comité Mixte.

ANNEX A

TECHNICAL ANALYSIS OF THE MCH/FP II PROJECT

I. Overview of Population Policy and Program Development in Rwanda

The following section provides a brief overview of demographic trends in Rwanda, the evolution of population policy and family planning program activities, and current unmet demand for family planning. These issues are discussed in detail in a series of documents published in the last several years (e.g. The Rwandan Social and Institutional Profile, 1986; Final Evaluation of the MCH/FP Project, 1987; May, Murray and Vekemans, 1988; Me Neseke Mandendi-Vita, 1988; and MINISAPASO and ONAPO publications, including Politique Demographique et Politiques de Population, 1988 and Enquete Nationale sur la Fecondite, 1983).

1. Demographic Pressures

Rwanda is faced with one of the world's most severe population pressures, with a current rate of population growth of 3.7 percent per annum and population density on arable land exceeding 500 km². These trends are threatening Rwanda's natural resource base and posing serious consequences for the nation's social and economic development.

The current population is estimated at 6.8 million, living in an area of 26,338 km², of which only 18,724 km² is tillable land. Ninety-five percent of the population is rural and living on farms averaging less than 1 hectare in size. Rwanda's mounting population pressures are a result of continued high fertility, declining mortality and limited international migration in the last 15 years. The estimated crude birth is 54 per thousand and the total fertility rate is 8.6 live births per woman, one of the highest in Africa. If current trends continue, Rwanda could have a total population in 2010 of 15.5 million and a density on arable land of more than 1,100 people per km².

Government projections are somewhat more optimistic, indicating a total population of 10.9 million by 2002, with a decline in the rate of natural increase from 3.7 to 3.1 percent and a decrease in the total fertility rate from 8.6 to 6.5. Even at this level, population pressures will be extremely severe for a nation already struggling to address growing population-resource imbalances and to meet the food, education, health, housing, and employment needs of its population.

2. Policy and Program Response

Political Commitment: The Government of Rwanda has been concerned about rapid population growth since the 1970s. An early indication of this concern was the creation of a Scientific Advisory Council in 1974 to study the problem and to make recommendations about how to deal with the growing imbalance between agricultural production and population growth. One of the objectives of Rwanda's Second Five-Year Development Plan (1977-1981) was to increase public awareness of the population problem and to promote appropriate "education and preventive" actions.

A major step was taken in January 1981 when the Government created the Office National de la Population (ONAPO). The mandate of ONAPO was to:

- study the relationship between population growth and socio-economic development;
- make all levels of the population aware of the demographic problem;
- ensure that family planning methods are properly employed;
- propose ways of integrating family planning into health services;
- carry out evaluation, research, staff training and program development; and
- help prepare a population education program for schools.

With the Third Five-Year Plan (1982-1986), the GOR's increased commitment to address the problem of rapid population growth was reflected in the development for the first time of specific demographic objectives and action programs. The plan called for stabilizing the rate of population growth at 3.7 percent and setting in motion a series of activities and conditions which would lead to an eventual reduction in the population growth rate. These measures included the launching of ONAPO's research, IEC and training activities along with steps to increase the legal age of marriage and to introduce family planning services.

The Fourth Five-Year Plan (est. 1988-1992) has set far more ambitious objectives calling for a reduction in the annual rate of national increase from 3.7 percent to 3.2 percent. The draft Plan states that " it will legitimize all forms of birth spacing and limitation and will launch a mass education and research campaign for social well-being. An ideal family size of 4 children in the year 2000 will be the education theme." The Plan includes a detailed strategy for policy and program improvements, as discussed in Section III below.

Another indication of the GOR's increasing commitment to address the issue of rapid population growth are a series of important speeches by the President of the Republic, Juvenal Habyarimana. In a major address in July 1987, the President stated that Rwanda must bring the demographic situation into equilibrium with the country's ability to feed its people. The President asked all Rwandan people, within their own cultural and religious background, to look for ways to accomodate a smaller family size. Other senior government officials are calling attention to the negative consequences of current population trends in their public statements.

Evolution of Family Planning Activities: Over the past seven years since the creation of ONAPO, there have been substantial advances in understanding, on the part of government officials and the general public, of the relationship between population growth and socio-economic development and the need for family planning information and services. The major thrust of ONAPO's efforts since 1981 has been on informing and educating the public on population issues and the importance of family planning for individual and national well-being.

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As a semi-autonomous institution under the tutelage of the Ministry of Health and Social Affairs (MINISAPASO), ONAPO has overall responsibility for formulating, implementing and coordinating all population activities.

ONAPO's activities have included:

- organizing national and regional seminars for political, religious and medical leaders on population and family planning;
- promoting legislative and regulatory reform to improve the status of women and access to contraception;
- integration of demographic variables into development planning;
- conducting policy dialogue with the Catholic Church and encouraging the Church's efforts to promote natural family planning (NFP) in the context of responsible parenthood;
- construction or upgrading of four MCH/FP centers and building a national training center;
- organizing basic training in family planning for health personnel and social workers;
- launching a program to introduce population and family planning into the curriculum of medical, paramedical, primary, secondary and vocational schools;
- developing data collection and analysis capabilities;
- conducting the National Fertility Survey in 1983 providing important baseline information on contraceptive knowledge, attitudes and practice;
- establishing a contraceptive procurement, storage and distribution system; and
- in collaboration with MINISAPASO, progressively introducing family planning into health facilities.

There has been heavy donor involvement in providing technical and financial assistance for all of these activities. Assistance by USAID, UNFPA, the World Bank and other donors is summarized in Annex F.

Family planning service delivery in Rwanda has developed far more slowly than the IEC, training and research activities. In 1981, family planning services were only available in three pilot centers in Butare, Ruhengeri and the Kigali hospital. Since then, family planning information and services have been progressively introduced in other health facilities throughout the country. Regional offices of ONAPO have been established in each of the ten prefectures. An estimated 233 out of 392 health centers are providing at least limited family planning information and services. Sixty percent of the nation's health facilities are run by churches.

According to ONAPO service statistics, the annual number of new contraceptive acceptors among Rwandan women has grown from 706 in 1981 to 18,513 in 1987. An analysis of the 1987 statistics shows that:

- 70 percent of the contraceptive acceptors live in rural areas;
- 76.8 percent are women aged 20-35; and
- 25 percent were using oral contraceptives; 66 percent injectables, 5 percent IUDs and 2 percent barrier methods.

4. Unmet Demand for Family Planning

As mentioned earlier, ONAPO's intensive IEC efforts and official government statements have helped generate widespread awareness among the general public of the seriousness of population pressures in Rwanda. Eighty percent of the women and 97 percent of the men interviewed in the 1983 National Fertility Survey (NFS) said that the population was growing too rapidly, and over half were in favor of government intervention to deal with this problem. Knowledge of family planning is also widespread, with 67 percent of the women knowing at least one modern method of contraception.

There continues, however, to be a wide gap between knowledge of modern contraception and actual practice. At the time of the survey, 11 percent of women in union at risk of pregnancy were practicing family planning. Of that number, only 0.9 percent reported using a modern method of contraception. The reported demand for family planning, however, was substantially higher. In the 1983 NFS, 20 percent of the women of reproductive age stated that they did not want any more children, including nearly 25 percent of women with four or five children and fully 44 percent of women with six children. Desired family size, as measured in the survey, was an average of 6.3 children per woman compared to the total fertility rate of 8.6. Furthermore, among women who have never practiced contraception, 31 percent indicated their intention to use a modern method of contraception. These findings are confirmed in a smaller survey conducted by ONAPO in 1985 where 31 percent of the respondents reported an unwanted pregnancy.

B. Family Planning Program Constraints

There are many factors contributing to this wide gap between contraceptive knowledge and practice. These factors can be grouped into those affecting demand for family planning and those affecting the supply of services. The constraints to contraceptive use in Rwanda have been analyzed and documented in numerous reports in the last several years (Final Evaluation of MCH/FP Project, 1987; Jemai and Hoben; UNICEF, 1987; Sebakali, 1987; Albert, 1987; and May, Murray and Vekemans, 1988). The following is a brief summary of some of the major constraints to modern contraceptive use in Rwanda:

1. Factors Affecting Contraceptive Demand

Socio-economic, cultural and religious factors which currently limit demand for and use of modern methods of contraception include:

- A strong pro-natalist tradition;
- High value of children;
- Demand for child labor in a society which is 95 percent rural;
- Low status of women who are confined to low-input agricultural activities;
- High illiteracy rates, particularly among women (72 percent according to the 1978 census);
- Limited access of women to formal education;
- Fatalism and religious convictions;
- Limited informal discussion of sex and family planning among rural families;
- Bans by the Catholic Church on the use of modern contraception;
- Widespread misconceptions and fears about side effects of different contraceptive methods (often fueled by the Catholic Church);
- Ignorance of the risks of repeated pregnancies; and
- Fear of infertility.

These and other factors are examined in more detail in the Social Soundness Analysis in Annex E-3.

2. Factors Affecting Contraceptive Supply

There are major constraints to the delivery of family planning services in Rwanda which are typical of other countries in the region with fledgling family planning programs. These weaknesses include:

- Inadequate family planning IEC efforts, particularly method and source-specific information;
- Inadequate number of trained and motivated personnel to deliver family planning services;
- Limited number of public health facilities providing family planning;
- Limited capacity of health facilities to deliver family planning services effectively and efficiently;
- Lack of integrated family planning and MCH services, with only limited hours available for family planning;

- Limited choice of contraceptive methods and often restrictions on access to certain methods (e.g. women requiring a prescription and/or husband's consent);
- Unavailability of modern methods of contraception in Catholic-run health facilities which represent 40 percent of all health facilities in the country;
- Few private physicians offering family planning;
- Unavailability of family planning services outside of health facilities;
- Very limited involvement of the commercial sector in family planning except for a few pharmacies selling contraceptives at prohibitive prices;
- Poor quality of family planning services;
- Inadequate supervision and follow-up; and
- Weak logistics system and periodic interruptions of stock.

A description of the organizational structure of ONAPO and MINISAPASO and the strengths and weaknesses of both institutions is included in the Institutional Analysis in Annex E-5.

C. Policy and Program Priorities: The Public Sector

To address the many cultural and program constraints to family planning outlined above, an aggressive, comprehensive and well-coordinated plan of action is needed. The GOR is fully cognizant of the many obstacles facing the national family planning program and has developed a sound strategy for strengthening and expanding family planning service delivery and contraceptive use over the next five years. This strategy is detailed in a draft document entitled "Politique Demographique et Politiques de Population" to be included in the GOR's IVth Five-Year Development Plan which is expected to be finalized by the end of 1988.

The discussion below addresses population and family planning policy and program priorities in the public sector over the next six years. Key activities are outlined in the following areas: policy formulation and implementation; service delivery; information, education and communication (IEC); training; and research and evaluation. Section D of this Technical Analysis examines the role of the private sector in Rwanda in the provision of family planning information and services.

1. Policy Formulation and Implementation

The objective of the GOR's IVth Development Plan is to achieve food self-reliance, by increasing agricultural production, and slowing the rate of population growth. Rwanda's population policy is directed primarily at reducing fertility by increasing contraceptive prevalence. Indirect measures of reducing fertility -- decreasing infant and child mortality and improving the education and employment status of women--are also mentioned in the FFYP.

The principal population objective for the next five-year period is to decrease the total fertility rate from 8.6 to 8.0 children per woman, by increasing prevalence of modern methods of contraception from a current level of approximately 3 percent to 15 percent among fertile women in union aged 15 to 49. This is an ambitious objective requiring strong policy measures, a dramatic increase in the availability of family planning services through public and private channels, and rapid expansion in the number of contraceptive users, particularly those using more effective methods (e.g. oral contraceptives, injectables, IUDs. and voluntary surgical contraception)

The GOR projects that the number of fertile women in union using a modern method of contraception will increase from 25,250 at the beginning of the Plan to 140,250 in 1992. The estimate of births averted (46,784 by 1993) corresponds, according to ONAPO calculations, to a decrease in the crude birth rate from 54 per 1,000 population in 1987 to 49 per 1,000 in 1993. The Plan calls for a reduction in the annual rate of population growth from 3.7 percent to 3.2 percent in 1992.

Partly to encourage and support Rwanda's FFYP targets and partly because they are very likely feasible given the political/social environment and proposed initiatives, the project objective is to accomplish the same contraceptive prevalence targets as the FFYP. Table 1 roughly presents how population numbers figure into contraceptive prevalence and numbers of acceptors for each year of the project.

	Table 1 (000s)						
	1988	1989	1990	1991	1992	1993	1994
Population, estimated Absolute nos. [Annual growth rate: 3.7%] X	6,800	7,052	7,312	7,583	7,864	8,155	8,456
% Women of Reproduc- tive Age (15-49 yrs) [estimated 22%] X	1,496	1,551	1,609	1,668	1,730	1,794	1,860
% Women of Reproduc- tive Age in Union [estimated 63%] X	942	977	1,014	1,050	1,090	1,130	1,172
Contraceptive Use (contraceptive Preva- lence) for modern methods of FP =	3%	3.9%	5.1%	6.7%	8.8%	11.5%	15%
Number of Acceptors	26,621	38,103	51,714	70,350	95,920	129,950	175,800

An alternative way of estimating contraceptive prevalence needed to reach a given level of total fertility is by using the TARGET model (developed by Bongaarts and Stover, 1986). ONAPO has agreed to use this model in calculating annual contraceptive prevalence targets over the next six-year period.

In the coming year, the GOR plans to undertake an extensive review of legislative, regulatory and fiscal policies which have an impact on fertility. A new Family Code is expected to be enacted in 1988 aimed at improving women's status and opportunities. In addition, new legislation on family planning will be drafted during the IVth Plan providing guidelines on the delivery of family planning services. These guidelines are designed to facilitate widespread availability of contraceptive methods, to all individuals and couples desiring them for birth spacing as well as limitation, using a variety of service channels in both the public and private sectors. Other measures include promotion of breastfeeding and longer birth intervals as well as raising the legal age of marriage for women from 15 to 18, as is the case for men.

To ensure effective implementation of these new measures, ONAPO in its role of defining and guiding population policy and program implementation, must increase public support for family planning at all levels and coordinate carefully with other Government agencies and private institutions, including the Catholic Church. It should be noted here that while the Catholic Church does not support the use of modern or "artificial" methods of contraception, it does support the spacing of births and limiting of family sizes through natural family planning.

2. Service Delivery

The most important component of the Government's family planning program strategy over the next six years is improving the quality, availability and accessibility of family planning services in the public and private sectors. Out of the 392 medical facilities in the country, only 233 are equipped to provide family planning, and a much smaller number are actually offering quality services on a regular basis. Family planning acceptance rates in most health facilities have been low due to lack of qualified and motivated personnel, poorly organized services, lack of method-specific information, restricted hours for family planning services, limited choice of contraceptive methods and high drop-out rates.

An important step towards expanding the availability and use of family planning in the public sector was taken by MINISAPASO in March 1988 with the release of new family planning guidelines. These guidelines call for:

- the full integration of family planning in all health facilities in the country by 1995;
- offering family planning to all who desire it for spacing or for limiting births;
- informing the population on all available modern and natural methods of family planning to ensure free and informed choice;
- approving voluntary surgical contraception to individuals with at least three living children, an important medical need and a written spousal consent; and
- training of health personnel in the delivery of family planning information and clinical services.

The responsibilities of MINISAPASO Regional Medical Directors and ONAPO Regional Delegates have also been more clearly defined to ensure full collaboration and coordination in the development, implementation and evaluation of family planning activities. ONAPO retains specific responsibility at the regional level for: the organization and supervision of population and family planning activities; coordinating with other development programs in family planning; IEC efforts; and supply of family planning commodities and equipment. The ONAPO Delegate remains under the supervision of the Regional Medical Director.

The section on Population for the FFYP details the strategy for improving the availability and quality of family planning services through medical and non-medical channels in the public and private sectors. The strategy calls for increasing the number of health centers providing family planning and integrating family planning fully with maternal-child care, improving IEC and providing better follow-up to counter rumors about contraceptive side effects and to improve continuation rates.

The most innovative feature of the strategy is the development of a nationwide community-based distribution program working with grass-roots organizations. The GOR is planning to train over the next couple of years 18,000 community workers (two from each cellule) in family planning motivation, IEC, supply of barrier contraceptives (condoms and spermicides) and resupply of pills. At a later date, injectables are to be made available by specially trained individuals. These volunteer workers will provide an important link between the community and the local health centers for contraceptive referral and follow-up.

Other service delivery mechanisms will be tested, including introducing family planning into cooperative development groups, community pharmacies, women's and youth organizations. The other major initiative during the next five years will be stimulating family planning availability and use through the private and commercial sectors, as discussed in Section D below.

The target population for family planning information and services will be expanded to include:

- young and unmarried men and women;
- men and women who have completed their desired family size;
- high parity women and men with more than 4 children;
- women who have had short birth intervals (less than two years);
- post-partum women; and
- women with a previous unwanted pregnancy.

Available Contraceptive Methods.

Theoretical versus actual effectiveness of each family planning method varies greatly from one individual to another (depending largely on fecundity, knowledge of how to use, and perhaps most importantly, the couple's combined motivation to use the method). Therefore, careful attention must be made to

ensure that each family planning acceptor is matched with a method that he or she (and eventually the couple together) is most comfortable with. For this reason, a mix of contraceptive methods will be made available, including natural family planning.

Injectable hormonal contraceptives are effective and widely accepted by the Rwandan population but are not supplied by A.I.D. due to FDA regulations. Voluntary surgical sterilization allows men and women who want no more children to do so with 100 percent effectiveness. Though investment costs of training and equipment are high, the method requires no further investment on the part of the acceptor. Oral contraceptives and intrauterine devices (IUDs) are also highly effective, relatively inexpensive and will be provided corresponding to demand. It should be noted, however, that these can carry contraindications and require skilled technicians to prescribe, administer and follow-up on their use. Condoms and spermicides (barrier methods) are less effective, both theoretically and practically, and are relatively expensive methods to use, but seldom have side-effects, require little training in their use, and can be acquired without medical supervision. Further, barrier methods have been found to reduce the transmission of the AIDS/HIV virus. Natural family planning (NFP) is the method of monitoring a woman's bodily functions to estimate when she is in highest risk of fertilization. NFP is useful for those individuals who are unable to use modern or artificial methods which may have contraindications for their health or are contrary to their religious, social or health beliefs. Unfortunately, effective use of NFP requires expensive training and follow-up in its use and is dependent on the regularity of the woman's bodily cycles and high motivation on the part of the couple.

Contraceptive methods currently available include injectables, pills, IUDs, barrier methods and condoms. Hormonal methods are the most widely used, with less than seven percent currently using an IUD. Plans call for training additional personnel in IUD insertions, and for greatly expanding the distribution of condoms in view of the serious and rapidly escalating problem of AIDS. An estimated 18 percent of the urban population was serum positive in the 1986 nationwide survey. With additional trained personnel, the availability of voluntary surgical contraception (tubal ligations and vasectomies) will increase over the next several years as will NORPLANT (a hormonal implant) which is currently being tested on a pilot basis. A special effort must also be made to expand the availability and use of natural family planning to respond to the special needs of the large Catholic population.

The following tables present how contraceptive method requirements and their respective costs have been established for the next six years. Each year of the project, contraceptive procurement tables will be filled in reflecting actual method utilization and projecting subsequent yearly requirements.

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3. IEC and Training

Now that government officials and the general public are aware of the serious population pressures facing Rwanda, ONAPO's task over the next several years is to broaden its awareness-raising efforts and carefully target messages to different segments of the population. The GOR intends over the period of the IVth Plan to integrate population and family planning information into socio-economic, political and cultural programs. Messages should be tailored to the concerns of individual families. Topics such as responsible parenthood, the cost of children and the importance of birthspacing for maternal and child health should be stressed as well as specific information provided on the variety of contraceptive methods available-- where to obtain them and how to use them.

Existing IEC materials and communication approaches will need to be evaluated and new ones developed, tested and implemented. The most effective media for reaching the rural target population should be emphasized, particularly face-to-face communication, simple brochures and illustrated materials, radio, theater, and songs, etc. Staff at the prefectural and local levels will need additional training and supervision to become effective communicators and agents of change. Information and service providers must be equipped with simple guides describing each method and giving responses to rumors and the most frequently-asked questions.

A powerful vehicle for informing and motivating the general public on family planning will be the nationwide network of volunteer community workers (Abakangurambaga) who will be trained to conduct household visits over the next several years. Other important vehicles for family planning education are women's groups and youth organizations. As family planning activities are introduced more widely in the non-profit and for-profit private sector, demand for IEC materials will escalate, and ONAPO must be ready to respond effectively and on a timely basis.

Implementation of the GOR's population and family planning strategy will require an ambitious training and retraining program for all levels of medical, paramedical personnel and outreach workers in the country. Other staff requiring basic and specialized training are program administrators, accountants, IEC personnel, research and evaluation specialists, and teachers. In each of these categories, there are needs for short, medium and long-term training.

Training of paramedical and non-medical personnel will be decentralized with each prefecture developing and implementing their population and family planning training plan. A core multidisciplinary group of trainers will train staff at the prefectural level who will in turn train personnel at the commune and cellule levels. The GOR's goal is to have by the end of the IVth Plan two staff in each health facility in the country with clinical training in family planning service delivery. More frequent and improved supervision will also be critical during the next several years.

NUMBER OF ACCEPTORS BY CONTRACEPTIVE METHOD

<u>METHOD</u>	<u>%USE</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>TOTAL</u>
<u>PILLS</u>									
Lo-Femeral - 30	12.5%	3,328	4,763	6,464	8,794	11,990	16,244	21,975	73,558
Ovrette	7.5%	1,996	2,858	3,878	5,276	7,194	9,746	13,185	44,133
Other Donor Provided	5.0%	1,331	1,905	2,586	3,517	4,796	6,497	8,790	29,422
<u>IUD's</u>	5.0%	1,331	1,905	2,586	3,517	4,796	6,497	8,790	29,422
<u>Spermicides</u>	.5%	133	191	258	352	480	650	879	2,943
<u>Condoms *</u>	1.5%	399	1,143	2,327	4,221	7,194	11,695	17,580	44,559
	(10.0%)	(1.5%)	(3.0%)	(4.5%)	(6.0%)	(7.5%)	(9.0%)	(10.0%)	
<u>Injectables</u>	66.0%	17,570	25,148	34,131	46,431	63,307	85,767	116,028	388,382
(Not provided by A.I.D.)									
<u>TOTAL</u>	100.0%	26,621	38,103	51,714	70,350	95,920	129,950	175,800	

* Condom use will be increased to 10% use over the life of the project to reflect an anticipated increase in acceptance due in part to its use for AIDs prevention. This increase to 10% will not, however, reduce the percent use for other methods as this specific reduction cannot be projected at this time.

PROJECTED NUMBERS OF UNITS NEEDED OF EACH CONTRACEPTIVE METHOD

METHOD	# OF ACCEPTOR-YEARS (1989-1994)	UNITS REQUIRED PER ACCEPTOR-YEAR	TOTAL UNITS REQUIRED
<u>PILLS</u>			
Lo-Femeral-30	70,230	13.0	912,990
Ovrette	42,137		547,781
Other	28,091		365,183
<u>IUDs</u>	28,091	0.5	140,455
<u>Spermicides</u>			
Conceptrol	2,810	20.0	56,200
<u>Condoms</u>	44,160	250.0	11,040,000
<u>Injectables</u>	361,761	3.0	1,085,283

PROJECT FINANCED CONTRACEPTIVE REQUIREMENTS

METHOD	TOTAL UNIT REQUIRE- MENTS FOR 1989-1994	(-) PROJECTED END OF YEAR STOCK OF CONTRACEPTIVES 1988	(-) OTHER SUPPLY	(=) ADDITIONAL CONTRACEP- TIVES / REQUIRED
<u>PILLS</u>				
Lo-Femeral-30	912,900	71,336		841,564
Ovrette	547,781	74,872		472,909
<u>IUDs</u>	140,455	269,334		NONE
<u>Spermicides</u>	56,200	1,432,250		NONE
<u>Condoms</u>	11,040,000	1,432,250	10,607,750*	3,182,325

* 70% of condom requirements will be supplied through the National Program Against AIDS.

**Total Projected Cost of
Rwanda Contraceptive Needs
(1989 - 1994)**

A Contraceptive		Lo-femenal-30	Ovrette	Contraceptol	Condoms	Total
B Units		841,564	472,909	0	3,182,325	
C Cost per Unit		\$0.1300	\$0.1300	\$0.0950	\$0.0435	
D Total Unit Cost	(B X C)	\$109,403	\$61,478	\$0	\$138,431	
E Units in a Case		1,200	1,200	4,800	6,000	
F Cases	(B / E)	701	394	0	530.39	
G Air Transport/case		\$64	\$64	\$64	\$120	
H Sea Transport/case		\$12	\$12	\$12	\$25	
I Tot Air Transp	(F X G)	\$44,883	\$25,222	\$0	\$63,647	
J Tot Sea Transp	(F X H)	\$8,416	\$4,729	\$0	\$13,260	
K Total Cost Air	(D + I)	\$154,287	\$86,700	\$0	\$202,078	\$443,064
L Total Cost Sea	(D + J)	\$117,819	\$66,207	\$0	\$151,691	\$335,717

Teachers will be continued to be trained and population/family planning curricula developed and integrated in all levels of the education system -- primary, secondary, vocational schools, university, paramedical and medical faculties. Training in population/family planning and materials will also be provided for staff of communal development and training centers (CCDFP), party members, and rural development and agricultural outreach workers.

4. Research and Evaluation

The 1978 Population and Housing Census and the 1983 National Fertility Survey have provided essential baseline information to guide the development and evolution of Rwanda's population policy and family planning program activities. There is an important need, however, for updated information on the size and structure of the population, mortality, fertility, migration and urbanization trends, etc. This information will become available with the results of the Second General Population and Housing Census, tentatively scheduled to be carried out in 1989/1990. However, with only limited progress to date on preparations for the census, it is unlikely that it will take place for at least two years.

As the family planning program enters the critical phase of service delivery expansion and improvement, ONAPO research priorities are directed at gaining insights into such determinants of fertility as:

- changing attitudes towards contraception and family size;
- cost of children;
- current and intended contraceptive practice;
- contraceptive preference and reasons for discontinuation; and
- contraceptive side effects and rumors about different methods.

Additional studies on the improvement and expansion of service delivery:

- integration of FP/MCH services;
- the integration of family planning, including the health information system, into the existing health care system;
- availability and potential of non-medical channels for the delivery of family planning information and services; and
- cost-effective approaches to service delivery.

An operations research (OR) study is currently underway in the prefecture of Ruhengeri which is testing for the first time the feasibility, acceptability and effectiveness of community-based distribution (CBD). The results of this study will guide the design of an eventual nationwide CBD program. Other OR studies should be undertaken in the next several years to examine such issues as appropriate contraceptive mix, training and supervision of health and non-medical personnel, effective IEC strategies, community participation, fees and financing, logistics and management. Priority should be assigned to testing, in an operations research study, the acceptability and effectiveness of charging a small fee for family planning services. If the experiment proves successful on a pilot basis, it should then be implemented nationwide.

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The ONAPO research agenda also includes application of the Bongaarts target model, development of policy implementation plans, updating of population-development models (RAPID and TTU) and integrating demographic variables in the Vth Five-Year Development Plan.

As a follow-on to the 1983 National Fertility Survey, a Demographic and Health Survey is planned for 1991 or 1992. Such a survey will be critical to provide the GOR with essential data on the impact of its family planning efforts. Data from a nationally representative sample of reproductive-age women will be provided on fertility history and preferences; knowledge, ever use, current and anticipated use of contraceptive methods; awareness of and use of contraceptive supply sources; as well as information on maternal and child health. Additional questions can be added to the core questionnaire to obtain information on such topics as female employment and status, health, socio-economic conditions, family structure and value of children, etc.

Service statistics play a critical role in monitoring family planning program performance and in providing regular feedback to program managers and service providers on contraceptive acceptors. To allow for the efficient collection and analysis of service data, it is critical to have a simple, unified family planning/maternal-child health record keeping system. ONAPO is currently testing a new integrated FP/MCH form which will then be revised as necessary and introduced into all health facilities.

D. Family Planning and the Private Sector

USAID's Country Development Strategy Statement (CDSS) promotes the private sector as an important complement to current and planned efforts by the public sector to increase family planning service delivery in Rwanda. Historically, the private sector has played a very minimal role in family planning service delivery; however, recent policy statements on the part of MINISAPASO and ONAPO support increased participation of the private sector in family planning activities and have eliminated existing legal constraints. Under the new FP II project, assistance to stimulate family planning activities in the private sector will be addressed through two major initiatives: technical assistance and development of subprojects in the non-profit and for-profit private sectors; and development of a contraceptive social marketing program. These two project components are outlined below.

1. Technical and Financial Assistance to the Private Sector

The following is a description of the four types of private sector organizations (NGOs, parastatal enterprises, commercial entities and private clinics) through which family planning services can be initiated:

a) Non-Governmental Organizations

There are approximately 160 NGOs in Rwanda, 130 of which spend 28% of their budgets on health and related social services. Church-related NGOs are responsible for providing health care to 60% of Rwanda's population. A majority of these clinics are run by the Catholic Church, which opposes the use of modern contraception. Nevertheless, the Catholic Church has recognized the high population growth rate in Rwanda as a problem and began in 1984 to take steps to address this issue through the introduction of natural family planning (NFP) as it does not forbid the practise of child spacing or limiting family size. The Catholic Church plans to provide information on NFP

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in its 84 secondary schools throughout the country. The Church is also promoting natural family planning through pilot centers at the national level which, in turn, serve local establishments known as Service Local d'Action Familiale (SLAF) centers. There are presently 3 pilot centers and 34 SLAF centers. A total of 120 SLAF centers are planned for completion by 1990. The GOR must continue to encourage the Catholic Church to stress the importance of birthspacing for both the health of women and children as well as for the welfare of the nation.

Among the NGOs, there are also numerous Protestant church institutions which represent excellent potential for expanding the availability and use of family planning. They have generally well-established health systems in place and many have begun to integrate family planning services in their health care systems. For example, ADRA, formerly the Seventh Day Adventist World Service organization, has a health network comprising 63 health workers and 1,600 voluntary health workers, the latter being members of the local village administrative unit "Comite de cellule". ADRA is also affiliated with primary and secondary schools and a university located near Gisenyi. There are an estimated 500,000 members attending church services every week. FP services could be made available through ADRA's health centers, its educational affiliates, or its 660 churches.

The vehicle for mobilizing and including the various Protestant church institutions is the Council of Protestant Churches (CPR). Among major churches included under the CPR are the Episcopal, Anglican, Baptist, Presbyterian and Seventh Day Adventists.

BUFMAR (Bureau des Formations Medicales Agreees) is an umbrella organization which groups the Catholic and various Protestant churches and represents about 50% of the country's medical units. In collaboration with ONAPO, BUFMAR is beginning to offer training in family planning service delivery and informational materials. Among its activities to date, BUFMAR has provided assistance to the German Technical Cooperation (GTZ) in the development of family planning materials for their pilot MCH/FP project in the Gikongoro and Butare prefectures.

Still other NGOs, relatively new to Rwanda whose purpose may be family health or economic development, are ideal vehicles for the proposed private sector component as their target audience is women. For example, the newly established institution Duterimbere (a chapter of the U.S.- based Women's World Banking) is working through 10 regional committees to provide technical assistance to women throughout Rwanda in an effort to involve them in the economic mainstream. Duterimbere also guarantees loans that are made through local banks. It appears to be an excellent vehicle for linking women's groups with other private FP activities. One of Duterimbere's founders is the Director of ONAPO. In addition, the Rwandan Association for Family Welfare (ARBEF) offers the potential for extending the availability of family planning through its network of volunteer doctors and nurses.

b) Parastatal Enterprises

Parastatal organizations offer another opportunity to expand family planning services. Of the six State-run enterprises examined in the 1987 Albert report, three (Electrogaz, the Caisse Sociale du Rwanda, and Sonarwa) currently offer family planning in their health centers. The largest parastatal, the

Office du The, with a workforce of 25,000, has also shown interest in developing a family planning program. The 1987 comprehensive review of the role of the private sector in family planning indicated growing interest on the part of parastatals to initiate family planning services. With the new guidelines issued by MINISAPASO in March 1988 sanctioning provision of family planning services by all private sector organizations, the door is now open for greatly expanded activity in this area.

c) Commercial Entities

According to the Albert report, two of the eight enterprises contacted in 1987 reported that they were already providing family planning services. These companies are the Banque Commerciale du Rwanda (BCR) which offers services in its dispensary, and another, the Banque Nationale du Rwanda (BNR) which refers its employees to the hospital of Kigali for family planning information and services. A number of other private companies have expressed interest in providing family planning services for their employees. In October 1987, three Rwandans (including representatives from the Banque de Kigali and SULFO) attended a regional conference in Dakar on family planning in the private sector (hosted by the Enterprise program) and are considering the introduction of family planning services.

d) Private Clinics

Private health care which has only recently been legislated offers another vehicle for attracting new family planning acceptors. There are currently three private clinics in Kigali which offer a range of services including pre-natal care, birth delivery and vaccinations. All three clinics have expressed an interest in providing family planning services. These clinics could also serve the family planning needs of commercial sector employees by providing services on a contractual basis.

E. Contraceptive Social Marketing

Contraceptive Social Marketing (CSM) is a method of distributing and promoting safe and effective contraceptives through existing channels of distribution and communications at subsidized prices. This approach was developed more than 20 years ago in order to allow the majority poor greater access to modern contraceptives at affordable prices. The social marketing of contraceptives and other family health products is successfully operating on every continent.

1. Advantages of CSM for Rwanda

There is strong interest in establishing a CSM project in Rwanda. ONAPO, various entities in the private and commercial sectors, as well as OAR/Rwanda have expressed support for such a program. The potential for a CSM program is exemplified by findings from the 1983 Rwanda Fertility Survey:

.Low prevalence (3.0%) of modern methods;

.High awareness (70%) of contraceptive methods;

.Large proportions of women (20%) and men (34%) who do not want any more children; and

.Strong intentions to use contraceptives in the future--39% for women and 50% for men.

The estimated target market for a CSM program would be 12,800 couples during the first year. This first year target can be achieved by simply utilizing the existing distribution and communication systems already in place. Expansion of services would contribute to the GOR target of 15% contraceptive prevalence by 1994.

The Rwandan commercial sector already sells contraceptives, namely condoms and oral contraceptives, through pharmacies. Only small quantities are sold presently, largely due to the prohibitive prices, which are far beyond the means of the CSM target market. Both ONAPO's Director and Deputy Director have expressed strong interest in a CSM program. They have stated that the commercial sale of contraceptives is an important step in lightening the public sectors's financial burden of providing free contraceptives. They also feel that CSM's use of a variety of outlets would attract new users. ONAPO's planned training of community-based distributors/promoters would complement a CSM program by providing local resource people to whom the population could turn for information on family planning.

The current unmet demand for modern contraceptives can be filled by the commercial sector through the establishment of a social marketing program. Although there are significant costs associated with the start up of a CSM project (see CSM Budget estimate), many of these costs are offset by the subsidized purchase price as well as the increasing sales volume. Therefore, in the medium and long run, CSM is an extremely cost-effective means of increasing knowledge and use of modern contraceptives.

2. Components of the Rwandan CSM Program

a) Market Research

In order to establish a viable CSM project, it is essential to understand the potential market. Market Research is used by CSM programs to develop a strategy that will ensure acceptance and correct use of the contraceptives to be offered. This kind of research will help determine an acceptable retail price for the products. Pricing is a particularly sensitive issue. If the price is too low, potential consumers will perceive the products have less value. If the price is too high, the target market will not be able to afford the products. Packaging and promotion must be designed that will be acceptable to the consumer. The determination of appropriate sales outlets can also be assessed by market research.

Marketing of contraceptives at subsidized prices is a highly sensitive proposition. Careful and extensive market research is an essential first step in the establishment of a viable CSM program.

b) Distribution

Widespread distribution of contraceptives is the key to CSM success. Rwanda has both public and commercial distribution systems. The public pharmaceutical distribution is operated by the National Pharmaceutical Office of Rwanda (OPHAR). OPHAR supplies MINISAPASO clinics and hospitals with pharmaceuticals, but does not provide contraceptives. ONAPO is the public supplier of contraceptives. As mentioned in the previous section, the Bureau des Formations Medicales Agreees du Rwanda (BUFMAR) is an association of all Christian churches and groups involved with health care. It imports and manufactures drugs, and provides them at reasonable costs to church affiliated clinics and hospitals.

There are commercial pharmacies in cities and larger towns. A few pharmacies based in Kigali have branches, notably Sodephar with 8 branches, Kipharma with 9 branches and Pharmacie du Peuple with 12 branches. The pharmacies import their products directly from international manufacturers, as there are no large commercial distributors in Rwanda. These larger pharmacies distribute to some of the smaller pharmacies in addition to their own branches. Additionally, the SOMARC feasibility team looked at other potential distribution networks, such as Sulfo-Rwanda, a soap manufacturer/distributor; Bralirwa, a beer and soft-drink manufacturer/distributor; and Trafipro, a cooperative which imports and distributes basic household necessities.

While Rwanda has good roads to all of the major towns, most distribution networks do not reach into the hillsides, where a majority of the population resides. People living on the hillsides (collines) must periodically travel to towns for many of their purchases.

In the initial stages of implementation, the CSM team will carefully examine the current and potential capability of the distribution organizations described above, as well as others, in order to determine the most effective method of expanding the availability of contraceptives. In order to effectively extend distribution, a combination of distribution networks may be desirable. Following careful evaluation of both the potential distributor's willingness and capability to effectively distribute contraceptives, contracts will be prepared between the CSM project and the selected distribution organizations.

c) Advertising

In order for the public to become aware of the availability and value of modern contraceptives, it is necessary to develop informational and promotional messages for the existing channels of communication. Although, this is called advertising, the sensitive nature of family planning, by necessity, emphasizes the educational and informational aspects of public dissemination, contrasted with the promotion of non-sensitive products such as beer or soap. There are no established advertising agencies in Rwanda. There is a small business consulting firm, Agence Andrew's, which has coordinated some advertising and publicity. Agence Andrew's has access to artists and has created and placed ads for Rwandan companies.

ONAPO has a well-established IEC division with a staff of 22, which are experienced in the conceptualization and production of print materials and radio programs concerning family planning. They should be considered as a potential source of advertising material. The existing media is limited to three state run newspapers; a few small private papers; two sports journals; one national radio station; and sparsely scattered cinema. The SOMARC team has assessed the reach of each of these media and in the course of implementation will determine what combination of these communication channels is most effective in reaching the target audience.

Market research, described earlier, will not only assist in the development of appropriate messages, but can also identify and validate the most effective channels of communication.

d) Packaging and Printing

This element of social marketing is often downplayed, but can have a significant impact on consumer acceptance of CSM products. Market research will be utilized to ensure packaging that is acceptable to the Rwandan public. There is only one Rwandan firm with capacity to produce product packaging, SIEVA. It is a paper and business products firm that has only recently acquired the capability to do packaging. The SOMARC team assessed their capability as "technically well-executed and satisfactory for the needs of a CSM program." SOMARC identified several printers in Kigali and visited one called Printer Set. They found modern equipment, well-trained personnel, and examples of fairly sophisticated work. Such a printer would be quite capable of producing posters, brochures, or other printed materials.

Each of the components described above is essential to the establishment and operation of a successful CSM program. Each of these elements is sufficiently established in Rwanda to permit the development of a CSM program, without incurring the enormous costs of establishing a new organization to meet each of these described tasks. One potential exception is distribution. There is sufficient capability to initiate a CSM program and meet the first and second year coverage targets, but true nationwide distribution will require capabilities that do not presently exist in Rwanda. If initial targets are reached with the existing distribution network, then the "comité consultatif", consisting of representatives of ONAPO-USAID-Private Sector entities, should consider expansion of the existing distribution system and/or the creation of a nationwide network for the distribution of contraceptives and other family health care products, such as Oral Rehydration Salts (ORS).

3. How the CSM Program would work

The CSM program will be executed by SOMARC II, with funds provided by a buy-in to the bilateral project as well as with funds from the central project. The "comité consultatif" including private sector representation will advise SOMARC on project objectives and implementation and will provide policy guidance and review of annual workplans.

The CSM Project Advisor will begin as soon as possible after the MCH/FP II Project is signed. The initial task of the technical advisor is to work with the "comite consultatif" to set up some form of CSM Advisory Council. The Consultant in consultation with the Advisory Council will prepare a scope of work for initial market research and work with one or more of the research organizations described earlier to produce a marketing plan for CSM in Rwanda. As noted previously, these research groups will probably require some short-term technical assistance that will be provided by SOMARC.

While market research is underway, the project advisor will continue to explore the existing and potential distribution capability in the country. Based on findings of the SOMARC team, it is highly likely that more than one distribution firm will have to be utilized, in order to reach the modest first year target level of distribution. One of the distribution firms should agree to providing the following management functions:

- a) Operational responsibility for warehousing, packaging, distribution, sales, and promotion of CSM products;
- b) General administration (including financial administration) of the project. In this regard, a separate bank account would be opened by the distributor under the name of the CSM program, for the purpose of depositing revenues generated by the sale of CSM products. Such funds would be used exclusively to further the aims and development of the project;
- c) Organizing orientation and training of sales staff and retail sales personnel.

If none of the selected distributors would agree to these responsibilities, then these activities would be handled by a SOMARC Consultant, until such time that a local manager can be identified and trained.

In subsequent years, SOMARC management and the Comité Consultatif may have to consider expanded and possibly new distribution systems, if nationwide coverage is to be attained. This expanded distribution system will be costly. It is not accounted for in the present estimated budget. If the initial targets are reached during the first two years of sales, then amending the SOMARC contract is recommended to provide additional funds for a nationwide distribution system

Under the present circumstances, it is advisable to engage a commercial advertising agency to carry out CSM advertising. Considerable technical assistance from SOMARC will be required. Advertising messages; project logos; campaign themes; package design; radio spots; newspaper adverts; posters etc. will be developed by this consortium, with concurrence by the PA and the Advisory Council. The approved packaging and poster designs would be given to the selected printer for production. The printed packages would then be turned over to the distribution companies to insert the A.I.D. donated contraceptives and distribute them to the retailers, along with an ample supply of promotional and educational materials. The retailers will have already received training on the proper use and value of the CSM products, from ONAPO.

Upon signing of the MCH/FP II Project Agreement (the ProAg), representatives of the SOMARC project should return to Rwanda to do the following:

- 1) Request USAID to convene a meeting of representatives of ONAPO; MINISANTE; the medical community; and the commercial sector to coincide with the SOMARC team visit.
- 2) SOMARC will select one of the distributors to be the implementing agency, and initiate technical assistance to assist them in that process.
- 3) SOMARC will contract with one or more of the research organizations described in an earlier segment of the CSM description.

ANNEX B

ECONOMIC ANALYSIS OF THE MCH/FP II PROJECT

The seriousness of the current 3.7% population growth rate in Rwanda, and an even higher future rate if the total fertility rate is not reduced soon, was discussed at the beginning of the PP. The purpose of this section is to elaborate upon that discussion, place it in an economic framework, and provide an analysis of the efficiency of the proposed program to reduce the fertility rate and hence the population growth rate.

The Effect of Rapid Population Growth on Economic Development

Rwanda is a country of contrasts and contradictions: population density on arable land, estimated at 390/sq km, is the highest in Africa; per capita GNP at \$270 is among the lowest in the world; while at the same time, since independence in 1962, GDP has grown annually by almost 6%, nearly double the average for sub-Saharan Africa. Food production increases during the period have exceeded the rate of population growth, again in stark contrast to the rest of the continent.

As remarkable as these achievements have been, they have masked the problems that were and still are being created by a rapidly growing population confined to a fixed land area, the absolute low level of pre capita income, the dependence upon one agricultural export crop for the majority of the government's foreign exchange earnings as well as its revenues (through export taxes), low levels of literacy, poor vocational and management skills, and an inadequately developed industrial sector to absorb the increasingly redundant rural labor.

One page 3 of the "Staff Appraisal Report, Rwanda, Family Health Project", March 6, 1986, the World Bank summarizes the situation quite well:

"Rwanda's agricultural performance over the past decade has been excellent, with production keeping pace with population growth. But the increase in food production cannot be sustained, because the intensification of cultivation has led to deforestation, erosion and a decrease in soil productivity. As land reserves vanish, it will be a difficult challenge for Rwanda to develop and apply, within 30 years' time, agricultural technology and methods adequate to support the projected 800 people per sq. km of agricultural land. The effect of population growth on consumption needs will be most strongly felt in the area of food availability...Population growth will also increase the demand for jobs, housing, water, electricity, schooling, and health care. This increasing pressure on the country's social and economic system makes the need for large-scale efforts to reduce fertility more urgent".

The March 1987, CDSS prepared by USAID/Rwanda paints a stark landscape if the population growth rate is not reduced:

"If the population of 6.8 million continues to grow at the current annual rate of 3.7 percent, Rwandan will have more than 15 million people by the year 2010...Density on arable land will be over 1100 people per sq. km. Available tillable land per capita will have declined by over 60 percent, to a mere half hectare per family.

"Expansion of the arable land base, the means by which Rwandans have maintained economic growth to date, will no longer be possible. Agriculture will be incapable of providing productive employment for the vast majority of the rural population, currently 95 percent of all Rwandans."

The country is faced with two major challenges: (1) the development of policies and programs that will foster and accelerate the productive capacity of sectors outside the agricultural sector; and taking as much pressure off that process as possible with (2) a population policy and program that will lead to the reduction in the fertility rate.

Population policy is seen to be a key policy tool for many developing countries in Africa. In the World Bank issues and policies paper titled "Rapid Population Growth in Sub-Saharan Africa", several points are made that are particularly germane for Rwanda:

"...Many factors, including policy, influence the speed and pattern of economic growth. Population is only one of these factors and it is very difficult to isolate its impact from that of all other influences at work. It would be difficult to maintain, nevertheless, that the acceleration of population growth in the 1970s has been a positive influence on African economic change. On the contrary, we conclude that rapidly expanding population has greatly complicated the inherently difficult task of securing rapid economic progress in Africa."

The report concludes that the future behavior of fertility will influence the ability of African countries to develop and that a slower growth in population will help support faster economic development. At the same time, the report concludes that population policies which lead to reduced fertility rates are not a panacea.

Rate of Return Experience and Assumptions

Experience of the past decade indicates quite clearly that the continuation of rapid population growth rates for sub-saharan Africa, including Rwanda, will impose unacceptable costs on the economies as a result of stagnant or falling per capita GDP growth and as a result of the escalating costs that governments will have to bear just to provide minimum services such as education and health to name two that normally consume large portions of government budgets.

During this same period, family planning programs have demonstrated that reductions in population growth rates can be obtained at costs much lower than the costs societies will incur if the rapid population growth rates are allowed to continue. There is, thus, an acceptance that the benefits to be derived from the reduction in high population growth rates far outweigh the costs.

The real question then is not how high a Benefit-Cost ratio, or an Internal Rate of Return (IRR) may be, because no reasonable person today would deny that the benefits far exceed the costs, but how cost effective is the family planning program that has been designed to attack the fertility rate problems?

As the Table at the end of this section indicates, for the public sector portion of MCH/FP II Project, increased efficiencies during the life of the project are expected to reduce cost per acceptor by 81 percent between the first and fifth years of the project. During the last two years of the project, the cost is expected to fall to \$24 and finally to \$19 per acceptor. The World Bank estimates that the average recurrent cost for all sub-saharan African family planning programs is \$20 per acceptor. Thus, assuming the project technical design team is correct in its estimates of the relationship between project inputs and outputs, on the basis of international cost effectiveness comparisons, the mission is confident that the project design is both reasonable and economically sound.

However, as a result of the rather high costs per acceptor during the first two years of the project, the mission decided to take the analysis one further step and to submit the project to a benefit-cost or IRR analysis. A partial analysis, similar to that conducted for an A.I.D. family planning project in Swaziland, was performed. Births averted as a result of the project's impact on fertility were used to estimate the benefits in the form of cost savings that would accrue to the public primary and secondary school and health systems as a result of fewer students and patients requiring the services. The analysis produced an internal rate of return (IRR) of 8 percent. This is equivalent to a Benefit-Cost ratio of 1 at a discount rate of 8%.

If the benefits associated with the reduced levels of maternal and child mortality and morbidity, as a result of improved spacing of children, and other public services such as roads, transportation, electricity, water, etc., of dealing with a smaller population clearly would produce an IRR well in excess of 8 percent (data in the form needed to estimate the total change to the economy in the form of a change in per capita income were not available). The results from this partial IRR analysis are further confirmation that the expenditure of funds for the MCH/FP II project will produce a reasonable rate of return for the country at an internationally competitive cost per acceptor.

Average Annual Cost Per Acceptor
Of Family Planning Services

	Project Costs US Dols	Number Acceptors (Person-years)	Average Cost US Dols
1989	2,640,000	25,250	150
1990	2,640,000	50,950	52
1991	2,640,000	78,650	34
1992	2,640,000	108,350	24
1993	2,640,000	140,250	19
Total	13,200,000	403,450	33 Average Cost

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Table 1

Assumptions Affecting Cohort Size								
(1) Year	(2) Births Averted	(3) Survival Rate 0-5 yrs	(4) Average % Of Cohort Attending (Primary)	(5) Adjusted Cohort Entering Primary (2x3x4)	(6) % Of Prio Grads Entering Secondary	(7) Adjusted Cohort Entering Secondary (5x6)	(8) Continuation Rate After 9th Grade	(9) Adjusted Cohort Size Remaining 3 Years (7x8)
1989	6000	0.77	0.55	2541	0.08	203	0.88	179
1990	8419	0.77	0.55	3565	0.08	285	0.88	251
1991	16996	0.77	0.55	7198	0.08	576	0.88	507
1992	26233	0.77	0.55	11110	0.08	869	0.88	782
1993	36153	0.77	0.55	15311	0.08	1225	0.88	1078

Cohort figures in columns 5, 7, and 9 are rounded to nearest student.
Column 6, .08 equals 8%.

Table 2

Grade / Level/Year	NUMBER OF STUDENT SLOTS AVOIDED AT PRIMARY LEVEL AS RESULT OF PROJECT											
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1	2541	3565	7198	11110	15311							
2		2541	3565	7198	11110	15311						
3			2541	3565	7198	11110	15311					
4				2541	3565	7198	11110	15311				
5					2541	3565	7198	11110	15311			
6						2541	3565	7198	11110	15311		
7							2541	3565	7198	11110	15311	
8								2541	3565	7198	11110	15311
Total Slots Avoided/yr	2541	6106	13304	24414	39725	39725	39725	39725	37184	33619	26421	15311

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Table 3

NUMBER OF STUDENT SLOTS AVOIDED AT SECONDARY LEVEL AS RESULT OF PROJECT

Grade / Level/Year	1996-2003	2004	2005	2006	2007	2008	2009	2010	2011
9		203	285	576	889	1225			
10			179	251	507	782	1078		
11				179	251	507	782	1078	
12					179	251	507	782	1078
Total Slots Avoided/Yr	0	203	464	1006	1826	2765	2367	1860	1078

Table 4

GOR Educational Savings Benefits Resulting From The Reduction In Number Of Students (U.S. Dols)

Year	Primary Level		Secondary Level		Total Educa. Benefits (2x3+4x5)
	Change In No.	Avg. Cost/ Student	Change In No.	Avg. Cost/ Student	
1989					0
1990					0
1991					0
1992					0
1993					0
1994					0
1995					0
1996	2541	64			0
1997	6106	64			162624
1998	13304	64			390784
1999	24414	64			851456
2000	39725	64			1562496
2001	39725	64			2542400
2002	39725	64			2542400
2003	39725	64			2542400
2004	37184	64	203	770	2542400
2005	33619	64	464	770	2536086
2006	26421	64	1006	770	2508896
2007	15311	64	1826	770	2465564
2008			2765	770	2385924
2009			2367	770	2129050
2010			1860	770	1822590
2011			1078	770	1432200
					830060

Table 5

Survival Rate Calculations for Health Cohorts

Year	Cohorts				
	1989	1990	1991	1992	1993
1989	1.000				
1990	0.950	1.000			
1991	0.903	0.950	1.000		
1992	0.857	0.903	0.950	1.000	
1993	0.815	0.857	0.903	0.950	1.000
1994	0.774	0.815	0.857	0.903	0.950
1995	0.774	0.774	0.815	0.857	0.903
1996	0.774	0.774	0.774	0.815	0.857
1997	0.774	0.774	0.774	0.774	0.815
1998	0.774	0.774	0.774	0.774	0.774
1999	0.774	0.774	0.774	0.774	0.774
2000	0.774	0.774	0.774	0.774	0.774
2001	0.774	0.774	0.774	0.774	0.774
2002	0.774	0.774	0.774	0.774	0.774
2003	0.774	0.774	0.774	0.774	0.774
2004	0.774	0.774	0.774	0.774	0.774
2005	0.774	0.774	0.774	0.774	0.774
2006	0.774	0.774	0.774	0.774	0.774
2007	0.774	0.774	0.774	0.774	0.774
2008	0.774	0.774	0.774	0.774	0.774
2009	0.774	0.774	0.774	0.774	0.774
2010	0.774	0.774	0.774	0.774	0.774
2011	0.774	0.774	0.774	0.774	0.774

The entire cohort is assumed to require health services in the first year.

There is then assumed to be a mortality rate of 5%/yr until the 5th year, so that in 1994, for example, the number of births averted at the beginning of the 5th year for the 1989 cohort is equal to $(1.05)^4$ multiplied by the size of the cohort in 1989, i.e. 6000×0.774 . See Table 7 which calculates the health benefits.

The cohort size is then assumed to remain constant at the 5th year level through the year 2011 to match the final year that education benefits occur for the 1993 birth cohort.

The annual 5% mortality rate up to the 5th year is approximately equal to a 25% mortality rate during the first four years.

The results will be upward biased by the amount of deaths that occur in a cohort after the first 5 years.

Table 6

Calculating Per Capita Health Benefits

	1984	1985	1986	1987	1988	Avg.
Budget MINI-SAMC/MI's mill	1060	1228	1325	1380	1007	
Total Population millions	5.9	6.1	6.3	6.6	6.8	
Per Capita Health Cost in US \$	180	201	210	209	148	2.26

The average five year figure is used to calculate Health Savings in Table 7.

Table 7

Benefits Resulting From The
Reduction in Number of Health Users

Program Year \ Year	1989	1990	1991	1992	1993	Total Fewer Users	Per Cap Health Costs	Total Health Benefits (US \$)
1989	6000					6000	2.26	13560
1990	5700	8419				14119	2.26	31909
1991	5415	7998	16996			30409	2.26	68724
1992	5144	7598	16146	26235		55121	2.26	124573
1993	4887	7218	15339	24921	36153	88518	2.26	200051
1994	4643	6857	14572	23675	34345	84092	2.26	190048
1995	4643	6514	13843	22492	32628	80120	2.26	181071
1996	4643	6514	13151	21367	30997	76672	2.26	173279
1997	4643	6514	13151	20299	29447	74054	2.26	167362
1998	4643	6514	13151	20299	27975	72582	2.26	164035
1999	4643	6514	13151	20299	27975	72582	2.26	164035
2000	4643	6514	13151	20299	27975	72582	2.26	164035
2001	4643	6514	13151	20299	27975	72582	2.26	164035
2002	4643	6514	13151	20299	27975	72582	2.26	164035
2003	4643	6514	13151	20299	27975	72582	2.26	164035
2004	4643	6514	13151	20299	27975	72582	2.26	164035
2005	4643	6514	13151	20299	27975	72582	2.26	164035
2006	4643	6514	13151	20299	27975	72582	2.26	164035
2007	4643	6514	13151	20299	27975	72582	2.26	164035
2008	4643	6514	13151	20299	27975	72582	2.26	164035
2009	4643	6514	13151	20299	27975	72582	2.26	164035
2010	4643	6514	13151	20299	27975	72582	2.26	164035
2011	4643	6514	13151	20299	27975	72582	2.26	164035

Per Capita Health Costs average for 1984-1988. See Table 6.

Number of users per year per cohort derived from Tables 1 and 5.

Also see notes to Table 5 for further details.

Table 8

Family Planning Rate of Return Analysis

(1) Year	Total Costs (U.S. Dols)						Benefits (U.S. Dols)			
	(2) Total BMAPD Budget	(3) % BMAPD Budget To FPII	(4) BMAPD Budget For FPII (2x3)	(5) AID	(6) All Other Bonors	(7) Total Costs (4+5+6)	(8) Health	(9) Educa	(10) Total Benefits (8+9)	(11) Net Benefits (10-7)
1987	1333333	100	1333333	1500000	500000	3333333				
1990	1333333	100	1333333	1500000	500000	3333333	13560		13560	-3319773
1991	1333333	100	1333333	1500000	500000	3333333	31909		31909	-3301424
1992	1333333	100	1333333	1500000	500000	3333333	68724		68724	-3264609
1993	1333333	100	1333333	1500000	500000	3333333	124573		124573	-3208760
1994	1333333	100	1333333	1500000	500000	3333333	200051		200051	-3133282
1995							190048		190048	-3143285
1996							181071		181071	181071
1997							173279	137214	310493	310493
1998							167362	329724	497086	497086
1999							164035	718416	882451	882451
2000							164035	1318356	1482391	1482391
2001							164035	2145150	2309185	2309185
2002							164035	2145150	2309185	2309185
2003							164035	2145150	2309185	2309185
2004							164035	2145150	2309185	2309185
2005							164035	2164246	2328281	2328281
2006							164035	2172706	2336741	2336741
2007							164035	2201354	2365389	2365389
2008							164035	2232814	2396849	2396849
2009							164035	2129050	2293085	2293085
2010							164035	1822590	1986625	1986625
2011		100	3.231				164035	1432200	1596235	1596235
							164035	830060	994095	994095

MAJOR ASSUMPTIONS UNDERLYING THE INTERNAL RATE OF RETURN ANALYSIS

1. The ONAPO estimates of the number of births that would be averted as a result of the project formed the basis for determining the benefits of the project. It was assumed that the births averted would mean that there would be fewer students, in the case of education, and fewer patients, in the case of health, placing demands on these public services.

Source: Table I, page 19, "3rd Part Politique Demographique et Politiques de Population." Note: The 472 figure in the original table was obviously wrong. Consultation with ONAPO officials led to the use of the 6000 figure in this analysis rather than the erroneous one in the source document.

2. The official exchange rate of 70 RWFs per US dollar was used to convert the ONAPO recurrent cost estimates for the project. The currency is somewhat overvalued. However, no attempt was made to shadow price the foreign exchange rate, since the adjustment would have little impact on the final results.

Explanation of the Assumptions and Calculations of the Eight Tables Used in the Analysis

1. Table 1: Assumptions Affecting Cohort Size

Col 2: is discussed above.

Col 3: Survival Rate, 0-5 years

If as many as 23 percent of children will not reach their fifth birthday, I interpreted that to mean that at their fifth birthday, a cohort born five years earlier would be 77 percent of its original value.

Col 4: Average % of Cohort Attending Primary

Of the children who are eligible as a result of age to be in primary school, i.e., ages 7 through 14 for grades 1 through 8, only 55 percent attend. This is an average figure which I assume takes into account drop outs and repeats. Thus, I have made this one time adjustment beginning at grade one and have assumed that there is no need to adjust for drop outs and repeaters in the remaining years. As a result of this adjustment, the number that enter the first grade (shown in Col 5) are assumed to continue all the way through to eighth grade graduation. The data was not available to more finely tune this aspect.

Col 5: Adjusted Cohort Entering Primary

The calculation is Col. 5 adjusts the original size of the birth cohort in Col. 1 for deaths and for attendance experience as noted above.

Col 6: % of Primary Grads Entering Secondary

The secondary school system admits only 8 percent of primary school graduates. This figure is applied to Col 5 for the reasons discussed under Col 4.

Col 7: Adjusted Cohort Size Remaining 3 Years

Drop out rates for the first year of secondary school are high, at 12% of the entering class, but low thereafter. Since I had no sense of what low meant, I assumed it to be zero. Thus, I have assumed that after the first initial large drop out rate, the size of the cohort does not change for the final three years of secondary school. Since nothing is said about repeaters, since the numbers are absolutely small and occur late in the period of analysis so that their present value will be quite small, I assume this simplification does not significantly affect the results.

2. Table 2: Number of Student Slots Avoided At Primary Level As Result Of Project

The table is derived from Table 1, Col. 5.

The table assumes that the surviving members of the cohort averted in 1989 would begin primary school in 1996, the surviving members of the cohort averted in 1990 would begin 1997, etc., for the remaining cohorts.

3. Table 3: Number of Student Slots Avoided At Secondary Level As Result of Project

The table is derived from Table 1, Cols. 7 and 9.

The table assumes, as explained in Table 1, that all the primary graduates attend the 9th grade, thus Col. 7 of Table 1 pertains to the first year. With the 12% drop out rate at the end of the first year, each cohort is reduced by that amount for the remaining three years, thus Col. 9 of Table 1 pertains to the last three years of each cohort.

4. Table 4: GOR Educational Savings Benefits Resulting From The Reduction In Number of Students

The Table brings together the total student avoided totals from Tables 2 and 3 and multiplies them by the appropriate average cost per student in order to obtain the total savings in any given year between 1989 and the year 2011, the period used for the rate of return analysis.

The \$54 and \$770 figures are based on 1985 estimates of the government budget for primary and secondary schools and total enrollments.

The educational budget for primary and secondary education in 1985 was estimated at 85% of the educational budget of F5,050,000,000, of which 70% went for primary education which had an enrollment of 790,000 students. This gives a figure of F3,804 per student, or at an exchange rate of F70 per dollar, a figure of \$54 per primary student. The average cost to the government in 1985 was F46,600 and that tuition was F7200. These two figures were added together and divided by 70 to express the cost per secondary student at a rounded figure of \$770. Later year numbers were not available.

5. Table 5: Survival Rate Calculations for Health Cohorts

The purpose of the coefficients is to take the 77% survival rate (derived from the 23% mortality rate discussed in Table 1) at the end of four years of life and prorate it over the first four years because, unlike the demands upon the educational system in the educational analysis the health system would be affected by the cohorts at the moment of birth. Thus health benefits will begin to accrue to the project from the very first year, 1989, as a result of the averted patients. Thus, in 1991, 0.903 percent of the original cohort that was averted in 1989 would have still been living and demanding health services had they not been averted. See the extensive footnotes to Table 5 for further details.

6. Table 6: Calculating Per Capita Health Benefits

The appropriate exchange rate for each year was used to convert the RWF figures to US dollars.

7. Table 7: Benefits Resulting From the Reduction In Number Of Health Users

The cohort survival rates from Table 6 are multiplied by the original size of the cohorts in Col. 2 of Table 1 to obtain the number of health users that would have been using the health system in any of the years from 1989 through the year 2011.

8. Table 8: Rate of Return Analysis for the Public Sector Portion of the MCH/FP II Project

The health and educational benefits are taken from Tables 4 and 7. The budget data in columns 2 and 5 are taken from the financial tables.

ANNEX C - SOCIAL SOUNDNESS

**Social Impact Analysis of the Proposed
USAID Assistance to Family Planning in Rwanda
by Lucie Colvin Phillips, Ph.D.**

Kigali, April 1988

Acknowledgements: This report would not have been possible without the kind hospitality and collaboration of many people, particularly the ONAPO and USAID staff who have worked tirelessly to make this a vital program in its initial years, and planned carefully for the next five years. The analysis here is the viewpoint of the author, and should not be construed as the policy of the U.S. Government or any of its agencies. Any errors of interpretation or omission are the responsibility of the author.

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I. Introduction

Rwandan culture is fundamentally pronatalist: children represent wealth, good fortune, and helping hands. Women with many children are envied--to the extent that one of the traditional methods of birth control cited by informants in the 1983 World Fertility Survey was bewitching another woman so that she could not become pregnant. The children "belong" to the man, and his patrilineage, in the complex customary law that governs dowry, land allocation, marriage and divorce. One of the ways a woman earns the love of her husband is by bearing him many children. The man with many children is, in turn, admired by those on his hillside as one who has done well--even if the family has barely enough to eat. The Catholic Church, which is the largest denomination and provides at least thirty-five percent of maternal and child health services in the country, has come out recently in firm opposition to all "artificial" methods of family planning. These motivational factors, combined with a rapidly declining infant mortality rate, have generated among the highest total fertility rates in the world: 8.5 children per woman.¹

The proposed 5/year expansion of the family planning program is nevertheless both socio-culturally feasible and necessary. The demographic pressures on the land cited above are not merely a national statistical problem: a large percentage of rural families recognize that there is no hope of adequate agricultural land in their vicinity for the sons already born. The policy and legal context are favorable, and the population has, in the last seven years, become unusually widely informed about the demographic problem and contraceptive possibilities. Thirty-one percent of women of child-bearing age nationwide say they plan to use contraception in the future, compared to 49 percent who do not plan to (the remaining 20 percent being infertile).² At the time of the survey only 1.5 percent of fertile women were actually using modern contraceptive methods, and five years later the prevalence rate is still less than three percent. The new program has to address the service delivery gap.

The three key issues from a sociological point of view are:

- (1) how to reach the rural population.
- (2) how to get accurate knowledge and experience of specific methods quickly to the population, medical and lay, urban and rural.
- (3) how to bring the currently open and hostile debate with the Catholic Church back to a working compromise along the lines of the original accord.

¹ 1978 Population Census and 1983 Enquete sur la Fecondite.

² ONAPO, Rwanda 1983, Enquete nationale sur la fecondite, version resumee, p. 34.

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1.2. Settlement Patterns and Modes of Production

The rural population comprises about 95% of the total, and lives in dispersed homesteads, not villages, with an average of only 61 ares (1.5 acres) of fields in fragmented plots. The Futures Group team that visited Rwanda in an earlier phase of Project Paper preparation argued that it is easier and more cost effective to focus on the urban population. It is true that dispersed settlement, weak mass media, and mountainous terrain make it harder to reach the rural than the urban population, but with 95% of the population and 70% of current FP users living in rural areas, the FP program must devise effective rural outreach strategies from the beginning if it is to have any significant impact on demographic growth or the land/employment crisis.

Small family farming is the predominant mode of production, with agriculture providing 93% of employment nationwide. The rural population is considered fully employed in agriculture, but the ILO estimated in 1976 that rural males are actually 30% underemployed.

Population density averages 250 p./km.2 nationwide, 351 p./km.2 per arable hectare. The historical evolution of this concentration is shown in Table 1.

Table 1. Population Density 1934-1987*

Year	Pop.	Physical Density	Density on Arable Land
1934	1595400	61	85
1940		73	102
1950		74	104
1960		102	144
1970	3756607	143	200
1980		200	281
1987		250	351

Source: Alain Mouchiroud, "Population, Agriculture et Nutrition," draft IVth 5-year Plan, Population/Developpment.

1.2.1. Population and Food Production

Food crop production has increased more rapidly than the population in the last twenty years, mainly through expansion of the area under cultivation, with negligible increase in productivity per hectare. Now the remaining land is mainly in inaccessible areas, has poor soils, and/or requires capital-intensive improvement to be viable, e.g. swamp drainage or irrigation. The evolution of main agricultural indicators is shown in Table 2.

Table 2. Evolution of Main Agricultural Indicators, 1966-1983***

Variable	1966		1983		Avg. Ann. Growth %
	#	Index	#	Index	
Population (millions)	3.2	100	5.7	180	3.5
Food Prod.	2.3	100	4.7	200	4.0
Area Planted	308	100	615	200	3.9
Productivity (Theor. T/ha.)	7.5	100	7.6	101	=0
Food Prod. per capita kg/yr.	720	100	820	115	0.8
Calories/d. per capita	1987* [1666**100]	100	2161*	109	0.5

*1966-70 avg./1980/84 avg. calculated by GOR for the IV Plan.

**FAO estimates. Depending on the proportions estimated as lost during harvesting, storage and preparation, the FAO calculation of the 1966-70 average actually available for consumption was 1666 per person, or 75.7% of estimated need (FAO est. 2200 cal/p/d.) The GOR Miniplan figures reflect revised assumptions more characteristic of Rwandan food processing practice.

***Source: Mouchiroud, draft IVth 5-Year Plan.

Production of tubercules increased from 205.8 kg/p 1966-70 to 317.4 kg/p 1980-84, or from 27% of total calories to 38%. Bananas declined from 58% to 49% of calories, and vegetables from 8% to 6%, while cereals stayed constant at 7%. This translates into a much needed growth in calories, but the quality of nutrition has diminished, as tubercules produce more calories per hectare than legumes and bananas, but have less protein and other nutrients. Moreover, three quarters of the arable land theoretically available for expansion in 1966 has now been brought under cultivation. Most families have no prospect of providing adequate land to the sons already born, much less future generations.

1.2.2. Socio-economic differentiation

The poorest quartile of families faces a particularly acute situation, in which the economic motivation for FP is already conscious for many. The smallest farms, 26.4% of the total, are less than 1/2 hectare in total cultivable area, and cannot, with existing technologies, produce enough to feed a normal size household of 5.5 members. (See Table 3) The lowest

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quintile of households consumes only three quarters of the necessary daily caloric equivalent.³ Households in that category average only FRW 10234 in cash earnings each year and 55% of that is spent on food and drink.⁴ (The middle three quintiles earn FRW 35000-42000 per year, and the top quintile averages FRW 80,554.

Table 3. Distribution of Farm Sizes in Rwanda*

Area (ha)	Prop. of Area as % Farms	% of Total
0.25	7.4%	1.0%
0.25 - 0.50	19.0%	5.9%
0.50 - 0.75	16.5%	8.4%
0.75 - 1.00	13.8%	10.0%
1.00 - 1.50	15.6%	15.7%
1.50 - 2.00	11.1%	16.1%
2.00	16.4%	42.9%
	100.0%	100.0%

*Source: Draft IVth 5-Year Plan, Population/Development.

1.2.3. Population movements

The rural population has very limited mobility. There was, during the colonial period, a tradition of emigrant labor in which several hundreds of thousands of Rwandans participated. From 1937 to 1956 Gatanazi has estimated that an average of 5,800 permanent and 21000 temporary emigrants left Rwanda every year. They worked as miners in Zaïre. It is estimated that some 3 million people of Rwandan origin live outside the country today, either as a result of these colonial migrations or of the troubles that accompanied the social revolution of 1959. With the coming independence, migrant labor opportunities dried up, and today there is very little movement, either international or internal. Permits are needed to travel out of one's district or to settle in the city, and most of the rural population cannot afford transportation in any case. Urban residents travel regularly to the hills they come from, but sex and family planning are taboo subjects of conversation in most families. Therefore there is little spontaneous informal communication of new attitudes toward family planning from the more open urban population to their rural cousins.

1.2.4. Employment

³ MINIPLAN, draft results, Enquête Nationale sur le budget et la consommation des menages.

⁴ Ibid., vol. 2, pp. 66-67, 78.

Modern wage labor and commercial opportunities are very limited in Rwanda. Only 7.2% of the labor force is salaried, and 28% of those jobs are in agriculture; 93% of total employment is in agriculture. Five percent of the active population works in the secondary sector and three percent in the tertiary.

The draft IVth 5-year Plan concludes that, "There is little prospect of creating sufficient jobs to absorb the growing labor force even if the population program meets its objectives. The cost of creating an industrial job averages 4-5 million Rwandan francs. The possibilities of expanding the cultivated land area are exhausted.... Malnutrition is correspondingly on the increase".⁵

2. Social Organization and FP Delivery

2.1. Family Roles and Work

The family is the basic unit of social life and work organization. Nearly every Rwandan marries at some time, and three quarters of ever-married women were living with a mate at the time of the 1983 WFS. (20% were divorced/separated and 5% widows). Four-fifths of the unions were monogamous and less than one-fifth of women (14% of men) lived in polygamous unions (Polygamy has been against the law since 1957, but not entirely suppressed). Informal and traditional marriages are becoming the most common initial union; 83% of 20-24 year olds living in unions began that way, while among 30-34 year olds, over half had begun with a civil marriage. Now a casual union tends to be transformed into civil marriage after a trial period, or when a child is expected.

A time-use study of the division of labor between men and women farmers in rural Rwanda [Gatovu] found that women spend two-fifths of their time of agricultural work and animal breeding compared to men who spend only one-fifth of their time of these activities.⁶ It found that women spend 41% of their time on agriculture and agricultural processing, while men spend 22% of theirs. Cooking and cleaning were entirely women's work, while the collection of wood was done by both sexes. The construction and maintenance of the home is the responsibility of the men who are also take charge of the fight against erosion in agriculture and forestry. Animal husbandry, once an exclusively male occupation, is being taken up by women or girls, who now usually milk the cows. Women and girls also make baskets and are involved, with men, in the production of beer from bananas and sorghum.

With regard to decision-making, the woman normally decides what crops to plant but relies on the man to purchase seeds. Men sell banana beer, dried coffee, and animal products and choose how to spend the proceeds, which might

⁵ Dr. R. Pierre Louis, and Dr. B. Sebikali, "Population and Nutrition" ch. 4 of draft IVth Plan.

⁶ O. Ubonabenshi, "Participation de la femme Rwandaise a l'effort de production" UNR, June 1977.

be used to purchase clothes for their families or to pay school expenses [or on beer purchases.] Women market surplus vegetables and use the earnings to buy household necessities.

The work roles of children, unfortunately, are not covered by the above study, although this is an important factor in the motivation of farm families to procreate. Children take on many of the tasks of child-raising, for example. With an average birth interval of 31 months, there is normally a child about five years older than the newborn (the second older sibling) who will be assigned the role of carrying the infant. The carried (who may be male or female) develops a very close, usually life-long bond with the infant, and becomes its tutor through school (age 7), the infant can toddle alone around the rugo--and another infant is usually due.

From about five years on there is a sharp sexual division of labor among children, preparing them for adult roles. Girls, like their mothers, are expected to put in many more hours of work on the farm and in the household--in fact more than four times as much time as their brothers according to one study (See Table 4). The demand for girls' help at home is one factor in the traditional and continuing low enrollment of girls in school, compared to boys

Table 4. Time Use of Family Members in Hours Per Year*

	Men	Women	Sons	Daughters
Housework	96	773	123	811
Crafts/Paid Work	381	64	260	168
Agricultural work	805	1458	157	1099
work related to agriculture	118	195	42	151
Total	1400	2490	582	2229
Hours per day (260 d./yr.)	5.4	9.6	2.2	8.6

*Source: UNCP/ILO, Evaluation finale du programme pilote de travaux a haute intensite de main-d'oeuvre au Rwanda", Geneva, March 1983, p. 71.

Men take on 50% more wage labor or cash-earning opportunities than women, and are much more likely than women to leave the home compound in order to do so. Rural sex-ratios are predominantly female, while the cities are predominantly male. The 1978 census showed 25% of the households nationwide were headed by females, 92% of whom were illiterate. In urban areas (5% of the total population) 20.6% of households were headed by a woman, and their illiteracy rate was less--73.6%

2.1.1. Land and Child Custody: Family Economics

Land is acquired primarily through patrilineal inheritance, clearing (with the permission of the burgomestre), rent or purchase. Each nuclear family builds its home compound (rugo) on its own land, which, for an average

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family is comprised of 10 small plots totalling 61 ares (1.55 acres). The male head of household allocates land so that all males in the family have cash crop plots (bananas, coffee, tea) and the women have food-crop fields. A married woman joins her husband's family at marriage and receives the use of land from them, together with the responsibility for feeding her family. The women belonging to the partilineage could be visited by males other than the husband. This assured that children were always of the same male line, kept men from going outside the family when wives were indisposed, and allowed the presumption of paternity to be always with the husband (allowing the problems of absent migrant workers and infertile men, for example, to be glossed over). The dowry given to the wife's parents traditionally included at least one cow, if this was within the family means, lesser livestock for poorer families. The offspring of the married couple belong to the patrilineal family. The offspring of the dowry livestock belong to the maternal family, with the exception of the first-born which was returned to the paternal family at the time of the birth of a first child.

Dowry is tending to become monetized today, but the traditions of patrilocality and the children belonging to the male remains intact. It means that in case of divorce, a woman loses her children and her land. A widowed woman can usually retain her home with her in-laws and children if she has maintained good relations with them, but if she remarried she must leave them.

The possibility of losing one's children through divorce, separation, or widowhood adds to the fear women have of sterilization. One woman in four will be divorced or widowed after 10 years of marriage according to the WFS. For this reason, combined with Catholic Church opposition, few women choose sterilization, even when they currently want no more children.

2.1.1. Childbirth and the Determinants of Fertility: Targetting IEC

FP programs normally target high-risk pregnancies:

- mothers under 18 or over 35 years of age
- births spaced less than two years apart
- parity greater than four.

Of these, only 4 parity and mothers over 35 years are common in Rwanda. Thus the main target of IEC health messages should be women in their thirties and forties having four previous live births. It has also been shown that whether a child was desired or not has a significant influence on his/her chances of survival and general well-being. A recent study in Rwanda showed that 27-39% of mothers in three geographic areas described their last child as not-wanted.⁷ The largest percentage was in a rural area, the smallest in Kigali, and the suburban area was in between. These women should also be targetted in the IEC campaign.

⁷ ONAPO, "Etude sur les besoins non-satisfaits...." P. 35

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Pregnancy and child bearing have an extremely high health risk to both mother and child in Rwanda compared to other countries. Following the WFS the overall maternal mortality has been estimated at 7 per thousand live births, as compared to 4 per thousand live births estimated for East and Central Africa generally (WHO) and less than 01 per thousand in most developed countries. Eighty percent of Rwandan rural women deliver at home, while in Kigali the proportions are reversed: 70-85% of women deliver in a maternity or health center".⁸ Of those who deliver at home one third have the help of a relative (often husband), while nearly half have no deliveries, the most common means of getting to a health facility in an emergency is to walk or to be carried in a hammock by neighbors on foot (75% of respondents in rural and suburban areas); only 23% have access to a vehicle of any sort.

In Kigali vehicle access increases to 59%.

Five of the ten most important causes of hospitalization for women aged 15 to 44 years are related to pregnancy:

1. Indirect obstetrical causes*
2. Malaria
3. Spontaneous abortion*
4. Obstructed delivery*
5. Undiagnosed
6. Measles
7. Hemorrhage early in pregnancy or before or after delivery*
8. Digestive problems
9. Complications following childbirth*
10. Pneumonia⁹

Child-spacing is already a well-established custom in Rwanda. The problem is not persuading families of the need for it, but of introducing women to the advantages of modern FP methods in maintaining the desired spacing. Nursing on demand, for an average of 21.1 months helps assure the average birth interval of 31.1 months, even though nursing is not accompanied by post-partum abstinence. Post-partum amenorrhea lasts an average of 10.9 months. Contraceptive prevalence reported by women was 11% at the time of the 1983 WFS, of which only 1% were using modern methods (injectable, pill, IUD, spermicide). Today, with an estimated 25000 users out of 1809000 fertile women, prevalence is 1.4%. Periodic abstinence and withdrawal have been used in the past by 18% of women.

Marriage traditionally comes late, and is getting later (now 21.1 years for women, somewhat older for men) and illegitimate births are rare, partly because young couples tend to marry when a child appears to be on the way.

⁸ ONAPO, WFS and "Enquete sur les besoins non-satisfaits..."

⁹ UNICEF, Enfants et femmes du Rwanda; analyse de la situation, Kigali, April 1987, P. 27

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In the past, an unmarried woman who became pregnant had to commit suicide. Teenage pregnancy is becoming more common in the city where morals are laxer, but it is a sensitive enough subject that it would be wiser to address it discretely in private consultations rather than through FP IEC media messages. Some FP providers will not, as a matter of conscience provide FP to unmarried young women, even though government policy was recently relaxed to allow this.

The profile of existing acceptors derived from ONAPO research, reflects where initial demand was strongest and service-availability greatest:

--30% are from Kigali, 12% from Gisenyi, and 10% from Kibungo. In the other prefectures the percentage is less than 10 percent. This reflects high demand in urban areas, and poor service availability in many predominantly rural prefectures.

--70% of acceptors live in rural areas, cf. 95% of the population is rural. Demand is clearly not limited to urban areas. To have any hope of affecting overall population growth FP services must reach rural areas better.

-- 77% of acceptors are women aged between 20 and 35, with 32% in the prime-child-bearing years 25-29. This reflects demand for help with the traditional practice of birth spacing.

-- 64% percent are literate, which is far above the national average of 33% (for women).

-- 70% are farmers and 12% from middle and upper socio-economic groups; cfr. 93% of all workers and 98% of women are farmers.

-- acceptors have on average 3.9 children, and desire 1.5 more.

-- 34% of acceptors want no more children. Cf. WFS finding that 20% of fertile women nationwide want no more children. Since acceptors are only 1.4% of fertile women, it is very surprising that those wanting no more children are not better represented. In effect, only about 3% of those wanting no more children are currently using FP. This audience should clearly be targetted, both the IEC program and by better, more convenient service delivery.

A significant number of men and women plan to use birth-control (50% and 31% respectively), and a surprisingly large number want no more children (20% of women). These figures bespeak a significant unmet demand for FP services. In retrospect it is unfortunate that the emphasis in the FP program over the last seven years has been so strongly on IEC, without an accompanying development of service delivery.

Men deserve major attention in the IEC campaign because of their roles as family managers, which appears again in the question of frequency of conception. There is no information for Rwanda on the frequency of sexual

relations; worldwide the average is twice a week or about 100 times per year. The WFS showed that 45% of men claimed to be practicing contraception, whereas only 10% of women said they were. The main known methods are periodic abstinence and withdrawal, which it is easier for men than for women to control. It appears that a significant number of men are avoiding unwanted children without their spouses being aware of it. Seventy percent of men knew of at least one method of contraception, against 60 percent of women. Men desired slightly fewer children than women: 5.9 vs. 6.3. Thus the occasional opposition of husbands to women who come for FP should not be taken as evidence of male opposition in general. The key is that the children belong to them, and they want to control the process of procreation. The IEC program should build on this existing role of family management, in addressing economic messages to general and primarily male audiences: e.g.

ASK YOURSELF

- can I afford to feed and clothe another child?
- can I pay school fees for another child?
- will the land I have suffice for my sons--and their sons?
- if I have another child, will he find a job when he grows up?

2.2. Education and Family

The level of women's schooling is the primary indirect factor influencing fertility. The total fertility rate is lower and contraceptive prevalence higher for Rwandan women with even one to two years of primary school. This is different from the situation in some African countries where fertility is higher for women with primary schooling than those with none, and only declines for women with secondary education. In Rwanda the clear influence of education is seen in the following table.

Table 5. Women's schooling and Fertility

Level	No. of children Women _ 45 years	Completed fertility	Contracep. Prevalence
None	8.47	8.9	5.5
Primary 1-2 yrs.	7.99	8.5	9.0
Primary 3-6 yrs.	7.23	7.7	10.7
Secondary and above	4.00	na	12.7
Posprim. and above	na	6.8	34.4

Source: Draft IVth Plan, Population/Development.

Unfortunately the educational system has barely been able to grow as fast as the population, and women have considerably less than an equal educational opportunity in Rwanda. At independence in 1962 the enrollment ratio of 7-14 year olds was about 55%, boosted by the introduction of split morning and afternoon sessions. By 1972 it has dropped to 48%, but in 1985 it was estimated to be back up to 60% (See Table 6). A combination of discrimination by the educational system (decreasing since independence, even in primary school. In the 1987 census, only 38% of those who had more than a year of primary school were women. For 10-19 year olds with more than a year of primary school women comprised 45%, which reflects some historical progress.

Educational disadvantage, both in general and for women, becomes more acute in secondary and higher education--just where it would make a substantial difference in the acceptability of FP. Women held 21% of 791 baccalaureats reported in the census, 15% of the first university degrees, 9% of the 373 masters and doctorates, and 3% of the 380 engineering degrees.

TABLEAU 6: RYTHME DE LA CROISSANCE DEMOGRAPHIQUE & EVOLUTION DE L'ENSEIGNEMENT PRIMAIRE 1962-1985

ANNÉE	Population totale en millions	Taux de croissance X	Population scolarisable en millions	X	Population scolarisée en millions	Taux d'accroissement	Taux de scolarisation Z	Taux d'accroissement Z	Nombre de Maîtres	Nombre d'Ecoles	Nombre de Salles	Nombre de Classes	Rapport Maîtres par Elèves	Nombre d'Elèves par Classe	Nombre d'abandons	Taux de redoublements	Coût par Elève en (1000R)
1962	2,9		0,58	20	0,32		55		5.104	9		8.861	61	35	-	-	-
1972	4,0	3,2	0,83	21	0,40	2,2	48	0,98	7.586	2.013	7.683	11.081	52	36	13,9	23,9	-
1982	5,5	3,2	1,3	23	0,75	6,4	58	1,9	13.590	1.572	13.585	18.172	54	41	12,2	14,2	4,04
1985	6,1	3,5	1,4	23	0,84	3,8	60	1,1	14.896	1.594	15.147	20.151	56	42	9,9	12,8	4,21

SOURCES: Annuaires Statistiques du Ministère de l'Enseignement Primaire et Secondaire, années 1962 - 1985
 Perspectives démographiques de l'Office National de la Population 1984

LEGENDES: Pt: Population Totale
 r : Taux de Croissance
 Pt-14: Population scolarisable
 Tx d'/:>: Taux d'accroissement

$$P_t = P_0 (1+r)^t$$

$$(1+r)^t = \sqrt[t]{\frac{P_t}{P_0}}$$

$$r = \sqrt[t]{\frac{P_t}{P_0}} - 1$$

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2.3. Local Institutions

A profile of local institutions in rural areas shows the organizations that influence the lives of the population. The organizational chart below lists the major categories present at the local level and shows their hierarchical links to central authorities. Institutions at the commune level and below can be considered local, and capable of at least monthly contact with rural families. The four main types are the local administrative authority, represented by the Burgomestre and commune council (responsible to the Ministry of the Interior), the Party (MRND), the Catholic Church (in some communities Seventh Day Adventist or Protestant churches), and non-governmental organizations. Each of these plays an important role in people's lives and can influence the success of FP, positively or negatively.

The Party and local government representatives probably have the most regular contact with the population, and both are under orders to encourage FP. Monthly party meetings and weekly communal labor sessions offer opportunities for formal and informal discussion (potentially for distribution) of FP. Unfortunately much of the local authorities' other contact with the population is coercive in nature (tax collection, communal labor enforcement), so that unless a burgomestre and his staff are particularly tactful and popular, they may meet a well established tradition of passive resistance among the population. This is a problem for FP at present, but should diminish with time and experience. FP messages have stressed the dangers of too rapid population growth for the nation as a whole. Since there is little popular experience of the advantages of FP for individuals and families, this tends to feed the paranoid attitude that, "Those people (government, rich people, educated people, city people, ethnic or religious groups other than own--any others") want us to use FP to keep us down." This attitude tends to recede substantially when populations have direct experience of the personal advantages of FP. A reorientation of IEC messages to deemphasize "the national good" and emphasize "your personal good" will help lay this to rest.

2.3.1. Health Centers

Every commune has a health center, and soon most communes are due to have communal pharmacies. These report to the regional medical officer (RMO) in terms of line authority, but are expected to cooperate with the burgomestre and his council on local issues. Just over half of the health facilities are public, and the rest are private, mainly run by religious institutions (80% Catholic) under government licensing. The health centers are the primary institution responsible for FP distribution, although for this function they report to the ONAPO regional medical officer, who in turn reports to the RMO locally and to ONAPO headquarters as his line authority. The distribution of FP supplies and collection of statistics currently duplicate the networks of the health system. An integrated statistical system is currently being tested in Gitarama, and is expected to be implemented in the near future. The medicine distribution system is unfortunately so weak that it is not yet feasible to envisage integration of FP supply and storage with it. Over the long term that would theoretically be more efficient, but it should be part of a larger reform that would assure adequate local funding for medicines. The

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present project focuses on strengthening FP service delivery through health centers. Communal pharmacies could have a very important role as well, functioning with greater flexibility and lower cost (in both money and time) than the health system, reaching a larger clientele--much like social marketing.

The experience of requesting and receiving FP services at a health center needs to be studied from the patient's point of view. At present clients line up to pay their fees before entering a center (20 FRW per day for up to 5 days in a government center, 40 FRW or more in a private center). FP patients find out when they get to the front of the line that they do not have to pay, and are funneled to a special line to await service (some describe being seen there as akin to being seen waiting for help in a sexually transmitted diseases line). No studies of waiting time were available, but it seems likely that, as elsewhere in Africa, patients must plan to spend 1/2 to a full day walking to and from a health center and waiting for attention.

Women who bring their young children to one of 170 nutrition centers, also located at the commune level, go to a separate institution--with its own hours and waiting times. Some thirty percent of the Rwandan population suffers from some form of malnutrition; among one to three year olds it is over half, with 6% severely malnourished. Many of those mothers and children would not be malnourished if they could control their fertility.

There is no need for the segregation of FP services from nutrition, maternal, well-baby and sick care. FP is a simple technology with infinitesimally small health risk compared to the risk of pregnancy in Rwanda. It could and should readily be offered in conjunction with a mother's first infant or post-partum consultation, visit to a nutrition center or a sick-call by any patient (male or female). Condoms, spermicides, and pill prescription refills could and should be available in the regular health-center pharmacy, not just from the FP specialist.

2.3.2. Schools

The commune is also usually the locale for the primary school, which, like the health center, may be religious or public (secondary schools are mainly urban, boarding schools). During the colonial period the entire educational system was established and run by the Catholic Church, with government subsidy. Since independence, the government has tried to secularize the curriculum and has built its own schools. Most recently, other sects and private groups of parents have organized private schools, mainly secondary schools, to fill the gap in educational opportunity. ONAPO is developing demographic and FP curricula for schools at all levels, and indeed these could be key vehicles of the IEC campaign. Most primary schools function in Kinyarwanda with few written texts and there is no feedback on what children actually learn. ONAPO could break ground in this respect by making sure that children at all levels receive written materials for study, and are tested on their knowledge.

2.3.3. Private Voluntary Organizations and Local Development Projects

Some 130 NGOs are active at the local, commune level in Rwanda (out of 160 total registered PVOs in Rwanda), and a recent World Bank study identifies them as the preferred development partners of rural residents in most areas. Seventy percent of them are working to improve the situation of women. Nearly all of these are likely to realize that planning one's family responsibilities is the most fundamental of women's development needs, and complements activities in virtually any other area, social or economic. An undetermined number of these are Catholic, and will wish to limit their intervention to natural FP, but this should be encouraged strongly. PVOs working directly with rural women tend to understand their needs and be less interested in theoretical debates than members of church hierarchies.

The proposed AID assistance provides for an umbrella PVO to administer a project fund to which such local PVOs can apply. Some may wish to add FP IEC and distribution activities to their existing programs of community outreach--others may merely want to make them available to their existing membership.

In addition to the PVOs there are some 30,000 local cooperative groups with memberships ranging from about 10 to several hundred members. They are generally kin, friends, and neighbors who band together to pool their labor or capital. Those that involve the contribution of a regular sum in cash, with the pool taken in turn by each of the members, are called tontines. A similar type exists in Rwanda involving roof tiles--the individual contributions are sufficient to tile the roof of one member each month. IWACU serves as a national coordinating body for such cooperatives, and should be encouraged to consider offering them an FP program under the umbrella PVO component of the project.

Most major development projects, e.g. for integrated rural development, agricultural development, housing improvement, rural water supply, etc. serve a defined geographic area and have their headquarters at the prefecture level. These also, like private corporations, could be encouraged to provide FP to their members.

2.3.4. The Catholic Church

The church is the main social institution outside the family in Rwanda, irrespective of denomination. The focus here is on the Catholic church for two reasons:

- it has a unified hierarchy and numerous social services, making it an institution almost as powerful as the State, and
- it opposes modern methods of FP.

Although only 51.6% of the population officially belongs to the Catholic church, its influence is extended to non-members when they read its publications, listen to its radio broadcasts, attend its schools or clinics, or merely live in a community where the predominant climate of opinion is Catholic. The next largest single modern denomination, the Seventh Day

Adventist, has only one sixth as many members. The 1978 census showed the following religious affiliations for Rwandans:

Table 7. Religious Affiliations of Rwandans

Religion	
Catholic	51.6
Protestant	15.2
Adventist	6.3
Muslim	0.8
Traditional/oth.*	26.9

* I have lumped together those adhering to the traditional religion and those listed as "without religion," because the age-group breakdown shows that most of the latter are children under ten, apparently belonging to adherents of traditional religion. One can conjecture as to why children under 10 are not listed as adherents of traditional religion, but no explanation is given.

ONAPO had negotiated a sound working agreement with the Church on FP, which provided that ONAPO would support natural FP training, that Catholic personnel would not be required to provide FP methods contrary to their consciences, that ONAPO would provide personnel to furnish services where this left a gap in FP delivery (i.e. where the only clinic in a commune is Catholic), and that Catholic medical personnel would inform FP clients as to the availability of other methods and refer those desiring them to ONAPO services.

This agreement has broken down in the last several months, and ONAPO, MINISANTE, and the Church are currently in a stand-off. Following the Pope's official visit in 1987, the Rwandan bishops received firm instructions to discourage the use of modern FP methods. In April 1988 was added a papal instruction opposing the use of condoms for AIDS prevention. Government officials from the President, through the Minister of Health, and on down, have encouraged the population to determine their own needs and not be guided by outside instruction. At least one of the Bishops (of Butare) has, however, instructed his followers not to allow FP service delivery in Catholic clinics, regardless whether the personnel are Catholic or ONAPO. His letter was circulated to the entire hierarchy. (copy attached)

There are widespread reports that parish priests and some Catholic medical personnel are spreading false rumors about the side-effects of FP methods--to the effect that they cause sterility, cancer, etc. At the same time ONAPO personnel have become more vocal in their belief that natural FP is a waste--that it does not work, and therefore discourages people from FP entirely.

This situation is most unhealthy for the future of FP in Rwanda. It was, in retrospect, a strategic mistake to engage the debate on FP a theoretical level among policy makers (pro and con), and while at the same time there has been so little FP service available among the population at

large that people have no basis of experience with which to judge for themselves. Rumors about sterility, for example, could be put to rest more easily if the population had a few years experience of using FP and then having more children.

It is recommended that ONAPO renegotiate a working agreement with the Church. ONAPO cannot "win" a battle with the Church for the hearts and minds of the population over a matter so delicate and little understood as FP. It needs to enlist the Church's cooperation. The only way to do that is to encourage the Church to provide natural FP as widely as possible. To do this it will also have to persuade its own personnel to stop denigrating natural FP. They should be persuaded that the lesser reliability of natural FP is not a critical factor in a population where the goal is to reduce total fertility from 8.5 children per woman to 6. Some uncertainty can be tolerated by families who are used to having no control at all. If these two stumbling blocks can be worked out, the practical questions regarding referral of patients from Catholic facilities or the provision of services there by ONAPO personnel could be determined on a case by case basis.

2.3.5. Markets, Commercial Centers, and Social Marketing

A separate study has already been conducted by SOMARC of the potential for social marketing in Rwanda, and the best means of organizing it. It is not necessary to repeat the analysis here. It is worth noting, however, that the commercial sector is poorly developed in Rwanda in comparison with other African countries. The average Rwandan farm family has only FRW 22000 (\$300) per year in net spendable income (after production costs), and most of that is spent on food and drink.¹⁰ The cash economy is very weak. Rural markets are once a week in most communes, and they draw a smaller portion of the population than elsewhere in Africa. Because of the difficulties of travel on foot over mountainous terrain, people consolidate their errands and buy what they can on the hillside or from small permanent shops.

Social marketing of contraceptives may be less immediately successful in Rwanda for these reasons, and may need to devise new strategies to reach potential consumers, especially in rural areas. It is for this reason that the full range of rural institutions was sketched above, and all should be considered potential agents of FP.

2.3.6. IEC among a Dispersed Population

Of the mass media, only the radio reaches rural residents, and audiences are predominantly male. Because of the dispersed population, formal meetings (called by the Party, the Church, the Burgomestre or other local organizations) play a much larger role in communications than elsewhere, and informal work-of-mouth a lesser role. National literacy is 53% for males and 33% for females, and the literate population is concentrated in the

¹⁰ Draft report, Enquete sur le budget et la consommation des menages, milieu rural, 1982-83.

towns. The most common printed material in circulation is the Bible, followed by other religious publications. Printed hand-outs nevertheless have substantial potential to reach rural populations, since there is lively interest in the interpretation of pictorial and written handouts, and nearly every family has ready access to a literate interpreter.

ONAPO has devised a program of volunteer community mobilisers, which is currently being tested. Because of the dispersed character of settlement and the fact that the vast majority of women deliver babies at home without medical attendance, such a community-based distribution program is justified, even though it is expensive both in terms of both time and budget. One of the essential missing ingredients in the approach currently being tested, however, is simple technical handouts on each method. This gap can rapidly be remedied with the information and publication facilities already functioning at ONAPO. After testing for comprehensibility, sufficient handouts should be published to allow all distribution networks to provide them to potential clients.

The efficacy of different channels of communication and different messages needs to be tested as part of the ongoing program of operational research ONAPO conducts. The messages spread to date have focused on the dangers of population growth for the nation, and the need to join the ONAPO movement to counteract it. Comparative research suggests that people respond much more quickly to messages addressed to the individual family perspective:

(1) the economic message: can we afford to clothe and pay school fees another child?

(2) the health message: high risk pregnancies are dangerous to the health of existing children and the mother (even mothers are more concerned about their children's health than their own).

3. Motivation

Motivation has to be considered as a factor influencing the success of FP programs, including the motivations of clients and those of service providers. The following analysis presents what is known about current motivations, and then discusses potential incentives and disincentives.

3.1. Current motivations of FP users and non-users

The only systematic research on motivation concerns why non-users of FP did not use it and was conducted in 1983. The responses are seen in Table 8. Ignorance was the most important factor for 82% of rural women, but was much less important in the city. Among the urban population where FP methods and means of obtaining them are well known, other factors, seem more important. The husband's opposition, reported by 9% of women, is evidence of the need for IEC to reach out to male audiences. If men are encouraged to participate in the decision, they are less likely to see FP as a threat to their marital authority.

The much higher portion of urban women reporting fear is evidence of incomplete information -- another gap that needs to be filled. Women know that certain methods exist, but do not know that the risks of side effects are so much less than those of pregnancy. They have been taught all their lives to brave the risks of pregnancy fearlessly; no information is available on its real risks, particularly for women who deliver at home unaided. In contrast the rumors about the possible long-term effects of FP methods seem impossible to refute.

Table 8. Primary Reasons for not using Contraceptives

Reason	Rushashi (Rural)		Rutongo (Suburb.)		Kigali (Urb.)		Total	
	No.	%	No.	%	No.	%	No.	%
Knew no method	69	49%	33	27%	10	10%	112	31%
Not yet well informed	46	33%	41	34%	19	19%	106	30%
Afraid	1	1%	7	6%	14	14%	22	6%
Good spacing already	2	1%	7	6%	11	11%	20	6%
Post-partum amenorrhea	2	1%	5	4%	10	10%	17	5%
Husband does not want	4	3%	3	2%	9	9%	16	4%
Is not necessary	4	3%	7	6%	9	9%	16	4%
Wants no more children	2	1%	3	2%	5	5%	10	3%
Did not know where to go	2	1%	4	3%	0	0%	6	2%
No partner	1	1%	2	2%	6	6%	9	3%
Other reasons	8	6%	9	7%	5	5%	22	6%
Total sample	141	100%	121	100%	98	100%	356	100%

Source: ONAPO, Rwanda: Etude sur les besoins non-satisfaits en sante maternelle et planification familiale.

From less scientific sources, including field interviews with FP personnel, it is reported that the most common conscious incentives for adopting FP are:

--fatigue (including that due to malnutrition that often accompanies repeated pregnancy and nursing).

--desire to space children more reliably.

--for condom users, fear of sexually transmitted diseases (STDs), particularly AIDS (See Appendix 1).

ONAPO IEC materials try to build the concept of joining the ONAPO movement as a motivational tool. This seems to build team spirit among the staff. It is doubtful whether it has much potential for individual users, however, as it would require people to vaunt what has traditionally been a shameful misfortune--having a small family. Most people prefer to adopt FP discreetly without much discussion.

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Currently reported disincentives include:

--fear of infertility

--other secondary effects

--novelty/inconvenience

--religious teaching

--husband's reluctance (when the initiative comes from the wife)

--in rural areas the cost of children is still minimal, while their help is substantial.

--insecurity. Children represent hope for the future, security for their parents and for each other.

--competition/rivalry/defense. For national defense purposes, high fertility was at least tacitly encouraged in the sixties and seventies. Group consciousness, whether national, religious, ethnic or other often includes the idea that it is better for us to outnumber the "others"

--shame of poverty, lack of virility/fertility associated with small families, especially in rural areas.

The direction of social and economic pressures is gradually changing, however. It is no longer free to educate, feed, and deliver health-care for a child. People are aware that there will be insufficient land and jobs for the present generation--the problem is to apply that awareness, drawing conclusions about one's own fertility.

3.2. Cost Recovery and Motivation of FP Service Providers

Family planning services and supplies are now free through the health care system. Condoms on sale in private pharmacies cost FRW 30-50 (\$.40 - .70) each. The first is too low from the point of view of motivation, the latter is artificially high, sustained by an elite health insurance system.

The financing of health care should be studied not only from an accounting/cost-recovery point of view, but also taking into account the motivations of health-care providers. One can observe in Rwanda as elsewhere that health-care providers are motivated to attend best to whatever their source of funding is. People within the hierarchy respond promptly and efficiently to their superiors, and are extremely gracious and hospitable to the representatives of outside funding agencies. Patients, on the other hand, are expected to wait long periods for services, and rarely find adequate medicines available once they have done so.

Observer after Observer notes that public facilities and staff are less well kept and provide less efficient service to patients than private (mostly religious) centers, yet

there has been no systematic study of the motivations and incentive structures affecting service providers. The problem is not in the individuals--it is in the structures. Salaried medical personnel receive their salaries whether they attend well to patients or poorly--good service brings no sense of success, just a greater work burden. In contrast, in private clinics patients pay more for services, but are assured of finding medicines and a sympathetic welcome. The greater work burden that good service brings for private clinics is seen as success--and brings in monies used to provide necessary medicines, supplies and maintenance. Salaries for public medical personnel are low in relation to their clients for their long training, and conditions of service less desirable, especially in rural areas. Even with the recent reform of health financing in Rwanda that allows health center fees to be kept in the commune in which they are generated, they still do not stay with the health center management itself. Instead of going to the central government coffers, they now go to the commune coffers. There is an increasing body of evidence from throughout the developing world that the best way to assure effective health care, even for the poorest of the poor, is to charge patients for services--and keep the funds under the management of health centers. If health care providers are answerable, at least in part, to their clients for their livelihood, they provide better quality care.

The feasible level of charges for FP services should be tested in the current program's operational research component. The idea of keeping communal health center funds reserved for health care should also be tested. Let selected communes develop budgets that include allocations for medicines, supplies, maintenance, and part of the income of the health center personnel.

4. Participants and Benefits Incidence

Family planning tends to be adopted most readily by educated women, urban residents, and upper socio-economic levels. It allows them to care for their children more carefully. Thus FP is much like nearly every development benefit--those who are already beginning to improve their socio-economic status are more likely to participate than the poorest, most isolated rural residents.

It is important to note, however, that current FP users in Rwanda are 70% rural. Even if the rural population is proportionately slower to adopt FP than the urban, the idea and the practice already have roots in both areas, and both populations have solid practical motivations for adopting FP.

There are major differences between FP and other imported development technologies, moreover. One is that the real cost of FP supplies to users (\$2-\$6 per year per family), even if totally unsubsidized, would be less than the cost of doing nothing (i.e. having uncontrolled fertility and raising the children who result). Once the idea of FP is generally accepted, the basic methods taught in the school curricula and the service provided as part of standard medical care, the current high levels of expenditure for a separate bureaucracy, IEC, research, etc. can be substantially reduced.

The second difference is that non-participants benefit from the fact that others participate. As contraceptive prevalence increases and population growth rates decrease, there will be more places available in schools and less pressure generally on land and other resources, social services, housing and infrastructure. This improves opportunities for social mobility and improves quality of life for non-participants as well as participants.

5. Summary of Recommendations

[N.B. Many of these recommendations have already been proposed by ONAPO policy-makers, and some are scheduled for implementation. Listing them here merely implies that they have not yet been implemented effectively, and that program evaluation should consider to what extent they have been implemented at different stages.]

--That the time constraints affecting patients, especially women, be considered in improving integrated service delivery. Women's ten hour work days make it a difficult choice, and sometimes last priority, to go spend a day waiting at a health clinic. A time-distance study should be undertaken to determine the number of visits, travel, waiting, and consultation time, currently needed to complete the recommended series of prenatal, infant, vaccination, and post-partum consultations, plus sick visits. That a time efficiency study be done to integrate and improve service delivery.

--That FP be recommended in the course of the first infant consultation, along with nutritional counseling, not just in group sessions, but again when the patient is seen individually. That it be provided during the same visit, not at a separate FP clinic unless IUD is determined to be the appropriate method.

--When post-partum consultations become more common, they should be combined with the first infant consultation--as both mother and child will almost certainly be there in any case and two visits should not be necessary.

--That FP be offered during consultations of sick women and children, and provided at the same time if desired. Male patients should also be advised to use FP, especially if they show signs of STDs, malnutrition, or heavy family burdens.

--That FP (barrier, spermicide, and pill prescription renewal) be offered in all pharmacies dispensaries, hospitals, etc.

--That the same FP methods be offered in communal pharmacies.

--That a cost-recovery proposal be developed for the FP program, tested and phased in during the proposed five-year program.

--That the IEC program develop fiches-techniques for each method--in detail for use by FP personnel and in simplified form in large quantities for patients and attendees at mobilization meetings. They should include side-effects and comparison with the risks associated with pregnancy in Rwanda. There should be blanks to be filled in showing where, from whom and when, [and at what cost] people in that locale can obtain different FP methods.

That the IEC program develop new messages focused on:

(1) individual family concerns, which have been found in comparative research to be, in rank order:

--socio-economic concerns: can the next child be clothed, school fees paid, will land be available for him, or a job when he grows up?

--health concerns: first priority is the health of existing children, secondly the health and tiredness of the mother.

--in Rwanda FP providers report more emphasis on the tiredness of the mother--local message testing will resolve the question of the efficacy and appropriateness of different messages.

(2) information on different methods, how and when they are used, possible side effects (always compared to potential complications of pregnancy). There is reported widespread disinformation circulating on side-effects of different methods. Therefore it is important to present the scientific evidence--using both international and Rwandan statistics wherever possible--over the radio, in health centers, and at ONAPO mobilizational meetings. These messages could usefully be combined with health-education for pregnancy--telling women danger signals and what to do about them during pregnancy and delivery. Since such a large portion of Rwandan women deliver alone, or with the assistance of only the husband or relative, this education should be aimed directly at the popular audience here instead of mid-wives or traditional birth attendants.

--That all IEC messages and media be pretested for efficacy of response (size of audience reached, proportion who respond positively), correct interpretation by the audience, and socio-cultural appropriateness (audience opinion).

--That ONAPO develop a united policy of encouraging and supporting the Catholic Church to the maximum in spreading "natural FP", in the confidence that for clients, the decision to try to plan one's family is the major obstacle to the spread of FP--and the institutional help one gets with that the better. ONAPO personnel will have to "swallow" their doubts about the efficacy of "natural FP" and their resentment of the disinformation put out by some Catholic personnel for the sake of this

approach. The absolute efficacy of a method is less important in a country with a total fertility rate of 8.5 children than the transformation of the social climate and motivational situation.

--That USAID supports the efforts to reach the rural population from the beginning, and not assume that FP will "trickle down" from city to countryside. This is one of the least mobile populations in the world, and one of the most rural. The urban effort will certainly gain more subscribers for less investment, but the base for a rural program must be laid immediately as the land/employment crisis is already well-developed and worsening rapidly.

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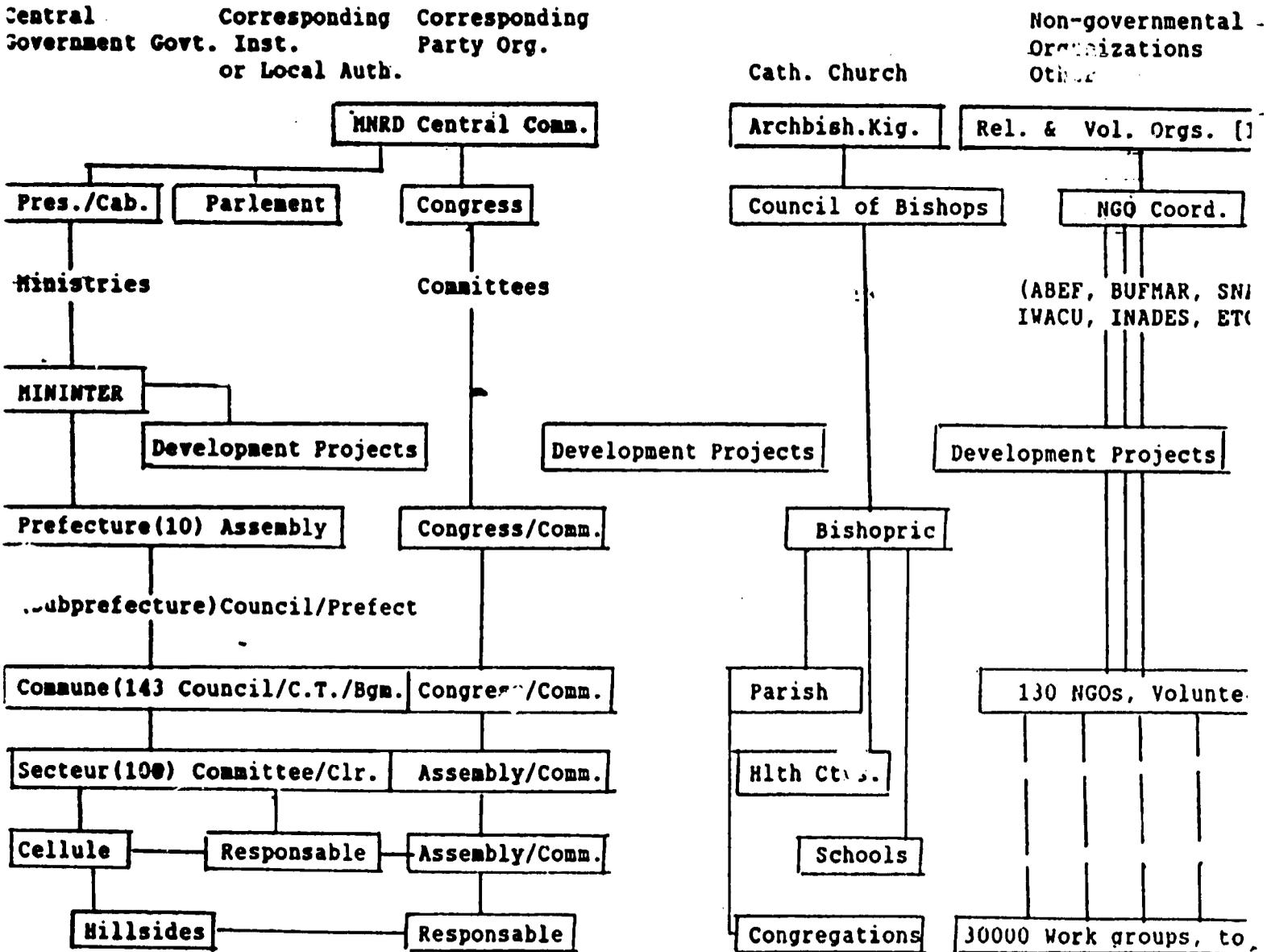
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Appendix 1:

STRUCTURE OF MAIN ORGANIZATIONS REACHING RWANDAN POPULATION



Appendix 2: AIDS

Acquired Immune Deficiency Syndrome is a major health threat, especially among the small urban population of Rwanda, as the following tables shows. its presence has motivated a sharp increase in condom usage in the last year. This threat, however, is being dealt with by a separate unit of the MINISANTE, under WHO guidance. It is thought best not to stress AIDS in the FP media campaign, as an AIDS IEC program is already underway.

PROGRAMME/PROJETS DU FNUAP AU RWANDA 1987-1991

PAYS : RWANDA
 STATUT : PRIORITAIRE
 ANNEE : 1988

Code	Titre	Agence d'exécution	Ressources Approuvées 6/1/1987 (en dollars)			Allocations (en dollars)				
			Scénario Bas (\$)	Ress. Multi-Bi (\$)	Scénario Haut (\$)	1987	1988	1989	1990	1991
RWA/87/P01	Planning Familial Santé Familiale	GVT	1.300.000	1.400.000	2.700.000	374.270	378.600	371.700	-	-
			1.124.570							
RWA/87/P03	Politiques de Population Assistance à l'ONAPO	DTCD	560.000	190.000	750.000	72.000	133.000	136.500	52.500	62.000
			456.000							
RWA/87/P04	Information-Education Communication IEC (pipeline)	FAO	740.000	310.000	1.050.000		296.000	188.100	115.900	-
			600.000							
RWA/87/P02	Collecte de données de base Recensement Population (en voie de programmation)	DTCD	400.000	100.000	500.000					
			(2) 417.063							
TOTAL	Programme Projets approuvés Projets en pipeline et Projets en Programmation		3.000.000	2.000.000	5.000.000	446.720	511.600	508.200	52.500	62.000
			1.580.570							
			(3) 1.017.063							
	Ressources non programmées par rapport au Scénario bas		402.367							
	Ressources non programmées par rapport au Scénario haut		2.402.367							

- 1) Projet en pipeline - soumis au Siège du FNUAP pour approbation;
 2) Projet en program. - le gouvern. est en train de formuler une requête;
 3) = (1)+(2)

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AIDS Cases in Rwanda, 1983-87

	1983		1984		1985		1986		1987*		Total		% of Total
	Cases	Deaths											
15+ years)	10	8	47	23	89	31	313	67	189	NA	648	129	72%
female	7	6	17	9	49	18	216	39	96	NA	383	72	43%
male	3	2	30	14	40	13	99	28	93	NA	265	57	29%
15 yrs)	NA	NA	26	12	72	36	148	NA	7	NA	253	48	23%
female	NA	NA	10	3	39	20	72	NA	4	NA	125	23	16%
male	NA	NA	16	9	33	16	76	NA	3	NA	128	25	14%
	NA	NA	99	47	233	103	609	NA	203	NA	901	177	100%

Annual Change

	1983-84		1984-85		1985-86		1986-87		Avg. Ann. Increase '83-85	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
15+ years)	470%	288%	189%	135%	352%	216%	NA	NA	337%	213%
female	263%	150%	288%	200%	437%	217%	NA	NA	323%	189%
male	1000%	700%	133%	93%	248%	215%	NA	NA	460%	336%
15 yrs)	NA	NA	277%	300%	206%	NA	NA	NA	NA	NA
female	NA	NA	390%	667%	185%	NA	NA	NA	NA	NA
male	NA	NA	206%	178%	230%	NA	NA	NA	NA	NA
	NA	NA	235%	219%	261%	NA	NA	NA	NA	NA

MINSAPASO, Rapport Annuel 1987, pp. 169-171.

AIDS Serum Positivity Rates in Rwanda, 1986 National Survey

Group	Rural			Urban			Sample			Nationwid		
	Number	Positives	%	Number	Positives	%	Number	Positives	%	Number	Positives	%
	81	1	1.2%	89	12	13.5%	170	13	7.6%	NA	NA	NA
	122	1	0.8%	221	13	5.9%	343	14	4.1%	NA	NA	NA
	111	2	1.8%	294	37	12.6%	405	39	9.6%	NA	NA	NA
	173	5	2.9%	487	125	25.7%	660	130	19.7%	NA	NA	NA
	114	3	2.6%	404	109	27.0%	518	112	21.6%	NA	NA	NA
	99	0	0.0%	238	27	11.3%	337	27	8.0%	NA	NA	NA
	46	1	2.2%	126	13	10.3%	172	14	8.1%	NA	NA	NA
	746	13	1.7%	1859	336	18.1%	2605	349	13.4%	6574000	165242	2.6%

MINSAPASO, Rapport Annuel 1987, pp. 169-171.

AIDS Serum Positivity Rates in Rwanda, 1986 National Survey
Urban Adults (15+ years) by Profession

Profession	Men			Women			Sample		
	Number	Positives	%	Number	Positives	%	Number	Positives	%
Farmers	323	31	9.6%	560	117	20.9%	883	148	16.8%
Artisans	124	30	24.2%	22	11	50.0%	146	41	28.1%
Merchants	97	26	26.8%	25	8	32.0%	122	34	27.9%
Civil Service	96	15	15.6%	35	6	17.1%	131	21	16.0%
Domestics	38	8	21.1%	7	4	57.1%	45	12	26.7%
Total	678	110	16.2%	649	166	22.5%	1327	256	19.3%

Source: NINISAPASO. Rapport Annuel 1987, pp. 169-171.

N.B. Serum positivity rates are highest among single adults in urban areas, reaching 44.8% for divorced persons; cf. 0.6% for legally married rural residents.

Cd A. a. Lx.

MUTANGA, B.P. 001, LE 27 FÉVRIER 1988



REPUBLIQUE RWANDAISE
AFRIQUE CENTRALE
Proc. no. 13/88

Monsieur le Médecin-Directeur
de la Direction Sanitaire
B U R U N D I

Date d'entrée 17.3.88
A traiter par GEP
N° classement 252
jeu: 694

Monsieur le Médecin-Directeur,

Agréons tout d'abord mes salutations bien respectueuses. Ensuite je viens vous entretenir d'un problème sérieux surgi récemment. Il s'agit de l'introduction des pratiques contraceptives dans les formations agréées, par certains agents médicaux en particulier, qui en ont reçu la consigne et la stratégie.

Je vous en informe par souci de clarté, de bonne collaboration et du bon fonctionnement de nos Centres agréés. Je ne pourrais admettre qu'un agent médical œuvrant dans un de nos Centres applique la contraception. Je ne pourrais me dévaloriser de l'enseignement et de la pratique de l'Eglise catholique, à travers le monde, et repris notamment très clairement dans notre lettre pastorale comme des Evêques du Rwanda en précisant que

"la collaboration de l'Eglise à la solution du problème démographique se situe au niveau du recours aux méthodes nouvelles quant à la planification familiale. Pour cela, elle se tient sur "le terrain de la foi en propre", car elle supplée ainsi à certaines lacunes des familles, la fidélité à son identité et à sa doctrine, elle offre une action exclusive pour la stimulation naturelle des naissances, elle offre des consultations personnelles, gratuites et confidentielles, elle ne peut admettre la distribution ou l'utilisation de contraceptifs hormonaux, toute application à la sterilisation ou à l'avortement est formellement interdite. Cette option de l'Eglise doit être respectée, car elle constitue un des droits fondamentaux reconnus dans la Déclaration Universelle des Droits de l'Homme. Le droit à l'autonomie de pensée, à la conscience et au mariage, à la liberté de manifester sa religion ou sa conviction, à l'absence de servitude, tant au public qu'au privé, par l'enseignement, les pratiques, le culte ou l'accomplissement des rites". (pages 27-28)

En acceptant un travail dans un de nos Centres socio-médicaux, l'agent médical s'engage à se soumettre avec loyauté

Best Available Document

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tout comme le titulaire, un cas de doute, ont tenu par loyauté à suivre l'enseignement de l'Eglise universelle. Si, au cas où l'agent médical ne pourrait se soumettre avec loyauté à la ligne de conduite adoptée en matière de régulation des naissances et voudrait suivre sa conviction personnelle en cette matière - dictée par sa conscience à lui -, il devrait alors demander la permission pour un Centre qui offre la contraception à la population.

L'Eglise catholique ne pourra jamais perdre son identité face à la population en acceptant - de façon plus ou moins déguisée - le recours massif à des méthodes et à des techniques contraceptives contraires à l'éthique familiale en matière de natalité. Si jamais une loi quelconque nous y obligerait, je n'hésiterais pas de laisser travailler mon personnel dans le cadre de la médecine privée envisagée.

Bien conscient de votre responsabilité devant le problème démographique du pays, je n'ai cessé - depuis la première session tenue à l'intention des titulaires des Centres de Santé et des Centres Nutritionnels en décembre 1984 - de les encourager à établir un service efficace et approprié d'information sur toutes les méthodes existantes de régulation des naissances, aux méthodes naturelles et à la planification familiale. Je tiens à leur rappeler aux titulaires - qui me lisent - de continuer à leur rappeler dans le pays - de s'y conformer et de rendre ce service toujours plus opérationnel.

Monsieur le Médecin-Directeur, j'ai tenu à être clair en cette matière complexe. Pour votre information personnelle, veuillez trouver ci-joint le texte de la récente lettre pastorale des Evêques catholiques du Rwanda.

Je prie, Monsieur le Médecin-Directeur, l'expression de ma considération distinguée.

Copie pour information

- Son Excellence Monsieur le Ministre de la Santé Publique et des Affaires Sociales
- Leurs Excellences Messieurs les Evêques catholiques du Rwanda
- Monsieur le Préfet de la Préfecture de BUTARE
- Monsieur le Préfet de la Préfecture de GICNGORO
- Aux Titulaires des Centres de Santé agréés du Diocèse de Butare (total)



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ANNEX D

FINANCIAL MANAGEMENT/RECURRENT COST ANALYSIS

**Dr. Hans-Peter KOERNER
Financial Management and
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c/o COREC S.P.R.L.,
B.P. 1105, Kigali, RWANDA**

Kigali, April 12, 1988

**The Representative,
US Agency for International Development
B.P. 28, Kigali, RWANDA**

**ANALYSIS OF FINANCIAL MANAGEMENT
ACCOUNTING AND RECURRENT COST
ASSOCIATED WITH
FAMILY PLANNING
IN RWANDA**

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LIST OF ACRONYMS

AID	United States Agency for International Development
ARBEF	Association Rwandaise du Bien-Etre Familiale (Rwanda Branch of International Planned Parenthood Association)
CCCD	Combatting Childhood Communicable Diseases
CCDFP	Community Center for Development and Permanent Training
CCIR	Rwandan Chamber of Commerce and Industry
CDSS	Country Development Strategy Statement
CERAI	Center for Integrated Rural and Artisanal Training
CERAR	Center for Rural and Artisanal Training of Rwanda
CJF	Youth Training Center
CIC	Interministerial Coordinating Committee
CND	National Development Council
CRS	Catholic Relief Services
CUSP	Centre Universitaire de Sante Publique
DAI	Development Alternatives, Inc.
DIU	Dispositif Intra-Uterine
EPI	Extended Program of Immunization
FP	Family Planning
GOR	Government of Rwanda
HC	Health Center(s)
IEC	Information, Education and Communication
INR	National Research Institute
INTRAH	International Training in Health (Chapel Hill University)
IPPF	International Planned Parenthood Federation
ISAR	Rwandan Institute for Agronomic Sciences
IUD	Intrauterine Device
MCH/FP	Maternal and Child Health/Family Planning
MINIFINECO	Ministry of Finance and Economy
MININTER	Ministry of the Interior and Communal Development
MINIPLAN	Ministry of Planning
MINEPRISEC	Ministry of Primary and Secondary School
MINISAPASO	Ministry of Public Health and Social Affairs
MRND	National Revolutionary Movement for Development
NGO	Non-Governmental Organization
ONAPO	National Population Office
RF	Franc Rwandais (Rwandan Franc)
UNFPA	United Nations Fund for Population Activities
UNICEF	United States Agency for International Development
USAID	United States for International Development
WHO	World Health Organization

INTRODUCTION

Following the request of the US Agency for International Development, American Embassy at Kigali, Rwanda, of February 29, 1988, I have taken up work of the present study the same day by collecting information at the

- USAID office, Kigali, and its files
- Office National de la Population (ONAPO)
 - with the Director, Madame Habimana Nyirasafari Gaudence
 - Head of the Service Etudes et Programmes (Studies and Activities),
Monsieur Hakizimana Evariste, M.D.
 - Head of the Service Administratif et Financier,
Monsieur Higaniro Hermogène
 - Head of the Section Secrétariat Général et Relations Publiques,
Monsieur Nzahabwanamungu Patrice
 - Head of the SEction Comptabilité Générale et Trésorerie
Madame Mukabideli Thérèse
- Ministère de la Santé Publique et des Affaires Sociales (MINISAPASO)
 - with the Directeur Général des Services Généraux,
Monsieur Ntezilyimana Antoine, and
 - the Coordinateur National of IDA/GOR Family Health Project,
Monsieur Nyandagazi Prosper
- Offices of the Resident Representatives of the World Bank, UNICEF and
- The Canadian Embassy

I had frequent discussions and exchanges of opinion with the Futures Group experts working for the FP II Project preparation.

After having received the last important items of information on March 15, 1988 I carried out the study from March 16 to April 6 in close cooperation with the USAID Project Design Coordinator, Mr. John Blumgart.

On April 9, part of the Project Design team and the Economic analyst of OAR/Rwanda discussed the draft report submitted on April 6, 1988 with me, asking me for two supplements to the report. Consequently, due date for the Final Report was pushed back to April 12, 1988.

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1. RECURRENT COST OBLIGATIONS TO THE GOR FOR FAMILY PLANNING

1.1. ONAPO

1.1.1. Analysis of 1988 Budget Draft (Budget de Fonctionnement - Recurrent Cost Budget)

As outlined in the chapter INSTITUTIONAL ASSESSMENT OF ONAPO in the Futures Group Study, the 1988 Budget Draft shows a certain effort into the direction of a budget per activity. Yet the most important portion of Recurrent Cost, PERSONNEL COST, has not been budgeted per activity, nor have other significant cost items. Only office supplies, gas and vehicle maintenance, material costs for information and education, travel expenses in Rwanda, have been divided up by activity.

To arrive at an attribution of ONAPO overall recurrent cost to F.P. and the other activities of the Office, the relevant percentage of each Section and Subsection for FP had to be estimated, see Annex 2. The calculation contained in Annex 2 shows that 97.8% of recurrent cost can be attributed to the following tasks of ONAPO, i.e. to Family Planning:

- to stimulate an awareness among all social groups as to the demographic problems of the country, through a program of information, training and education, respecting human dignity, freedom, religious and moral convictions of couples
- to ensure that family planning methods are properly employed
- to examine the procedure for integrated family planning services into general health services and to submit proposals as to the best methods of such integration to the officials in charge of Public Health
- to participate in drawing up educational programs at all levels with regard to population questions

For the remaining tasks, (a) to examine all matters concerning population growth, and its effects on socio-economic development, and (b) to submit proposals to obtain a balance between production and population growth annual Personnel Costs of about RF. 1.3 million seem RF 21,533 per month for each of 5 employees concerned (overall monthly average for 241 employees: RF. 19.935).

1.1.2. Relations between drafts, drafts revised with MINIFINECO, Budgets approved by CND, really effected disbursements for the years 1984-1987 and execution of the Budgets

As shown in Annex 1, ONAPO has never received an adequate GOR contribution to cover its modestly calculated Recurrent Cost Budget submission. The latter has always been exceeded by actual disbursements. In 1987, the actual GOR contribution of RF 42.4 million for Personnel Cost was less than salaries payable to permanent staff (RF 52.1 million; total Personnel Cost 55.3 million).

Even approved but inadequate GOR Budget allocations have not been entirely made available. For example MINIFINECO has withheld RF 4.4 million in 1987.

MINIFINECO has openly indicated for the 1986 Budget, that ONAPO should look for the missing RF 3,2 million (see Annex 1, line 12) with foreign donors. For 1986, USAID has in fact contributed an amount of RF 55.8 million to ONAPO's Recurrent Costs.

In 1986 and 1987 ONAPO has managed to bridge the gap (Annex 1, line 12) between GOR contribution and necessary current expenditures by availing itself of the "pipeline effect", using undisbursed balances of funding by USAID and other donors (more than RF 11 million on 01/01/87 and 1988), and not yet used by ONAPO for the original intentions.

Considerable short-term obligations towards the GOR Treasury, the Caisse Sociale du Rwanda (Social Security) and private creditors had to be used as well to finance the budget deficit. The financial "gap" between ONAPO's recurrent cost requirements and GOR contributions amounts to more than RF 15 million in 1987 and to RF 11.5 million in 1988 (see Annex 1, line 12).

The position of GOR towards covering all necessary recurrent costs, which are not provided for by USAID and other donors should be clarified. On the other hand, it has to be pointed out that GOR funding of ONAPO recurrent costs has risen from RF 47.8 million in 1984 to RF 88.6 million attributed by MINIFINECO for 1988.

1.1.3. Financial Management and Accounting analysis of ONAPO relative to suitability for the proposed project

With reference to "Institutional Assessment of ONAPO" in the Futures Group Study, and drawing on the "Analysis of ONAPO Management" by Alain Joyal of August 1986, the situation as it has evolved can be summarized as follows:

1.1.3.1. Financial Management

This difficult task, including procurement, stock control and fixed assets management, has to be fulfilled by the head of the Administrative and Finance Department (Chef de Service Administratif et Financier - SAF) who has no budgeting and accounting experience (preceding post: Chef du Personnel at the Caisse d'Epargne du Rwanda - National Savings Bank).

Apart from his staff in the Sections:

Accounting and Treasury	5 employees
Procurement, stock an fixed assets management	4 employees

There have been recently appointed two qualified staff members to the Section Planification and Evaluation which is directly attached to the Director's Office. They and the head of the Section Secretariat and Public Relations, who has just returned from a long study leave (in Public Health Service) in the US, will be able to establish a sound data basis for the calculation of the Budget.

But apparently there is still nobody in the Service Administratif et Financier who is capable to calculate and establish with these data a correct and comprehensive budget comprising all activities, financed by GOR, USAID and other donors, and per activity.

1.1.3.2. Accounting

Invoices do not bear a serial number and are filled by booking dates only, so vouchers for entries of the same date can be retraced only with difficulty. The separate bookkeeping for USAID funds utilization is done in pencil.

1.1.3.3. Stock Control

Important portions of categories of stocked articles, like contraceptives, medicine kits and health center outfits, drugs, brochures, books, video- and audio-cassettes are administered by sections of the Studies and Activities Department (Service Etudes et Programmes), that is not controlled by the administrative and Finance Department (SAF). Inventory and Stock control by a stock consuming Department is a contradiction to the rules of Internal Control.

1.1.3.4. Vehicle Fleet Management

There is progress in the control of vehicle utilization and times of absence by the introduction of a well conceived form. However, it will still take considerable efforts until high performance at reasonable cost is achieved.

1.1.3.5. External Audits

The two "Commissaires aux comptes" and the "Commissaire d'Etat" do not exercise a sufficient control over accounting, stock and fixed assets management. The three commissaires are not members of ONAPO staff.

RECOMMENDATIONS

The Ministry of Civil Service has recently filled the long-time vacancy at the post Chef de Service Administratif et Financier with a legal specialist who has no budgeting and accounting experience. This Ministry should have been asked to appoint an executive to this post with leadership and professional qualities that allow him to introduce sound budgeting and stock control procedures and to improve the functioning of the Accounting Section.

Until the eventual achievement, of such an appointment, Technical Assistance and training on the job will help and are necessary.

The post "Foreign Donors Contributions" in the Accounting Section should be occupied by an experienced budgeting expert who can translate the data about planned activities into budget figures.

A strict control of the manifold and valuable stocks (see 1.1.3.3., mostly grants from USAID and other donors) and their distribution down to health center level will have to be established. All fixed assets and stocks have to rest under control of the Administrative and Finance Department from arrival at MAGERWA Customs depot until distribution to final receiving units (health centers). This applies for all stocks, be they stored at the Control Office, the Warehouse (Centre de Formation), Regional Offices or in transport. The employees responsible for stock management at the Regional Offices will have to report directly to the SAF.

As, procurement for ONAPO (stocks, services, investments) is not directly controlled by MINIFINECO, and there is not sufficient auditing capacity available for ONAPO, the establishment of an Inspection and Internal Audit Service reporting directly to the Director like in other Public Enterprises, and the nomination of an independent external auditor, based in Rwanda, should be considered.

1.1.4. Recurrent Cost Obligations of GOR for ONAPO for the years 1989-1993

For planning and cost estimation purposes, one can consider Rwandan fiscal years 1989 to 1993 as equivalent to US fiscal years 1988/89 to 1992/93.

Annex 4, "Estimated Recurrent Cost Budgets for Family Planning 1989-1993" is calculated assuming the 3.2% yearly inflation rate which was applied in the PID, Estimate of AID contributions, page 16 and Annex 2 (US \$ 787,000, i.e. 17%, equivalent to an inflation rate of 3.2% during 5 years).

The comprehensive ONAPO estimated Recurrent Cost Budgets for Family Planning (Annex 4) rise from RF 126.4 million (US \$ 1.8 million) in 1989 to RF 151.5 million (US \$ 2.16 million) FOR 1993. They contain a reserve for contingencies of 2,24% (RF 2,315,000 for 1989, increasing by 3.2% each year to RF 2,624,000 for 1993). Annex 2 shows, that 97.8% of ONAPO Recurrent Cost can be attributed to FP. Rather than reduce all the figures for the different Budget items by 2,24%, the author simply took the 100% Budget figures, thus - at the same time - creating the before-mentioned reserve.

The financing section of Annex 4 contains of UNFPA and GTZ to recurrent costs through 1993 on the assumption that the projects concerned will continue or be replaced in some way after their expiration (UNFPA: 1989; CTZ: 1990).

The GTZ contribution to Recurrent Costs will be channeled - as in the past - neither through ONAPO nor through MINISAPASO accounts, but commodities and services will be procured directly by the GTZ project office in Butare.

One of the priority items of future ONAPO activities (based on the experience with two local pilot projects begun in 1987) is the creation, in stages, of a network OF 17.000 voluntary "animateurs" at the lowest local (cellule) level. This network may also eventually be given responsibility for the distribution of FP services. The author has included the costs for 15 supervisors, considered necessary in accordance with the USAID Project Design Coordinator, for the guidance and control of the proposed 17,000 voluntary FP "animateurs" (see Annex 4, footnote**). If the "animateur" project should not be carried out, the 15 posts will be needed to improve and extend F.P. services in the field.

1.2. MINISAPASO

1.2.1. Analysis of 1986 and 1987 Budgets , 1988 Budget draft and Recurrent Cost Obligations of GOR in the MINISAPASO complex for the proposed Project 1989-1993

As shown in Annex 4, F.P. related costs in the central and regional structures of MINISAPASO are composed of two items:

- RECURRENT COSTS AT MINISAPASO, which are detailed in Annex 3. They are composed of an estimated F.P. occupation percentage of the personnel and other costs caused by the employees working in the Sections/Subsections shown in Annex 3. The total of RF 3,894,000 for 1988 is reported with a 3.2% inflation increase to 1989 (Annex 4, line 16).
- FAMILY HEALTH PROJECT, co-financed by GOR (Budget de Développement) and IDA loan, 50% of its recurrent costs are considered and accounted for as FP related (totalling RF 101.7 million or US \$ 1.45 million). RF 84.7 million thereof represent 50% of the Personnel Cost caused by 16 staff members of the Project Coordinator's office and 200 additional health auxiliaries at the Public Health Centers. Each year 40 of them are supposed to pass examination at the nurses schools which will be built and maintained during the 5 projects year to come. As these auxiliaries will probably spend half of their time on MCH/FP including nutrition advice, 50% of their recurrent cost was attributed to FP, as was done for the Project Coordinator and his staff. In the recurrent cost calculation for the post project period this staff will be replaced by 16 teaching staff members of the nurses schools.

1.2.2. Financial Management and Accounting Analysis of MINISAPASO relative to suitability for the proposed Project

The Management Office for the IDA/GOR financed Family Health Project is located in MINISAPASO. This project has strong FP components and accents, see Futures Group Study, "Institutional Assessment of MINISAPASO, World Bank (IDA) Participation".

The National Project Coordinator is well-trained and qualified for his task. Apart from a long period of studies abroad, he has been Director of Administration and Finance Division at MINISAPASO before. He has a secretary, two accountants with good training, an architect, a technician, an expatriate expert in Medical Service and F.P., and 1 teaching specialist. He is to get an administrative assistant.

The accounting service is well organized to cope with the accounting workload occasioned by a project volume of over US\$14 million. Investments financed by the project are attentively supervised.

There is a professional audit of project accounts and utilization of funds each year, executed by a C.P.A. from Mauritius, who is also doing other audits of World Bank projects in Rwanda.

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CONCLUSION

Apart from the administration of the MINISAPASO part of the FP II Project funds, this Project Office would be technically capable to handle the financial administration of the funds attributed to ONAPO also, provided it was augmented by a third accountant.

1.3. GOR Recurrent Cost Obligations for Family Planning 1989-1993

Annex 4, line 25, shows the TOTAL RECURRENT COST ESTIMATE FOR FAMILY PLANNING in the PUBLIC SECTOR for the period 1989 (10/01/88) to 1993 (09/30/93) and for each of the five Rwandan fiscal years, rising from RF 140.4 million (US \$2.24 million) in 1989 to RF 187.9 million (US\$ 2,67 million) in 1993. The latter amount is an indication for the recurrent cost obligations to be supported by GOR after the end of FP II Project. The Cost Estimates in Annex 4 are based on the following assumptions:

1. Figures concerning ONAPO Personnel Costs and "Other expenditures" and for 2.1. RECURRENT COST at MINISAPASO (see Annex 3) are based on the 1988 Budget drafts ("Prévisions Budgétaires"), i.e. for salaries and social security contributions on actual salaries (see Annex 2 and 3). These 1988 amounts have been augmented by 3.2% (inflation rate) per year. For details see Annex 1 and chapters 1.1.4. and 1.2.1. as well as footnotes in Annex 4.
2. The "OTHER COST" items financed by the GOR and AID have been increased by 3.2% each year also.
3. The "OTHER COST" items financed by IDA, UNFPA and GTZ remain unchanged until 1993. Project continuation or replacement by other donors after expiration (UNFPA: 1989, GTZ 1990) is assumed.
4. The important cost item of 15 supervisors for 17000 FP "animateurs" on the village level (totaling RF 14.7 million) is detailed in line 2 of Annex 4 and chapter 1.1.4.
5. 50% of the Recurrent Costs of the IDA/GOR financed Family Health Project (equalling RF 101.7 million, annex 4, line 17) which started in 1987 and will last until 1993 are considered as F.P. related. Financing is divided up between IDA and GOR according to the Project Financing Plan. The cost and financing volume of RF 101.7 million is not contained in Annex 6 "Overall Program Costs of FP II Project". For details see chapter 1.2.1.

An outlook on the FINANCING POSSIBILITIES by the GOR, USAID, UNFPA, IDA, GTZ is given in Annex 4, line 23 to 27. While in 1987 GOR financed 68% of ONAPO recurrent cost, the GOR percentage of Total Recurrent Cost for Family Planning is likely to rise from 71.2% in 1989 to 75.8% in 1993. This includes half of the recurrent cost in IDA Family Health Project (FR 10 million in 1989, rising to FR 31 million in 1992).

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In view of the austerity forced upon the GOR by the situation of the Rwandan national economy, the FP II Project Agreement should include GOR budgetary provisions of an irreducible character, covering recurrent cost requirements for the whole duration of the project. Their magnitude is indicated in Annex 4 (in RF 1000s) and in Annex 6, lines 16 to 23 (in US \$ 1000s).

Recurrent costs are, or may be incurred by other Departments of the GOR by FP activities (MINEPRISEC - Ministry of Education; MININTER - Ministry of the Interior and Communal Development). However, these activities can be supported by the personnel of these Departments, e.g. the appointed commune mayors and accountants, so that they should not give rise to additional recurrent costs for the GOR.

2. Cost Budgets (overall program costs - annual and life of project) for planned activities with identification of GOR contribution for each element.

Detailed estimated Cost Budget for the cost planned activities of FP II Project (Public Sector only) with financing provisions - USAID, GOR, other donors - are given in Annex 6, per year (Rwanda fiscal year 1988 through 1993, for estimating purposes regarded equal to US fiscal years 1988/99 through 1992/93) and totals for the complete project period of five years.

3. Assessment of accuracy of the PID Budget estimates for FP II Project

During the course of the analysis of Financial Management, Accounting and Recurrent Costs associated with FP II Project, the author has closely cooperated with the Futures' Group program experts. There were no indications that PID budget estimates for AID and - very small - GOR contributions to costs of Technical Assistance, Training (basic and upgrading) and Equipment were insufficient. On the other hand, PID estimates for GOR contribution to Recurrent Cost Budgets, totalling US \$ 3,500,000 do not cover more than 46% of the GOR Recurrent Cost Budget estimates established by the author (US\$ 7,539,000, see Annex 6). Of the total GOR contribution estimated in the PID, page 17, with \$3,635,000, the provisions for commodities (\$ 27,000 per year, i.e. \$135,000) had to be deducted to arrive at \$3,500,000, PID estimate for GOR Recurrent Cost estimate.

4. Assessment of the Magnitude of other Donor contributions to Family Planning in Rwanda 1988-1992

The compilation given in Annex 7 is based on the information collected by the Project Design Coordinator, the author, and one of the Futures Group experts (UNFPA). For details of the planned activities of other Donors see Futures Group study, "Other Donors Participation".

5. Constraints of inadequate Financial Resources of the GOR on its contributions to the Project

The GOR Budget policy in general and towards ONAPO especially during the years 1986, 1987, and, as far as one can see, for 1988 also (see chapter 1.1.2. for ONAPO and footnote c) in Annex 3 for MINISAPASO) leads to the recommendation in chapter 1.3. concerning the GOR's binding commitment to honor its budgetary obligations for the whole duration of FP II Project.

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One of the strongest emphases for the reduction of recurrent cost budget submission is always put on gasoline and vehicle maintenance by MINIFINECO and the CND. Yet the efficiency of IEC and FP services activities depends largely from adequate provisions for these expenditures.

In the CND discussion on the 1988 Budget Law on March 17, 1988 the demand for a general reduction of these cost items by 20% against 1987 has been raised (Bulletin Agence Rwandaise de Presse of 03/18/88, Page 5).

6. Analysis of Current Procedures for disbursing AID funding and Recommendations for possible changes

The analysis of current disbursing procedures leads to the following recommendations and conclusions:

- (a) to avoid diverting AID funds meant for other purposes to cover recurrent costs, the "pipeline effect" should be eliminated by all suitable means.
- (b) channeling funds through autonomous unities (ONAPO, Family Health Project Administration, etc...) is preferable to using GOR Treasury at the central, regional, and commune level. The latter way takes more time, primarily because of the (necessary) Budget execution control. Each Order form has to receive the visa of this control unit.
- (c) However, using the other way through autonomous units presupposes their capacity of establishing correct and comprehensive budgets, and to control the execution by efficient internal and external audit institutions.

As for the relevant capacities of ONAPO and PSF office (IDA/GOR-Family Health Project) reference to chapters 1.1.3. and 1.2.1. is made.

- (d) If the ONAPO Administrative and Finance Department in its present state (see 1.1.3.) should be trusted with disbursing funds to suppliers and contractors of services, USAID Kigali office could retain refunding until presentation of exact evidence that supplies or services concerned have been effected.

The eventual ONAPO Project Coordinator could be charged with control of supplies and services also. The head of Secrétariat Général and Public Relations Section is well capable to do so, see 1.3.1.1. above.

ANNEX I OMAPO RECURRENT COSTS, FINANCING AND COST BUDGETS 1984-1987, 1988 (PROVISIONAL)
- RF 1000's -

Line no.	BUDGET DE FONCTIONNEMENT (RECURRENT COSTS)	1 GOR Contribution (1) (PID)	2 1988 GOR Contribution (MINIFINECO)	3 Effective 1987	4 GOR 1986	5 Contribution 1985	6 1984
1	PERSONNEL COSTS	31,430	57,652	55,335	44,522	36,777	29,000
OTHER COSTS:							
2	VEHICLE MAINTENANCE		6,850 (2)	5,402			
3	FUEL		9,351 (2)	6,817			
4	RENT & related expenses		8,850	6,809			
5	INSURANCE		1,500	1,487			
6	OTHER		15,906	14,936			
thereof:							
7	PUBLICITY, INFORMATION		3,732	3,961			
8	TRAVEL ABROAD		3,851	2,188			
9	TRAVEL INDEMNITIES IN RWANDA		4,110	1,730			
10	SUB TOTAL OF OTHER COSTS	17,570	42,457 (2)	35,451	16,188	8,189	18,819
11	GOR FINANCED RECURRENT COSTS	49,000	<< 88,599>>	<< 75,664>>	<<57,430>>	44,966	48,619
12	RECURRENT COSTS FINANCED BY AVAILABLE ASSETS (BANK JAN.1)		<< 11,510>(3)	<< 15,122>(4)<< 3,200>>		-	-
13	RECURRENT COST WHICH SHOULD BE COVERED TOTALLY BY GOR	49,000	100,109	90,786	68,638	44,966	48,619
14	CURRENT PAYMENTS: AID	28,300 (3)	> 11,510 <	8,145	55,789	51,784	68,484
15	OTHER DONORS	16,700	16,701	12,300	2,229	16,538	6,875
16	TOTAL RECURRENT COST:	86,000	116,810 (5)	111,231	118,648	113,288	115,178
PERCENTAGE: GOR							
	AID, BUDGETED		68.0%				
	AID, EXTRAORDINARY (6)		7.3%				
	OTHER DONORS		10.1%				
BREAKDOWN OTHER DONORS							
	UNFPA	8,898 (7)	8,898 (7)	5,818	1,193	2,661	785
	IDA/P.S.F.	4,348 (8)	4,348 (8)	1,200	-	2,522	5,370
	GTZ/1984 to 1987 others	3,478	3,478	6,082	1,036	11,355	-
		16,700	16,700	12,300	2,229	16,538	6,875
	OMAPO sales & revenues (9)	-	-	-	638	1,115	35

- (1) not specified between OMAPO and MINISAPASO
(2) fuel & maintenance too low by about RF 3 million
(3) of USAID
(4) 11,248 of USAID, rest of UNFPA, see OMAPO Annual Report Draft 1987, page 91,92,99
(5) the (non existing) comprehensive OMAPO Recurrent Cost Budget 1988 would amount to this total
(6) Bank assets Jan. 1 1988 (line 12)
(7) contraceptives, maintenance, printing, till '89
(8) medical supplies (contraceptives, etc.)
(9) without Centre de Formation, these revenues to be budgeted

ANNEX 2

ANALYSIS OF ONAPO 1988 RECURRENT COSTS FOR FAMILY PLANNING

- RF 1000's -		1	2	3		
Line	S =SECTION SS =SUBSECTION	EMPLOYEES	SALARIES FEBRUARY 1988	ESTIMATED OCCUPATION FOR F.P.	ATTRIBUTED TO F.P.	PER EMPLOYEE
1	S Planification et Evaluation	2	121.9	90 %	109.6	
2	S Recherches	7	237.3	90 %	213.6	
3	SS Statistique et Informatique	2	66.8	90 %	60.1	
4	S Sante Familiale	4	111.1	100 %	111.1	
5	S Information, Education, Communication	1	33.4	100 %	33.4	
6	SS Formation et Programation scolaire	4	112.7	100 %	112.7	
7	SS Sensibilisation	3	98.1	100 %	89.1	
8	SS Documentation et Publications	4	93.1	90 %	89.2	
9	SS Prod'n Materiel Didactique	13	251.0	100 %	251.0	
10	S Bureaux Regionales (10)	107	1,917.2	100 %	1,917.2	
11	- Centre de Formation	27	238.7	100 %	238.7	
12	Subtotal Operational Units	174	3,277.2	98.4 %	3,224.7	
13	Management and Administration	61	1,176.4	98.4 %	1,157.6	
14		235	4,453.6	98.4 %	4,382.3	
15	for 12 months + remaining new engagements '88	235	53,443.2	98.4 %	52,588	
16		6	1,462.8	75 %	1,098	
17		241	54,906.0		53,686	FR 18,985/mois
18	+ 5% soc'l security		2,746.0	97.8 %	2,674	
19	TOTAL PERS. COST	241	57,652.0	97.8 %	56,360	FR 19,935/mois
20	OTHER COST (ONAPO BUDGET CALCULATION)		42,457	97.8 %	41,506	
21	TOTAL RECURR. COST		100,109		97,866	
22	Difference column 1 - 3		2,243	2.24%		

**ANNEX 3: ANALYSIS OF MINISAPASO 1988 RECURRENT
COST FOR F.P.**

-BF 1,000's-

BUDGET ELEMENTS (BUDGET DE FONCTIONNEMENT -RECURRENT COST)	GOR PROPO- SITION FOR 1988	1987 BUDGET	1986 BUDGET
1 Secretariat General	31.413	35.323a	45.430a
2 Thereof: estimated portion for FP (b)	125		
3 Dir. Gen. General Services (line 4+6)	13.819	12.497	10.237
4 Personnel Cost	10.157		
5 thereof: Direction	2		
6 Studies & Evaluation (6 employees)	15,7	1.598	
7 Other Costs	3.652		
8 thereof: Dir. Studies & Evaluation proportionally	15,7	575	
9 Total Dir. Studies & Ev. (line 5+7)	15,7	2.173	
10 40% thereof estimated for FP	669		
11 Dir. Gen. Social Affairs (line 11+13)	54.679	55.072	50.640
12 Personnel Cost	47.326		
13 thereof: Direction	2		
14 Basis Education & Family Promotion (12 employees)	17,48	3.584	
15 Other Costs	6.753		
16 thereof: Dir. Basis education & Family Promotion proportionally	17,48	505	
17 Total Dir. Basis Education & Family Promotion (line 12+14)	17,48	4.089	
18 50% thereof estimated for PF	2.045		
19 Dir. Gen. Public Health (line 18+20)	868.901c	894.475	875.773
20 Personnel Cost	703.007		
21 thereof: Dir. Médecine Intégrée (8 employees)	10,3	2.303	
22 Other Costs	165.894		
23 thereof: Dir. Méd. Intégrée proportionally	10,3	543	
24 Total Dir. Méd. Intégrée (line 19+21)		2.846	
25 35% thereof estimated for PF		980	
26 Total line 3+10+17	937.399		
27 Estimated Recurrent Cost for FP (line 9+16+23)	3.694		

- a) 1986: 14,8 mill., 1987: 141.000 in-country travel expenses
b) line 9+16+23 in percent of line 24 (=0.42); percentage applied to line 1
c) cut-down gas and vehicle maintenance by 18 millions, of personnel
cost by 12 million BF against 1987

ANNEX 4: ESTIMATED RECURRENT COST BUDGET AND FINANCING POSSIBILITIES FOR FAMILY PLANNING 1989 - 1993

BUDGETS DE FONCTIONNEMENT (RECURRENT COSTS) -RF 1,000s-		ESTIMATED BUDGETS, GOR & OTHER DONORS CONTRIBUTIONS					TOTAL	Column 6 in: US\$ 1,000s (18=70RF)
		1989	1990	1991	1992	1993	1989-93	
		1	2	3	4	5	6	7
1. ONAPO								
1.1. PERSONNEL COSTS								
1	idea, originating from projects in execution(**)	59.400	61.300	63.300	65.300	67.400	316.700	4.524
2		1.200	2.400	3.600	3.700	3.800	14.700	210
3	Total Personnel Costs	60.600	63.700	66.900	69.000	71.200	331.400	4.734
1.2. OTHER COSTS								
4	contraceptives, medical supplies	13.440a	13.870a	14.300a	14.800a	15.200a	71.610	1.023
5	maintenance, printing, miscellaneous	1.890a	1.890a	1.890a	1.890a	1.890a	9.450	135
6	maintenance vehicles+ fuel**	8.250b	9.300b	10.800b	11.200b	11.500b	51.050	729
7	direct procurements (of items in lines 4 to 7) by GTZ, Butare	12.150b	14.100b	16.900b	17.500b	18.000b	78.650	1.124
8	other expenditures	3.000	3.000	3.000	3.000	3.000	15.000	214
		27.070b	27.940b	28.810b	29.710b	30.710b	144.240	2.061
9	Total Other Costs	65.800	70.100	75.700	78.100	80.300	370.000	5.286
10	1.3. COMPREHENSIVE ONAPO BUDGET	126.400	133.800	142.600	147.100	151.500	701.400	10.020
1.4. FINANCED by: GOR								
11	USAID	88.800	95.500	103.600	107.400	111.000	506.300	7.233
12	UNFPA	20.900	21.600	22.300	23.000	23.800	111.600	1.594
13	IDA	8.890	8.890	8.890	8.890	8.890	44.450	635
14	GTZ	4.340	4.340	4.340	4.340	4.340	21.700	310
15		3.470	3.470	3.470	3.470	3.470	17.350	248
2. MINISAPASO (F.P. RELATED COSTS)								
16	2.1. RECURRENT COST at: MINISAPASO	4.018	4.147	4.280	4.417	4.558	21.420	306
17	2.2. FAMILY HEALTH PROJECT(***)	10.000	15.000	20.000	25.800	30.900	101.700	1.453
18	2.4. RECURT COST MINISAPASO for FP	14.018	19.147	24.280	30.217	35.458	123.120	1.759
2.5. FINANCED by: GOR, corresp. 2.1.								
19	GOR(****)	4.018	4.147	4.280	4.417	4.558	21.420	306
20	IDA	8.480	12.720	16.360	21.878	26.203	86.241	1.232
21		1.520	2.280	3.040	3.922	4.697	15.459	221
22	3. TOTAL RECURRENT COST Family Planning (line 10+18)	140.418	152.947	166.880	177.317	186.958	824.520	11.779
4. FINANCED by: GOR								
23	USAID	101.298	112.367	124.840	133.695	141.761	613.961	8.771
24	UNFPA	20.900	21.600	22.300	23.000	23.800	111.600	1.594
25	IDA	8.890	8.890	8.890	8.890	8.890	44.450	635
26	GTZ	5.860	6.620	7.390	8.262	9.037	37.159	531
27		3.470	3.470	3.470	3.470	3.470	17.350	248

(**) 5 new supervisors each year 1989, 1990, 1991 for intended 17,000 voluntary FP "animateurs" at RF 240,000 per year. The same amount per agent is added to "Fuel" and "Maintenance Vehicles" (2/3 and 1/3)

(***) figures based on 50% (FP attributed) of amounts in Financing Plan and 1987 Budget of FH Project

(****) GOR contribution for Family Health Project, contained in "Budget de Développement" not in MINISAPASO-Budget de fonctionnement

a) continuation or other donor supposed

a) fully financed by USAID and other donors

b) partly financed by USAID and other donors

+) augmented by RF 1 million, provision 1988 too low

++) augmented by RF 2 million, provision 1988 too low

ANNEX 5

SUMMARY OF ONAPO'S BUDGET FOR 1988

The previsionnal budget prepared by ONAPO for 1988 shows the following main points:

TOTAL: 108,698,153 RF (approx. US \$ 1,441,618)
(Budget de Fonctionnement, RF 100,109,153;
Budget d'Investissement, RF 8,589,000)

Categories applied by ONAPO

A) "Activities" (without Personnel Costs)	RF
1. Santé Familiale:	
a) 3 seminars on community-based contraceptives delivery	1,500,000
b) supervision in the field	500,000
c) mobile team (contraceptive delivery)	150,000
d) distribution of FP methodology guide	1,000,000
	<u>3,150,000</u>
2. IEC	
a) Education of 17,000 volunteer promoters in the communes and sectors (basis seminars)	246,000
b) Quarterly rehearsal days	492,000
c) Supervision CCDFP activities	1,200,000
d) Education material production	903,000
e) Graphic arts, theater, cinema, video	3,080,000
f) Broadcasting	2,250,000
g) Training and education (health personnel, schools) including program elaboration	4,131,000
	<u>12,302,000</u>
3. Documentation, publications	<u>3,086,000</u>
Subtotal "Activities" (without Personnel Costs)	<u>18,538,000</u>

Continued

Balance: Subtotal "Activities" (without Personnel Costs)	18,538,000
B) Other costs	
1. Statistics, Data Processing	454,000
2. Rents, maintenance, water, electricity for central office, training center and regional centers	9,840,000
3. Vehicles maintenance	6,850,000
4. Maintenance office furniture and machines	270,000
5. Postage and telephone	800,000
6. Travel abroad	3,051,000
7. Insurances	1,500,000
8. Customs fees	250,000
9. Indemnities (Board Meetings) and representation	404,000
10. Indemnities de caisse	150,000
11. Temporary labor; UMUGANDA utensils	350,000
Subtotal "Other Costs"	23,219,000
Subtotal A + B	42,457,000
C) Personnel Costs	57,652,000
Total "Budget de Fonctionnement" (Recurrent Cost Budget) A + B + C	100,109,000
1) Buying two vehicles	2,800,000
2) Office furniture	789,000
3) Telephone at Centre de Formation	2,000,000
4) Loans to staff	3,000,000
Total Budget Equipment and Loans to Personnel	8,589,000
GRAND TOTAL	108,698,000

ANNEX 6: OVERALL PROGRAM COSTS FP II PROJECT (excluding PRIVATE SECTOR)

-USD 1,000- (US\$ 0 = 1000)

	ANNUAL BUDGET ESTIMATES					1989-1993 USAID contribution PID figures	1989-1993 GOR contribution	1989-1993 Other Donors' contribution	1989-1993 Total Cost & Financing
	1989	1990	1991	1992	1993				
1 TECHNICAL ASSISTANCE; 2 TRAINING; EQUIPMENT									
1 Technical Assistance, long term	350	350	175	175	175	1225			
2 short term	68	68	68	68	68	340			
3 Project Assistant	4	4	4	4	4	20			
4 Sub-total	422	422	247	247	247	1585			
5 Basic or upgrading training long term	120	60	60	60	60	360			
6 short term	60	60	60	60	60	300			
7 study tour	40	25	25	25	25	140			
8 in-country	40	40	40	40	40	200			
9 Sub-total	260	185	185	185	185	1000			
10 Evaluation/audit	-	25	-	25	50	100			
11 Commodities: vehicles, office	178	53	53	48	18	350			
12 other	25	25	25	25	25	125			
13 GOR contribution to equipment	27	27	27	27	27		135		
14 Total Investment in Training, Education, Equipment	912	737	537	557	552	3160	135	-	3295
RECURRENT COST									
15 Supervisors for 17,000 promoters	17	34	51	54	55		211		211
16 Personnel Cost: DMAPO	849	876	904	933	963		4525		4525
17 MINISAPASO	57	59	61	63	65		305		305
18 Total Personnel Cost									
19 Other Costs: for DMAPO	940	1001	1081	1116	1147	1594**	2498	1193	5285
20 Contingencies									
20 Inflation, Rate of Exchange	100	113	127	142	158	640			640
21 Total Recurrent Cost	1963	2083	2224	2308	2388	2234	7539	1193	10966
22 Overall Program Costs FP II Project***	2875	2820	2761	2865	2940	5394	7674	1193	14261
23 GOR contribution anticipated in PID (3.580 thereof for Recurrent Costs)							3635		

* includes other small costs

** inclusive of contraceptives 150

*** contrary to Annex 4, FP-related costs of IDA/IDN Family Health Project are not included

ANNEX 7: PROJECTED LEVELS OF OTHER DONOR CONTRIBUTIONS TO FAMILY PLANNING IN RWANDA 1988 TO 1992

- in US \$ 1,000s -

DONOR/Project	DURATION	CIVIL WKS. EQUIPMT., CONTRD.	TECHNICAL ASSISTANCE	TRAINING FELLOWSH	RECURRY. COSTS	STUDIES EVALTH.	OTHER	PROJECT TOTAL	OBSERVATIONS

WORLD BANK-IDA MID Family Health Project	2/87-2/93	7.464	1.212 725	776	3.600*	234	440	14.451	!>1.985 thereof ! contained in ! Annex 4

UNFPA Project FP/FM Progr.	1987-1989	302	120	322	381*			1.125	!> 100% in Annex 4
Project Assist. to ONAPO	1987-1991	+	+		+			750	! for population studies ! in cooperation with ! 6TZ
Project IEC	1987-1989				+			513	!
Subtotal UNFPA								2.388	!

German Agency for Technical Cooperation Project ONAPO-6TZ BUTARE-GIKINGORO	2/88-1/91	600e	530e	220e	150*	-	-	1.500	!>100% in Annex 4 !e=estimated
UNICEF, 6 projects	1988-1992	-	-	1050	-	82	50	1.182	!for 1.165 other donor !funding required

TOTAL								19.521	!

Value of FP activities of donors not listed above was not available,
as there are: IPPF, Columbia University, Governments of Belgium and of
People's Republic of China

*> no detailed amounts available

SUPPLEMENT ESTABLISHED APRIL 20, 1988 AFTER REDUCTION OF DEFINITE GOR SUBSIDIES FOR ONAPO TO RF 77,090,000

DEVELOPMENT OF MINISAPASO BUDGET ELEMENTS 1986 TO 1988
INCLUDING ONAPO SUBSIDIES (GOR AND APPROVED)

-RF 1000's-	Budget 1986	Initial Budget 1987	Reduced Budget 1987	Subsidies Shifted To MINIFINECO Budget-1988	- Cuts by C.N.D. (20%) + Increases	Definite Budgets 1988	Columns 1-6 %
	1	2	3	4	5	6	7
Dir. Gen. Public Health							
Gasoline	47,846	49,424	44,786		-8,942	35,764	75%
Vehicle Maintenance	39,269	35,874	31,156		-8,981(1)	22,175	56%
Personnel Costs	679,773	716,853	716,853			716,853	105%
Other Costs	117,805	111,760	101,760		+ 33,438	135,198	115%
Sub Total	884,773	913,911	894,475		15,515	989,990	103%
Subsidies	256,918	253,418	231,418	-231,418			
Total Public Health	1,141,691	1,167,329	1,125,893	-231,418	15,515	989,990	88%
Dir. Gen. Social Affairs							
Gasoline	2,253	2,415	2,415		-483	1,932	86%
Vehicle Maintenance	1,260	1,800	1,800		-360	1,440	114%
Personnel Costs	44,292	47,926	47,926			47,926	108%
Other Costs	2,835	2,931	2,931		450	3,381	119%
Sub Total	58,640	55,072	55,072		-393	54,679	108%
Subsidies							
-ONAPO	57,438	79,898	79,898(2)	-79,898(3)			
-Other	28,888	28,888	28,888	-28,888			
Total Social Affairs	128,078	154,162	154,162	-99,898	-393	54,679	43%
Dir. Gen. General Services							
Gasoline	631	1,365	1,365		-273	1,092	173%
Vehicle Maintenance	540	1,080	1,080		-216	864	160%
Personnel Costs	8,316	9,246	9,246			9,246	111%
Other Costs	750	886	886		-75	731	97%
Total General Services	10,237	12,497	12,497		-564	11,933	117%
Administrative Offices							
Gasoline	1,898	2,363	2,363		-473	1,898	100%
Vehicle Maintenance	1,980	2,340	2,340		-460	1,872	95%
Personnel Costs	16,420	23,145	23,145			23,145	141%
Other Costs	19,132	12,545	4,481(4)		-75	4,486	23%
Sub Total	39,430	40,393	32,329		-1,016	31,313	79%
Subsidies	6,000	6,000	3,000	-3,000			
Total Administrative	45,430	46,393	35,329	-3,000	-1,016	31,313	69%
TOTAL MINISAPASO Budget	1,325,428	1,380,381	1,327,881	-333,588	+ 13,542	1,087,915	76%

(1) 29%

(2) Officially 83,493 (includes 3,426 investments) of which 4,483 were withheld.

(3) The CND cut the ONAPO Budget Submission (Recurrent Costs) already reduced from 100,109 to 88,599 by MINIFINECO (Annex 1, column 2) by another 12,935 to 75,664 (same level as 1987). Carried through to 1993, this would mean a reduction of GOR contribution to ONAPO Recurrent Cost for FP by 14.6%, i.e. US\$ 1,056,000 or RF 73.9 million (line 11 of Annex 4).

(4) Cashiers indemnities abolished (8,864).

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ANNEX E

ADMINISTRATIVE ANALYSIS

1.1. Introduction

An informed analysis of administrative aspects of the project is possible for several reasons. First, AID has had first hand experience with a major beneficiary of the proposed project, ONAPO, as a result of its previous assistance to that agency dating back to 1981. Second, as part of pre-project planning, USAID commissioned a thorough evaluation of the previous project and, subsequently, a number of studies on the family planning situation in Rwanda and its institutions. All of these papers included, or directly focused on, administrative and management issues on both the private and public sectors. Third, the development and early implementation of the World Bank's 1987 Family Health project with MINISANTE sheds valuable light on management consideration relating to that institution. AID is therefore in a good position to assess the project's administrative considerations and to deal with their implications in its design.

2.1. Rwandan Agencies

2.1.1. ONAPO

ONAPO was established in 1981 as the country's official policy, advocacy, public awareness and research/analysis instrumentality for family planning and demography. An autonomous agency now under the supervision of the Ministry of Health, ONAPO has now grown from a fledgling entity to an organization with 241 employees and a budget of \$1.4 million. The Director of ONAPO reports directly to the Minister of Health and is a confidant of the President. Her dynamic leadership and presence account for much of ONAPO's success in building popular awareness and political impetus for family planning. It is acknowledged, however, that management and organization are not her strongest suits.

ONAPO's organizational structure is shown in Chart A. Although officially "autonomous", its budget and personnel appointments, particularly for senior Administrative positions, must be approved by an Administrative Council and sometimes by the Civil Service Administration and the Office of the President. These constraints tend to slow down management and senior personnel actions. ONAPO has frequently had difficulty retaining well qualified employees because many of its professional positions are not "officially decreed", that is, have career status and tenure. As a result, there has been considerable staff turnover and unfilled vacancies.

As indicated in the diagram, ONAPO headquarters is organized in four units of varying size and importance, all of which report directly to top management, the Office of the Director. Two of these (Sections) are quite small, the other two (Services) much larger. One of the latter (Research and Programs) is responsible for all of ONAPO's substantive activities while the second (Administrative and Finance) for nearly all of ONAPO's administrative, logistic and financial operations. The head of Research and Programs also performs some of the functions of deputy director and runs the Office in the absence of the Director. In addition to headquarters, ONAPO's structure

includes ten regional offices, one for each prefecture, and a training center (financed by AID) located in a suburb of the capital. An important organizational problem of ONAPO is over-centralization of decision making with even minor administrative or financial actions requiring the Director's signature.

Up to the present, emphasis in ONAPO has focused on initiating, developing, accomplishing and expanding family planning activities throughout the country. As indicated elsewhere, results have been indeed noteworthy. Less attention, priority and staff resources have been given to management, budgeting and accounting procedures. Weaknesses in these areas have been noted in the 1987 evaluation and by a number of consultants including those engaged in planning for the new project. Although a number of improvements have been noted, deficiencies continue in management, financial and budgeting practices. These are summarized below, together with a discussion as to how the project proposes to address them.

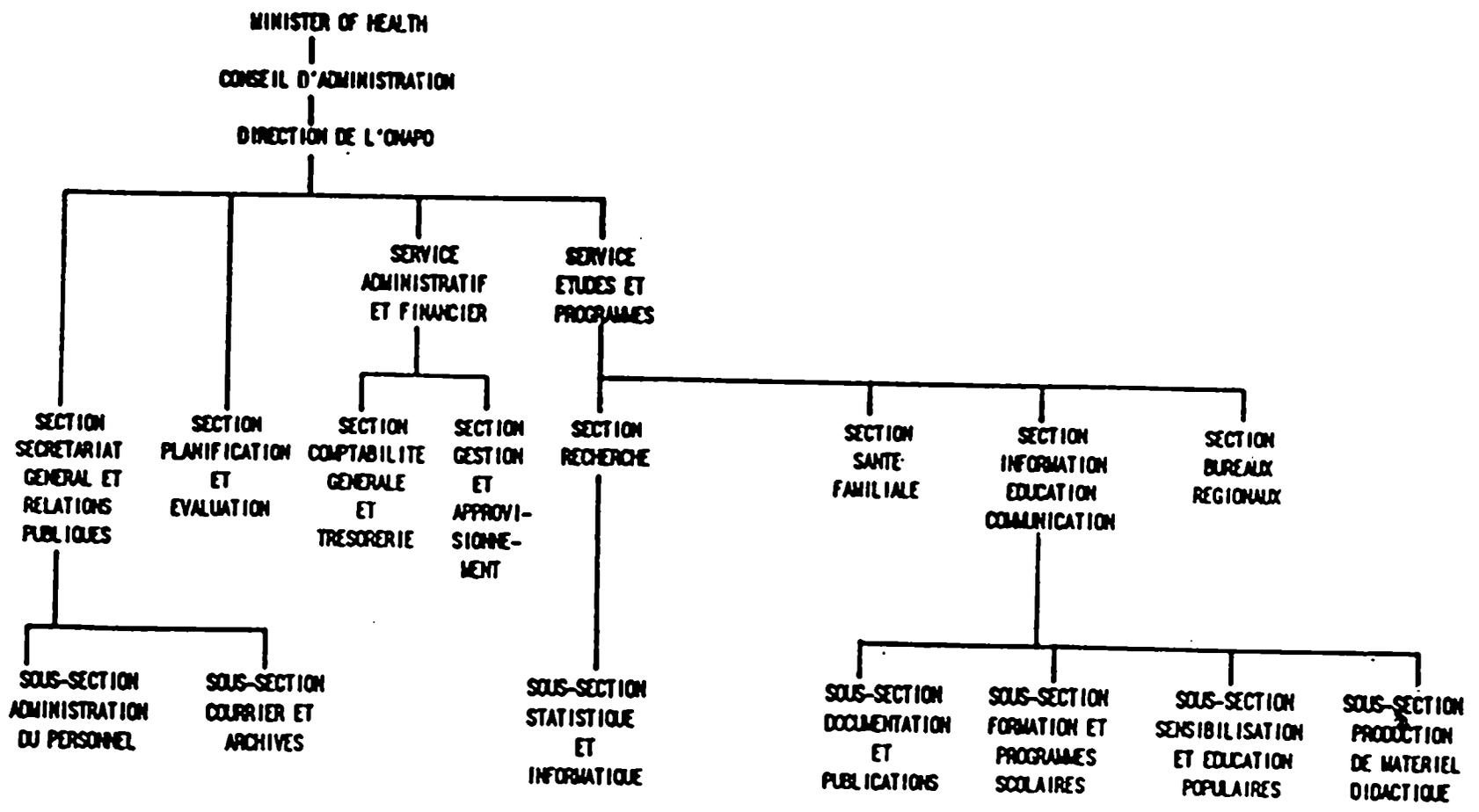
2.1.1.1. Administration

Inadequate procedures in management and administration have been cited by evaluators and consultants as chronic ONAPO problems. Difficulties range widely in character including inadequate coordination with MINISANTE, inability to prepare annual work plans, poor management of equipment, supplies and vehicles and dispersed inventory controls. A recent consultant characterized ONAPO's administrative procedures as "bureaucratic, rigid and authoritarian". Responsibility for inventory management of stocks of supplies and commodities is divided among two offices. While some improvements were noted in the management of ONAPO's motor pool (which absorbs 25% of the operating budget), other long-standing deficiencies, e.g. poor controls on fuel consumption, still persist. Also noted is a need to provide greater autonomy and status to the management of the training center and the appointment of a qualified director if it is to fulfill its potential.

ONAPO's administrative problems limit its effectiveness as a family planning institution and impair its capacity to make optimal use of assistance under the new project. These problems have been discussed frankly and at length with ONAPO leadership; there is understanding and agreement that change is an essential element to accompany the provision of further assistance.

Progress in initiating and implementing these changes will require careful monitoring and periodic review -- functions that will be exercised by the ONAPO Project Coordinator (for ONAPO) and by the resident management/financial advisor in consultation with the USAID Project Officer (for AID). Significant accomplishment or shortfalls will be reported to the Comit Mixte with recommendations for appropriate action. These procedures are described more fully in the implementation plan.

CHART 1: CURRENT ORGANIZATIONAL CHART OF ONAPO



Note: The Centre de Formation at Kicukiro will probably come under the Sous-Section Formation et Programmes Scolaires.

2.1.1.2. Financial Management and Budgeting

Financial management, fiscal control and budgeting practices represent other areas in which ONAPO is experiencing problems. These may have been exacerbated by unexpected fluctuations in donor support or by delays and uncertainties in the GOR budgetary process. A more basic problem is an inadequacy of qualified or adequately trained staff and prolonged vacancies in key positions.

While budgeting practices have improved, ONAPO is still unable to prepare, on an annual basis, accurate, comprehensive expenditure and revenue budgets, by activity and source of financing. Annual budgets and annual work plans show little interrelationships. Thus, ONAPO lacks a means of relating its priorities to its resources. When there is a budget crunch, ONAPO resorts to such expedients as delaying payments due suppliers, the social security agency or the treasury (for taxes) or "borrows" unexpected balances from donor contributions.

Accounting, disbursing and cash management procedures were deemed to be below accepted practices in a recent review. For example, invoices and vouchers are difficult to track down, bookkeeping of USAID donations is done in pencil, revenues or subsidies for running expenses are inadequately recorded and poorly related to expenditure, no record is kept of grants payable, budget management of cash on hand is adequate, financial reporting is irregular and incomplete, and journal entries are not usually maintained. ONAPO's financial records and procedures are such that the establishment of an internal review and audit service, reporting directly to the Director, and of an independent external audit has been recommended.

The financial management difficulties can be traced to problems of staffing and to inadequate emphasis on establishing sound financial and accounting procedures during the earlier project. Until recently filled, the position of head of Administrative and Financial Services had been vacant since 1983. The new incumbent has no financial or administrative background but is well educated and regarded as a person of good potential if provided with adequate training. The staff of the Accounting and Treasury Section likewise requires considerable training, particularly for the Chief Accountant. In addition, the vacant position for head of the section on management and supply and the position of "Foreign Donor Contributions" in the Accounting Section requires filling by people with strong management and budgeting skills. Training (external and in-country) must be accompanied by considerable technical assistance to help plan, guide and monitor improvements. This would be another key task of the long term manager/financial advisor in addition to short term assistance. Thanks to the administrative/financial/management analyses done by Alain Joyal in 1986 and 1988, ONAPO has a fairly complete road map of what needs to be done and how.

These issues have been discussed at length with ONAPO leadership and senior staff. ONAPO understands the importance of financial management improvements to strengthen its own effectiveness and to assure that donor inputs are well spent. Agreement has been reached on a time-phased program of corrective

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measures -- including the preparation of annual work plans and budgets -- that will be included in the project agreement. Many of these actions will be taken as part of the project's covenants while subsequent measures will be required as elements of annual work plans. Again, careful monitoring and review will be necessary by the ONAPO Project Coordinator (for ONAPO) and by the resident management/financial adviser in consultation with the USAID/Rwanda Project Manager (for AID), with periodic reporting to the Comité Mixte.

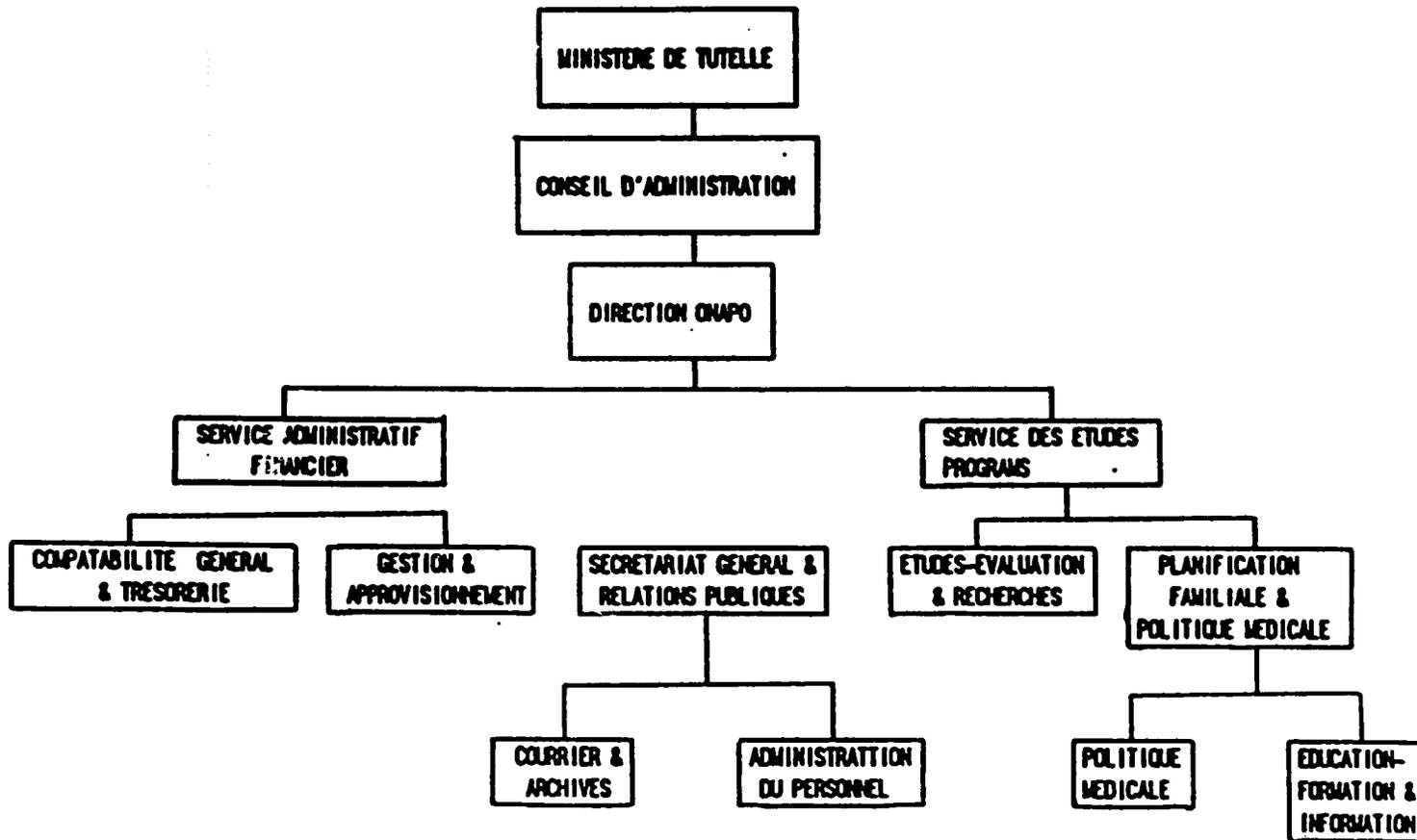
The picture that emerges from an administrative analysis of ONAPO is of an over-centralized organization with weak administrative and financial practices. There is a need to delegate greater responsibility (and accountability) for implementation actions but this must be accompanied by improved procedures, upgraded skills and increased leadership in mid-level management. A major improvement could result if the position of Deputy Director or Secretary General were established, filled with a well qualified administrator charged with responsibility for internal management of ONAPO, leaving the Director free to perform the leadership, advocacy and policy roles she does so well. This idea has been discussed with the ONAPO Director with encouraging results. However action (and the selection of a candidate) would require approval of the Administrative Council, the Minister of health, the Civil Service Office and probably the Office of the President -- a long and uncertain process. USAID proposes to continue pressing the proposal with the GOR. However, it does not propose to hold up the project pending a decision because it believes that the project's viability will be secured by the actions required in the Project Agreement.

2.1.2. MINISANTE

The Ministry of Health (MINISANTE) has general responsibility for policy, regulation, and public sector services in Rwanda. Its responsibility for providing family planning and nutrition services grew out of a reorganization in 1984 in which the Ministry of Health and the Ministry of Social Affairs were combined and ONAPO and the Nutrition Bureau came under the jurisdiction of the new entity.

The Ministry's headquarters now comprise two Departments, General Services, and Public Health. Within the latter, a Division of Maternal and Child Health, comprising Offices of Family Planning, Nutrition and EPI, reports to a Direction of Integrated Medicine which in turn reports to the head of the Department, the Director General of Public Health (see Chart B). Below the level of the Minister, decision making on health questions is largely concentrated in the hands of its ranking civil servants, the Secretary General and the Director General of Public Health, the former on matters of national policy, the latter on administering the Department and its ten Medical Regions (Prefectures) and their directors. Subordinate units at headquarters, including the Direction of Integrated Medicine, and its components, have little authority. Staffing is lacking in experience and training, particularly in management. Dilapidated buildings, overcrowded offices and lack of equipment severely impede efficiency. Improvements in this situation may be expected as a result of the World Bank's Family Health project (see below).

CHART 2: FORMER ORGANIZATIONAL CHART OF ONAPO (AUGUST 1984)



Rwanda's health infrastructure includes 27 hospitals, 170 health centers and 69 dispensaries. Sixty percent of these are operated by MINISANTE, the remainder by religious missions under MINISANTE supervision. Provision of health services in MINISANTE facilities leaves much to be desired. "Buildings are often dilapidated, poorly maintained and too small to accommodate their outpatient load. Medical equipment is generally minimal, and being old, is difficult to maintain. The number of vehicles is insufficient, and most health centers have no vehicles at all" (World Bank, 1986).

In addition to lack of physical facilities, Rwanda's health infrastructure suffers from lack of staff, both quantitatively and in regard to capacity. Shortages are particularly acute for nurses and nurses aides. Another problem is a lack of in-service training programs for upgrading staff skills. The introduction of ONAPO's training in FP was the first large scale organized attempt at in-service training for health staff.

For these reasons the Ministry of Health was ill equipped to provide, in addition, family planning services when it inherited this responsibility as a result of the 1984 reorganization. Its already overburdened staff had no training in the subject nor was the Ministry organized to provide contraceptives and follow up advice and monitoring.

The World Bank's 1987 Family Health project represents a major effort to strengthen MINISANTE's capability to deliver health services to the population and to integrate them with the provision of health care in general and maternal child care in particular. By-passing the Ministry's normal chain of command, an Office of the Project Coordinator has been established (at the World Bank's request) which reports directly to the Secretary General and which supervises project implementation.

Summarizing, the project contemplates (a) a major in-service training program for 1,400 MINISANTE personnel in FP technology and skills, (b) the upgrading of 30 health centers (including facilities for FP, nutrition and MCH services), (c) training and technical assistance for the MCH Division and its FP and Nutrition Offices, (d) monitoring and supervision of integrated MCH services at eight refurbished regional offices, (e) expanded pre-service training of nurses and nurses aides including the construction of two nursing schools. Although the project has gotten off to a slow start, it represents an important effort to re-orient the Ministry's health care priorities and to align them in a way which complements ONAPO's policy, information and public awareness responsibilities.

AID, in the current project, will strengthen this approach. Fortunately, the joint PP team involved senior representatives from both ONAPO and MINISANTE. The inclusion of both institutions in the AID project helps to assure the complementarity of AID assistance and, with respect to MINISANTE, will supplement and reinforce the support being provided by the World Bank. As indicated in the Project Description, technical assistance and training has been carefully designed to provide skills in areas not covered, or insufficiently attended to, by the Family Health project. Also to be noted is that AID assistance will not by-pass the existing organizational structure of MINISANTE. Rather, AID will work within that structure and will seek to improve it so that it can accommodate to, and benefit from, the proposed

changes. Furthermore, by dealing with both institutions in the same project, AID can help to ameliorate and resolve the problems of coordination between them.

2.1.3. Public Sector Coordination

The FP program in Rwanda has suffered from problems of coordination and jurisdiction between MINISANTE and ONAPO. The source of these problems are largely historical and partly attitudinal. ONAPO was created in 1981 with a mandate to formulate policy and to launch a campaign of consciousness raising, information dissemination and policy research in support of family planning. Although its statutory authority did not include the furnishing of contraceptive supplies and services, ONAPO has performed this function from the beginning as its regional offices (which are separate from the MINISANTE health centers) were set up and began functioning. This configuration had the advantage of getting FP service delivery off to an early start. The disadvantage was its separation and lack of reinforcement from MCH nutrition and other health care services plus the inconvenience and stigma which often discouraged potential users.

Ambiguity of function between ONAPO and MINISANTE was intensified after 1984 when ONAPO came under the latter's jurisdiction. Although MINISANTE was the health delivery institution of the GOR, it had neither the staff, experience or expertise to add FP to its functions. Moreover, it was widely regarded as being dubious as to the merit of FP and whether it should be added to the Ministry's already overloaded portfolio. Confusion and ambivalence as to ONAPO/MINISANTE relationships has continued until quite recently. In 1987, for example, the AID project evaluation team noted: "...the ambiguous nature of their relationship at the regional level, have limited national capacity to deliver efficient and effective FP services".

Events over the past two years have laid the basis for improved cooperation and coordination. The first is the initiation of the Family Health Project which aims to strengthen MINISANTE's capability to provide FP services as part of an integrated MCH approach. The second is a Directive issued by the Minister of Health on March 3, 1988. The Directive reemphasized the priority the GOR attaches to FP and its policy of fully integrating it into all health care services throughout the country. In regard to ONAPO/MINISANTE collaboration, the Directive clearly assigns coordinating responsibility at the regional level to the MINISANTE Medical Director while the ONAPO Medical Representative "provides support for MCH/FP activities" and, in addition, is responsible for managing ONAPO's demographic, IEC and liaison activities including the provision of FP supplies and drugs. Thus the Directive endorses the continuation of ONAPO's present functions while bringing them within the policy framework and supervision of MINISANTE.

The present project will reinforce these gains in program coordination. A project coordinating committee ("comite mixte") will be established with representation from MINISANTE, ONAPO and USAID. In addition to serving as a vehicle for reviewing and coordinating US inputs and project performance, it will also serve as a forum for USAID to press for and monitor improved FP coordination within the public sector generally.

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3.1. Private Sector Arrangements

The private sector FP program will be a new initiative of the Project. A new body, Comite Consultatif, will be established with ONAPO, USAID, and private sector representatives to develop the role of NGOs, provide assistance in designing proposals, review and approve sub-grants and coordinate the private sector component of the Project.

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ATTACHMENT A

UNCLASSIFIED

STATE 396241

C

ACTION: AID INFC: CDA

VZCZKXK062
PP RUBLOD
LB RUEHC #6241 3570634
ZNR UUUJC 228
F 23 0302 DEC 87
FM SECSTATE WASHDC
TO AMEMBASSY SINGAPORE PRIORITY 0928
BT
UNCL S STATE 396241

LOC: 11 538
23 DEC 87 0932
CN: 25926
CHRG: AID
DIST: AID

*Actions
TCW*

AIDAC

I.O. 12356: M/A

SUBJECT: FAMILY PLANNING 11 PID (696-0128) - ECPR REVIEW

THE ECPR MET ON DECEMBER 18, 1987 AND APPROVED THE SUBJECT
PID. A GUIDANCE CABLE WILL FOLLOW. WHITEHEAD
BT
#6241

NNNN

UNCLASSIFIED

STATE 396241

15

SECTION: AID INFC: CDA

VZCZCKKY424
BB RUEHLGE
EE RUEHPC #2926/01 0151110
ZNY UUUUU ZEE
R 151106Z JAN 88
FM SECSTATE WASHDC
TO AMEMBASSY KIGALI 7865
BT
UNCLAS SECTION 01 OF 02 STATE 012926

LOG: 27 498
15 JAN 88 1144
CN: 07935
CHRG: AID
DIST: AID

Action: CS

AIDAC

P.O. 12358: N/A

SUBJECT: ECPR GUIDANCE CABLE - RWANDA FAMILY PLANNING
II PII (090-0128)

1. THE ECPR FOR THE SUBJECT WAS CHAIRED BY AFR/ED CAROL PEASLEY ON DECEMBER 18, 1987 AND ATTENDED BY AFR/TF, AFR/EA, AFR/TR/EPN, PPC/PDR/SD, ST/POP/IT, ST/POP/PD AND CARINA STOVER OF OAR/RWANDA. THE FOLLOWING GUIDANCE IS PROVIDED FOR THE PP DESIGN.

2. MANAGEMENT: THE ECPR WAS CONCERNED WITH THE NATIONAL POPULATION OFFICE (ONAPO) AND MINISTRY OF HEALTH (MINISAPASO) MANAGEMENT CAPABILITIES. MISSION IS REQUESTED TO CONDUCT A DETAILED INSTITUTIONAL ANALYSIS TO DETERMINE WHETHER ONAPO AND MINISAPASO HAVE THE INSTITUTIONAL AND MANAGEMENT CAPACITY TO PLAN AND IMPLEMENT THE PROJECT. IN PART, ECPR'S CONCERN IS BASED UPON THE AUGUST 1987 MCH/FP EVALUATION WHICH FOUND THAT (1) THE MCH/FP PROJECT HAD BEEN ASSIGNED TO A LOW ORGANIZATIONAL LEVEL WITHIN THE MINISAPASO AND (2) THE INSTITUTIONAL CAPACITY OF IMPLEMENTING RWANDA'S POPULATION POLICY IS SERIOUSLY UNDERDEVELOPED. ECPR IS

INTERESTED IN KNOWING HOW ONAPO AND MINISAPASO INTERACT AND COORDINATE THEIR ACTIVITIES WITH OTHER MAJOR DONORS. IN THIS REGARD, THE PP SHOULD NOTE WHAT WILL BE THE INSTITUTIONAL ARRANGEMENTS BETWEEN THESE AGENCIES AND MAJOR DONORS UNDER THE PROJECT.

ECPR WAS ALSO CONCERNED WITH THE NUMBER AND COMPLEXITY OF ANTICIPATED ACTIVITIES UNDER THE PROJECT. THE PROJECT MAY BE TRYING TO ACCOMPLISH TOO MUCH AT ONE TIME. THEREFORE, ECPR RECOMMENDS THAT THE PP DESIGN GIVE SPECIAL ATTENTION TO (A) MANAGEMENT IMPLICATIONS OF SHIFT TO PRIVATE SECTOR DELIVERY SYSTEM; (B) IMPACT OF CENTRALLY FUNDED ACTIVITIES; AND (C) IDENTIFICATION OF IMMEDIATE PRIORITY ACTIVITIES UNDER THE PROJECT AND THOSE WHICH CAN BE IMPLEMENTED IN LATER YEARS.

3. STAFFING: THE ECPR QUESTIONS IF THE LOWE WFO POSITION IN THE MISSION WILL BE ADEQUATE FOR AID PROJECT

Best Available Document

MANAGEMENT. ECPR RECOMMENDS THAT THE PP DESIGN EXPLORE SEVERAL POSSIBILITIES INCLUDING IDI, PROJECT FUNDED PSC AND PSN ASSISTANCE.

4. BUDGET: GIVEN THAT FAMILY PLANNING IS THE MISSION'S NO. 1 PRIORITY, PROPOSED MORTGAGE FOR THIS PROJECT WOULD BE ACCEPTABLE. HOWEVER, THE MISSION SHOULD BE PREPARED TO FUND THE PROJECT FROM ITS CURRENT FY 86 AND PROPOSED OUTYEAR CY2 LEVELS. IF THIS IS NOT POSSIBLE, THE PROJECT SHOULD BE SCALED DOWN ACCORDINGLY.

5. RELATIONSHIP OF PROJECT TO AIDS PROGRAM: ARGUMENTS PRO AND CON WERE PRESENTED FOR INCLUSION OF AIDS AND FAMILY PLANNING EFFORTS IN THIS PROJECT. ECPR AGREED THAT THE TWO EFFORTS SHOULD BE KEPT SEPARATE BUT EMPHASIZED THAT THE PP SHOULD ADDRESS THE AIDS PROBLEM BY STATING THE EXTENT OF THE PROBLEM IN RWANDA AND HOW THE PROJECT MAY SECONDARILY CONTRIBUTE TO THE BATTLE AGAINST AIDS THROUGH CONDOM USE AND COUNSELING/TRAINING ACTIVITIES. WHILE THE ECPR DID NOT FEEL AN AIDS COMPONENT SHOULD BE BUILT INTO THE PROJECT, IT FELT THAT THE PROJECT SHOULD ATTEMPT TO INFORMALLY TRACK AND MONITOR THE AIDS PROBLEM IN RWANDA. IT WAS FELT THIS INFORMATION COULD BE EXTREMELY USEFUL IN THE UNDERTAKING OF SUBSEQUENT PROJECT EVALUATION. WHEN FEASIBLE, THE MISSION SHOULD CONSIDER UTILIZING THE AIDS/COM AND AIDS/TECF CENTRALLY FUNDED PROJECTS.

6. THE EPAC IS ENCOURAGED TO VISIT THE KENYA MISSION TO GATHER INFORMATION ON THE KENYA PRIVATE SECTOR FAMILY PLANNING PROGRAM (615-3223) WHICH HAS BEEN UNDERWAY SINCE SEPTEMBER 1983.

7. DEMOGRAPHIC HEALTH SURVEY (DHS): THE ECPR RECOMMENDED INCLUSION OF DHS IN THE PROJECT. THE DHS WILL SERVE TO EVALUATE THE PROGRESS MADE SINCE THE 1983 FERTILITY SURVEY AND AS BASELINE INFORMATION FOR FURTHER EVALUATION OF THE PROPOSED PROJECT.

8. CONDITIONALITY: THE CONDITIONALITY POSSIBILITIES PROPOSED IN THE PID SEEM REASONABLE, BUT THE ECPR CAUTIONS THE MISSION TO APPROACH AND WEIGH CAREFULLY THE NEED FOR NEW CONDITIONS DURING THE PP PREPARATION.

9. ABORTION/STERILIZATION: THE PP SHOULD DESCRIBE THE GOV'S POLICY AND PRACTICE ON ABORTION AND STERILIZATION. THE PP ALSO SHOULD STATE THAT THE PROJECT WILL COMPLY WITH A.I.D. POLICY ON ABORTION AND STERILIZATION. IN ADDITION, IMPLEMENTING DOCUMENTATION SHOULD INCLUDE APPLICABLE A.I.D. STANDARD CLAUSES ON THESE MATTERS.

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10. BUY-IN AGREEMENTS: IN MISSION ANTICIPATED BUYING INTO ANY S & T FUNDED PROJECTS, CAREFUL ADVANCE PLANNING WITH RELEVANT S & T PROJECT OFFICERS SHOULD BE UNDERTAKEN DURING THE PREPARATION STAGE. IN THIS REGARD, NOTE THAT PROCUREMENT ISSUES MAY BE RAISED IN ADVANCE OF THE POINT WHICH THE MISSION PROJECTS EXPIRES BEFORE THE COMPLETION OF THIS PROJECT.

11. PROCUREMENT WAIVERS: THE MISSION SHOULD NOTE THAT THE PROPOSED FINANCING RESOLUTION GENERALLY WAIVES THE APPLICATION OF SOURCE AND ORIGIN PROCUREMENT REQUIREMENTS UNDER THE FAA FOR ACTIVITIES FUNDED FROM THE FEDERAL GOVERNMENT AFRICA ACCOUNT INCORPORATED IN THE C.F. AFRICA BUDGET. GUIDANCE ON THE APPLICATION OF THIS WAIVER SHOULD BE AVAILABLE IN TIME FOR THE MISSION'S CONSIDERATION WITH RESPECT TO ANY WAIVERS REQUIRED BY THIS PROJECT.

12. INITIAL ENVIRONMENTAL EXAMINATION (IEE): THE IEE HAS BEEN APPROVED AND COPIES HAVE BEEN PROVIDED.

13. DELEGATION OF SP APPROVAL TO CAR/AMTR: UNDER LOCAL APPLICATION OF THIS LEVEL OF PROJECT IS ADEQUATE FIELD RESPONSIBILITY. WITH NOTED CIRCUMSTANCES IN CAR/AMTR WHERE THE FIELD OFFICER

PLC IS RESPONSIBLE DESIGN/AUTHORIZATION WITH REGARD. NEVERTHELESS, LOCAL RECOMMENDED DELEGATION OF SP APPROVAL TO FIELD PROJECT OFFICER/PLC IS PRESENT AT THE LOCAL REVIEW OF THE SP. THIS INDIVIDUAL SHOULD NOT REPORT SHOULD NOT BE THE SAME PLC WHO PARTICIPATES IN THE DESIGN OF THE SP. THE ECRB STRESSED THE IMPORTANCE OF HAVING A REPORTING TO WORK ON THE SP DESIGN ESPECIALLY GIVEN THE ABSENCE OF THE MISSION PLC DURING THE PERIOD OF DEVELOPMENT. SHOULD

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LOGICAL FRAMEWORK FOR SUMMARIZING PROJECT DESIGN

Project Title: Maternal and Child Health/Family Planning II Project 696-0128

Date of this Summary _____

ATTACHMENT B

MANAGEABLE INTEREST
If Input, Then Output
If Output, Then Purpose
If Purpose, Then Goal
DEVELOPMENT HYPOTHESES

NARRATIVE SUMMARY		OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																
<p>Program Goal: The broader objective to which this project contributes:</p> <p>To reduce fertility rates in Rwanda.</p>		<p>Measures of Goal Achievement:</p> <p>Total Fertility Rate from 8.6 to 8</p> <p>Annual Population Growth Rate reduced from 3.7% to 3.2%</p>	<p>Census and DHS data</p> <p>GOR population statistics</p>	<p>Concerning long term value of program/project:</p> <p>—Economic and political stability</p>																
<p>Project Purpose:</p> <p>To expand and improve the delivery and use of family planning information and services through both the public and private sector.</p>		<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>Increased contraceptive prevalence from 3% to 15% for women in union between the ages of 15-49.</p> <p>95% of all men and women between the ages of 15 and 49 with knowledge of all available family planning methods.</p> <p>Decreased desired family size from 6 to 5.</p>	<ol style="list-style-type: none"> 1. Census and DHS data 2. GOR population statistics 3. Private sector population statistics 4. Project evaluations and reports. 	<p>Affecting purpose-to-goal link:</p> <p>—High level GOR officials continue to support FP</p> <p>—Economic situation does not deteriorate</p> <p>—Other donors continue FP program support</p> <p>—Rural infrastructure (roads, centers radio) adequately maintained.</p>																
<p>Outputs:</p> <ol style="list-style-type: none"> 1. Improved GOR research, evaluation coordination and policy analysis capability. 2. Improved delivery of FP services in Public and Private sectors. 3. Improved dissemination of FP info. 4. Effective fin/prc/mgmt systems in place for FP programs. 		<p>Magnitude of Outputs necessary and sufficient to achieve purpose.</p> <p>DHS/RAPID models/6 OpResearch Studies/ 3 Policy Seminars/Regular Coordination Mtgs.</p> <p>Integrated MCH/FP services in all public and 50% private h. centers/8NGO sub-grants/ CSM/175,000 FP acceptors/120 MDs-250 paramedical trained.</p> <p>75 trainers-600 auxiliaries-600 teachers trained in IEC/CSM/materials developed ONAPO-8 NGO annual workplans/budgets/MOH logistics system ONAPO admin systems.</p>	<ol style="list-style-type: none"> 1. DHS data; project reports; RAPID models; consultant reports 2. GOR population and service statistics; CSM sales statistics; site visits and reports 3. Project reports; IEC materials; CSM advertizing 4. Eval/audit; annual workplans. 	<p>Affecting output-to-purpose link:</p> <p>—ONAPO and MINISANTE obtain and retain adequate staff</p> <p>—NGOs apply for sub-grants</p> <p>—Research carried out and recommendations implemented</p> <p>—Availability of injectable contraceptives increases</p>																
<p>Inputs: Activities and Types of Resources A.I.D.</p> <ol style="list-style-type: none"> 1. TA: Long and short term 2. Training: Long and short term, in-country, study tours 3. Commodities 4. Other Costs <p>GOR</p> <ol style="list-style-type: none"> 1. Personnel 2. Health facilities/Offices 3. Operational Costs 		<p>Level of Effort/Expenditure for each activity. A.I.D.</p> <table border="0"> <tr><td>1. Technical Assistance:</td><td>\$2095</td></tr> <tr><td>2. Training:</td><td>2172</td></tr> <tr><td>3. Commodities:</td><td>749</td></tr> <tr><td>4. Other Costs:</td><td>2942</td></tr> <tr><td>5. Evaluation/Audits</td><td>200</td></tr> <tr><td>6. Contingency</td><td>429</td></tr> <tr><td>7. Inflation</td><td>413</td></tr> <tr><td>TOTAL</td><td>\$9000</td></tr> </table> <p>GOR \$8170</p>	1. Technical Assistance:	\$2095	2. Training:	2172	3. Commodities:	749	4. Other Costs:	2942	5. Evaluation/Audits	200	6. Contingency	429	7. Inflation	413	TOTAL	\$9000	<p>MACS, annual workplans, audits, evaluations, project reports, contractor reports.</p>	<p>Affecting input-to-output link:</p> <p>—NGO fin mgmt systems adequate</p> <p>—Coordinated donor inputs</p> <p>—Adequate amounts of acceptable contraceptives available</p> <p>—GOR staff, facilities and operational funds available in a timely manner</p> <p>—ONAPO planning and monitoring process adequate for managing project</p> <p>—Management team given responsibility and authority to manage inputs.</p>
1. Technical Assistance:	\$2095																			
2. Training:	2172																			
3. Commodities:	749																			
4. Other Costs:	2942																			
5. Evaluation/Audits	200																			
6. Contingency	429																			
7. Inflation	413																			
TOTAL	\$9000																			

ATTACHMENT C - CHECKLIST

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? No
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? No legislative action is required

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. Project is not susceptible to execution as part of a regional or multi-lateral project.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and Iban associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. The project will: (a) limited stimulus to international trade in commodities, (b) encouragement to private initiatives in the provision of family planning services both profit-making and non-profit enterprises.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). Project will finance technical services by a U.S. institution and training in U.S. institutions.

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9. FAA Secs. 612(b) & 636(h). Describe steps taken to assure that to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

An important object of the project is to increase GOR contributions for recurrent project costs to 25%.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

N/A

11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

No

13. FAA Sec. 119(q)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other

No

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wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A
15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? This criterion will be applied to any U.S. PVO selected to receive assistance under the project.
16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? These requirements will be applied to any PVO selected to receive assistance under the project.
17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N/A
18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). The Project Agreement for this project will be below the minimum necessary for the application of this provision.

B. FUNDING CRITERIA FOR PROJECT

Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental

(a) The project support dissemination of family planning services and information to all social strata, especially the rural poor who comprise 95% of the population.

(b) The project will work through local health centers and community groups and leaders to bring health and FP services to the rural and urban poor.

(c) the aim of the project is to promote food self-sufficiency by reducing the gap between the rate of population growth and that of agricultural production.

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institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

(d) participation by women is intrinsic in any material child health and family planning project.

(e) The project will not have a direct effect on regional cooperation.

- c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used? Yes
- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Yes
- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes. The recipient country contribution is well in excess of 25%.
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes. The project has been designed to assist the government and the private sector to take measures, adopt policies and strengthen institutions aimed at benefitting the poor majority.

- g. FAA Sec. 291(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. The project focuses on assisting the government to adopt more favorable family planning policies and to carry out improved measures to provide FP services and information throughout the country. The project also aims at mobilizing the resources of the private sector to provide such services. The project supports improvement of local research capability and provides training to upgrade the skills of Rwandan officials, PVOs and entrepreneurs so that they can participate more effectively in FP activities.
- h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No
- Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No
- Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization, as a means of family planning? No
- i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? No
- If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? No

- j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
- k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? It is expected that the strong participation of women in contract awards that characterized the previous FP project will continue in the present or
- l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase Yes; the project is in compliance with Regulation 16. Other items in this section are not applicable.

production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

- n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? No
- o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? No
- p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA; Yes

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(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

Yes. The project aims at assisting U.S. and other PVOs to engage in FP activities.

Yes. The project support voluntary family planning services, policy and legal reforms, encouragement of private sector participation and income-generating opportunities for women.

The project addresses the improvement of health conditions, particularly for mothers and children, by encouraging the utilization of voluntary family planning services.

3. Economic Support Fund Project Criteria

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A
- b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? N/A
- c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

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5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes; all contract awards will observe AID's competitive procurement procedures.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Yes
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

5. FAA Sec. 604(q). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) No
6. FAA Sec. 603. Is t... shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No
7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes.
Utilization of the facilities and resources of other Federal agencies is not anticipated.
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes
9. FY 1989 Appropriations Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

10. FY 1989 Appropriations Act Sec. 521. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes
4. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f); FY 1989 Appropriations Act Secs. 525, 536.
(1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion? Yes
- b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes
- c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes
- d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes
- e. FAA Sec. 662. For CIA activities? Yes

- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Procurement actions will conform to the requirements of the authorizing legislation of the Development Fund for Africa.
- g. FY 1989 Appropriations Act Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes
- h. FY 1989 Appropriations Act Sec. 505. To pay U.N. assessments, arrearages or dues? Yes
- i. FY 1989 Appropriations Act Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes
- j. FY 1989 Appropriations Act Sec. 510. To finance the export of nuclear equipment, fuel, or technology? Yes
- k. FY 1989 Appropriations Act Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes
- l. FY 1989 Appropriations Act Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes
5. FY 1989 Appropriations Act Sec. 584. Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? YES

22 JUIN 1989

17.03/439/1110/89

Monsieur l'Attaché pour la Coopération

U S A I D

KIGALISous-Couvert de Monsieur le Ministre des Affaires
Etrangères et de la Coopération InternationaleKIGALIDemande d'assistance de
l'USAID pour le projet
MCH/PP à l'ONAPO

Monsieur l'Attaché pour la Coopération,

J'ai l'honneur de vous adresser la présente pour solliciter l'appui de l'Agence des Etats-Unis pour le Développement International (USAID) dans le programme national de population, Santé Maternelle et Infantile et Planification Familiale pour une nouvelle phase de 5 ans à partir de septembre 1989.

L'USAID, depuis le début de notre programme en 1981, a apporté un soutien important et très apprécié au Rwanda en général et à l'ONAPO en particulier pour le démarrage et la consolidation des actions entreprises par le pays dans le domaine démographique, de Santé et de Planification Familiale. Un projet "Santé Maternelle et Infantile/Planification Familiale" fut signé par l'USAID et le Rwanda et a couvert les besoins du programme depuis 1981.

La période de ce projet qui expirait en septembre 1988 a été prolongé jusqu'en septembre 1989. L'évaluation de cette 1ère phase du projet a montré des résultats hautement positifs dans la réalisation des objectifs du programme national de population et de planification familiale, et ceux du projet lui-même.

Je voudrais ici renouveler mes sincères remerciements pour l'assistance fournie par l'USAID et exprimer mon souhait de voir l'assistance de l'USAID à notre programme maintenue sous forme d'une deuxième phase du projet MCH/PP couvrant une période de 5 ans.

Cette deuxième phase du projet MCH/PP reprendra globalement les objectifs de la 1ère phase du projet en mettant un accent tout particulier pendant cette période à l'offre des services de PP (amélioration de la prestation des services et la promotion des services de qualité), à travers à la fois le secteur public et privé.

Dans l'espoir d'une suite favorable à ma requête, je vous prie de croire, Monsieur l'Attaché pour la Coopération, en l'assurance de ma considération distinguée.

La Directrice de l'Office
National de la Population
Mme HADIMANA NYIRASAFARI Gaudence


C.P.I. à:

- Son Excellence Monsieur le Président
de la République Rwandaise

KIGALI

- Monsieur le Ministre de la Santé

KIGALI

- Monsieur le Ministre du Plan

KIGALI

ATTACHMENT E - OTHER DONOR ASSISTANCE

Other donors are playing a growing role in assisting the GOR to deal with its population and demographic problems. Of principal interest is the World Bank which provided a \$10.8 million IDA credit (supplemented by a \$750,000 WHO grant for technical assistance) in 1987 to assist MINISANTE to strengthen its MCH/FP facilities and services. Other donors with smaller but active FP programs are UNFPA, Germany (GTZ) and UNICEF. Canada is a potential donor. Their programs or intentions are summarized below.

A. WORLD BANK

The World Bank became a major donor in support of FP (in the context of strengthening MCH services) in 1986 with the provision of a \$10.8 IDA credit to the GOR. Total funding for the 5 year project amounts to \$14.5 million including a GOR contribution of \$2.9 million and a WHO grant of \$725,000 for technical assistance.

The objectives of the project are, in the words of the loan documents, to "(a) make FP services available in all health facilities as part of the MCH program; (b) improve the quality and increase the coverage of MCH services; (c) target and integrate nutrition activities into MCH central and regional levels; (d) strengthen the institutional capacity of MINISANTE at the central and regional levels; (e) increase the output and improve the quality of basic paramedical training programs; and (f) improve ONAPO's data base for population policy formulation."

To meet these objectives, the project has the following major components:

1. Strengthening family health services (\$3.7 million).

This component is aimed at making FP services available nation-wide through (a) a major in-service training program for 1,400 health center staff (200 medical assistants, 400 nurses and 800 lower grade medical personnel) with training provided jointly by MINISANTE and ONAPO instructors, (b) the provision of medical supplies, particularly contraceptives and other MCH medical products, (c) the upgrading and rehabilitating of 30 health centers (including facilities for providing FP, nutrition and MCH services).

2. Institutional strengthening of MINISANTE (\$3.2 million).

Activities under this heading aim at better management at both the central and regional levels of the Ministry. At headquarters the project will strengthen the MCH Division of the Ministry, including its FP and Nutrition Offices, through technical assistance and overseas training for senior staff. Activities of the Nutrition and FP Offices will be integrated and made more mutually reinforcing. In addition, the Training Division will receive technical assistance in curriculum development and in the planning, supervision and evaluation of the training program. The Studies and Evaluation Division will also receive to provide health information statistics, to monitor the program and to carry out two fertility/MCH surveys.

At the regional level the project involves financing construction, staff housing and equipment for eight regional offices. These improvements are to be accompanied by workshops and training sessions for the regional office and health center staff and by increased supervisory visits and monitoring activities. The additional MCH supervisors will be hired to monitor the integration of FP, nutrition and health services.

3. Human Resource Development (\$3.3 million).

This component includes (a) pre-services training and deployment by MINISANTE of Nurses Aides (A4 level) and (b) construction and management by MINEPRISEC of two A3 nursing schools.

The first category would be held to address the critical shortage of staff to implement an integrated MCH/FP/nutrition program. It would furnish MINISANTE assistance in training of trainers, operating costs and monitoring and evaluation. Some 200 Nurses Aides would be trained over the five year period at existing MINISANTE schools.

The second category would address the equally critical shortage of A3 level nurses (500 currently available out of a need 1,000) by the construction of two new nursing schools. About twenty-five graduates per year from each school's four year program would become available starting in 1992. The project would also provide technical assistance in teaching methods to the teaching staff.

4. Population policy (\$232,000). Funding would be provided to ONAPO to conduct two studies, one on factors influencing the acceptance and continuation of modern contraception, the second an analysis of maternal and infant mortality and morbidity. ONAPO will direct the studies with assistance from MINISANTE staff and the University Public Health Center in Butare.

Management of the project is predominantly the responsibility of MINISANTE which, at the Bank's request, has set up a Project Coordination Office, the head of which reports directly to MINISANTE's Secretary General. Funding is also provided for an accountant, an architect, support staff and related equipment. MINEPRISEC manages the nursing school component (20% of project costs) through a comparable management office.

Current Status.

The project did not go into effect until February 1987. Implementation during the first year has been slow, reflecting perhaps the fact that MINISANTE is a first time borrower of the Bank. In any case, a February 1988 supervisory mission found that only "minor" progress had been achieved in implementing the first three major components of the program discussed above. Construction activities were a year behind schedule. In addition, little progress had been made by the GOR in carrying out actions that were to have been completed in 1987 such as (a) the application of recommended measures in health financing, (b) preparation of investment and operating budgets for 1988 and (c) recruitment of a MCH/FP adviser. The Mission pointed out that adequate implementation was not just the job of the Project Coordinator -- who, unfortunately, the Mission noted, is part time and also runs the Finance and Administration Department -- but also required the preparation of an integrated work plan supervised by the Ministry's Secretary General in which each participating office pulled its own weight.

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More recently, the Project Coordinator expressed the opinion that the project was moving ahead more rapidly. For example, he noted that the in-service training program was scheduled to begin in July, that the up-grading of the 30 offices and construction of the 8 regional centers would start in September and that a long term MCH/FP adviser would begin work in this year.

Assuming favorable progress, the Mission initiated preliminary discussions for a follow on health project (Population Health Project II) for the planning horizon 1990-93. Major elements suggested in the new project would be malaria prevention and vector control, community pharmacies and health centers and broad-scale community participation in financing of health services, particularly in family planning.

B. UNITED NATIONS FUND FOR POPULATION ACTIVITIES (UNFPA)

UNFPA's support for population and demographic activities can be traced back to the mid-1970's when it was involved with the GOR in preparations for the 1978 census. Some family planning activities were initiated in the early 1980's but execution was hampered by funding constraints and administrative problems. As a result of an evaluation in 1984, the existing program was reorganized and completed while, following a program development mission in 1986, a new "second country program" was initiated and is currently being implemented.

The current program consists of the following projects:

1. RWA/87/P01 Family Health (1987-89). The project provides \$1.1 million in general support to ONAPO. The major objectives are to strengthen ONAPO's capabilities at both headquarters and in the rural areas, to train and sensitize rural health care and rural development personnel in FP services and information, to facilitate the integration of ONAPO and MINISANTE personnel in the health centers and to promote donor coordination. In addition, the project provides medical and other equipment for 22 rural hospitals and two ONAPO centers as well as equipment for setting up pilot mobile teams to deliver FP services to the rural areas. Other components of the projects of the project include importation of contraceptives, particularly Depo-provera and Norplant and the construction and equipping of a central warehouse.

2. RWA/87/P03 Assistance to ONAPO for Population Studies 1987-91. The project, funded in the amount of \$456,000, is to strengthen ONAPO's research, data collection and analysis capability by providing a resident adviser (demographer/economist), the recruitment of two Rwandais statisticians and an economist as well as data processing equipment and a vehicle. Studies are contemplated on the relationship of economic factors and fertility, surveys on fertility, mortality and migration, and demographic projections and analyses related to the Fourth and Fifth Five Year Plans.

3. RWA/87/P04 Assistance to ONAPO on IEC 1987-89. The project, funded for \$600,000, represents a pilot project in Ruhengeri Prefecture for testing a community based approach to increasing local knowledge and support for family planning. Administered by FAO, the project aims at selecting and mobilizing the efforts volunteer "social agents" (Abakangurambaga), two to each "cellule" (the lowest unit in the party), to spread FP information and advice among the inhabitants of each "cellule", to motivate them toward receiving FP services at the nearest local source and to distribute pills, condoms and spermicides.

4. RWA/87/P02 National Census (\$417,000). This item, support for the next census, is a "shelf project" depending on decisions within the GOR on suitable timing for the next census. Funding represents about 10% of total estimated cost.

The following table shows UNFPA project and funding plans, 1987-1991.

PROGRAMME/PROJETS DU FNUAP AU RWANDA 1987-1991

PAYS : RWANDA
 STATUT : PRIORITAIRE
 ANNEE : 1988

Code	Titre	Agence d'exécution	Ressources Approuvées 6/1/1987 (en dollars)			Allocations (en dollars)				
			Scénario Bas (\$)	Ress. Multi-Bi (\$)	Scénario Haut (\$)	1987	1988	1989	1990	1991
RWA/87/P01	Planning Familial Santé Familiale	GVI	1.300.000 1.124.570	1.400.000	2.700.000	374.270	378.600	371.700	-	-
RWA/87/P03	Politiques de Population Assistance à l'ONAPO	DICD	560.000 456.000	190.000	750.000	72.000	133.000	136.500	52.500	62.000
RWA/87/P04	Information-Education Communication IEC (pipeline)	FAO	740.000 600.000	310.000	1.050.000		296.000	188.100	115.900	-
RWA/87/P02	Collecte de données de base Recensement Population (en voie de program- mation)	DICD	400.000 (2) 417.063	100.000	500.000		(2) 183.666	(2) 224.243	(2) 9.154	-
TOTAL	Programme Projets approuvés Projets en pipeline et Projets en Program- mation		3.000.000 1.580.570 (3) 1.017.063	2.000.000	5.000.000	- 446.720	- 511.600 (3) 599.566	- 508.200 (3) 595.566	- 52.500 (3) 9.154	- 62.000 -
	Ressources non programmées par rapport au Scénario bas		402.367							
	Ressources non programmées par rapport au Scénario haut		2.402.367							

- (1) Projet en pipeline - soumis au Siège du FNUAP pour approbation;
 (2) Projet en program. - le gouvern. est en train de formuler une requête;
 (3) = (1)+(2)

C. GERMANY

Germany assistance in family planning, made available through GTZ (Deutsche Gesellschaft fur Technisch Zusammenarbeit) was initiated in March 1986 and concentrated initially in strengthening the delivery of ONAPO services in the Gikongoro Prefecture. Between that time and the end of January, Germany technical assistance amounted to the equivalent of DM 1,75 million (about \$1 million) and included a long term expatriate physician, supplies and equipment, the construction of a regional office, staff housing, a dispensary and a health center and various operating costs. During the same period the GOR contributed the equivalent of nearly \$300,000 for local salaries, fuel, teaching materials and contraceptives.

Project activities have emphasized (a) the retraining of regional health care personnel in the region in MCH/FP skills, (b) refresher courses for FP assistants, (c) FP courses for regional officials such as Bourgmesters, youth trainees, social assistants, (d) introduction of FP materials in the secondary schools and the training of their instructors, (e) preparation of FP training materials, and (f) the construction of facilities.

The project has since been extended (subject to final GOR approval) for another three years at an estimated cost to the FRG of DM 2.5 million (about \$1.5 million). The GOR's contribution to the extension is estimated at the equivalent \$400,000. Project activities will be continued in Gikongoro and extended to the Prefecture of Butare. Technical assistance will continue with the same physician. Plans also call for the construction of an integrated health and family planning center, one of the first in the country, at Munini in Gikongoro.

UNICEF

Family Planning is a fairly minor element of the UNICEF program in Rwanda which devotes most of its resources (\$1.1 million per year or more, depending on contributions from other donors) to primary health care, water supply projects, immunization, nutritional surveillance and maternal and child health (MCH). Family planning activities are justified as a sub-topic under MCH. In 1987 UNICEF financed at a cost of \$70,000 (a) the establishment of an audio/visual production unit at ONAPO, including equipment, a vehicle and technical training and (b) provision of tv monitors for regional office training activities.

UNICEF has just completed work on its program for Rwanda 1988-92 which includes a number of family planning activities related to MCH and supports ONAPO's efforts to increase the contraceptive prevalence rate. These include (a) the integration of MCH/FP subject materials into all GOR health training programs and (b) training family planning agents at the communal level.

Under the first rubric, the plan is to (a) integrate MCH/FP material into the curricula of nursing schools (A2 & A3) and the social/nutritional schools while providing the necessary teaching and classroom materials, and (b) include MCH/FP materials in six day specialized sessions to upgrade health personnel, (the curricula of which will be jointly developed by ONAPO and MINISANTE) for sixty health workers per year.

1982

E. CANADA

Family planning falls outside of the main priorities of CIDA (Canadian International Development Agency) which emphasize human resources development, agriculture and rural development and, in the future, infrastructure. However, the president of CIDA agreed to help the GOR in the population and family planning field during a visit in 1984. For various reasons, including the somewhat negative appraisals of the GOR's family planning operation by two CIDA consultants, implementation of the commitment has moved slowly.

At the present time CIDA's position on assistance for family planning has crystalized into two themes. The first applies to direct assistance to ONAPO staff and to generally help the agency to develop its human resource capabilities. To this end, ONAPO has been invited to participate (along with other GOR agencies) in a new CIDA training program which will be financed by a training fund of \$5 million Canadian (about US \$ 4 million) which will be made available in annual tr riches over the next 4-5 years beginning in 1989.

ONAPO requests for training will be considered in accordance with procedures to be set up in annual programming exercises (although ONAPO's will enjoy a favored status in view of the 1984 commitment).

The second theme relates to the next census. CIDA has indicated that once the GOR has decided how it proposes to go about executing the next census, CIDA would be prepared to consider a request for a contribution to its costs through a donation to an international agency. Thus, Canada's support to this subject is rather indefinite and circumspect.

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ATTACHMENT F

APPENDIX F

MINISAPASO FAMILY PLANNING GUIDELINES, MARCH 1988

Instruction ministérielle no. 779 du 3 Mars 1988 relative à la promotion du programme de Santé Maternelle et Infantile y compris la Planification Familiale (SMI/PF) dans les Etablissements de Santé du Rwanda.

Le Ministre de la Santé Publique et des Affaires Sociales,

Considérant la politique nationale en matière de Santé et les directives sur la promotion des Soins de Santé Primaires dans toutes leurs composantes;

Considérant la politique nationale de la Santé pour tous et de Médecine de masse axée prioritairement sur les groupes les plus vulnérables qui sont les mères, les enfants et les travailleurs;

Vu que les activités de Santé Maternelle et Infantile y compris la Planification Familiale (SMI/PF), en tant que composante des Soins de Santé Primaires, doivent être intégrées à tous les niveaux du système de Santé;

Vu que les activités, programmes et méthodes de SMI/PF doivent être standardisés dans les Etablissements de Santé tant publics qu'agréés;

Considérant que l'absence de réglementation en matière de PF donne lieu à des décisions anarchiques et contradictoires pouvant porter préjudice aux utilisateurs des méthodes de PF;

Vu que des formations permanentes et/ou régulières doivent être organisées tant à l'intention des formateurs que des autres personnels de Santé en insistant sur la gestion des programmes, y compris ceux de SMI/PF;

Se référant aux recommandations de la réunion des Médecins-Directeurs des Régions Sanitaires et des Médecins Délégués de l'ONAPO tenue à Kigali le 28/10/1987,

Demande à Madame la Directrice de l'ONAPO, à Monsieur le Directeur Général de la Santé Publique, aux Médecins Délégués de l'ONAPO, aux différents responsables des Etablissements de Santé du pays, aux responsables de la formation et du recyclage du personnel en PF d'appliquer des Directives suivantes:

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Chapitre I: Directives générales

Art. 1: Les responsables des Etablissements de Santé publics, privés, et agréés doivent:

- 10 Considérer les programmes de SMI y compris la PF comme des programmes prioritaires dans le cadre de la prestation des services médicaux et sanitaires.
- 20 intégrer pleinement les activités de PF dans tous leurs aspects sociaux, techniques et médicaux dans les services sanitaires et offrir les services de PF à toutes les familles qui le désirent; les services de PF devant être disponibles en permanence pour la population au sein de toutes les formations sanitaires du pays.
- 30 informer correctement la population sur toutes les méthodes de PF admises par la politique de notre pays, (méthodes modernes de contraception et méthodes naturelles) de manière à permettre un choix libre et objectif de la méthode par les familles qui veulent planifier leurs naissances.
- 40 veiller à ce que, dans le cadre de la formation continue du personnel, les agents sous leur autorité disposent et assimilent toutes les informations pertinentes sur la PF et sur l'application des méthodes de contraception. Ces responsables pourront faire appel à cette fin aux compétences et à l'assistance des services centraux et régionaux du Ministère de la Santé Publique et des Affaires Sociales et de l'ONAPO pour encadrer et dispenser toutes les formations jugées nécessaires.
- 50 intégrer la promotion et la prestation des services de PF à la population dans les mécanismes et critères d'évaluation régulière des formations sanitaires et des agents de Santé à tous les niveaux.

Une évaluation des activités de la SMI y compris la PF devant faire partie intégrante des rapports de services des responsables des Etablissements de Santé et des Medecins Directeurs des Régions Sanitaires du pays.

Chapitre II: Directives spécifiques

Section I: De la formation et du recyclage du personnel en PF

Art. 2: Les responsables des programmes de formation et de perfectionnement du personnel du Ministère de la Santé Publique et des Affaires Soiales et de l'ONAPO doivent:

- 1o intégrer pleinement la PF dans les curricula de formation du personnel médical et paramédical à tous les niveaux;
- 2o renforcer et généraliser sans plus tarder le programme déjà entamé de formation clinique en PF pour tous les agents de Santé non encore touchés par cette formation;
- 3o examiner les possibilités de décentraliser et d'exécuter le programme de formation clinique en PF sous la supervision directe des équipes régionales ONAPO/MINISAPASO et des responsables des formations médico-sanitaires.

Section II: De la supervision du personnel de terrain et des Etablissements de Santé

Art. 3: Une bonne supervision des formations socio-sanitaires et des agents de Santé en PMI/PF doit être retenue comme une fonction importante et urgente par les équipes régionales ONAPO - MINISAPASO

Ainsi ces derniers ont l'obligation de:

- 1o Renforcer la supervision des formations socio-sanitaires et des agents de Santé oeuvrant dans ces formations.
- 2o Elaborer rapidement et mettre en application, les schémas de supervision et des standards de travail à tous les niveaux.

Art. 4: Les Médecins Directeurs des Régions Sanitaires, les Médecins Délégués de l'ONAPO, les responsables des Etablissements de Santé doivent:

- 1o Se sentir au premier chef concerné par la responsabilité d'intégrer pleinement et de gérer correctement la prestation des services de PF à la population;

L'application d'une méthode de PF ou de contraception irréversible est pour le moment la seule circonstance où l'accord formel des conjoints est requis en PF.

Art. 7: Comme pour tous les autres actes médico-sanitaires, il appartient au responsable de l'Etablissement de Santé, sous la supervision du Médecin Directeur de la Région Sanitaire et son équipe de décider dans quelle mesure il peut autoriser tel ou tel autre personnel sous ses ordres à prêter tel ou tel acte dans le domaine de la PF et des méthodes de contraception suivant la complexité des actes et/ou la compétence éprouvée des agents sous sa responsabilité. Il devra de ce fait aussi veiller scrupuleusement à la formation approfondie et continue du personnel dans ce domaine.

Art. 8: -Dans le but de sauvegarder la parenté responsable et d'éviter des grossesses non désirées chez les jeunes, l'éducation à la vie familiale et l'information correcte sur la PF seront privilégiées et promues.

-L'application des méthodes de PF et de contraception s'adresse particulièrement aux couples et aux mères.

Section IV: De la collaboration entre les Médecins Directeurs des Régions Sanitaires et les Médecins délégués de l'ONAPO

Art. 9: Le Médecin Directeur de la Région Sanitaire assure la coordination de toutes les activités en matière de Santé et des Affaires Sociales au niveau de la Région Sanitaire.

Art. 10: Le Médecin Délégué de l'ONAPO apporte son appui aux activités de SMI/PF au niveau de la Région Sanitaire et des Etablissements de Santé, participe à leur supervision, et dépend techniquement du Médecin Directeur de la Région Sanitaire seulement dans ce même domaine (SMI/PF).

Il a comme responsabilité en outre de:

- gérer les autres activités en rapport avec le programme national de la population et la politique démographique du pays au niveau de la Préfecture,
- superviser et gérer le programme d'Information, Education et Communication en matière de population et de PF;
- assurer la liaison avec divers autres programmes de développement pour le programme de PF et de population au niveau de la Préfecture;

- assurer la liaison avec les services centraux de l'ONAPO pour les Directives et les fournitures de matériel et médicaments relatives au programme de PF;
- représenter le programme de l'ONAPO au niveau de la Préfecture.

Art., 11: Le Médecin-Directeur de la Région Sanitaire et le Médecin Délégué de l'ONAPO devront aménager des mécanismes permanents de concertation et de collaboration pour harmoniser le programme de SMI/PF et maintenir une bonne cohésion entre l'équipe ONAPO-MINISAPASO afin de maximiser les chances de réussite de programme de PF. Les deux médecins doivent se concerter régulièrement, notamment pour:

- 1o Concevoir, planifier et évaluer les programmes et activités en matière de SMI/PF exécutés dans les Etablissements de Santé de leur ressort;
- 2o Identifier les Etablissements de Santé nécessitant un encadrement spécial, l'équipement matériel ou une formation appropriée du personnel et leur fournir l'assistance requise;

Des réunions régulières de concertation hebdomadaires au moins de l'Equipe ONAPO-MINISAPASO seront institutionalisées au niveau de la Région Sanitaire pour rendre plus harmonieuse la collaboration souhaitée.

Art. 12: Pour tous les programmes de Santé en général dans les Régions Sanitaires, et de SMI/PF en particulier, le Médecin Délégué doit acquérir un s/couvert du Médecin-Directeur de la Région Sanitaire qui endossera toutes les responsabilités en tant que coordinateur des activités de Santé.

L'accord du Médecin-Directeur de la Région Sanitaire s'impose également avant la distribution du matériel médical et l'équipement pour la PF dans les formations sanitaires qui en nécessitent.

Chapitre III: Dispositions finales

Art. 13: Dès l'entrée en vigueur de la présente instruction, l'appréciation de mérite des Médecins-Directeurs des Régions Sanitaires, des Médecins Délégués de l'ONAPO, des responsables des Etablissements de Santé et des personnels de Santé tiendra compte aussi des performances réalisées en matière de PF dans leurs secteurs de responsabilité respectifs.

RAPPORT DE LA MISSION DE CONSULTATION
POUR LA FORMULATION DES PROJETS USAID - ONAPO - MINISAPASO

Ce Rapport a été lu et approuvé dans la Séance de travail
de vendredi après midi le 15 Avril 1988 en présence de la
Directrice de l'Office National de la Population

INTRODUCTION

En référence à la lettre de l'Attaché pour la Coopération
de l'USAID Bureau de Kigali du 27 février 1988 et de celle y donnant
suite du Ministre de la Santé Publique et des Affaires Sociales n°17/
1900/MIN/88 du 24 mars 1988 et n°17/1419/SAP.1/88 du 11 avril 1988,
la Commission chargée de la formulation de la IIème phase du projet
MCH/FP - USAID-ONAPO-MINISAPASO était composée comme suit:

- 1° Du côté USAID:
- Mme Elisabeth MACGUIRE
 - Mme Ann ARNES
 - Mme Carina STOVER
 - Mme PHILIPS
 - Mr Benjamin SEVREN
 - Mr Jhon BLUMGART
 - Mr Gregg WIITALA

- 2° Du côté RWANDAIS:
- Dr. HAKIZIMANA Evariste
 - Mr. NYANDAGAZI Prosper
 - Mme MUKAMANZI Monique

Le mandat de cette commission est de mettre au point
le document de la IIème phase du projet MCH/FP USAID-ONAPO-MINISAPASO
dont le but est de soutenir les activités de Planification Familiale
et de Population au Rwanda pour les cinq années à venir. La Commission
a officiellement travaillé du mercredi 6 avril 1988 à ce jour. L'ONAPO
a mis à la disposition de la Commission un bureau de travail au siège
social de cet Office.

I: CALENDRIER DE TRAVAIL SUIVI PAR LA COMMISSION

- Mercredi 6 Avril 1988

Visite à l'ONAPO, entrevue avec la Directrice et le Staff
de cet Office, fixation du calendrier de travail de la Commission et
Information générale sur les questions diverses en rapport avec le pro-
gramme de Population et de Planification Familiale, le travail de la
Commission.

- Jeudi 7 Avril 1988

Travail au bureau de la Commission.

- Vendredi 8 avril 1988

Visite de travail au Ministère de la Santé Publique et des Affaires Sociales; entrevue avec le Ministre de la Santé Publique et des Affaires Sociales travail en groupe; exploitation des documents collectés (vendredi, samedi, dimanche).

- Lundi 11 Avril 1988

Visite sur terrain aux Formations médicales prestant les services de Planification Familiale, la commission a visité l'Hôpital de Ruhengeri, le Centre de Santé de Gitare et le Centre de Santé de Shyorongi.

- Du Mardi 12 au Vendredi 15 Avril 1988

Travail au bureau de la Commission. Discussions pour la formulation du programme à inclure dans le document du projet.

- discussions sur les politiques générales de population et de Planification Familiale au Rwanda
- discussion sur les procédures de gestion du projet et les conditions de mise en oeuvre du projet
- discussions sur les programmes prioritaires à inclure dans le projet
- discussions sur le plan de financement et le plan budgétaire du projet.

- Vendredi le 15 Avril 1988

Visite à la Directrice de l'ONAPO pour faire le compte-rendu de l'avancement des travaux de la Commission.

II: ECHANGE DE DOCUMENTS

Pour faciliter les informations mutuelles et accélérer les discussions sur les programmes; les deux parties (ONAPO-USAID) ont échangé et/ou remis à la Commission des documents de travail qui ont servi de base et de document de référence pour le travail de la Commission. Il s'agit:

- Côté ONAPO:
- Un volumineux document sur les politiques démographiques et politiques de population reprenant le programme prioritaire de population et de planification familiale retenu par le Rwanda (ONAPO) pour les 5 prochaines années (Annexe I).

- Un mémorandum reprenant les conditions et procédures générales de gestion du projet, les composantes prioritaires du projet et un aperçu sur la contribution attendue de chaque partie pour l'exécution du projet (Annexe II)
- Un document reprenant la proposition de répartition du budget à allouer au projet en rapport avec les besoins prioritaires du programme de l'ONAPO (Annexe III)
- Un tableau reprenant les contributions attendues du FNUAP (autre intervenant principal dans le programme de population et de planification familiale au Rwanda) pour les 5 prochaines années (Annexe IV)

Côté USAID:

- Un mémorandum reprenant les propositions sur la contribution de l'USAID pour la IIème phase du projet et les conditions générales pour la mise en oeuvre du projet (Annexe V)
- Un document reprenant de manière synthétique (mais en détail):
 - les objectifs du projet
 - les indicateurs de mesure de l'atteinte de ces objectifs
 - les critères d'évaluation de ces objectifs
 - les conditions générales nécessaires pour la bonne réalisation du projet (Annexe VI)
- Un document reprenant la proposition de répartition du budget à allouer aux différents programmes retenus dans le projet (Annexe VII)

III: COMPTE RENDU DES NEGOCIATIONS AU SEIN DE LA COMMISSION

La Commission a progressivement pris acte de toutes les informations fournies sur le programme de population et de Planification Familiale tel qu'envisagé par l'ONAPO et l'USAID. Les négociations au sein de la Commission ont été essentiellement axées sur 3 éléments principaux:

- * Les mécanismes de gestion du projet et les conditions pour la bonne réalisation du projet.
- * Les programmes prioritaires à inclure dans la IIème phase du projet pour financement.

- * Le plan de financement des programmes retenus et le plan budgétaire du projet.

A. Les Mécanismes de gestion du projet et les conditions pour la bonne réalisation du projet

Les membres de la Commission sont tombés d'accord sur le fait que le mémorandum remis par l'ONAPO (Annexe II) contient tous les éléments essentiels pouvant garantir la bonne gestion du projet envisagé. La Commission a insisté particulièrement sur la nécessité de prévoir un mécanisme approprié pour mobiliser et encadrer l'action du Secteur Privé dans le programme national de Planification Familiale. Les parties se sont convenues sur les éléments essentiels suivants :

1° La IIème phase du projet MCH/FP USAID-ONAPO-MINISAPASO bien que couvrant les deux secteurs publics et privé gardera son caractère unitaire dans sa gestion.

2° L'ONAPO en tant que agence d'exécution désigné par le Gouvernement Rwandais pour le projet, aura la responsabilité première de coordonner l'exécution de toutes les activités prévues dans le projet.

3° L'appui de l'USAID sera fourni sous forme d'une subvention de projet couvrant les 5 années.

4° L'exécution du projet se fera sous forme de programmes annuels établis de commun accord entre l'USAID et l'ONAPO. A cet effet une réunion mixte (USAID-ONAPO) de revue de programme (annuelle au moins) sera institutionalisée pour examiner les éléments faisant l'objet de la subvention du programme annuel.

5° Pour une meilleure mobilisation et coordination des initiatives du secteurs privé, un groupe technique mixte (ONAPO-USAID)-Intervenants en Planification Familiale) appelé "Comité Consultatif" sera mis sur pied. Il aura pour but d'être un organe de concertation au sein du projet pour stimuler et encadrer les initiatives du secteur privé. Le Comité travaillera sous la responsabilité de l'ONAPO.

6° L'assistance à proposer par l'USAID pour le secteur privé sera envisagée sous forme d'une assistance technique et un appui à l'ONAPO dans ses actions en faveur du secteur privé. Des termes de référence de cette assistance et/ou des protocoles d'accord seront formulés au besoin avant la mise en oeuvre des actions en faveur du secteur privé.

La Commission a souhaité vivement que ces procédures de gestion du projet soient formulées dans les détails lors de la rédaction définitive du document de projet.

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Les conditions générales de bonne réalisations du projet tel que formulé dans le document synthétique du programme soumis par l'USAID (annexe VI) ont été aussi retenus moyennant certaines légères modifications et ont été considérées par la commission comme pertinentes. Elles pourront être incluses au besoin dans le projet lors de la rédaction du document de projet.

Une série d'autres conditions particulières ont été jugées pertinentes par la Commission. Il s'agit en l'occurrence de:

- 1° Une description plus précise d'une stratégie d'intégration des activités de Planification Familiale dans les formations socio-sanitaires.
- 2° La formulation d'un plan détaillé de formation et de recyclage du personnel de santé en Planification Familiale, et la stratégie de mise en oeuvre de ce plan.
- 3° Mieux définir la stratégie d'IEC en matière de Planification Familiale.
- 4° Bien définir les mécanismes de coordination entre les diverses bailleurs de fonds sur le programme, et entre les divers autres intervenants locaux en Planification Familiale.
- 5° La mise en place d'un système d'objectifs annuels et l'élaboration d'un plan de travail annuel par l'ONAPO.
- 6° Que les postes clés dans le programme de Planification Familiale soient pourvus de personnels compétents durant la période du projet.
- 7° Qu'il soit désigné, auprès de l'ONAPO, un fonctionnaire chargé de la coordination administrative de l'exécution du projet.
- 8° Que le Gouvernement Rwandais réserve au moins une subvention au projet équivalent à 25 % du coût global du projet.

B. Les programmes prioritaires à inclure dans le projet.

Le consensus a été acquis quand aux programmes prioritaires à orienter dans le projet. La Commission a apprécié beaucoup le programme de population et de Planification Familiale envisagé par le Gouvernement Rwandais (Annexe I) pour les 5 prochaines années et l'a jugé très pertinent.

La commission a été informée cependant que compte tenu de sa politique actuelle, l'USAID n'était pas prêt à s'engager dans certains programmes tels:- les infrastructures,
- les constructions.

Le programme de population et de Planification Familiale tel que repris dans le document synthétique élaboré par l'USAID (Annexe IV), a été finalement retenu comme base de travail pour la Commission. Les programmes ci-après ont été retenus et jugés comme prioritaires pour le financement.

i) Pour l'USAID

1° L'assistance technique à long terme et à court terme

2° Les formations et Recyclages du personnel:

- formation à long terme { à l'étranger
- Formation à court terme {
- Formations et séminaires sur place
- Les voyages d'études à l'étranger

3° Equipement et Fournitures

- Contraceptifs
- Les véhicules
- Les ordinateurs
- L'équipement médico-chirurgical
- les équipements de bureau

4° Les coûts opérationnels (support aux programmes)

- La supervision
- Les coûts d'entretien et de maintenance
- Les fournitures consommées

5° L'évaluation

- En cours du programme
- A mi terme
- Fin terme

ii) Par le Gouvernement Rwandais

1° Mise à disposition des facilités institutionnelles et techniques pour le développement du programme

2° Facilités d'accès et l'utilisation des médias locaux (radio, presse écrite)

3° La participation des autres institutions publiques intervenant dans les réalisations du programme tels:

- système de santé publique
- système d'enseignement
- système de formation permanente (CCDFP)
- système d'encadrement du MRND

Les salaires du personnel national affecté directement à la réalisation du programme (personnel ONAPO & MINISAPASO)

5° Mise à disposition des locaux de travail pour les activités du programme et du projet.

6° Les frais de fonctionnement de l'ONAPO.

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C. Le Plan de Financement et le Plan budgétaire du Projet

Les plans de financement et les plans budgétaires tels que présentés par l'ONAPO (Annexe III) et l'USAID (Annexe VII) ont été jugés par la Commission comme concordant en grandes lignes.

La Commission a recommandé que des ajustements soient faits ultérieurement suivant examen de la pertinence dans les détails de chaque programme présenté et retenu comme prioritaire.

L'Enveloppe moyenne de la IIème phase du projet MCH/FP-USAID-ONAPO-MINISAPASO a été estimé à + 9.500.000 \$USA.

La Commission recommande que si l'USAID et l'ONAPO marquent leur accord sur les conditions générales, les programmes et les plans budgétaires proposés par la Commission;

Il soit donné autorisation à la Commission de procéder à la rédaction détaillée et définitive du Projet.

Fait à Kigali, le 17 Avril 1988

Pour la Commission
Dr. HAKIZIMANA Evariste, Porte parole
désigné de la Commission



MINISAPASO : REUNION DE CONCERTATION SUR LE PROGRAMME DE PLANIFICATION
AU RWANDA.-/C

Le Ministre de la Santé Publique et des Affaires Sociales, le Dr. Césaire DIZIMUNGU a dirigé, hier jeudi 28/4/88, une réunion de concertation sur le développement du programme de planification familiale au Rwanda qui s'est tenue au Centre de Formation en Santé Familiale de l'Office National de la Population (O N A P O) à Kicukiro (Kigali).

Elle regroupait tous les évêques de l'Eglise Catholique du Rwanda, la Directrice de l'O N A P O, le Directeur de l'Office Rwandais d'Information, e n t o u r é s des hauts fonctionnaires de la Présidence de la République, du Ministère de la Santé Publique et des Affaires Sociales, de l'Office National de la Population, de l'Office Rwandais d'Information, de la Conférence Episcopale du Rwanda et du Secrétariat National d'Action Familiale.

L'objet de cette réunion était de poursuivre le dialogue entre l'Eglise Catholique et le Gouvernement et la concertation sur les problèmes de population et de planification familiale qui se posent dans notre pays; ainsi que de définir les responsabilités de chacune des parties dans la recherche des solutions plus appropriées pour notre population.

La réunion a reconnu que le problème démographique dans notre pays exige la conjugaison des efforts de tous pour lui trouver des solutions équitables tel que l'a souligné à maintes reprises le Chef de l'Etat.

A l'occasion, l'Eglise Catholique a réaffirmé une fois de plus son soutien ferme au programme de planification familiale dans notre pays et a renouvelé son engagement à apporter au Gouvernement Rwandais sa contribution positive à la recherche de solutions à ces problèmes socio-démographiques. Plus particulièrement, l'Eglise Catholique s'engage à promouvoir et à mettre en place un vigoureux programme de planification familiale par les méthodes naturelles dans la tolérance et le respect des méthodes de planification familiale prônées par le Gouvernement Rwandais.

(suite ci-après)

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MINISAPASO : REUNION DE CONCERTATION.....(doux)

La réunion a en outre adopté un texte définissant les modalités pratiques de collaboration entre le Ministère de la Santé Publique et des Affaires Sociales, l'Office National de la Population et le Service National d'Action Familiale (S N A F) de l'Eglise Catholique, dans la promotion du Service de Planification Familiale Naturelle au Rwanda.

Par ailleurs, toutes les questions en rapport avec l'exécution du programme de population et de planification familiale, et la prestation des services de planification familiale ont été abordées par la réunion.

Celle-ci a jugé opportun de poursuivre le dialogue et les discussions. Les participants se sont convenus de dégager des voies et moyens pour assurer la collaboration de tous, sur le programme de planification familiale. La prochaine réunion aura lieu dans un délai d'un mois.

La réunion a profité de l'occasion pour mettre en garde et conjurer les personnes malveillantes qui diffusent des rumeurs tendant à faire croire qu'il y aurait conflit entre l'Eglise Catholique et le Gouvernement sur le Programme National de Planification Familiale et ont appelé la population à considérer ces rumeurs comme sans fondement.

Les participants à la réunion se sont réjouis en revanche de la bonne collaboration qui a toujours existé entre les confessions religieuses, notamment l'Eglise Catholique, et le Gouvernement, en vue de la promotion du bien-être du Peuple Rwandais.

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ATTACHMENT I - PROCUREMENT METHODS

The control and management of all commodities procured for this project will be shared by USAID/Rwanda, ONAPO (with phase into MINISAPASO responsibility), and the Private Sector Contractors. USAID/Rwanda, however, will be the primary agent for overseeing the procurement of all project commodities.

The Institutional Contractor will procure one vehicle, office equipment, and household furniture and appliances through its own independent procurement system.

Method of Procurement

1. Contraceptives

The procurement policies and procedures applicable to contraceptives and related supplies for projects are outlined in Hand Book 15, Chapter 6. As indicated in HB 15, these commodities must be procured under consolidated procurement contracts in accordance with the procedures outlined below. Responsibility for ensuring that the procedures are complied with rests with the USAID/Rwanda Health and Population Officer.

a) Oral Contraceptives

The USAID must advise AID/W by cable by October 15 of each year of its requirements for oral contraceptives for shipment from the U.S. during the next contract year (e.g., by October 15, 1989, for shipment from July 1, 1990 through June 30, 1991).

USAID/Rwanda will submit a non-funded PIO/C worksheet and AID Form 11-94 (Document Distribution and Shipping Instructions) to arrive in AID/W (S&T/POP) no later than December 31. The PIO/C worksheet shall specify: (1) the quantity of oral contraceptives required; (2) the approximate dates the shipments from the U.S. are required, and (3) that the contraceptives will be purchased and shipped with funds allotted to AID/W.

Shipment of the contraceptives shall be in accordance with the instructions transmitted to GSA from S&T/POP and will conform as closely as possible with the delivery schedule(s) established by the mission.

b) Condoms

The mission must cable AID/W by September 15 of each year regarding its condom needs from the U.S. during the contract year (e.g., by September 15, 1989 for shipment from April 1, 1990 through March 31, 1991). The mission will submit non-funded worksheet PIO/C(s) to AID/W together with a completed Form AID 11-94 specifying the quantity (units of 6,000 pieces), sizes and colors desired, and the approximate dates for delivery. The PIO/C is due in S&T/POP no later than December 31 of each year. Shipment shall be in accordance with the instructions indicated on Form AID 11-94.

c) Other Contraceptives and Related Family Planning Equipment

For the procurement of medical kits, Lippe Loops, contraceptive jelly, vaginal foams and applicators, and diaphragms and vaginal ring fitting sets, PIO/C worksheets are submitted to AID/W for issuance to GSA for procurement action. The mission shall be advised of contract awards by circular messages and provided with item purchase description and specifications, unit cost, name of supplier, and ordering and shipping instructions. Time deadlines as described above for oral contraceptives and condoms do not apply.

d) AID Emblems

AID marking requirements for the shipment of contraceptives and related supplies have been waived. The mission should specify in PIO/C worksheets that AID emblems are not required.

2. Other Project Commodities

Procurement of all remaining project commodities--household furnishings and appliances, computers and office equipment, and vehicles--will be conducted in accordance with AID regulations and good commercial practices by the mission's Procurement Specialist working with the Health and Population Officer. As a matter of procedure the following will be observed:

- On the basis of the approved Equipment List the mission will prepare PIO/C's, as needed.
- PIO/C's will be issued on behalf of the host country by the mission.
- PIO/C's will be distributed, as needed, to initiate the procurement flow. This will also be notification to interested parties that the purchasing process is underway.
- RFQ's (Request for Quotations) and IFB's (Invitations for Bid) are required for all procurements over \$100,000. These will be prepared by USAID/Rwanda with REDSO's assistance, as the need arises. Advertising of anticipated U.S. procurements will be forwarded to AID/W for publication in the appropriate publications.
- Awards of procurement contracts for all purchases will be made by the mission after an evaluation panel composed of the Health and Population Officer, the mission's Procurement Specialist, and/or a representative of the GOR/grantee have examined all bids/offers and documented their findings.
- The mission will be responsible for proper receipt of commodities purchased.

Payment

Responsibility for payments will be with USAID/Rwanda. Payments for all non-U.S. purchases will be through a direct reimbursement authorization. Payments to U.S. suppliers will be in the form of Direct Letters of Commitment.

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Delivery

All imported goods will be shipped on the basis of CIF destination. Suppliers will be required to obtain all risk marine insurance in the amount of 110% of the CIF cost of the goods and similar insurance for inland freight. AID's shipping requirements will be observed. Thus at least 50% of the gross tonnage of all AID-financed commodities shipped on ocean vessels to Mombasa or Dar-Es-Salaam must be shipped on U.S. flag commercial vessels if such vessels are available at fair and reasonable prices.

Marking

The mission's Procurement Specialist is familiar with AID's marking requirements and will enforce these requirements in all procurement actions. Appropriate marking material will be maintained by the mission and placed on all AID-financed commodities (contraceptives excepted) per guidance contained in HB 1B, chapter 22.

Receipt and Utilization

The mission will be responsible for monitoring arrivals and clearing goods from customs. The Procurement Specialist will be responsible for the inspection of arrivals and for the preparation of receiving reports. Reports of shortages and damages will be recorded with the necessary documentation for filing insurance claims.

EQUIPMENT LIST

Category	Quantity	Source/ Origin	Cost \$1000s
1. Contraceptives			
- Oral	x	000	
- Condoms	x	000	
- Contraceptive Jelly	x	000	
- Vaginal foams	x	000	
- Diaphragms	x	000 (combined total)	300
2. Medical Equipment			
- medical kits	x	000	100
- medical kits 100			
3. Vehicles			
- 4 wheel drive	6 X 23,000	935	138
- passenger	4 X 20,000	935	80
4. Household Equipment			
- Furniture (for 3 bedroom house)	2	941 & Host Country	50
- Appliances	2	935	10
5. Computers			
- PC 8 slot 512K 30 Megabite hard disk	6	000/935	66
6. Office Equipment			
- Office furniture & misc. office supplies	x	941 & Host Country	5
		TOTAL:	749

GRAND TOTAL:

COMMODITY EXPENDITURE SCHEDULE BY YEAR (\$1000s)

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5</u>	<u>Total</u>
Contraceptive	60	60	60	120	-	300
Medical Equipment	20	20	20	20	20	100
Vehicles	138	-	80	-	-	218
Household Equipment	60	-	-	-	-	60
Computers	66	-	-	-	-	66
Office Equipment	5	-	-	-	-	5
Total Commodities	<u>349</u> ===	<u>80</u> ===	<u>160</u> ===	<u>140</u> ===	<u>20</u> ==	<u>749</u> ===

COMMODITY DELIVERY SCHEDULE

Commodity	Mode of Proc.	Procurement Sup. Agent	Project Mos. to Order	Estimated Mos. to Arr.	Commodity Entitlmt.

1. Contraceptives					
-Condoms	PIO/C	S&T/POP	By 10/15 of ea/yr.	7	GOR
-Oral	"	"	By 9/15 of ea/yr.	7	GOR
2. Medical Equip.	"	USAID/Rwanda	1-3	7	GOR
3. Vehicles	"	USAID/Rwanda	1-2	7	AID (for life of project)
4. Household Equip.					
- Furniture	"	"	1	3-4	"
- Appliances	"	"	1	6	"
5. Computers	"	"	4	8	GOR
6. Office Equip. P.O.		"	1	2-3	GOR

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ATTACHMENT J - DETAILED COST ESTIMATES

PRO FORMA DETAILED BUDGET

LONG TERM TECHNICAL ADVISOR UNIT COST

SHORT TERM TECHNICAL ADVISOR UNIT COST

TRAINING

STUDY TOURS AND SEMINARS

VEHICLE UNIT COST

COMPUTER UNIT COST

RESIDENTIAL APPLIANCIES/FURNISHINGS/AND OFFICE EQUIPMENT UNIT COSTS

ANNEX J - DETAILED COST ESTIMATES

PRO FORMA BUDGET (IN THOUSANDS OF U.S. DOLLARS)
 MATERNAL AND CHILD HEALTH/FAMILY PLANNING II PROJECT (696-0128)

USE OF FUNDS	QUANTITY	PERSON MONTHS	GOR CONTRIBUTION	A.I.D. CONTRIBUTION	TOTAL COMPONENT AMOUNT	PROJECTED EXPENDITURES OF A.I.D. CONTRIBUTION						TOTAL 1989-199
						Y1	Y2	Y3	Y4	Y5	Y6	
						89	90	91	92	93	94	1989-199
						89	90	91	92	93	94	1989-199
1. TECHNICAL ASSISTANCE			0	2095	2095							
Long term Advisor	1	48.0	0	1077		0	270	269	269	269	0	1077
Long term Advisor	1	24.0	0	538		0	269	239	30	0	0	538
SUBTOTAL				1615								
Short term consultants		32.0	0	480		80	100	100	100	100	0	480
SUBTOTAL				480								
2. TRAINING			0	2172	2172							
Long term	4	96.0	0	242		0	0	100	100	42	0	242
Short term (BUY-IN)		0.0	0	800		0	200	200	200	200	0	800
Short term (U.S.)		20.0	0	155		0	65	30	30	30	0	155
Short term (THIRD COUNTRY)		10.0	0	28		0	14	14	0	0	0	28
In-country		702.5	0	835		0	235	250	250	100	0	835
Seminars (IN-COUNTRY)	3	0.0	0	100		0	20	0	40	0	40	100
Study tours (U.S./THIRD COUNTRY)	2		0	12		0	6	6	0	0	0	12
3. COMMODITIES			0	749	749							
Contraceptives			0	300		0	0	75	75	150	0	300
Medical equipment			0	100		0	0	0	50	50	0	100
Vehicles	10		0	218		0	131	0	87	0	0	218
Household equipment/appliances	2		0	60		0	60	0	0	0	0	60
Office equipment			0	5		0	3	2	0	0	0	5
Computers	6		0	66		0	0	66	0	0	0	66
4. OTHER COSTS			7410	2942	10352							
A. Public sector:												
Supervision			0	250		0	25	50	50	50	75	250
IEC Material & Production			0	200		0	0	50	50	50	50	200
Maintenance (VEHICLES/EQUIPMENT)			0	184		0	15	25	35	45	64	184
Research and Evaluation			0	400		0	60	85	85	85	85	400
Contract support costs			0	62		0	2	15	15	15	15	62
Gasoline			0	246		0	22	36	49	63	76	246
Personnel			6569	0		333	1056	1275	1300	1335	1370	6666
Other direct costs			741	0		0	165	259	240	77	0	741
SUBTOTAL (Public sector)			7410	1342								
B. Private sector:												
Buy-ins			0	800		0	100	200	300	200	0	800
Sub-grants			0	800		0	0	270	270	260	0	800
SUBTOTAL (Private sector)			0	1600								

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ANNEX J - DETAILED COST ESTIMATES

PRO FORMA BUDGET (IN THOUSANDS OF U.S. DOLLARS)
 MATERNAL AND CHILD HEALTH/FAMILY PLANNING II PROJECT (696-0128)

USE OF FUNDS	QUANTITY	PERSON MONTHS	GOR CONTRIBUTION	A.I.D. CONTRIBUTION	TOTAL COMPONENT AMOUNT	PROJECTED EXPENDITURES OF A.I.D. CONTRIBUTION						TOTAL 1989-1994
						Y1 89	Y2 90	Y3 91	Y4 92	Y5 93	Y6 94	
5. EVALUATION AND AUDIT			0	200	200							
Evaluations			0	140		0	20	50	50	20	0	140
Audits and Financial Management Reviews			0	60		0	0	15	45	0	0	60
S U B T O T A L			7410	8158	15568	413	2836	3681	3720	3141	1775	15568
7. INFLATION			371	413	784	21	141	183	182	156	98	784

SUBTOTAL			7781	8571	16352	434	2977	3864	3902	3297	1873	16352
8. CONTINGENCY			389	429	818	22	148	192	174	164	98	818

G R A N D T O T A L			8170	9000	17170	456	3127	4056	4076	3461	1971	17170

A. LONG-TERM TECHNICAL ASSISTANCE COSTS

One two year tour (24 person months) for one advisor with a spouse and two children - one high school age and one grade school. Post of assignment is Kigali Rwanda. The estimated average Long-term Technical Assistance costs per Year is approximately \$230,000.00.

<u>Budget Item/Description</u>	<u>Amount</u>
1. Salary (FS 1/14 @ \$ 289 per day)	\$142,480.00
2. Post Differential (25%)	35,620.00
3. Fringe Benefits (25%)	35,620.00
4. Cost of living Allowance (Section 920)	23,268.00
5. Defense Base Insurance (est. \$ 125.00/mo.)	3,000.00
6. Travel to and from Post (est. 5,000.00 per traveller)	15,000.00
7. Air Freight to and from Post (\$3.50 x 750 lbs.)	5,250.00
8. Sea Freight to and from Post (\$2.50 x 7200 lbs. and POV)	18,000.00
9. Consumables Allowance (\$2.50 x 2500 lbs.)	6,250.00
10. Temporary lodging (\$60 x 30 days)	1,800.00
11. Education Allowance (Section 920)	30,500.00
12. R & R Travel (est. 3,000 per traveller)	10,500.00
13. In-country Travel (est. \$100/mo. x 20 trips)	2,000.00
14. Furnishings (PIO/C)	0.00
15. Appliances (PIO/C)	0.00
16. Storage (est. \$600 p/y)	1,200.00
17. Utilities (est. \$250/mo.)	6,000.00
18. Rent (\$13,000)	27,000.00
19. Residential maintenance (est. \$200/mo.)	4,800.00
20. Guard Service (est. \$250/mo. x 24)	6,000.00
21. Emergency medical/visitation (\$400 p/y)	800.00
22. Overhead (10% of salary)	37,508.00
23. Local support overhead (est. \$3,000 p/y)	6,000.00
24. Subtotal	418,596.00
25. Inflation (5%)	20,947.80
26. Contingency (4.762%)	20,931.08
Total estimated cost for 24 months (lines 1 thru 26)	\$460,458.16
Total estimated amount of Foreign Exchange	\$382,358.00
Total estimated of Local Currency	\$78,100.00

B. SHORT-TERM TECHNICAL ASSISTANCE IN U.S. (PER MONTH)

The estimated average Short-term Technical Assistance cost for one person month is approximately \$ 18,000

1. Salary (25 days @ \$250/day)	\$6,250
2. Overhead (100% of salary)	6,250
3. Defense Base Insurance (estimate)	300
4. Travel:	
a. US - Rwanda - US air fare/per diem/MSE	4,000
b. In-country transportation	950
c. Miscellaneous	500
Total estimated cost for one person month	18,000

C. TRAINING COSTS

1. LONG TERM U.S. TRAINING IN U.S.

Institutional fees and Maintenance Allowance (12 months)	\$ 25,200
Travel - International	5,000
TOTAL	<u>\$ 30,200</u>

2. SHORT-TERM U.S. TRAINING

a. U.S

Training Fees and Maintenance Allowance (\$3,500/mo.)	\$ 3,500
Travel - International	4,000
Travel - U.S.A.	250
TOTAL	<u>\$ 7,750</u>

b. THIRD COUNTRY

Training Fees (\$300/mo.) and Maintenance Allowance	\$ 300
Travel - International	2,500
Ground Transportation	600
TOTAL	<u>\$ 2,800</u>

D. STUDY TOURS AND SEMINARS

1. STUDY TOUR IN THIRD COUNTRY (PER MONTH)

Travel - International (Round Trip)	\$ 2,500
Ground Transportation (600/mo.)	600
Per Diem for 30 days	3,300
Logistician fees \$ 400/mo.	400

Subtotal \$ 6,800

Overhead 80% 5,440

TOTAL \$12,340

ROUNDED \$12,000

2. IN-COUNTRY SEMINAR (PER WEEK)

Participant Per diem (RF 1,000.00 p/day) for 30 participants, 6 days	\$ 2,400
Transportation round trip	1,500
Training materials	500
Transportation for field trips	500
Administrative Support	1,500
Miscellaneous Supplies	200
Audio-visual rental fees	500

TOTAL \$ 6,600

E. VEHICULE UNIT COST

1. 4X4 WD Pick-ups Dbl/Cabine	23,000
Spare Parts	4,600
Maintenance	2,450

TOTAL \$30,050

2. 4x4 WD Jeep Type	24,000
Spare Parts	6,000
Maintenance	3,360

TOTAL \$33,360

F. COMPUTER EQUIPMENT UNIT COST

1 Mono screen	-
1 Processor	-
1 Printer Adaptor	-
Serial and Parallel	-
1 keyboard	-
Software	-
WP 5.0	-
Lotus	-
DBase	3,619
Maintenance Contract and spare (12 months period)	568
Uninterrupted Power Supply 600W	4,000
TOTAL	\$8,187

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G. RESIDENTIAL APPLIANCES/FURNISHINGS AND OFFICE EQUIPMENT UNIT COSTS

1. Refrigerator	839
Spares parts	200
Packing and Shipping	250
TOTAL	<u>\$ 1,289</u>
2. Freezer	650
Spares parts	163
Packing and Shipping	250
TOTAL	<u>\$ 1,063</u>
3. Stove	652
Spares parts	163
Packing and Shipping	250
TOTAL	<u>\$ 1,065</u>
4. Washer	430
Spare Parts	108
Packing and Shipping	280
TOTAL	<u>\$ 818</u>
5. Dryer	360
Spare Parts	90
Packing and Shipment	250
TOTAL	<u>\$ 700</u>
6. Household Furnishings and Office Equipment:	
a. Living room	\$ 4,800
b. Dining room	3,900
c. Bedroom - Queen	3,950
d. Bedroom - single	3,300
e. Bedroom - Single	3,300
f. Packing and Shipping (one set)	17,950
g. Desk	950
h. File Cabinet	750
i. Chair	360
j. Calculator	190
k. Photocopying machine	8,850
l. Typewriter	1,900
m. Fax Equipment	2,000

ATTACHMENT K - ONAPO IN-COUNTRY TRAINING PLAN

1. TRAINING OF FAMILY PLANNING EXTENSION AGENTS

Objective: To improve the capacity of Rwandan family planning auxiliaries to teach, counsel in, and include family planning related information in their daily activities.

Specific Objectives: At the end of the training, up to 600 auxiliaries will be able to:

1. Explain to the population the advantages of birth spacing on maternal and child health, on the family, community and country well-being.
2. Describe the implications of the Rwanda demographic policy.
3. Explain all family planning methods.
4. Master the communication skills necessary to train and inform the population about family planning.
5. Counsel and orient couples in the choice and practice of birth spacing methods.
6. Give F.P. services in the area of Maternal and Child Health.

Duration: 13 days

2. CLINICAL TRAINING IN FAMILY PLANNING

Objective: To improve the capacity of Rwandan family planning service providers to provide a wide variety of quality services to their clientele.

Specific Objectives: At the end of the training, up to 370 family planning service providers will be able to:

1. Give quality family planning services following the standards and directives established.
2. Survey couples and individuals using contraceptive methods.
3. Manage contraceptive products and medical equipment used in the medical and social unit.

Duration: 14 days

3. TRAINING OF TRAINERS

Objective: To improve the capacity of ONAPO trainers to plan, organize and lead family planning related training sessions.

Specific Objectives: At the end of the training, up to 75 trainers will be able to:

1. Plan, execute, manage, and assess training programs.
2. Use participatory methods adapted to adult training.
3. Apply the group animation techniques in training.
4. Participate to the management of training programs of their departments.

Duration: 42 days

4. TEACHER TRAINING

Objective: To improve the capacity of Rwandan primary and secondary school teachers to teach the fundamentals of family planning and demography to their students.

Specific Objectives: At the end of the training, up to 600 teachers will be able to integrate family planning lessons into their regular curricula by:

- Explaining to pupils the objectives of the Rwanda demographic policy.
- Clearly defining contraception and family planning.
- Explaining to pupils the advantages of family planning on family health and country development.
- Motivating and training pupils to their futures responsibilities as parents and citizens.

Duration: 7 days

5. METHODS OF OPERATIONS RESEARCH

General Objective: To improve the capacity of GOR personnel to carry out operations research on family planning service delivery.

Specific Objectives: At the end of the training, up to 30 GOR personnel will be able to:

- Define and prioritize problems in service delivery;
- Design an operations research study responding to these problems;
- Use operations research methods to conduct such a study;
- Analyze the resulting data; and
- Prepare a budget and calendar of activities for an operations research study.

Duration: 12 days X 2 sessions

ATTACHMENT L

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

Project Country: Rwanda
Project Title: Family Planning II PID
Funding: FY (s) 1988 \$ 9.0 million
EE Prepared by: AFR/PD/EAP, Carlton Terry *CT*
Environmental Action Recommended:

Positive Determination _____
Negative Determination _____

Categorical Exclusion:

A categorical exclusion is recommended on the basis that this project is a program involving nutrition, health care or population and family planning services, under section 216.2(c)2(viii) of A.I.D.'s Environmental Procedures (Regulation 16). The project does not anticipate any activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc).

concurrence: *B. Boyd*
 Bureau Environment Officer
 Bessie L. Boyd, AFR/ER/AED

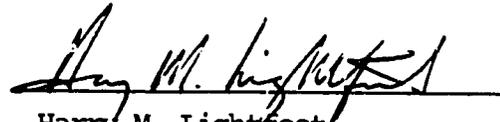
APPROVED X
DISAPPROVED _____
DATE 1-7-88

clearance: GC/AFR *DW Luten* Date 1/15/88
 GC/AFR, Drew Luten

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USAID/RWANDA CONTROLLER CONCURRENCE

I have reviewed the proposed methods of implementation and financing for this project, and find them to be appropriate. Where necessary, adequate provisions have been made for detailed assessments of financial management capabilities. I therefore recommend that you approve this proposed project paper.


Harry M. Lightfoot
Mission Controller
USAID/Rwanda